PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D29

PROVIDER –
UPHS 99 Medicare + Choice Beneficiaries Group and UPHS 00 Medicare + Choice Beneficiaries Group

Provider Nos: See Attached Schedules

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF HEARING –
May 15, 2007

Cost Reporting Periods Ended -
June 30, 1999 and June 30, 2000

CASE NOs: 05-0133G and 05-0243G

INDEX

ISSUE:

Was the Provider's reimbursement for indirect medical education (IME) and direct graduate medical education (DGME) for Medicare managed care patients properly disallowed for fiscal year 1999 and fiscal year 2000 for failure to file UB92s in accordance with CMS instruction.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Section 1886(h) of the Social Security Act (Act) prescribes the Medicare payment method for direct GME costs. 42 U.S.C. §1395ww(h). In brief, the direct GME payment is the product of a hospital's average per resident amount, derived and updated from a 1984 base period, times the hospital's number of interns and residents in approved GME programs during the payment year, times the hospital's Medicare patient load.

The Act at section 1886(d)(5)(B) provides that teaching hospitals that have residents in approved GME programs receive an additional payment for each Medicare discharge to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals. Regulations at 42 C.F.R. §412.105 establish how the additional payment is calculated. The additional payment, known as the IME adjustment, is based on the indirect teaching adjustment factor, calculated using the hospital's ratio of full time equivalent (FTE) residents to beds.

Prior to the enactment of the Balanced Budget Act of 1997 (BBA '97), the numerator of the Medicare patient load fraction included only the number of patient days attributable to the Medicare beneficiaries who were entitled to have payment made under the Medicare Part A fee-for-service program. CMS did not include inpatient days attributable to enrollees in Medicare risk plans (i.e., Medicare Health Maintenance Organizations (HMOs) or Competitive Medical Plans (CMPs) with risk sharing contracts under section 1876 of the Act). In 1989, when CMS promulgated the regulations implementing the prospective payment method for GME, the agency determined that these Medicare managed care plan days would not be counted as Medicare days in the Medicare patient load used to calculate Medicare payment for GME.[1]

Section 4624 of BBA '97 amended the DGME statute by adding a new provision in section 1395ww(h)(3)(D) for an additional GME payment with respect to patient days attributable to services furnished to Medicare beneficiaries enrolled in a Medicare + Choice plan or any other Medicare managed care plan with a risk sharing contract under section 1876 of the Act. The regulations implementing this provision were codified at 42 C.F.R. §413.86. Similarly, BBA '97 amended the IME statute by adding a new provision in 42 U.S.C. §1395ww(d)(5)(B). The regulations implementing this provision are set forth in 42 C.F.R. §412.105(g).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Hospital of the University of Pennsylvania, Pennsylvania Hospital and Presbyterian Medical Center (Providers) are Medicare-certified teaching hospitals located in Philadelphia, Pennsylvania. The Providers are related by common ownership and control through the University of Pennsylvania Health System (UPHS). For the cost reporting periods at issue in this appeal, FYE June 30, 1999 for Presbyterian Medical Center and the Hospital of the University of Pennsylvania, and FYE June 30, 2000, for all three providers, Mutual of Omaha (Intermediary) audited each of the cost reports and made final determinations relating to IME and DGME costs with respect to services provided to enrollees of Medicare Managed Care Organizations.

The Providers reported Medicare managed care days on Worksheet E-3, Part IV of the applicable cost reports.[2] Upon audit, the Intermediary proposed to reduce or eliminate the Medicare managed care days claimed by the Providers as the majority of the days were not timely billed and therefore not reported on the PS&R reports.

The Providers appealed the Intermediary's adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 - 405.1841. The Providers are represented by Mark H. Gallant, Esq. of Cozen O'Connor. The Intermediary is represented by Terry Gouger of Mutual of Omaha Insurance Company.[3]

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[1] 54 Fed. Reg. 40286, 40294-95 (Sept. 29, 1989)
[2] See Provider Exhibits P-1, P-3, P-4, P-5 & P-6.
[3] After the FYEs at issue in these cases, Wisconsin Physicians Services assumed responsibility as the Providers' intermediary.

