PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2019-D7

PROVIDER –
North Mississippi Medical Center, Inc. d.b.a. NMMC – Tupelo

RECORD HEARING HELD –
October 27, 2018

Provider No. –
25-T004

Cost Reporting Period Ended –
2017

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

CASE NO. – 17-0820

INDEX

ISSUE STATEMENT

Whether the reduction of the Provider's Annual Payment Update ("APU") by 2 percent for fiscal year ("FY") 2017 was proper.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the 2 percent reduction of North Mississippi Medical Center, Inc. d/b/a NMMC – Tupelo' APU for FY 2017 was proper.

INTRODUCTION

NMMC – Tupelo ("NMMC" or "Provider") is an inpatient rehabilitation ("IRF") unit that is part of North Mississippi Medical Center, a 650-bed regional referral center located in Tupelo, Mississippi. On July 18, 2016, CMS notified NMMC that its FY 2017 APU would be reduced by 2 percentage points because it failed to meet IRF Quality Reporting Program ("QRP") requirements for FY 2017.[1] Specifically, the QRP reporting year tied to FY 2017 was calendar year ("CY") 2015 and CMS alleged that the Provider failed to submit IRF QRP data measures for NQF #1716 (Methicillin-Resistant Staphylococcus (MRSA)) and NQF #1717 (Clostridium Difficile Infection (CDI) Outcome Measure) for the Fourth Quarter of CY 2015 (October 2015 through December 2015).[2] Following the Provider's request for reconsideration, CMS upheld its decision.[3]

NMMC timely appealed CMS' reconsideration decision and met the jurisdictional requirements for a hearing before the Board. At the request of the parties, the Board granted a record hearing on September 12, 2017. James P. Stanzell, the Chief Compliance Officer of NMMC, represented NMMC. Novitas Solutions, Inc. ("Medicare Contractor")[4] was represented by Joe Bauers, Esq., of Federal Specialized Services.

STATEMENT OF THE FACTS

The Medicare program pays IRFs[5] for services under the IRF prospective payment system ("IRF PPS").[6] Under the IRF PPS, the Medicare program pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7] The

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[1] Exhibit P-6.
[2] Stipulations at ¶ 5.
[3] Exhibit P-2.
[4] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.
[5] "Rehabilitation facilities" includes rehabilitation hospitals and rehabilitation units within a hospital. *See* 42 U.S.C. § 1395ww(j)(1)(A).
[6] *See* 42 U.S.C. § 1395ww(j); 42 CFR § 412.600, et al.
[7] *See* 42 C.F.R. § 412.624.

standardized amounts are increased each year by the APU to account for increases in operating costs.[8]

The Patient Protection and Affordable Care Act ("ACA") of 2010[9] amended 42 U.S.C. § 1395ww(j) to establish the IRF QRP, which requires each rehabilitation facility to submit quality of care data "…in a form and manner, and at a time, specified by the Secretary...."[10] For FYs 2014 and beyond, federal law specifies that a rehabilitation facility that fails to report the required quality data under the IRF QRP during the relevant reporting year is assessed a one-time 2 percent reduction to its annual increase factor to the standard federal IRF prospective payment.[11]

The regulation governing IRF QRP data submission is located at 42 C.F.R. § 412.634 (2015) and it states:

> *(b) Submission Requirements and Payment Impact.*
> (1) IRFs must submit to CMS data on measures specified under section 1886(j)(7)(D), 1899B(c)(1), and 1899B(d)(1) of the Act, as applicable. Sections 1886(j)(7)(C) and (j)(7)(F)(iii) of the Act require each IRF to submit data on the specified measures in the form and manner, and at a time, specified by CMS.
>
> (2) As required by section 1886(j)(7)(A)(i) of the Act, any IRF that does not submit data in accordance with section 1886(j)(7)(C) and (F) of the Act for a given fiscal year will have its annual update to the standard Federal rate for discharges for the IRF during the fiscal year reduced by two percentage points.[12]

