PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D35

PROVIDER –
Riverside Methodist Hospital
Columbus, Ohio

Provider No.: 36-0006

vs.

MEDICARE CONTRACTOR –
CGS Administrators, LLC

HEARING DATE –
April 6, 2016

Cost Reporting Period Ended –
December 31, 2015

CASE NO.: 15-3416

INDEX

ISSUE

Whether the determination that the Riverside Methodist Hospital ("Riverside" or "Provider") failed to meet the validation requirements for the Calendar Year ("CY") 2015 Hospital Outpatient Quality Reporting ("HOQR") Program was proper.[1]

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Provider Reimbursement Review Board ("PRRB" or "Board") majority concludes that Riverside Methodist Hospital has met the validation requirements for calendar year 2015 and is entitled to the full market basket update.

INTRODUCTION

Riverside Methodist Hospital is located in Columbus, Ohio. On December 18, 2014, the Centers for Medicare and Medicaid Services ("CMS") determined that Riverside failed to meet the HOQR validation requirements of CY 2015 and was subject to a 2 percent reduction in the Provider's CY 2015 market basket update.[2] Riverside filed a reconsideration request on January 29, 2015. On May 1, 2015, CMS upheld its decision that Riverside failed to meet the HOQR validation requirements and was subject to a payment reduction to its CY 2015 market basket update.

The Provider timely appealed the reconsideration denial to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1840. The PRRB held a live hearing on April 6, 2016. James F. Flynn, Esq., of Bricker & Eckler LLP represented Riverside. Joe Bauers, Esq., of Federal Specialized Services represented the Medicare Contractor, CGS Administrators, LLC.

STATEMENT OF FACTS

Medicare pays hospitals for outpatient services under the Outpatient Prospective Payment System ("OPPS").[3] CMS provides financial incentives to hospitals that report quality data for multiple settings of care if hospitals comply with reporting requirements "in a form and manner, and at a time, specified by the Secretary…."[4] For hospitals' outpatient care, quality data is reported through the HOQR Program.

The HOQR Program requirements are communicated to hospitals through multiple sources including Federal Registers, regulations and the QualityNet website.[5] One of the requirements of submitting outpatient quality data is compliance with "validation" requirements.

---

[1] Transcript ("TR") at 5-6.
[2] *See* Provider's Final Position Paper at P-5.
[3] 42 U.S.C. § 1395*l*(t).
[4] 42 U.S.C. § 1395*l*(t)(17)(B).
[5] QualityNet was also known as QualityNet Exchange or QNet Exchange. *See* http://www.qualitynet.org.

In a November 24, 2010 Final Rule, CMS required 800 randomly selected HOQR-participating hospitals to submit medical documentation for up to 48 self-reported cases from the total number of cases that the hospital had successfully submitted to the OPPS Clinical Data Abstraction Center ("CDAC").[6] The hospital had 45 days to submit paper copies of medical documentation for selected cases to the Medicare Contractor. Upon receipt of the requested documentation, CDAC independently re-abstracts the same quality measure data elements that the hospital previously abstracted to determine whether the two sets of data match. If the hospital achieved a validation score of at least 75 percent, CMS would pay the hospital the full annual payment update. If it failed validation, the hospital would receive a 2 percent reduction to their outpatient department fee schedule increase factor for the applicable payment year.[7]

Finally, the regulations at 42 C.F.R. § 419.46(f) allow a provider that fails the HOQR validation requirements to request that CMS reconsider its decision. A provider dissatisfied with the result of CMS' reconsideration decision may file an appeal with the Board under 42 C.F.R. part 405, subpart R.[8]

In the present case, Edaptive, a CMS contractor tasked with extracting clinical data from the Provider's medical records,[9] requested that Riverside produce medical records for 12 patients from each of four calendar quarters.[10] Edaptive made this request using two different form letters—the first requesting clinical data for the second quarter ("Q2") (April-June) of 2013 and the first quarter ("Q1") (January-March) of 2014, and the second requesting clinical data for the third quarter ("Q3") (July-September) and fourth quarter ("Q4") (October-December) of calendar year 2013.[11]