PARTIES' CONTENTIONS:

The Providers argue that the Intermediary improperly adjusted the settlement data used to determine DGME and IME payments with respect to Medicare managed care enrollees in their cost reports. The Providers assert that the Intermediary denied the reimbursement due to the alleged failure by the Providers to submit timely UB-92s for Medicare managed care patients under the Part A filing deadlines of 42 C.F.R. §424.44(a). The Providers claim that they did in fact mail UB-92s to the Intermediary for all the disallowed cases at issue within the timely filing guidelines of 42 C.F.R. §424.44(a). As the Intermediary maintains that it did not receive those claims, the Provider alternatively argues that the timely filing guidelines of 42 C.F.R. §424.44(a) do not apply to the claims at issue, and no other filing deadline was imposed on these claims in the implementing regulations or instructions.

The Providers argue that in response to the BBA, the UPHS' Director of Patient Accounting issued an internal memorandum on February 9, 1998 to the patient accounting staff, instructing them to submit to the Intermediary "a 'No-Pay' UB-92 with the correct condition codes" for all Medicare managed care cases. See Memorandum, Provider Exhibit P-13. The UPHS staff reportedly began mailing the UB-92s to the Intermediary promptly after receipt of the memorandum. The Providers assert that due to internal system limitations, they were unable to send the bills electronically; therefore all of these claims were prepared manually and mailed to the Intermediary's post office box in Omaha, Nebraska. The Providers assert that they were instructed by the Intermediary to only use first class mail because the use of certified mail or other courier services, which provided proof of mailing, could result in claims being lost.[4] The Providers claim that they had no reason to suspect that the claims were not being received or processed by the Intermediary. The Providers claim that they had conversations with Intermediary's staff regarding the claims; therefore, they must have been received by the Intermediary. The Providers argue that the Intermediary has failed to rebut the sworn testimony or documentary evidence presented by the Providers regarding the submission of the claims beginning in 1998.

The Providers contend that in 1999, they learned that the submitted managed care claims were not being included in the Provider Statistical and Reimbursement (PS&R) Reports because the days reported on the PS&R looked to significantly under-represent the Medicare managed cared days the Providers had furnished to those beneficiaries. Once the Providers identified the problem, the Providers claim they undertook a massive manual resubmission of the UB-92s. Then in 2001, after receiving new PS&Rs which had been delayed by six months or more due to Intermediary system issues, the Providers claim that they noted again that the PS&Rs "showed a disparately low volume" of data for Medicare managed care claims, and therefore initiated a massive electronic billing of all Medicare managed care days for FYE 2000. The Intermediary acknowledged that it received the electronically billed claims, but would not accept the claims for the first quarter of FYE 6/30/2000 or earlier, based on the position that the claims were not timely filed, as required by 42 C.F.R. §424.44(a).

[4] Tr. 157-59, 192-94, 251-52.

The Intermediary argues that they have no record of receiving the manual submissions of claims, neither from the billings beginning in 1998, or the resubmission in 1999 and argues that the Providers have no physical evidence that the claims were submitted timely. The Intermediary acknowledges that providers are requested to submit claims via regular mail, but asserts that providers are not required to do so, and the Providers could have sent the claims certified mail with a tracking mechanism. The Intermediary asserts that it properly denied the claims which were received electronically in 2001, which did not meet the timely filing guidelines of 42 C.F.R. §424.44(a). The Intermediary also points out that the Providers had ample opportunity to review the PS&R received during 1999 and 2000 to ascertain that the UB-92s were not being processed, but they did not do so within a timeframe in which they could have resubmitted the UB-92s timely.

The Providers also argue that even if a timely filing rule exists (and it will argue below that one does not), the Providers should not be prejudiced by the Intermediary's failure to process the claims that were submitted. The Providers argue that the Intermediary had the authority to extend the alleged claims filing deadline under the facts and circumstances and abused its discretion by failing to do so. 42 C.F.R. §424.44(b), authorizes the Intermediary to extend the claims filing deadlines under subsection (a) where a failure to timely file a claim is "caused by error" of the intermediary or the program. The Providers assert that "an administrative error" may include a "misrepresentation, delay, mistake or other action," and that the actions of the Intermediary in losing the submitted claims on two occasions would fall under this definition and, therefore, an extension could have been granted.

