CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
UPHS 99 Medicare + Choice Beneficiaries Group and UPHS 00 Medicare + Choice Beneficiaries Group	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: 06/30/1999- 06/30/2000**
Provider	
vs.	
Mutual of Omaha Insurance Company[1]	**Review of: PRRB Dec. No. 2008-D29**
Intermediary	**Dated: June 3, 2008**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in Section 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). Comments were received from the Intermediary requesting reversal of the Board's decision. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were also received from the Center of Medicare Management (CMM) requesting reversal of the Board's decision. Finally, comments were received from the Providers' requesting that the Administrator affirm the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue was whether the Provider's[2] reimbursement for indirect medical education (IME) and direct graduate medical education (DGME) for Medicare managed care patients was

[1] Wisconsin Physicians Service has assumed the responsibility for providers previously serviced by Mutual of Omaha.

[2] The Presbyterian Medical Center (PMC), Hospital of the University of Pennsylvania (HUP), and Pennsylvania Hospital (PH), collectively (Providers) are Medicare-certified teaching hospitals located in Philadelphia, Pennsylvania. The Pennsylvania Hospital (PH) is

properly disallowed by the Intermediary for fiscal year 1999 and fiscal year 2000 for failure to file UB-92s in accordance with CMS instruction.

The Board majority held that the Intermediary improperly disallowed IME and DGME reimbursement with respect to discharges of Medicare beneficiaries who were enrolled in the Medicare + Choice or other Medicare risk plans in fiscal years ending June 30, 1999, and June 30, 2000. The Board remanded the case to the Intermediary to include the days applicable to the Medicare managed care enrollees.

In reaching this determination, the Board majority noted that, prior to the Balance Budget Act of 1997 (BBA 1997)[3], IME and DGME payments for services provided under a risk Medicare Health Maintenance Organization (HMO) contracts were not available. These payments were added by the BBA 1997 for cost reporting periods occurring on, or after January 1, 1998. Specifically, § 1886(d)(11) of the Act mandates that the Secretary provide additional IME payments for each applicable discharge of any subsection (d) hospital that has an approved medical residency training program. Section 1886(h)(3)(D) provides that the Secretary make additional DGME payments for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under § 1876 and who are entitled to Medicare Part A, or with a Medicare + Choice organization under Part C.

The Board majority then examined the conditions which must be met to entitle a hospital to payment for this benefit. The Board majority found that the regulations at 42 C.F.R. § 424.30, *et seq.*, governed this issue. This section requires that claims for payment be filed in all cases, except when furnished on a prepaid capitation basis. The Board majority noted that, prior to the BBA 1997, hospitals filed claims directly with their Medicare intermediaries. However, if the Medicare beneficiary who received services furnished by the hospital was a member of a risk HMO, which had been prepaid by Medicare, the hospital filed its claim with the HMO, not the Intermediary. Thus, the Board majority concluded, the claims at issue in this case were "specifically exempt from the requirements, procedures, and time limits" noted in 42 C.F.R. § 424.30, *et seq.* In addition, the Board majority noted, any information that would be needed by an Intermediary to process such a claim would be contingent upon the Medicare HMO plans' payment processing methods, which is separate from the fee-for-service plan.

The Board majority also noted that, prior to the BBA 1997, hospitals were required to file "no pay" bills for tracking, or utilization purposes, despite the process for filing claims for payment for services furnished. The data from these "no pay" bills was referred to as

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not part of the 6/30/1999 fiscal year ending group appeal. The Providers are related by common ownership and control through the University of Pennsylvania Health System (UPHS).

[3] *See* Pub. L. No. 105-33

"encounter data". The BBA 1997 shifted the burden for filing this encounter data to the risk HMOs. Additionally, the interim final rule published in June 1998 at 42 C.F.R. § 422.257(a) stated that each Medicare + Choice organization must submit to CMS all data necessary to characterize the context and purpose of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner.

The Board majority asserted that, despite these changes, no changes were made to 42 C.F.R. § 424.30, nor to the regulations implementing the new IME or DGME payment. No other regulation gave notice that hospitals would now be required to file separate IME and DGME claims with the intermediary, even though the claim was virtually identical to the one filed with the HMO to recover for inpatient services. The Board majority stated that the IME and DGME payments arise 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 Board majority recognized that the Secretary had been given broad authority to implement procedures for payment. However, the Board found that 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 Program Memorandum (PM A-98-21) was insufficient notice, which deprived a provider of its statutory right to payment.