As a result of the format and language differences between these two forms, Riverside submitted different information, excluding the anesthesia record, perioperative record and electrophysiology log which validated antibiotic administration for 2013 Q2 and 2014 Q1, but submitted complete medical records for 2013 Q3 and Q4.[12] Specifically, although the first form indicated that the Provider should submit the "ENTIRE OUTPATIENT RECORD," it also included a specific list of items that "may be of importance to our abstraction of this record."[13] The second form stated "Please submit a complete copy of the outpatient medical record related to the listed encounter dates."[14]

---

[6] 75 Fed. Reg. 71800, 72103-05 (Nov. 24, 2010).
[7] 78 Fed. Reg. 74826, 75108 (Dec. 10, 2013). A copy of the pertinent parts of the preamble may be found at the Medicare Contractor's Final Position Paper, Exhibit I-1. *See also* 42 U.S.C. § 1395*l*(t)(17)(A). By 2012, CMS amended its regulation to reduce the number of hospitals whose quality data was subject to a validation audit to 400. *See* 77 Fed. Reg. 53258, 53551-52 (Aug. 31, 2012).
[8] 42 C.F.R. § 419.46(f)(3). *See also* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835 (2008).
[9] Medicare Contractor's Final Position Paper, Exhibit I-4.
[10] Provider's Final Position Paper, Exhibit P-4.
[11] Provider's Final Position Paper at 3. *See* Provider's Final Position Paper, Exhibits P-2 and P-3.
[12] *Id.* and Provider's Final Position Paper, Exhibit P-6 at 2.
[13] Provider's Final Position Paper, Exhibit P-2.
[14] *Id.* at Exhibit P-3.

Riverside met the validation requirements for 2013 Q3 and Q4, but missed the validation requirements for the two other quarters (2013 Q2 and 2014 Q1), representing an average validation score of 73 percent for the four quarters.

At reconsideration, Riverside realized the interpretation error and submitted the complete medical records for the two quarters and requested that CMS reverse the 2 percent penalty on reconsideration because it satisfied all validation requirements.

The Medicare Contractor asserts that all instructions and reporting requirements of the HOQR Program are communicated through, and readily available in, the Federal Register and that the Provider received instructions to submit the entire outpatient medical record for each of the patients selected for the validation review, but failed to do so. At reconsideration, the Medicare Contractor argues that CMS made the correct determination based on the clinical data as it was submitted to the validation contractor and that it was not at liberty to consider additional data. The Medicare Contractor notes that the Federal Register states:

> If a hospital requests reconsideration on the basis that it disagrees with a determination that one or more of the complete medical records it submitted during the quarterly validation process was classified as an invalid record selection … [and] we conclude that the hospital did not submit correct and *complete* medical record documentation, we do not further consider the hospital's request.[15]

The Medicare Contractor maintains that if the Provider failed to submit all documents at reconsideration, the Board should reject consideration of this documentation at its hearing and conclude that the Provider failed to meet HOQR requirements.

Riverside argues that there is no statutory authority for an imposition of the 2 percent penalty for failure to achieve a 75 percent score in the validation audit.[16] CMS' authority to impose a 2 percent penalty for failure to submit quality data under the statute did not extend to imposition of the penalty by regulation[17] to validation audit requirements. The Provider argues that insofar as any medical record information was not initially submitted to the CDAC, any corresponding latent defect in data completeness was fully cured by the submission of further and complete medical record data with the Provider's reconsideration request.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Provider's participation in the HOQR Program is set forth at 42 U.S.C. § 1395*l*(t)(17). The HOQR requires that providers submit quality data reporting elements on a *quarterly* basis. There is no dispute between the parties that the required quarterly submissions were made on a timely basis. The dispute at hand pertains to the associated validation audit of a selected sample of the quarterly data performed subsequent to the quarterly submissions and used to validate the accuracy of the quarterly submissions.

---

[15] *See* 78 Fed. Reg. at 75119 (emphasis added). *See* Medicare Contractor's Final Position Paper, Exhibit I-1 at 30. .
[16] 42 U.S.C. § 1395*l*(t)(17).
[17] 42 C.F.R. § 419.46.