The Providers contend that although the days and DRG payments related to Medicare managed care enrollees were not captured in the PS&Rs, the Providers reported those items on the as-filed cost reports.[5] The data reported on the as-filed cost reports was derived from internal patient records which the Providers used to identify all patients over 65 in HMO plans. The data was initially accepted as filed for the Hospital of the University of Pennsylvania for both fiscal years, but those cost reports were subsequently reopened and adjusted when the Intermediary identified the same issue in another Provider.[6] Upon notice from the Intermediary that the data would not be accepted, the Providers worked with the Intermediary to refine the data and ensure its accuracy for inclusion on the cost reports. The Providers were then notified in a letter dated March 23, 2004 that regardless of the accuracy of the data, the Intermediary was precluded by PM A-98-21 from allowing a manual adjustment on the cost report to claim reimbursement for GME/IME supplemental payments for Medicare managed care enrollees because the UB-92s were not timely billed to the Intermediary.[7]

The Providers argue that although they made every attempt to submit these claims to the Intermediary subject to the timeliness standards, the controlling laws impose no timely filing requirement on the submission of IME and DGME claims associated with Medicare managed care enrollees. The Intermediary held the Providers to the timeliness

[5] See Exhibits P-1, P-3, P-4, P-5 and P-6 for the audit adjustments.
[6] Providers' Position Final Paper, page 15-16.
[7] See Exhibit P-32.

standards at 42 C.F.R. §424.44, yet neither the controlling laws or PM A-98-21,[8] the Program Memorandum issued by CMS to Intermediaries, reference the timely filing regulation at 42 C.F.R. §424.44. In addition, by its own terms, 42 C.F.R. §424.44 does not apply to claims relating to services for Medicare managed care patients as 42 C.F.R. §424.30, the regulation governing the scope of 42 C.F.R. §424, subpart C (which includes the timely filing regulations) states:

> This subpart sets forth the requirements, procedures, and time limits for claiming Medicare payments. Claims must be filed in all cases except when services are furnished on a prepaid capitation basis by health maintenance organization (HMO), a competitive medical plan (CMP), or a health care prepayment plan (HCPP). . .

Therefore, even if PM A-98-21 was implicitly intended to impose such filing deadlines applicable to PPS claims, those requirements would not be legally binding as the regulations specifically exclude services furnished on a prepaid capitation basis, i.e. managed care (HMO) claims.

The Intermediary contends that Provider is incorrectly interpreting 42 C.F.R. §424.30 to justify its late filing of UB-92s. The Intermediary asserts that while the general services to Medicare managed care enrollees are subject to the prepaid capitation exemption for filing a claim, the teaching portion is not. The Provider is claiming "Medicare payment" for the teaching portion and 42 C.F.R. §424.30 provides that the time limits apply when claiming Medicare payments. The Intermediary asserts that the payment mechanism for the IME/DGME services for Medicare managed care enrollees was a new payment methodology (not the capitated payment methodology included in exclusion) which would be held to the timely filing requirements.

The Intermediary relies on PM A-98-21, issued on July 1, 1998 to address the BBA provision. The PM instructed intermediaries as follows:

> This Program Memorandum outlines intermediary and standard system changes needed to process requests for IME and DGME supplemental payments for Medicare managed care enrollees. Section 4622 and 4624 of the Balanced Budget Act of 1997 state that hospitals may now request a supplemental payment for operating IME for Medicare managed care enrollees. . . .

The PM goes on to say:

> PPS hospitals must submit a claim to the hospitals' regular intermediary in UB-92 format, with condition codes 04 and 69 present on record type 41, fields 4-13, (form locator 24-

[8] See Exhibit P-12.

> 30). Condition code 69 is a new code recently approved by the National Uniform Billing Committee to indicate that the claim is being submitted for operating IME payment only.

The Intermediary argues that the text of the instruction is clear that the supplemental payment for IME and DGME costs is no longer part of a capitation payment, and that a provider must bill in order to obtain the payment. Thus, the Intermediary argues that it would be unreasonable, arbitrary and capricious not to apply the same timeliness standard to claims for IME/DGME payments for managed care enrollees as issued for all other Medicare claims. The Intermediary contends that although the claims timeliness regulations were not specifically referenced in PM A-98-21, there is certainly enough information to indicate that these regulations apply and there is direct evidence that the payment was intended to be made based on submitted claims, and not on the final settlement of the cost report. The Intermediary further argues that the Providers' claims had to be timely submitted to the Intermediary as required by the timely filing standards.