Finally, the Board majority disagreed with the Providers' argument that CMS' billing requirement must fail because it was not approved by the Office of Management and Budget (OMB). The Board majority found the Providers' argument to be insufficiently developed and, furthermore, unnecessary, in light of the Board majority's determination that 42 C.F.R. § 424.30 is dispositive.

One member of the Board dissented. The dissenting Board member held that CMS notified intermediaries and the public regarding the added payments for Medicare managed care enrollees when it formally modified the IME and DGME regulations on August 29, 1997 (62 Fed. Reg. 45,965). CMS' publication of PM A-98-21 instructed intermediaries to notify their hospitals of the right to request the additional payments and the methodology that was required to secure them. Therefore, the dissenting Board member reasoned that teaching hospitals had adequate time to comply with CMS' instructions regarding the submission of the specially coded UB-92 claims forms. The dissenting Board member also concluded that the claims at issue were not claims for services furnished on a prepaid capitation basis by an HMO. Instead, the clams at issue were "claims for payment" of additional teaching costs. Therefore, the UB-92 claim forms were required to be filed within the time limitations set for at 42 C.F.R. § 424.44.

The dissenting Board member noted that the data used to calculate the IME and DGME payments for regular Medicare patients is processed by the claims payment system and

captured on the Provider Statistical and Reimbursement System (PS&R). The Dissent reasoned that it was 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. Therefore, reimbursement for the additional IME and DGME payment could not be made through the Providers' cost report.

Finally, the dissenting Board member noted the Providers' argument that the Intermediary lost all of their weekly filings, as well as, the "massive manual rebilling" that occurred during the summer of 2000. Looking at the record, the dissenting Board member noted that the record showed that the Providers' failed to establish internal processes that would have ensured that the claims the Providers' maintain 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 Provider Statistical and Reimbursement (PS&R).

SUMMARY OF COMMENTS

The Intermediary commented, requesting that the Administrator review and reverse the Board majority's decision. The Intermediary argued that the Board majority erred in interpreting the regulation at 42 C.F.R. § 424.30 that lists exceptions for filing claims for services furnished on a prepaid capitation basis. The Intermediary argued that IME and DGME additional payments are for costs associated with teaching hospitals, not for furnished services.

In addition, the Intermediary stated that the cost reporting instructions supported CMS' timely claims filing position. The Intermediary stated that the major contributing factor for IME reimbursement for Medicare managed care enrollees is the simulated DRG amount. However, in this case, the simulated DRG amount is unknown since the Providers did not timely file claims for Medicare managed care enrollees with the Intermediary. The Intermediary stated that the DRG amount could only be computed through the claims system, where it is priced with the PRICER program. The Intermediary noted that there are thousands of edits in the PRICER system. Therefore, if the simulated DRG was calculated outside of the cost report, it would not be subject to these edits. Accordingly, as the dissent stated, some information submitted by the Providers was therefore incorrect.

The Intermediary noted that the instructions for filling out the cost report, located at CMS Pub 15-2, § 3630.1, specifically require entering the simulated DRG amount from the PS&R. The PS&R captures the simulated payment from the PPS PRICER program which prices the timely filed and completed claim. The simulated DRG payment is necessary in

order to pay IME costs via each claim. The PS&R cannot capture any information unless a claim has been filed and process. Finally, the Intermediary noted that IME and DGME payments are conditional upon the delivery of properly coded and timely filed UB-92's.

CMM commented, requesting that the Administrator review and reverse the Board majority's decision. CMM disagreed with the Board majority's determination that "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 HMO to recover payment for inpatient services."

CMM stated that the preamble to the final rule, released on May 12, 1998, provided explicit notice to hospitals that they would be expected to submit Medicare managed care claims to their Intermediaries for IME and DGME payment purposes under Part A, in addition to the bills submitted to managed care plans for payment, under Part C. Furthermore, CMM noted that the issuance of PM A-98-21, in July 1998, explained that hospitals needed to submit Medicare managed care claims to their Intermediary in UB-92 format in order for the standard system to process the claims so that hospitals could be paid the supplemental IME and DGME payments for Medicare managed care enrollees. CMM stated that CMS has historically relied on the issuance of Program Memoranda to implement payment procedures and processes on a sub-regulatory basis subject to the applicable IME and DGME statutes and regulations. Accordingly, CMM agreed with the Board's dissenting opinion supporting CMS' discretion to use the PM as an implementation tool to require the submission of UB-92 claims in order to accurately pay hospitals supplemental IME and DGME for Medicare managed care enrollees.