Federal regulation requires that CMS or its contractor identify "[t] he specific sample that a hospital must submit … in the written request. A hospital must submit the supporting medical record documentation to CMS or its contractor within 45 days."[18] In this case, Edaptive, the Medicare contractor conducting the validation, sent a notice to the Provider that it submit, on the one hand, the entire medical record, and on the other hand, suggested *specific* items that "may be of importance to our abstraction." The hospital staff responded by including only the list of specific items as indicated by the "check marks" and, in doing so, excluded other items which were included in the outpatient record and necessary for correct validation of the data submission for two of the calendar quarters.[19]

At reconsideration, the Provider submitted the required written justification for each appealed data element classified as a mismatch during the validation process. In addition, the Provider submitted additional medical records demonstrating that it met the validation criteria related to both antibiotic timing and antibiotic selection and to the Emergency Department departure time.[20] CMS denied reconsideration without factual findings, so it is unclear on what basis CMS upheld the validation audit findings.

At the hearing, Riverside submitted additional medical records which demonstrate that the Provider met the validation criteria related to both antibiotic timing and antibiotic selection and to the Emergency Department departure time. The Provider was able to fully rebut Edaptive's audit findings.[21] In Riverside's post-hearing brief, the Provider included a summary of Edaptive's findings during the validation audit and the Provider's evidence refuting Edaptive's findings.[22]

The Board majority finds that the form and manner by which Edaptive requested the medical documentation was confusing and primarily contributed to the Provider's failure to submit all of the required information. Had Edaptive asked for the entire medical record as it did in 2013 Q3 and Q4, the confusion over what was requested would have been averted. As was demonstrated for Q3 and Q4, the Provider fully complied with the validation data submission request when it received a clear, and non-suggestive, directive to submit the entire medical record.[23] As a result of this confusing and somewhat deceptive notice, the Board majority will consider the additional evidence that the Provider submitted at the hearing and finds that the Provider submitted sufficient evidence to validate the quality data for 2013 Q2 and 2014 Q1.

Authority to Accept Additional Documentation

The Board majority disagrees with the Medicare Contractor's position that the Board can only review the evidence available at the validation audit. The Board majority agrees that during the reconsideration process, CMS is limited to accepting only the documentation submitted during the validation phase.[24] However, even though CMS chooses to limit its reconsideration review

[18] 42 C.F.R. § 419.46(e)(1).
[19] Provider's Final Position Paper, Exhibit P-2.
[20] *Id.* at Exhibit P-7.
[21] *See* Provider's Exhibit P-11.
[22] *See* Provider's Post-Hearing Brief at 10-16.
[23] Provider's Final Position Paper, Exhibit P-3.
[24] 42 C.F.R. §§ 419.46(f)(2)(vi) and (vii).

process, the Board is not so limited. Subsection (3) of the regulation authorizes appeal of the reconsideration decision to the Board, specifically, under part 405, subpart R. Under part 405, subpart R, the Board has independent authority to establish its own rules and procedures, including the authority to issue subpoenas, conduct discovery and accept new evidence that it determines is necessary for its review on appeal.[25]

Finally, the Board's statutory authority under 42 U.S.C. § 1395oo(d) empowers it to consider additional evidence that has not been considered by CMS or its contractors:

> A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary ***and such other evidence as may be obtained or received by the Board***, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) ***even though such matters were not considered by the intermediary in making such final determination***.[26]

See also Loma Linda Univ. Med. Ctr. v. Leavitt, 492 F.3d 1065, 1071 (9th Cir. 2007). ("Thus, § 1395oo(d) squarely allows the Board to modify a final determination based on evidence that was not considered by the [Medicare Contractor], and to make revisions on a cost or expense incurred during the year being reported even though the cost wasn't claimed and the matter wasn't considered by the [Medicare Contractor].")

Based on this statutory and regulatory authority of the Board, the Board majority concludes that the Board can consider the additional medical record documentation that the Provider submitted on appeal. Based on its review, the Board majority concludes that Riverside documented the timing and administration of antibiotics to the patient sample as well as emergency room care. The Board majority concludes that Riverside has met the validation requirements and is entitled to the full market basket update.[27]

---

[25] 42 C.F.R. §§ 405.1840, 405.1853, 405.1868. This role was recognized as early as 1987 by the first circuit in *St. Luke's Hosp. v. Sec'y of Health and Human Servs.*, 810 F.2d 325, 329 (1st Cir. 1987) which stated, "The special features of Board review suggest that its reviewing powers are, if anything, broader, not narrower, that those of the typical reviewing body. For one thing, the Board's authorizing statute contains a special, extra clause specifically stating that it can consider matters not brought to the [Medicare Contractor's] attention. *For another, the Board operates to a degree like an initial factfinder, not simply a reviewing body*…. All this is simply to say that the special circumstances of the reviewing body, as well as general legal principles, support the conclusion that the statute means what it says." (Emphasis added).