Finally, the Provider argues that it cannot be penalized for having failed to meet a requirement to submit claims directly to the Intermediary in order for it to obtain the IME and DGME payments, as no such requirement was ever approved by the Office of Management and Budget (OMB). The Provider asserts that the Federal Paperwork Reduction Act would preclude CMS from applying such a requirement to deny the Provider the benefit of the DGME and IME payments at issue without obtaining OMB approval for the data collection. See, 44 U.S.C. § 3512(a). The Intermediary responds that the Board may only affirm, reverse, modify or remand an intermediary determination, and therefore is without the authority to rule on whether the Paperwork Reduction Act was violated.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence and the parties' contentions, the Board finds and concludes as follows:

The Balanced Budget Act of 1997 (BBA '97) provided for IME and DGME payments for services provided under risk HMO contracts that, prior to the BBA, had not been available. The Secretary was given broad authority to provide for or devise a way to pay hospitals supplemental payments for DGME and IME. 42 U.S.C. §1395ww(h)(3)(D) entitled "Payment for managed care enrollees" states:

> (i) In general. For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1395mm of this title and who are entitled to part A of this subchapter or with a Medicare + Choice organization under part C of this subchapter.

42 U.S.C. §1395ww(d)(11) entitled **"**Additional payments for managed care enrollees" states:

> (A) In general. For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) of this section hospital that has an approved medical residency training program.

The question before the Board is what conditions precedent must be satisfied to entitle a hospital to payment for the additional benefit. The evidence in this case was conflicting, in that the Providers argued that they submitted manual claims in calendar years 1999 and 2000, and the Intermediary asserts that they never received them. The Board finds the Providers' evidence that it filed claims credible, but there is no evidence that the claims were proper for processing. However, the Board majority finds that whether the Providers filed the claims for processing prior to the timely filing deadlines set forth in 42 C.F.R. §424.44 is moot.

The Board majority finds that this dispute is governed by the regulations at 42 C.F.R. §424, subpart C. Prior to the BBA '97, whether a "claim" (described elsewhere as a form UB92) filed for each patient stay was required was governed by 42 C.F.R. §424.30 which states:

> This subpart sets forth the requirements, procedures, and time limits for claiming Medicare payments. Claims must be filed in all cases except when services are furnished on a prepaid capitation basis by [HMOs].

42 C.F.R. §424.32 et. seq. furnishes more detail regarding the "basic requirements" for filing all claims including the requirement that the claim be filed with the hospital's intermediary and within the time limits specified in 42 C.F.R. §424.44.

Therefore, prior to BBA '97, in order to receive payment for the services furnished to Medicare beneficiaries, the hospital filed its claim for payment directly with its Medicare intermediary. But if the beneficiary was a member of a risk HMO which had been prepaid by Medicare, the hospital filed its claim for payment for services furnished with the HMO, not the intermediary. The claims in question, for services furnished to Medicare HMO enrollees and paid for by M+C organizations (MCOs) or other Medicare risk plans, are specifically exempt from the requirements, procedures and time limits under this section. The information that would be needed to process these claims by intermediaries is contingent upon the Medicare HMO plans' payment processing methods which are entirely disparate from the fee-for-service plan.

In addition, prior to the BBA '97, despite the process for filing claims for payment for *services furnished*, hospitals were nevertheless required by the hospital manual to file

'no pay' bills for tracking or utilization purposes only, for example, to set capitated rates. These were referred to as 'no-pay' bills and the data assembled was referred to as 'encounter data.'

> A. No-Payment Situations Where Bills Must be Submitted.-- Situations for which bills are required include the following. If part of the admission will be paid and part not, prepare one bill covering the entire stay. . . .
>
> * * * * *
>
> For services provided to an HMO enrollee for which an HMO has jurisdiction for payment. Since HCFA is instructing you to provide this information, negotiate an agreement with the HMO for submitting to it bills it pays. Include in your agreement with HMOs a clear statement of the data elements required for proper identification of Medicare HMO/CMP enrollees and accurate submission to the intermediary.
>
> Where the HMO does not have jurisdiction, prepare a payment bill.

CMS Program Manuals - Hospital (Pub. 10), Chapter IV - Billing Procedures
411. Submitting Inpatient Bills In No-Payment Situations.