Next, CMM discussed whether UB-92 claims should be exempt from the timely filing deadlines under 42 C.F.R. § 424.44. CMM noted that the Administrator's decision in *Santa Barbara Cottage Hospital* (PRRB Decision No. 2007-D78) provided an in-depth analysis regarding the timely filing deadlines under 42 C.F.R. § 424.44 and whether UB-92 claims should be exempt. In that case, the Administrator distinguished between claims for services "furnished on a prepaid capitation basis by a health maintenance organization…" (that is, claims associated with Part C), which are exempt from the timely requirements, and claims for payments (the supplemental IME and DGME payments for Medicare managed care enrollees under Part A), which are subject to the timely requirements specified in the regulations. Therefore, CMM stated, the Provider must submit timely UB-92 claims to the Intermediary based on services provided to Medicare managed care patients in order to receive supplemental IME and DGME payments for Medicare managed care enrollees.

The Provider commented requesting that the Administrator affirm the Board majority's decision. The Providers argued that the timely filing regulation at 42 C.F.R. § 424.44 do not apply to claims for MCO IME/DGME payments since the regulation at 42 C.F.R. § 424.30

states that claims must be filed in all cases except when services are furnished on a prepaid capitation. The Providers contend that a preclusive filing deadline for data for IME and DGME is not set forth in the regulations and can not be established by PM A-98-21.

The Providers argued that PM A-98-21 is invalid since the Paperwork Reduction Act requires that a government agency cannot require the same document twice without prior authorization from the Office of Management and Budget (OMB). By requiring the UB-92 HMO claims forms to be filed with the HMO and the Intermediary and requiring the HMO to file with one of six designated intermediaries for encounter purposes this results in duplication.

However, should the Administrator decide to reject the Providers' contention that 42 C.F.R. § 424.44 does not apply to IME and DGME for Medicare MCO days as a matter of law, the Providers contended that the Board majority's decision should be upheld based on the preponderance of evidence introduced at the hearing that the UB-92s at issue in this case were mailed to (and presumptively received by) the Providers' Intermediary within the time frame prescribed by 42 C.F.R. § 424.44. The Providers contend that the UB-92 claims forms were lost by the Intermediary. Alternatively, this matter should be remanded to the Board pursuant to 42 C.F.R. § 405.1875, should the Administrator decide not to affirm the Board majority's determination.[4]

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. Comments timely submitted have been included in the record and have been considered.

Until 1983, Medicare paid for covered hospital inpatient services on the basis of "reasonable cost." Section 1861(v)(1)(A) of the Act defines "reasonable cost" as "the cost actually incurred," less any costs "unnecessary in the efficient delivery of needed health services." While § 1861(v)(1)(A) does not prescribe specific procedures for calculating reasonable cost, it authorizes the Secretary to promulgate regulations setting forth the methods to determine reasonable cost and the items to be included in reimbursable services.

In addition, Medicare historically has paid a share of the net costs of "approved medical education activities" under the reasonable cost provisions.[5] The Secretary's regulations

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[4] The Board majority concluded that the timely filing requirement set for at 42 C.F.R. § 424.44, did not apply since the claims at issue fell within the exception outlined in 42 C.F.R. § 424.30, "[c]laims must be filed in all cases except when services are furnished on a prepaid capitation basis by [HMOs]." PRRB Dec. No. 2008-D29 at 8 (Jun 3, 2008).

[5] 20 CFR §405.421 (1966); 42 CFR §405.421 (1977); 42 CFR §413.85 (1986).

define approved educational activities as formally organized or planned programs of study, usually engaged in by providers to enhance the quality of care in an institution.[6] The activities include approved training programs for physicians, nurses and certain paramedical health professionals. Under the reasonable cost system, the allowable costs of the activities included: the direct costs of salaries and fringe benefits of interns and residents, the salaries attributable to teaching physicians' supervisory time, other teachers' salaries; and indirect or institutional overhead costs, including employee health and welfare benefits, that were appropriately allocated to the proper cost center on a provider's Medicare cost report.[7]

In 1982, Congress modified the Medicare program to provide hospitals with better incentives to render services more efficiently. Pursuant to the Tax Equity and Fiscal Responsibility Act (TEFRA),[8] Congress amended the Act by imposing a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. However, under § 1886(a)(4), GME costs were excluded from the definition of inpatient operating costs for purposes of the TEFRA base year and, thus, were not included in the hospital's TEFRA base year costs for purposes of determining the hospital's target amount.

