CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Henry Ford Health System Managed Care GME/IME Payments Group, **Provider** **vs.** **Blue Cross Blue Shield Association/ National Government Services, LLC-WI** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: 12/31/98–12/31/00** **Review of:** **PRRB Dec. No. 2009-D20** **Dated: April 16, 2009**

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 U.S.C. 1395oo(f)). Comments were received from the Intermediary and CMS' Center for Medicare Management (CMM) requesting a reversal of the Board's decision. Comments were also received by the Provider requesting that the Board's decision be affirmed. Accordingly, this case is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION

The issue concerns whether the Intermediary properly disallowed payments for indirect medical education (IME) and direct graduate medical education (DGME) with respect to discharges of Medicare beneficiaries who were enrolled in the Medicare + Choice or other Medicare risk plans for the fiscal years at issue.

The Board noted that, prior to the Balanced Budget Act of 1997 (BBA 1997)[1], IME and DGME payments for services provided under risk HMO contracts were not available. These payments were added by the BBA 1997 for cost reporting periods

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

occurring on, or after January 1, 1998. Specifically, §1886(d)(11) of the Social Security Act (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 then examined the conditions which must be met to entitle a hospital to payment for this benefit. The Board found that the regulations at 42 CFR § 424.30, *et seq.*, governed this issue. This section requires that claims for payment must be filed in all cases except when furnished on a prepaid capitation basis. The Board noted that, prior to the BBA 1997, hospitals filed claims directly with Medicare intermediaries. However, if the hospital was a member of a risk HMO which had been prepaid by Medicare, it filed its claim with the HMO, not the Intermediary. Thus, the Board concluded, the claims at issue in this case are "specifically exempt from the requirements, procedures, and time limits" noted in 42 CFR § 424.30, *et seq.* Additionally, the Board 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 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 "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 CFR § 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 asserted that, despite these changes, no changes were made to 42 CFR § 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 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 CFR § 424.30.

The Board cited to the Administrators decision in Santa Barbara Cottage Hospital v. Blue Cross Blue Shield Association/National Government Services, LLC-CA,[2] where the Intermediary argued that the Provider was required to file Part A "claims for an established reimbursement methodology for hospitals' costs associated with being a teaching hospital and not for services furnished to a managed care enrollees [*sic*]."[3] However, the Board found that the IME and DGME payments at issue here were "additional payment amounts" provided for in the BBA '97, effective beginning with the 1998 period at issue here. Sections 1886(d)(11)(A)-(B) and 1886 (h)(3)(D)(i) of the Act. The Board further found that these additional payment amounts were not "for hospitals' costs associated with being a teaching hospital." Rather, the statute provided that both of these additional payment amounts are "for" the services furnished to Medicare HMO enrollees. The 1997 amendments to the IME statute provide that "the Secretary *shall provide* for an additional [IME] payment amount *for each applicable discharge… of any individual who is enrolled*" with a M+C organization. Section 1886(d)(11)(A)-(B) of the Act (emphasis added). Similarly, the Board noted that the 1997 amendments provided that "the Secretary shall provide for an additional [GME] payment amount under his subsection *for services furnished to individuals who are enrolled*" with a M+C organization. Section 1886 (h)(3)(D)(i) of the Act (emphasis added).

The Board found that the Secretary has been given broad authority to implement procedures for payment. However, once a system was established by regulation linking the obligation to file an intermediary claim with the method of payment, CMS' effort to impose a contrary claim filing requirement via informal guidance (Program Memoranda) is insufficient to deprive a provider of its statutory right to payment. The Board reasoned that no directive to the Provider was found, stating that in order to receive IME and DGME supplemental payments the Provider must bill.

The Board found that the lack of formal notice was evidence in the instant case, as nowhere did the Board find a directive to the Provider that stated in order to receive IME and DGME supplemental payments, the Provider *must* bill the Intermediary within the timeframe specified in the regulations at 42 C.F.R §424.44. The Board also found that the Intermediary did not identify any instances, other than the 2003 Program memorandum directed to non-PPS hospitals, where CMS ever said that teaching hospitals had to submit separate bills for payments for M+C enrollees in order to receive the DGME supplemental payments.

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[2] *See* PRRB Dec. No. 2008-D17; Medicare & Medicaid Guide (CCH) ¶ 81,859 (Nov. 16, 2007).

[3] *See* Transcript of Oral Hearing (Tr.) at 36-37.