The BBA '97 and the Secretary's implementing regulations clearly shifted the burden for filing encounter data squarely to the risk HMOs.

> In order to carry out this paragraph, the Secretary shall require Medicare + Choice organizations (and eligible organizations with risk-sharing contracts under section 1395mm of this title) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998. The Secretary may not require an organization to submit such data before January 1, 1998.

42 U.S.C. §1395w-23(a)(3)(B).

> *Data collection: Basic rule*. Each M+C organization must submit to CMS (in accordance with CMS instructions) all data necessary to characterize the context and purposes of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner.

42 C.F.R. §422.257(a) (interim final rule published in June 1998).

No changes were made to 42 C.F.R. §424.30 however. Furthermore, neither the regulatory changes implementing the new IME/DGME payment nor any other regulation gave notice that hospitals would now be required to file a separate IME/DGME claim with the intermediary that was virtually identical to the claim filed with the HMO to recover payment for inpatient services. If the regulatory obligation to file a "claim" is to be bifurcated so that a provider has an obligation to file its claim for payment of services to the beneficiary with the HMO and to also file a virtually identical claim to the intermediary, then the Board majority believes that a regulatory notice is required.

When 42 C.F.R. §424.30 governing claims filing was implemented, there was no contemplation of or any need for a "claim for payment" other than the claim to obtain payment for the inpatient *services furnished* to the beneficiary. When the additional payment for IME/DGME was authorized by the BBA' 97, it did not change the nature of the payment for "services furnished." Rather, the IME/DGME payment arises from "services . . . furnished on a . . . capitation basis . . ." for which filing a claim *with the intermediary* is excepted under 42 C.F.R. §424.30.

The Secretary has been given extremely broad authority to implement procedures for payment. However, once the system was established by regulation linking the obligation to file an intermediary claim with the method of payment, CMS' effort to impose a contrary claims filing requirement via guidance in a Program Memorandum is insufficient to deprive a provider of its statutory right to payment. Therefore, the Board majority finds that the Intermediary improperly denied the Providers' submission of IME/DGME claims for Medicare managed care enrollees due to untimely filing, and the Provider should be given the opportunity to support its claim for payment.

We find that the Provider's argument that the Agency's billing requirement must fail because it was not approved by OMB to be insufficiently developed to convince us that OMB approval is required in the particular circumstances of this case. Moreover, a determination whether the OMB approval process is applicable in unnecessary in light of our decision that 42 C.F.R. 424.30 is dispositive.

DECISION AND ORDER:

The Intermediary improperly disallowed DGME and IME reimbursement with respect to discharges of Medicare beneficiaries who were enrolled in the Medicare + Choice or other Medicare risk plans in fiscal years ended June 30, 1999 and June 30, 2000. The Intermediary's adjustments are reversed and the case remanded to the Intermediary to include the days applicable to the Medicare managed care enrollees.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A. (Dissenting)

Yvette C. Hayes
Michael D. Richards, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: June 3, 2008

UPHS Medicare Plus Choice Beneficiary Group

Dissenting Opinion of Elaine Crews Powell

The Board majority found that the Intermediary improperly excluded the subject Medicare managed care days/discharges from the calculation of the Providers' additional IME and GME reimbursement authorized by §§ 4622 and 4624 of the BBA of 1997. I respectfully disagree.

CMS is charged with the responsibility of ensuring proper program payments to providers of service. To accomplish this mandate, CMS employs various vehicles and processes such as the issuance of regulations and manual instructions as well as program memoranda. CMS notified intermediaries and the public regarding the added payments for Medicare managed care enrollees when it formally modified the IME and GME regulations on August 29, 1997. See, 62 Fed. Reg. 45565, 45968-45969. CMS' publication of Transmittal A-98-21 instructed intermediaries to notify their hospitals of the right to request the additional payments and the means by which the payments could be secured.

The additional IME and GME payment for Medicare managed care days/discharges was effective for portions of cost reporting periods beginning on or after January 1, 1998, and Transmittal No. A-98-21 was issued by CMS on July 1, 1998. Therefore, teaching hospitals had adequate time to comply with CMS' instructions regarding the submission of the specially coded UB92 claim forms.