In 1983, § 1886(d) was added to the statute to establish an inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital services furnished to Medicare beneficiaries.[9] Under IPPS, providers are reimbursed their inpatient operating costs based on prospectively determined national and regional rates for each patient discharge, rather than on the basis of reasonableness. Graduate medical education costs continued to be paid on a reasonable cost "pass-through."

However, applicable for all periods beginning on, or after, July 1, 1985, pursuant to § 1886(h) of the Act,[10] Congress established a new payment policy for DGME costs.[11] Generally, the DGME payment is a combination of a hospital's per resident amount and the hospital's Medicare patient load. The Medicare patient load means with respect to a hospital's cost reporting period, the total number of hospital inpatient days during the cost

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[6] 42 C.F.R. § 413.85(b).

[7] 54 Fed. Reg. 40,286 (Sept. 27, 1989).

[8] Pub. L. No. 97-248.

[9] Section 601(e) of the Social Security Amendments of 1983. Pub. L. No. 98-21 (1983).

[10] Section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

[11] 54 Fed. Reg. 40,297 (September 27, 1989). (Revised payment method applies to all hospitals regardless of status under PPS.) See 50 Fed. Reg. 27,722 (July 1985)(Final rule that hospitals would be reimbursed lesser of allowable costs for current year or hospitals' approved GME costs incurred during 1984 FY; nullified by Section 1861(v)(1)(Q) pursuant to Section 9202 of COBRA 1985). Section 9314 of Omnibus Budget Reconciliation Act of 1986 (Pub. L. No. 99-509) added Section 1886(h)(4)(E).

reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days. To implement the new payment policy, the Secretary promulgated regulations at 42 C.F.R. § 413.86, et seq.

Section 1886(d)(5)(B) of the Act also 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. The 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 FTE residents to bed. Each hospital's indirect medical education payment under the prospective payment system for inpatient operating costs is determined by multiplying the total diagnosis related group (DRG) revenue for inpatient operating costs by the applicable education adjustment factor.

Prior to the enactment of the BBA 1997, for purposes of the DGME payments, 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 (Medicare Health Maintenance Organizations or Competitive Medical Plans with risk sharing contracts under section 1876 of the Act) in the Medicare patient load used to calculate Medicare payment for DGME. However, § 4624 of BBA 1997 amended the Act by adding a new provision for GME payments 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 § 1876 of the Act. Section 1886(h)(3) of the Act states that:

> (D) Payment for Managed Care Enrollees.
> (i) 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 1876 and who are entitled to part A or with a Medicare + Choice under part C. The amount of such a payment shall equal the applicable percentage of the product of –
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> (I) the aggregate approved amount (as defined in subparagraph (B)) for that period; and
> (II) the fraction of the total number of inpatient-bed days (as established by the Secretary) during the period which are attributable to such enrolled individuals.
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> (ii) Applicable Percentage – For purposes of clause (i), the applicable percentage is -
> (I) 20 percent in 1998,
> (II) 40 percent in 1999,

(III) 60 percent in 2000,
(IV) 80 percent in 2001… [Emphasis added.]

Similarly, the BBA 1997 amended the Act by adding a new provision at § 1886(d)(11), addressing the IME payment, which states that:

> (11) Additional Payments for Managed Care Enrollees. –
> (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) hospital that has an approved medical residency training program.
> (B) Applicable Discharge – For purposes of this paragraph, the term "applicable discharge" means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or any individual who is enrolled with a Medicare + Choice organization under part C.
> (C) Determination of Amount. – The amount of payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (5)(B) if the individuals had been enrolled as described n subparagraph (B).[12] [Emphasis added.]

Thus, for discharges on, or after, January 1, 1998, the provisions of the BBA 1997 required the recognition of the Medicare managed care enrollees in the IME and DGME payment.

These statutory changes were promulgated in the regulation for the DGME payment at 42 C.F.R. § 413.86 and since re-codified at 42 C.F.R. § 413.76 (2004). The regulation at 42 C.F.R. § 413.76 states:

> A hospital's Medicare payment for the costs of an approved residency program is calculated as follows:
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> (a) Step one. The hospital's updated per resident amount (as determined under Sec. 413.77) is multiplied by the actual number of FTE residents (as determined under Sec. 413.79). This result is the aggregate approved amount for the cost reporting period.
> (b) Step two. The product derived in step one is multiplied by the hospital's Medicare patient load.

[12] The regulations implementing this provision were codified at 42 CFR §412.105(g).