The Board noted that, despite the short timeframe that CMS had to implement the provisions of the BBA 1997, specifically for the issue in question by the effective date of January 1, 1998, CMS should have followed the Administrative Procedure Act (APA) prescribed "informal rulemaking" process and made provisions to handle the period from January 1, 1998 until the finalization of the rule. The Board stated that, even 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 to the HMO and also file a virtually identical claim to its intermediary, then regulatory notice is required.

The Board reasoned that the Intermediary did not dispute that the Providers complied with requirements for timely filing its claims for payment for inpatient services with the HMO. In fact, the Board noted that the Providers seeks to rely on those records as proof of entitlement and for calculation of its IME/DGME additional payment to be claimed via its cost report. The Board contended that the data found in those claims to the HMOs, along with the remittance advices reflecting payment, is proper evidence and must be considered by the Intermediary to determine the IME/DGME payments due.

Finally, the Board noted that, for the period from January 1, 1998 through June 30, 1998, the option to bill and receive an interim payment was not available and the use of an alternate method was necessary to allow providers to make a request for these payments. For this reason, the Board found that the Intermediary's disallowance of the subject days, based on the fact that the Provider did not bill and the data was not captured on the PS&R, is without basis. The Board noted that the Parties have stipulated that the Provider furnished to the Intermediary paper copies of the claims at issue here before the issuance of the NPRs for the years at issue. The Board found that the Intermediary's refusal to audit the data made available to support the Providers' claims was improper and the case should be remanded to the Intermediary to complete the audit.

The Board considered the Provider's assertion that the public protection provision of the Paperwork Reduction Act (PRA), 44 U.S.C. 3501 *et seq.*, precludes the Intermediary from denying the Provider the benefit of additional IME/DGME payments on the basis that duplicate claims were not submitted. Nevertheless, the Board alleged that it reached its conclusion on the merits of the case independently of the Paperwork Reduction Act (PRA) considerations and, accordingly reaches no conclusion on the Provider's PRA assertions.

COMMENTS

The Intermediary commented requesting the reversal of the Board's Decision. The Intermediary argued that to claim IME and DGME payments for services to beneficiaries enrolled in risked based manage care contracts, the hospital was directed by CMS Program Memorandum A-98-21 to file a claim on the UB-92 format. Further, the Intermediary noted that the filing requirements of the A-98-21 are a reasonable method of ensuring the data, needed to calculate the IME and DGME payments, would be captured in the system. The Intermediary contended that the PRRB incorrectly concluded that the requirements of A-98-21 imposed claims filing requirements contrary to the regulations, and argued that the Decision constituted an improper reading of the instructions to submit claims using the UB-92 format with stated conditions codes.

CMM commented that the Secretary was given broad authority in implementing the BBA 1997 provisions to provide hospitals with supplemental IME and DGME payments for Medicare managed care discharges/patient days. CMS implemented the provisions first through a final rule published in the Federal Register on August 29, 1997. The policy was subsequently refined through the final rule published on May 12, 1998. CMM noted that, despite the Board's findings, the preamble of the May 12, 1998 final rule provided explicit notice to hospitals that they would be expected to submit Medicare managed care claims to the Intermediary for IME and DGME payment purposes under Part A (reimbursement for teaching costs associated with Medicare managed care enrollees), in addition to the bills submitted to managed care plans for payment under Part C (for services rendered to Medicare managed care enrollees).

Additionally, CMM noted, CMS also issued a Program Memorandum in July 1998, which explained that hospitals needed to submit Medicare managed care claims to the 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 noted that the Intermediary is required to submit the UB-92 claims that it receives from the hospital to the Common Working File where the claims are verified and the information on the claims eventually flows to the PS&R for the hospital.

CMM also addressed the Provider contention that it was not required to bill the Intermediary. CMM stated that the instructions in the Program Memorandum A-98-21 state that a Provider may choose whether it wants to receive supplemental payment for Medicare managed care enrollees but if it decides that it would like to receive this additional payment, the provider must submit a claim to its

intermediary. That is, there is no requirement that the Provider receives this additional payment, but if it chooses to receive this additional amount, it must follow the instructions noted in the Program Memorandum. The Program Memorandum also noted that the Intermediary would calculate the additional DGME payment using the inpatient days attributable to Medicare managed care enrollees.