Intermediaries have processes in place to manage the receipt of information and instructions from CMS and to disseminate that information to their affected providers; this Intermediary followed those procedures. Moreover, in this particular instance, the Providers were not only sent the Intermediary's Newsletter (Exhibit I-10) advising of the billing requirement, but were also notified by the American Association of Medical Colleges in November 1999 (Exhibit P-19) of the necessity of billing for the additional reimbursement. The latter notice included the deadlines for filing the required specially coded claims for services rendered in 1998. Finally, I note that Commerce Clearing House published the entire text of the Transmittal in its New Developments section one week after the Transmittal was released by CMS. Clearly, the Providers received adequate notice of their right to claim the additional reimbursement.

Regarding the necessity of filing claims, regulation 42 C.F.R. §424.30 states in relevant part:

> [c]laims must be filed in all cases except when services are furnished on a prepaid capitation basis by a health maintenance organization (HMO), a competitive medical plan (CMP), or a health care prepayment plan (HCCP). (Emphasis added.)

Based on the above regulation, I find that the regulatory exception for filing claims does not apply to the specially coded UB-92s required to receive payment of the additional IME and GME reimbursement because they were claims for additional reimbursement for the hospitals' costs associated with being teaching hospitals and not for services furnished by any of the aforementioned health plans on a prepaid capitation basis. Therefore, I find that the claims at issue were "claims for payment" of the additional teaching costs[9] and that they were, therefore, required to be filed within the time limitations set forth at 42 C.F.R. §424.44.

The data used to calculate IME and GME payments for regular Medicare patients is processed by the claims payment system and captured on the PS&R. It was, therefore, reasonable to include the additional claims data for the Medicare managed care patients in the same claims processing system to ensure proper processing of the claims and accurate payment of the additional reimbursement due.

The record in this case shows that the Providers failed to establish internal processes that ensured that the claims they say were submitted were accurate so that the claims could be processed by the Intermediary's claims processing software. There was no system established for the review of claims that were returned to the Providers (RPT) for correction, no tracking of payment using remittance advices that contained the code "MA" for HMO IME claims, and little if any follow-up when filed claims failed to appear on Report Type 118 on the PS&Rs.

One person directly responsible for filing the specially coded UB-92s at the Hospital of University of Pennsylvania (HUP) testified at the hearing, but there were no witnesses from either of the other two Providers. This witness testified (Tr. 315-316) that she was not sure whether both of the required codes (04 & 69) were added to the claims she submitted or just one of them. Finally, since the Providers failed to maintain a copy of the claims they filed, no documentary evidence was furnished to demonstrate that the UB-92s were actually sent to the Intermediary. The Providers maintain that they had a process in place, that the process was followed, and that the Intermediary lost all of their weekly filings as well as the "massive manual rebilling" that occurred in the summer of 2000. I find it difficult to envision such a scenario. It was not until the Providers' systems were updated in 2001 and they became capable of billing the UB-92s electronically that these types of claims could pass the Intermediary's system edits and be processed and paid as clean claims.

The Providers were responsible for following the processes mandated for claiming all the managed care-related IME and GME reimbursement to which they were entitled, and I find that they simply failed to do so.

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[9] In Saint Anthony's Health Center v. Blue Cross Blue Shield Association/AdminiStar Federal Illinois, PRRB Dec. No. 2006-D22, May 25, 2006, rev'd. CMS Administrator, July 19, 2006, the Board held that the time limitations for filing claims contained in 42 C.F.R. §424.30 did not apply to HMO claims. I distinguish my findings in Saint Anthony's from that in the instant case by the fact that the argument in Saint Anthony's pertained to the submission of HMO "encounter data" as opposed to the submission of specially coded UB-92 billing forms which I find are "claims for payment" and are, therefore, subject to the claim timeliness requirement.

In summary, I find that:

- the issuance of Transmittal A-98-21 was a proper means of implementing the regulation requiring that additional IME and GME payments be made to teaching hospitals for managed care enrollees;
- it was unnecessary for CMS to issue a new regulation with notice and comment period;
- the specially coded UB-92 claims were not exempt from the timely filing deadlines under 42 C.F.R. §424.30;
- the Intermediary's refusal to accept UB-92s claim forms after the filing deadline prescribed by 42 C.F.R. §424.44 was proper; and
- payment of the additional reimbursement cannot be made through the Providers' cost reports

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Elaine Crews Powell, CPA