The IRF QRP requires IRFs to submit various quality measures, including data regarding MRSA and CDI.[13] CMS instructed IRFs to submit MRSA and CDI quality data to the Centers for Disease Control and Prevention ("CDC") through a CDC computer system called the National Healthcare Safety Network ("NHSN").[14] IRF QRP instructions and deadlines[15] for data submission are posted on the CMS "IRF QRP" web site.[16] Since

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[8] *See* 42 U.S.C. § 1395ww(j)(3).
[9] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).
[10] *Id*. at § 3004(b)(2)(7)(C), 124 Stat. at 368. *See also* 42 C.F.R. § 412.634.
[11] *See* 42 U.S.C. § 1395ww(j)(7)(A)(i); 42 C.F.R. § 412.634(b)(1).
[12] *See* 80 Fed. Reg. 47135, 47139 (Aug 6, 2015).
[13] *See* 79 Fed. Reg. 45871, 45911-45914 (Aug. 6, 2014). *See also* https://www.cdc.gov/nhsn/training/patient-safety-component/.
[14] *See* 79 Fed. Reg. at 45912-45913.
[15] *See* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Data-Submission-Deadlines.html
[16] *See* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/

2012, the NHSN website has posted instructions and manuals for using the NHSN system.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

NMMC argues that "the relevant data was entered into the NHSN website;" however, the "NMMC monthly reporting plans for October 2015 and December 2015 did not include the MRSA or CDI measures," and in turn the "data [associated with those measures] was not reported to CMS."[17] NMMC recognizes that completing monthly reporting plans was "required" but states that the monthly reporting plans did not include MRSA or CDI measures for "reasons which are unclear" and was "an isolated error which occurred for unknown reasons."[18]

NMMC argues that it "acted reasonably and in good faith to meet the data reporting deadlines, and had a justifiable excuse for failing to submit the reports."[19] The Provider further argues that the error was a result of a process issue, and "should be deemed justifiable when taken in context with NMMC's otherwise exemplary history of compliance."[20] NMMC argues that the Board should exercise its equitable discretion and find justifiable cause to excuse its non-compliance.

The online *Operational Guidance for Inpatient Rehabilitation Facilities,* available on the CDC website, directed that IRF units within a hospital were required to conduct facility-wide inpatient surveillance of CDI events, meaning that they must report monthly location-specific denominators (total patient days and total admissions from the IRF unit), beginning on January 1, 2015.[21] The guidance stated that monthly reporting plans "must be created or updated in NHSN to include CDI LabID events" and that "CDI LabID event surveillance must be in the monthly reporting plans ('in-plan') in order for data to be shared with CMS."[22] Similar guidance on the monthly reporting plans was provided for CDI and MRSA measures in May 2015 in the *Monthly Checklist for Acute Care Hospital Units Designated as Inpatient Rehabilitation Facilities (IRFs) Reporting to CMS IRF IQR*.[23] Because NMMC's monthly reporting plans for the fourth quarter of CY 2015 did not include MRSA or CDI measures as required, the actual quality data associated with those measures for the fourth quarter of CY 2015 was not transmitted to

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[17] Provider Final Position Paper at 3.
[18] *Id.* at 3-4; Exhibit P-1 at Exhibit D (Aff. of the NMMC Dir. Of Infection Control).
[19] Provider Final Position Paper at 4.
[20] *Id.* at 4-5.
[21] *Available at* https://www.cdc.gov/nhsn/PDFs/irf/IRF-CDI-Op-Guidance.pdf.
[22] *Id.*
[23] *Available at:* https://www.cdc.gov/nhsn/pdfs/cms/IRFs-acute-Monthly-Checklist-CMS-IQR.pdf (stating "When NHSN releases LabID Event data to CMS for those IRF units participating in the CMS Reporting Program, *only those months in which the acute care facility included surveillance* of MRSA bacteremia and *C.difficile* in the IRF units *within its NHSN monthly reporting plan (MRP) will be included.* Each IRF unit should be listed separately on the facility's monthly reporting plan, and should be following both MRSA bacteremia LabID Event and *C.difficile* LabID Event. Note that you must specify the IRF unit on individual rows of the monthly reporting plan, separate from any "FacWideIN" LabID Event surveillance that your hospital may be following. It is the responsibility of each facility to check their MRPs for compliance with this requirement." (Emphasis added)).