[26] (Emphasis added); *see* Provider's Post-Hearing Brief at 2-7.

[27] *Id* at 5.

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board majority concludes that Riverside Methodist Hospital has met the validation requirements for calendar year 2015 and is entitled to the full market basket update.

BOARD MEMBERS PARTICIPATING

L. Sue Andersen, Esq.,
Charlotte F. Benson, CPA (Dissenting)
Gregory Ziegler, CPA

FOR THE BOARD

/s/
L. Sue Andersen, Esq.
Chairperson

DATE: May 2, 2018

Charlotte F. Benson, CPA, dissenting opinion:

I respectfully disagree with the Board majority's determination that the form and manner by which Edaptive[28] requested medical records from Riverside was confusing, somewhat deceptive, and primarily contributed to Riverside's failure to submit all of its required information. Specifically the Board majority stated "[h]ad Edaptive asked for the entire medical record as it did in 2013 Q3 and Q4 the confusion over what was requested would have been averted."

I reviewed the record and find that Edaptive asked for the entire medical record in all four quarterly medical record requests it sent Riverside. Edaptive used two different forms when requesting Riverside's medical records.[29] The request form that resulted in Riverside not submitting complete medical records contained the following language:

> Submit the ENTIRE OUTPATIENT RECORD for each of the cases in the case list. All documentation related to the specified outpatient encounter should be copied. The validation process requires the full supporting medical documentation including information that may not be stored in a single location. The hospital must ensure a full medical record is submitted for accurate validation. The following items may be of importance to our abstraction of this record.[30]

This paragraph was followed by a list that identified 24 different items but did not specifically identify the anesthesia record[31] - a record that Riverside did not include.[32] Riverside states its Medical record custodian interpreted the list as the entire request and therefore did not send the entire medical record to Edaptive.[33] I find this misinterpretation to be an error made by Riverside as the list was not described as being an all-inclusive list, rather it was described as "items that may be important." Further the first line of the paragraph directly preceding the list stated "[s]ubmit the entire outpatient record" underlined and in capital letters. The instruction continued on to say "the validation process requires full supporting medical documentation" and the "hospital must ensure a full medical record is submitted for accurate validation." Unlike the Board majority I do not find this request to be confusing or deceptive.

Further, I point out that the preamble to the quality reporting regulations explained that that full medical records must be submitted. Specifically the November 15, 2012 federal register stated "[t]he validation process requires full supporting medical documentation, including ECG tapes and/or other pieces of a medical record that may not be stored in a single location. The hospital must ensure a full medical record goes to the contractor for accurate validation."[34] Riverside did not follow the instructions in Edaptive's medical records request or in the federal register.

I also respectfully disagree with the Board majority's decision to consider the additional medical record documentation that Riverside submitted on appeal as a means for Riverside to meet the

---

[28] Edaptive was the Clinical Data Abstraction Center ("CDAC").
[29] See Provider Exhibit P-2 at 1 and Provider Exhibit P-3 at 1.
[30] Provider's Exhibit P-2.
[31] *Id.*
[32] Provider's Final Position Paper at 3.
[33] *Id.*
[34] 77 Fed Reg. 68467, 68486 (Nov. 15, 2012).

HOQR Program validation requirements. Although the Board majority correctly points out that 42 U.S.C. §1395oo(d) allows the Board to base its decision on evidence considered by the Medicare Contractor "*and such other evidence as may be obtained or received by the Board,"* in this case I disagree with considering the additional evidence for the following reasons:

First, CMS regulations are clear that "[a] hospital must submit the supporting medical record documentation to CMS or its contractor within 45 days of the date identified on the written request[35] and "[a] hospital meets the validation requirement with respect to a fiscal year if it achieves at least a 75-percent reliability score, *as determined by CMS*."[36] In implementing these regulations, CMS stated in the federal register that "[t]he hospital must ensure a full medical record goes to the contractor for accurate validation"[37] and "*[t]o participate successfully* in the Hospital OQR Program, hospitals must meet administrative, data collection and submission, and *data validation requirements.*"[38] Riverside admits it did not send the required validation information to Edaptive within the 45 day timeframe[39] as required by 42 C.F.R. § 419.46(e)(1). As a result Edaptive determined Riverside's combined validation score was 73%.[40] Although accepting this information (as the Board majority agreed to do) may result in Riverside exceeding the 75% threshold, that does not change the fact that Riverside was *not* compliant with 42 C.F.R. § 419.46(e)(1) as it did not submit its full medical record to the contractor for accurate validation within the 45 day time limit. As Riverside was not compliant with the data validation requirements in 42 C.F.R. § 419.46(e)(1), I conclude that Riverside *did not participate successfully* in the HOQR Program.[41]