Finally, CMM noted that, while the regulations at 42 C.F.R. §§413.76 and 412.105(g) do not include the filing instructions that CMS issued in the Program Memorandum, CMS has historically relied on the issuance of Program Memoranda to implement payment procedures and processes on a subregulatory basis subject to the applicable IME and DGME statutes and regulations. Furthermore, in this instance, CMS was not requirement to publish a new regulation because this process did not implement a new payment methodology. CMM argued that the payment of IME and DGME was an already established payment methodology for teaching hospitals that was already linked to the claims processing system. CMM also contended that consistent with the Administrative Procedure Act (APA), the proposed claims processing methodology was published in the May 1998 Federal Register subject to notice and comment. CMM argued that the claims processing instructions implementing IME and DGME payment for managed care enrollees did not violate the requirements of the APA, and the Provider received adequate notice of its rights to claim the reimbursement, but did not follow the procedures for doing so. In addition, CMM does not believe that CMS' requirement for submission of claims for managed care enrollees to the Intermediary would be in violation of the PRA since hospitals are already required to submit claims to their intermediary in order to receive payments for IME.

The Provider submitted comments, requesting that the Administrator affirm the PRRB decision. The Provider argued that the Intermediary improperly disallowed DGME and IME payments with respect to Medicare beneficiaries enrolled in Medicare managed care plans.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions.

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.[4] The Secretary's regulations 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.[5] 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.[6]

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),[7] 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), graduate medical education 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.[8] 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, Congress established a new payment policy for DGME costs. Generally, the DGME payment is a combination of a hospital's per resident amount

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[4] 20 CFR §405.421 (1966); 42 CFR §405.421 (1977); 42 CFR §413.85 (1986).
[5] 42 CFR §413.85(b).
[6] 54 Fed. Reg. 40,286 (Sept. 27, 1989).
[7] Pub. L. No. 97-248.
[8] Section 601(e) of the Social Security Amendments of 1983. Pub. L. No. 98-21 (1983).

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 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 CFR §413.86, *et seq.* (1998).

With respect to the indirect costs of teaching programs, §1886(d)(5)(B) of the Act also provides that teaching hospitals that have residents in approved graduate medical education 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.[9] The regulations at 42 CFR §412.105 (1998) establish the method for calculating the additional payment. 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. Each hospital's indirect medical education payment under the prospective payment system for inpatient operating costs is determined by multiplying the total diagnosis related groups (DRG) revenue for inpatient operating costs by the applicable indirect medical 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. The statute did not provide for inclusion of inpatient days attributable to enrollees in Medicare risk plans (e.g. Medicare Health Maintenance Organizations or Competitive Medical Plans with risk sharing contracts under § 1876 of the Act or Medicare + Choice plans) in the Medicare patient load used to calculate Medicare payment for DGME. However, § 4624 of the BBA 1997 amended the Act by adding a new provision for DGME 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

[9] Prior to the enactment of IPPS, the Medicare program had provided for adjustments for medical education under the routine cost limits of §1886(a)(2) of the Act.

> 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
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> (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 -
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> (I) 20 percent in 1998,
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> (II) 40 percent in 1999,
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> (III) 60 percent in 2000,
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> (IV) 80 percent in 2001… [Emphasis added.]

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

> (11) Additional Payments for Managed Care Enrollees. –
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> (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.
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> (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.
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> (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). [Emphasis added.]

Thus, for cost reporting periods occurring, or after, January 1, 1998, the provisions of the BBA 1997 allow for the recognition of the Medicare managed care enrollees in the IME and DGME payments.

These statutory changes were promulgated in the regulation for the DGME payment at 42 CFR § 413.86 and since recodified at 42 CFR § 413.76 (2004). The regulation at 42 CFR § 413.76 states:

> A hospital's Medicare payment for the costs of an approved residency program is calculated as follows:
> (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.
> (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…….[10]

Likewise, for the IME payment, 42 CFR § 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

[10] The regulation at 42 CFR § 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].

> percentages described in. Sec. 413.76(c)(1) through (c)(5) of this subchapter.[11] [Emphasis added.]

The regulation at 42 CFR § 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 payments for Medicare managed care enrollees were specifically addressed in the May 12, 1998 Federal Register[12] which promulgated the final rule published August 29, 1997 implementing the BBA 1997 changes. In response to comments regarding the claims process to be implemented for the DGME and IME payments, the Secretary stated that:

> Under §§ 4622 and 4624 of the BBA 1997, 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 managed care plans. The inpatient encounter data from these bills will be submitted by the managed care plans to HCFA for purposes of implementing the risk adjustment methodology. The fiscal

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[11] *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 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).