> (c) Step three. For portions of cost reporting periods occurring on or after January 1, 1998, the product derived in step one is multiplied by the proportion of the hospital's inpatient days attributable to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act and who are entitled to Medicare Part A or with a Medicare + Choice organization under Title XVIII, Part C of the Act. This amount is multiplied by an applicable payment percentage…….[13] [Emphasis added.]

Likewise, for the IME payment, 42 C.F.R. § 412.105(g) was amended to state that:

> (g) *Indirect medical education payment for managed care enrollees*. For portions of cost reporting periods occurring on or after January 1, 1998, a payment is made to a hospital for indirect medical education costs, as determined under paragraph (e) of this section, for discharges associated with individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act or with a Medicare+Choice organization under title XVIII, Part C of the Act during the period, according to the applicable payment percentages described in. Sec. 413.76(c)(1) through (c)(5) of this subchapter. [Emphasis added.]

The regulation at 42 C.F.R. § 412.105(e) explains:

> (1) *Determination of payment amount*. Each hospital's indirect medical education payment under the prospective payment system for inpatient operating costs is determined by multiplying the total DRG revenue for inpatient operating costs, as determined under paragraph (a)(2) of this section, by the applicable education adjustment factor derived in paragraph (d) of this section.[Emphasis added.]

The IME and DGME payment for Medicare managed care enrollees was specifically addressed in the May 12, 1998 *Federal Register*,[14] which promulgated the final rule published August 29, 1997 implementing the BBA 1997 changes.[15] In response to

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[13] The regulation at 42 C.F.R. § 413.75(b) defines the Medicare patient load as: *Medicare patient load* means, with respect to a hospital's cost reporting period, the total number of hospital inpatient days during the cost reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days. In calculating inpatient days, inpatient days in any distinct part of the hospital furnishing a hospital level of care are included and nursery days are excluded. [Emphasis added.]

[14] 63 Fed. Reg. 26,318 (May 12, 1998).

[15] *See* 62 Fed. Reg. 45966, 46003, 46029(Aug 29, 1997)(Final rule with commenting period for provisions resulting from the BBA 1997); 63 Fed. Reg. 26318 (May 12, 1998)(Final rule

comments regarding the claims process to be implemented for the DGME and IME payments, the Secretary stated that:

> Under section 4622 and 4624 of the BBA, teaching hospitals may receive indirect and direct GME payments associated with Medicare + Choice discharges. Since publication of the final rule with comment on August 29, 1997, we have consulted with hospitals, managed care plans, and fiscal intermediaries for purposes of developing a process to implement these provisions.
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> We anticipate teaching hospitals will need to submit claims associated with Medicare + Choice discharges to the fiscal intermediaries for purposes of receiving indirect and direct medical education payments. When the claims are processed, the fiscal intermediaries will make the IME payment associated with a Medicare + Choice discharge directly to the teaching hospital. Teaching hospitals will also be required to submit bills associated with Medicare + Choice organizations to the manage care plans. The inpatient encounter data from these bills will be submitted by the managed care plans to [CMS] for purposes of implementing the risk adjustment methodology. The fiscal intermediary's would revise interim payments to reflect the Medicare direct GME payment associated with Medicare + Choice discharges. However, until the fiscal intermediaries have more experience with paying hospitals for direct GME associated with Medicare + Choice discharges, we believe the fiscal intermediaries will have limited data upon which to base interim payment. We are making adjustments to the Medicare cost report to allow for settlement of the cost report reflective of direct GME payment associated with Medicare + Choice discharges. [Emphasis added]

On July 1, 1998, CMS issued PM A-98-21,[16] setting forth a process consistent with the claims process set forth in the rule. The PM stated that:

> This Program Memorandum outlines intermediary and standard system changes needed to process requests for IME and DGME supplemental payments for Medicare managed care enrollees. Sections 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. During the period January 1, 1998 through December 31, 1998,

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responding to comments received on those portions of the published August 29, 1997 final rule with comment period that revised IPPS to implement changes made as a result of BBA 1997).

[16] *See* Intermediary's Position Paper, Exhibit I-1.

> providers will receive 20 percent of the fee for service DGME and operating IME payment. This amount will increase 20 percent each consecutive year until it reaches 100 percent.