Second, CMS regulations require a hospital to include in its reconsideration request "a copy of all material that the hospital submitted to comply with the requirements of the affected Hospital OQR Program payment determination year."[42] The word *copy* denotes only what was submitted to the CMS contractor during the validation process. The federal register supports this interpretation stating "[i]f CMS has evidence that the hospital received both letters requesting medical records, the hospital would be deemed responsible for not returning the requested medical record documentation and the hospital would not be allowed to submit such medical documentation as part of its reconsideration request so that information not utilized in making a payment determination is not included in *any* reconsideration request."[43] In this case, it is clear that the hospital received the medical record request but responded with an incomplete version of its medical record[44] and, therefore, CMS' reconsideration decision was proper. If the Board accepts additional information, the regulations at 42 C.F.R. § 419.46(f)(2)(vii) and 42 C.F.R. § 419.46(e)(1) would become meaningless. As the Board is bound by *all* agency regulations,[45] I decline to take actions that would make the above regulations meaningless.

---

[35] 42 C.F.R. § 419.46(e)(1).
[36] 42 C.F.R. § 419.46(e)(2) (emphasis added).
[37] 77 Fed. Reg. 68467, 68486 (Nov. 15, 2012).
[38] 78 Fed. Reg. 74826, 75108 (Dec. 10, 2013).
[39] Provider's Final Position paper at 3.
[40] *Id.* at 4 and Exhibit P-8 at 5.
[41] See 78 Fed. Reg. 75108 stating "[t]o participate successfully in the Hospital OQR Program, hospitals must meet administrative, data collection and submission, and *data validation requirements.*"
[42] 42 C.F.R. § 419.46(f)(2)(vii).
[43] 77 Fed. Reg. at 68487.
[44] Provider's Final Position paper at 3 and Exhibits P-2 and P-3.
[45] 42 C.F.R. § 405.1867.

Finally, the Board majority points to two court decisions[46] in support of its position that the Board can modify a final determination based on evidence that was not considered by the Medicare contractor. While I agree with the Board majority that the Board *can* consider evidence not brought to the Medicare contractor's attention, I chose not to accept the additional evidence in this case as CMS' regulations clearly establish a firm due date for submission of this evidence.[47] Neither of the court decisions referenced by the Board majority mandate that in all circumstances the Board *must* consider evidence not brought to the Medicare contractor's attention. More importantly these decisions do not address whether the Board can accept additional information when CMS regulations specifically limit the time period for submitting information.[48] As Riverside did not comply with 42 C.F.R. § 419.46(e)(1), I decline to overlook this non-compliance and accept new information as a means for Riverside to meet the HOQR Program validation requirements. If the Board accepts information not submitted in compliance with 42 C.F.R. § 419.46(e)(1), any hospital could simply appeal to the Board to bypass 42 C.F.R. § 419.46(e)(1). It certainly was not CMS' intent to give non-compliant providers a means to bypass the HOQR Program regulations,[49] when it allowed HOQR Program reconsideration decisions to be appealed to the Board.

In conclusion I disagree with the Board majority and find that Riverside did not meet the HOQR Program validation requirements and therefore CMS' decision to reduce Riverside's market basket update for calendar year 2015 was proper.

/s/
Charlotte F. Benson, CPA
Board Member

[46] *St. Luke's Hosp. v. Sec'y of Health and Human Servs.*, 810 F.2d 325, 329 (1st Cir. 1987) and *Loma Linda Univ. Med. Ctr. v. Leavitt*, 492 F.3d 1065, 1071 (9th Cir. 2007).
[47] 42 C.F.R. § 419.46(e)(1).
[48] Unlike the HOQR Program regulations at 42 C.F.R. § 419.46(e)(1) which limit the time period to submit validation information, CMS' cost reporting regulations do not limit the time period to submit data related to a cost report audit.
[49] 42 C.F.R. § 419.46(e)(1).