CMS, leaving the NMMC out of compliance with the IRF QRP requirements for the fourth quarter of CY 2015.

Although the Board is sympathetic to NMMC's position, the Board's authority is limited to the application of statutory and regulatory requirements to the facts and circumstances of the issues presented and is unable to provide equitable relief. The Ninth Circuit weighed in on this question of equitable relief in *PAMC Ltd. V. Sebelius,* stating:

> [PAMC] claims a right to equitable relief or the benefit of the contract doctrine of substantial performance. In so doing, PAMC appears to have forgotten the aphorism: "Men must turn square corners when they deal with the Government." *Rock Island A. & L. R. Co. v. United States,* 254 U.S. 141, 143 . . . (1920). As we will discuss further, the Department has always insisted that the deadline for submitting data is a square corner, but PAMC now seeks to make it round. It is not entitled to do so.[24]

Similarly, the Board does not have the authority to make the corner "round" by considering factors outside those specifically recognized under the statute and regulations. Rather, the statute, regulations, and relevant final rules mandate application of the 2 percentage point penalty whenever an IRF fails to submit IRF quality data in the form, manner and time as specified by the Secretary.

The Board recognizes that, in the preamble to the FY 2015 IRF PPS Final Rule published on August 6, 2014, CMS stated that, for reconsiderations relevant to FY 2016 and beyond IRF payments, "[w]e may reverse our initial finding of noncompliance if: (1) The IRF provides adequate proof of full compliance with all IRF QRP reporting requirements during the reporting period; or (2) the IRF provides adequate proof of a valid or justifiable excuse for noncompliance if the IRF was not able to comply with the requirements during the reporting period."[25] However, the preamble discussion is unclear whether CMS alone has the authority to consider a "justifiable excuse" and it was not incorporated into the governing regulation at 42 C.F.R. § 412.634. The Board need not resolve this issue as it is clear from the record that NMMC did not have a "justifiable excuse"[26] and simply failed to follow the instructions for including the MRSA and CDI measures on the monthly reporting plans for the fourth quarter of CY 2015 which resulted in the quality data associated with those measures not being transmitted to CMS for those months. Finally, the Board notes that its decision in this case is consistent with

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[24] *PAMC, Ltd. v. Sebelius*, 747 F.3d 1214, 1217 (9th Cir. 2014).
[25] 79 Fed. Reg. 45872, 45919 (Aug. 6, 2014).
[26] The Board notes that NMMC failed to provide not only a "justifiable" excuse, but any excuse at all for its failure to submit the CY 2015 fourth quarter data. In essence, NMMC merely concedes that it failed to submit required data for the MRSA and CDI measures to CMS (timely or otherwise) for this quarter and offers as a justification that it has no explanation for its failure and characterizes it simply as "an isolated error which occurred for unknown reasons" or "reasons that are unclear." Provider Final Position Paper at 3, 4.

its decisions in similar cases where the provider failed to complete the required monthly reporting plan which resulted in certain quality data not being transmitted to CMS.[27]

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the 2 percent reduction of NMMC's APU for FY 2017 was proper.

BOARD MEMBERS:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
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FOR THE BOARD:

12/21/2018

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

[27] *See, e.g., Westchester Gen. Hosp. v. First Coast Serv. Options*, PRRB Dec. No. 2018-D24 (Feb. 12, 2018), *declined review*, CMS Adm'r (Mar. 20, 2018); *Conway Reg. Rehab. Hosp. v. Novitas Solutions, Inc.*, PRRB Dec. No. 2018-D42 (June 28, 2018), *declined review*, CMS Adm'r (Aug. 2, 2018).