Moreover, PM A-98-21 further explained that:

> PPS hospitals must submit a claim to the hospitals' regular intermediary in UB-92 format, which condition codes 04 and 69 present on record type 41, fields 4-13, (form locator 24-30). 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. [Emphasis added]

The submission of claims to intermediaries for, inter alia, Part A payment, is controlled by the regulation at 42 C.F.R. § 424.30. The regulation explains the scope of claims for payment and 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 a health maintenance organization, (HMO), a competitive medical plan (CMP), or a health care prepayment plan (HCPP).

Therefore, while claims for, inter alia, Part C managed care services are not controlled by this section, a hospital must submit claims in conformity with 42 C.F.R. § 424.30, et seq., to be able to include managed care enrollees for the Part A IME and DGME payments from its intermediary. The timeframe for filing claims is set forth at 42 C.F.R. § 424.44, which states that:

> (a) *Basic limits*. Except as provided in paragraph (b) of this section, the claim must be mailed or delivered to the intermediary or carrier, as appropriate –
> (1) On or before December 31 of the following year for services that were furnished during the first 9 months of a calendar year; and
> (2) On or before December 31 of the second following year for services that were furnished during the last 3 months of the calendar year.
> (b) Extension of filing time because of error or misrepresentation.
> (1) The time for filing a claim will be extended if failure to meet the deadline in paragraph (a) of this section was caused by error or misrepresentation of an employee, intermediary, carrier, or agent of the Department that was performing Medicare functions and acting within the scope of its authority.
> (s) The time will be extended through the last days of the 6th calendar month following the month in which the error or misrepresentation is corrected.

As the PM A-98-21 explained, filing a claim with the intermediary using the UB-92 form is required in order to generate data that may be used for payment. The procedures set forth in the PM A-98-21 are consistent with the Medicare Financial Management Manual,[17] which explains the role of the UB-92 form and claims processing in the settlement process. The claims system makes the required determination on eligibility rules and benefits available for Medicare, in contrast to the cost report settlement process. CMS provides each intermediary a standard "PS&R" to interface with billing form CMS 1450 (UB-92 form). This system provides reports to be used in developing and auditing provider cost reports and related data accumulation operations. The statistical reports produced are the Payment Reconciliation Report; Provider Summary Report and DRG Summary Report. The two primary reports produced by the PS&R system are the Provider Summary Report and Payment Reconciliation Report. The Provider Summary Report contains a summary of Medicare Part A charges, Medicare patient days, deductibles, coinsurance, payments, etc. for each provider for a specified period of time. The Provider Summary Reports are used by providers when preparing their Medicare Cost Reports. The Payment Reconciliation Report provides detailed claim data that supports the Provider Summary Report.

The Providers must use the reports in preparing cost reports and must be able to explain any variances between the PS&R report and the cost report. The intermediary uses information on such items as Medicare patient days (relevant for GME), discharges and DRGs. The statistical reports produced are the Payment Reconciliation Report; Provider Summary Report and DRG Summary Report. Thus, when a provider bills in accordance with the instructions for payment of the DGME and IME for Medicare managed care enrollees, the claims system would compute a simulated DRG payment and charges for patient days and issue a payment, all of which would be summarized on the PS&R. Consequently, if no claim is filed, no IME/DGME payment will be made and no data relating to payments, or days will be generated on the PS&R that can be reconciled with that claimed on the cost report or through alternative data.

The CMS PM-A-98-21 explained that:

> The intermediary will submit the claim to the Common Working File (CWF). CWF will determine if the beneficiary is a managed care enrollee and what their plan number and effective dates are. Upon verification from the CWF that the beneficiary is a managed care enrollee, the intermediary will add the HMO Pay code of 0 to the claim and make an operating IME only payment with the proper annotation of the remittance advice.…
>
> The DGME payments are to be made using the same interim payment calculation you currently employ. Specifically you must calculate the

[17] Pub. 100-6.

> additional DGME payments using the inpatient days attributable to Medicare managed care enrollees. As with DGME payments under fee-for-service, the sum of these interim payment amounts are subject to adjustment upon settlement of the cost report.

Thus, claiming costs on the costs report alone is not sufficient to make a DGME and IME payment for managed care enrollees. If no claim is filed, no IME payment will be made and no data relating to days will be generated on the PS&R that can be reconciled with the claimed cost report amounts.