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

> 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 the CMS Program Memorandum (PM) A-98-21, 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, 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 in the UB-92 format, for, *inter alia*, Part A payment, is controlled by the regulation at 42 CFR § 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 and § 1876 managed care services are not controlled by this section, a hospital must submit claims in conformity with 42 CFR § 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 CFR § 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.
> (2) 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 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 are consistent with the Medicare Financial Management Manual (Pub. 100-6), 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 Provider Statistical & Reimbursement (PS&R) system 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.

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. 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.[13] 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.

In the instant case, the Provider, Henry Ford Health System,[14] is a teaching hospital located in Detroit, Michigan. The Provider is claiming that a number of patient days and patient stays by Medicare beneficiaries enrolled in Medicare managed care plans were not included in the calculation of the hospital's Medicare managed care IME and DGME payments. The parties have stipulated to the number of patient days and patient stays at issue.[15] For FY 1998, the Provider is claiming 1,624 patient days with respect to 210 patient stays. For FY 1999, the Provider is claiming 11, 703 patient days with respect to 1,968 patient stays. For FY 2000, the Provider is claiming 3,353 patient days with respect to 576 patient stays. The Provider submitted paper copies of claims to the Intermediary on December 2002, prior to the

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[13] For example, the 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 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 [is] subject to adjustment upon settlement of the cost report."

[14] This group was initially formed with two providers: Henry Ford Hospital (Provider No. 23-0053) and Bi-County Hospital. Bi-County Hospital withdrew from the group appeal.

[15] *See,* Stipulation of Parties, ¶3 at p. 1.

issuance of the notices of program reimbursement for the periods at issue.[16] Subsequently, the Intermediary issued an NPR, dated September 30, 2003 for the Provider's FY1998; an NPR dated September 30; 2003 and a revised NPR dated May 13, 2005 for the Provider's FY 1999, and an NPR dated September 29, 2004 for the Provider's FY 2000.[17] The Provider appealed the IME/DGME payments.

The Provider contended that the Intermediary's determination to the years at issue should be reversed for four reasons. First, the determinations were inconsistent with the language of the Part A claims filing regulation that it purported to rely upon.[18] Second, there is a violation of the public protection provision of the Paperwork Reduction Act.[19] Third, the determination was arbitrary and capricious, and constituted a denial of due process because the Provider was not given fair notice of the requirements for filing claims for payment within any particular time period.[20] Finally, the Intermediary improperly failed to make its final payment and determination, based upon the best available evidence that was before it, at the time it rendered the determinations.[21]

However, the Intermediary contended that it is the Providers' responsibility to submit a timely UB-92 claim form to its Intermediary to be processed through the claims system in order to obtain payment. The Intermediary argued that the PM A-98-21 issued by CMS made clear that the Providers were required to bill their Intermediary if they wanted to receive the IME and DGME payments for Medicare managed care enrollees.

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."

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[16] *Id.*, ¶4 at p. 1.
[17] *Id.*, ¶5 at pp. 1-2.
[18] *See*, e.g., Tr. p. 26.
[19] *Id.*
[20] *Id.* at pp. 26-27.
[21] *Id.* at p. 27.

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.[22] The Federal Register preamble language and the PM A-98-21 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 requirements of 42 CFR §424.30 were controlling. The only exception to the claims processing requirements at 42 CFR §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.[23]

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

[23] 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 be 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

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.[24] 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. A provider was required to submit a regular claim to its Medicare Managed Care entity to be paid for services rendered to the Medicare beneficiary, and also had to submit an additional claim to its intermediary. The additional claim was a "no-pay bill" that required no payment for services rendered, but provided notice to the Medicare program of Medicare's obligation to pay IME and DGME adjustments for the services provided by the hospital to the Medicare Managed Care patients.

The Provider argued that it did not receive adequate notice from the Intermediary explaining the billing and filing requirements for the claims. However, the record supports a finding that the Provider's failure to file timely claims was not due to 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 fiscal years in contention. The record shows that the Provider directed a letter to the Intermediary, dated December 18, 2002 making reference to the new claims process and memorializing its practices for the cost years at issue. The letter specifically states that, "before the end of 1998, Henry Ford Health System [Provider] and the Medicare Intermediary had mutually developed a process to manually submit a UB-92 claim form in accordance with the final instructions for adjudication."[25] The letter goes on to state:

- On a quarterly basis, Henry Ford Staff would identify and manually prepare and mail the claim forms to the Medicare Intermediary for processing. The Fiscal Intermediary would process the claims on a fairly regular basis.
- The IME reimbursement was paid on the normal remittance file on a claim by claim basis commingled with other payments.