In this case, the Providers argued that the Intermediary improperly adjusted the settlement data used to determine IME and DGME payments with respect to Medicare + Choice beneficiaries in their respective cost reports. The Providers claimed, and the Board majority agreed, that nothing in the statute required the Providers to submit data directly to the Intermediary and within a specified time. The Providers also claimed that they timely submitted, by mail, the required "no-pay" UB-92 forms in order to receive IME and DGME payments for managed care cases. In 2001, the Providers asserted that they were not credited with all the managed care claims for which the Providers believed they had submitted bills. In 2001, the Providers also electronically submitted the "no-pay" UB-92 forms for fiscal year 2000. The Intermediary denied that it received the manually submitted claims, which the Providers then claimed the Intermediary lost. The Intermediary was able to process the electronically submitted "no-pay" UB-92 forms that met the timely filing requirements (for the periods after the first quarter of FYE 06/30/2000). The Providers contested the Intermediary's decision to not accept all the electronic claims.

The Administrator finds that, the statute did not set forth in detail the process by which a Provider was to receive payment for manage care enrollees. However, the provision for this payment for managed care enrollees is within the framework of a pre-existing methodology for IME and DGME payments. That pre-existing methodology requires that claims be made to the intermediary in order to generate a payment and for the related data to be captured on the PS&R. The provider community was given notice of this procedure through several means. The May 1998 preamble language published in the *Federal Register* set forth that this would be an anticipated requirement. In addition, CMS issued PM A-98-21. Dated July 1, 1998, and explicitly stated that hospitals "must submit a claim to the hospitals' regular intermediary in UB-92 format." The Intermediary in this case also issued a Medicare Part A Bulletin on July 13, 1998,[18] which detailing the filing requirements for payment to hospitals

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[18] Intermediary's Exhibit I-10. *See also* Provider's Exhibit P-18. In the body of the Medicare administrative bulletin where the requirements are described in substantive detail, it is specified that: "Section 4622 and 4624 of the Balanced Budget Act of 1997 state that hospital may request a supplemental payment for operating IME for Medicare managed care enrollees… PPS hospitals must submit a claim to their intermediary in UB-92 format with

for DGME and IME payments for Medicare managed care enrollees.[19] The record further shows that the Providers received notice from the American Association of Medical Colleges in November 1999.[20] This notice specifically indicates that claims for services rendered in 1998 must be filed by December 31, 1999; notably the same timely filing deadline at issue. This Memorandum states:

> This Memorandum is to remind you that December 31, 1999 is the deadline for submitting Medicare + Choice claims to your Fiscal Intermediary for purposes of receiving Direct Graduate Medical Education and Indirect Medical Education payments for the period January to September 1998.
>
> As you know, teaching hospitals are entitled to receive DGME and IME payments for Medicare managed care enrollees effective January 1, 1998. According to Medicare Program Memorandum A-98-22, teaching hospitals must submit these claims in the UB-92 format, modified to include condition codes 04 and 69…
>
> Section 268.1 of the Hospital Manual (attached) states that in order to receive payment, claims must be filed on or before December 31 of the calendar year following the year in which the services were provided
>
> Accordingly, the Medicare + Choice claims for which service were furnished between January – September 1998, the shadow claims must be submitted by December 31, 1999.

The Secretary has the responsibility of ensuring proper program payments to providers of services and utilizes various processes such as the issuance of regulations and manual instructions, as well as program memorandums for that purpose. CMS notified its intermediaries and the public regarding the claims processing instructions for the Medicare managed care enrollees IME and DGME payments.[21] The *Federal Register* preamble

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conditional codes 04 and 69 present on record type 41, fields 4-13 (form locator 24-30)." The Bulleting also stated that: "Teaching hospitals may submit bills for inpatient stays by managed care enrollees for payment of IME. Since hospitals are already submitting bills for payment (for services and IME) for members of cost HMOs, separate bills for IME are only be to be submitted for members of risk HMOs. Currently, hospitals submit (risk) HMO paid bills for these individuals for utilization purposes only."

[19] The need for encounter data for managed care rate setting purposes is separate and distinct from the claims processing required for the IME and DGME payments under §§ 1886(d) and 1886(h).

[20] Provider's Exhibit P-19.

[21] *See* 62 Fed. Reg. 45, 965 (August 29, 1997).

language, the PM A-98-21, and the Bulletin, instructed a hospital to bill its intermediary so that the DGME and IME claims could be processed. The Administrator finds that PM A-98-21 was an appropriate means to implement program payments pursuant to the applicable IME and DGME statutory provisions and regulations. In addition, the standard claim format is reasonably required as a simulated payment must be made and the claims must be reflected in the PS&R, as the PS&R, *inter alia*, is also the necessary mechanism for the intermediaries and providers to reconcile the cost report settlement.

The Administrator finds that requiring a standard claim format and processing, which determines whether the claim meets the threshold requirement for inclusion in the calculations and performs the necessary simulated payment, is a reasonable method of implementing the requirements of the BBA 1997. Because a claim was required to be filed, the regulatory requirement of 42 C.F.R. § 424.30 were controlling. The only exception to the claims processing requirements at 42 C.F.R. § 424.30 is for services furnished on a prepaid capitation basis to the beneficiary by a managed care plan, which is not at issue here. The claims in the instant case were claims that were required to be process under the claims processing system in order for payment to be made for an established reimbursement methodology for hospitals' costs associated with being a teaching hospital and not for the services furnished to a managed care enrollees.

The Administrator also finds that the APA does not require CMS to publish a new regulation under these circumstances. As noted earlier, the Secretary may promulgate interpretive rules, guidance, and procedures.[22] The payment of IME and DGME claims was an already established payment methodology for teaching hospitals that was already linked to the claims processing system and did not require the promulgation through notice and comment of specific instructions. In addition, the Provider received actual notice of its right to claim the reimbursement and the process for doing so. The records supports a finding that the Provider's failure to file timely claims was not because of confusion or the lack of notice. The Provider had adequate time to comply with the instructions requiring the submission of the specially coded UB-92 forms, for the years in contention and, in fact, did comply and receive payment for a portion of the claims for periods after the first quarter of FYE 06/30/00.

In the alternative, the Providers' contend that the matter should be remanded to the Board pursuant to 42 C.F.R. § 405.1875 to determine whether the Providers timely filed the UB-92s at issue with the Intermediary. The Providers claimed that the Board majority found the Providers' evidence credible that they filed the UB-92 claims, but determined that there was no evidence to support that the claims were proper for processing. The Board determined

[22] The Secretary in fact did publish pursuant to notice and comment that a Provider would be required to submit a bill to receive IME/DGME payments in the May 12, 1998 *Federal Register*.

that it was not required to reach the merits of that issue. The Administrator finds that the issue was developed before the Board and is appropriate for decision here.

As recognized in the dissent's opinion, the record shows that one employee, directly responsible for filing the specially coded UB-92s at one of the providers, testified at the hearing. There were no witnesses from either of the other two Providers. This witness testified that she was not sure whether the claims were properly filed with both of the required codes (04 & 69). No documentary evidence was submitted to demonstrate that the claims were manually filed. There was no testimony by any employees of the other two providers in the group appeals with direct knowledge as to whether claims were mailed and whether the mailing included the required codes 04 and 69. The Administrator finds that the Providers did not maintain copies of the claims they alleged to have filed, nor was any other documentary evidence furnished to demonstrate that he UB-92s were actually sent to the Intermediary. As Providers are required to keep UB-92s for five years according to CMS record-retention policies, the Administrator finds the lack of copies further undermines the Providers allegation of timely manual submission of the claims.[23] Based on the record, the Administrator finds that the Intermediary properly decline, as untimely, to accept all of the electronic claims made after the applicable timeframe for filing.[24]

Accordingly, the Administrator finds that the Intermediary properly disallowed DGME and IME payments with respect to discharges of Medicare beneficiaries who were enrolled in the Medicare + Choice or other Medicare risk plans. Thus, the Administrator reverses the Board's decision.

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[23] The Providers' argument regarding the Paperwork Reduction Act is not dispositive of whether reimbursement is due under the Medicare Act.

[24] In addition, the regulation at 42 CFR 424.44(b)(1) states that: "the time for filing a claim will be extended if failure to meet the deadline… was caused by error or misrepresentation of an employee, intermediary, carrier, or agent of the Department that was performing Medicare functions and acting within the scope of its authority." CMS Pub 100-4, Section 70.7 provides for an exception if there is an "administrative error." CMS Pub 100-4, Section 70.7.1, then provides several exceptions, including failure that resulted from excessive delay by Medicare, the Intermediary, or the carrier in furnishing information necessary for the filing of the claim. If a provider files what is called a "statement of intent" before the end of the timely filing period there could have been an extension of 6 months. However, even with a statement of intent, the provider must have notified the Intermediary before the end of the timely filing period that they would be submitting claims and provided the "placeholder for filing a timely and proper claim," in writing which would include beneficiary names, with dates of service. The record in this case does not support that there was error in not accepting the late claims. The Provider was not able to demonstrate that its failure to file timely was due to the conduct set out in 42 CFR 424.44(b)(1).

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: **7/31/08** **/s/**

Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services