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beneficiary names, with dates of services. 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).

[24] 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*.

[25] *See* Intermediary's Position paper, Exhibit I-3, p. 2.

- In the beginning, the Henry Ford Reimbursement Department would track the IME payments at a summary level via the PS&R reports. Sometime during this process, a decision was made to discontinue the normal PS&R report distribution process. The discontinuation of PS&R report distribution caused a breakdown in the Reimbursement Department's reconciliation process and they were no longer able to track the IME payments in a proper fashion.
- It was identified earlier this year that not all of the IME claims dating back to 1998 had indeed been processed and the System began the long arduous task of manually reconciling these claims and payments at the claim level detail. It has been since validated that a large number of claims were never processed and must have been lost in transition between Henry Ford and the Fiscal Intermediary. The gap is particularly large for service dates in 1999, indicating a process breakdown.[26]

The Provider further admitted that it has "now installed a process redesign effective with the current processing to generate the Medicare HMO claim in an electronic format and to ensure the proper tracking of these claim submissions to more efficiently and effectively reconcile the payments."[27] Thus, the record indicates that the Providers were on notice of the appropriate billing procedures, but failed to submit all the claims in a timely manner, and did not have the proper controls in place to identify issues in the filing process.

The Provider sent a subsequent letter to the Intermediary, citing a number of specific billing examples for review, and requesting a filing exception.[28] In each instance, the Intermediary informed the Provider that the claims were appropriately rejected, and the Provider had ample time to resubmit or adjust its claims by the timely filing deadlines.[29] The Provider either failed to resubmit or adjust its claims, or did so after the timely filing deadline. The Intermediary informed the Provider that evidence has not been provided warranting an exception of the timely filing requirements, pursuant to 42 C.F.R. §424.44.[30] It is clear from the record that the process that the Provider used to reconcile IME claims payments was unreliable, and the "breakdown in process" caused the failure to submit a number of claims. While the Provider has made efforts to efficiently and effectively reconcile the payments, the failure of the Provider's processes in FYs ending in 1998, 1999, 2000 was

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[26] *Id.*
[27] *Id.*
[28] *See* Intermediary's Position paper, Exhibit I-5.
[29] *See* Intermediary's Position paper, Exhibit I-6, at p. 1.
[30] *Id.* at p. 2.

through no fault but their own. Therefore, the record is not supportive of the Provider's arguments that the failure to file claims was due to lack of appropriate notice, but rather, the record indicates this failure was more likely due to flaws in the Provider's internal process and controls to ensure timely billing.

Finally, the regulatory time limits require that claims must be filed on or before December 31 of the calendar year following the year in which the services are furnished, or the second year after the year in which services were furnished, for services furnished in the last quarter of the calendar year.[31] The record indicates that for the periods at issue, the claims for IME/DGME were not filed timely. The Provider argued that it provided paper copies of claims to the Intermediary in December 2002, prior to the issuance of the NPRs for the periods at issue.[32] As a result, the Provider claims that the Intermediary must accept and review the additional data which was submitted to them, demonstrating the entitlement to payments for the FYs 1998 through 2000. However, the Provider's submission of the UB-92 claim forms at the time of the audits of the Medicare cost report was inconsistent with the CMS instructions. It is the Provider's responsibility to file a UB-92 claim form to its Intermediary through the claims processing system and in the same time frame required for other claims in order to obtain the additional IME/DGME payment for managed care enrollees. The Administrator finds that the claims at issue were subject to the applicable filing deadlines, and since they were not submitted until years later, the Intermediary properly disallowed the supplemental IME and DGME payments.[33]

Accordingly, the Administrator finds that the Intermediary properly determined the supplemental IME and DGME payments for Medicare managed care enrollees in the fiscal years 1998, 1999, and 2000 cost reporting periods. Thus, the Administrator reverses the Board's decision.

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[31] *See,* 42 C.F.R. §424.44.

[32] *See,* Stipulation of Parties, ¶4 at p. 1.

[33] The Administrator further notes that the PRA is not controlling with respect to the determination of Medicare reimbursement.

DECISION

The Administrator reverses the decision of the Board in accordance with the foregoing opinion.

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

Date: **6/5/2009** **/s/**

Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services