**CENTERS FOR MEDICARE AND MEDICAID SERVICES**
***Decision of the Administrator***

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| **In the case of:** | **Claim for:** |
| **QRS Medicare Part A Title XIX Eligible Patient Days Group I** | **Reimbursement Determination for Cost Reporting Periods ending: Various** |
| **Provider** | |
| **vs.** | |
| **Blue Cross Blue Shield Association/ Noridian Administrative Services** | **Review of: PRRB Dec. No. 2010-D26 Dated: April 14, 2010** |
| **Intermediary** | |

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 § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. The Providers submitted comments requesting that the Administrator reverse 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 is whether Medicaid eligible days for Medicare Part A patients should be considered for inclusion in either the Medicaid fraction or the Medicare Supplemental Security Income percentage of the disproportionate share hospital (DSH) adjustment payments.

The Board held that the Intermediary's determination to not include the days at issue in either the Medicare, or Medicaid fraction, of the Providers' DSH adjustment calculation was proper. The Board found that Medicare had an

established national billing process system used to generate the data used to determine the patient days in the Medicare fraction. With respect to these requirements and procedures, the Board found that the Providers' failed to timely submit bills into the system for the days at issue. Consequently, those days were not included in the database used for calculating the Providers' SSI percentage. The Board distinguished this case from Baystate,[1] in that, it was the Providers' inaction that caused the days not to be included in the Medicare fraction as opposed to CMS' system causing some patient days not being counted.

Finally, with respect to the days in question being included in the Medicaid fraction, the Board found that the patient days in question were for patients who, although eligible for Title XIX, were also entitled to Medicare part A. As such, the statute prohibited those days from being included in the Medicaid fraction.

## COMMENTS

The Providers commented requesting that the Administrator reverse the Board's decision. It is the Providers' position that the patient days at issue should be included in either the Medicaid fraction or the Medicare fraction. With respect to the Medicaid fraction, the Providers argued that entitlement to benefits under Medicare Part A means the right to have payment made on the patient's behalf for covered services. The Secretary has conceded that when payment is not made the dual eligible days are not Medicare "covered" days for which patients are "entitled to benefits under Part A" for purposes of the Medicare fraction of the DSH calculation. Thus, the Providers' maintain, such days should be included in the numerator of the Medicaid fraction if the patient was also eligible for Medicaid. However, if it is determined that these patients were entitled to Medicare Part A, whether or not they were paid by Medicare, then they must be considered entitled for purposes of inclusion in the Medicare fraction and cross-matched with the SSI files.

With respect to CMS Ruling 1498-R the Providers argued that the CMS Ruling is inconsistent with the language of the regulation in effect during the time periods relevant to this appeal. The Secretary's regulation in effect for the time periods at issue stated that Medicare/SSI fraction includes only "covered patient days." However, the CMS Ruling requires that the Medicare fraction include the "inpatient days where the patient was entitled to Part A benefits but the inpatient hospital stay was not covered under Part A." Therefore, CMS ruling 1498-R is inconsistent with 42 C.F.R. 416(b)(2)(i)(1998). Finally, applying the CMS Ruling retroactively would violate the prohibition against retroactive rulemaking because it was not the result of a formal notice and comment procedure.

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[1] 545 F. Supp. 2d 20 (D.D.C. 2008).

## DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

The regulations at 42 C.F.R. § 424.30 et. seq., sets for the requirements, procedures, and time limits for claiming Medicare payments. The regulation at 42 C.F.R. § 424.30 states in pertinent part that, a claim must be filed in all cases "except when services are furnished on a prepaid capitation basis by a health maintenance organization…." In addition, 42 C.F.R. § 424.32(a)(4) states that "[a] claim must be filed within the time limits specified in § 424.44." The regulation at 42 C.F.R. § 424.44 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—
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> (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
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> (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.
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> (2) The time will be extended through the last day of the 6th calendar month following the month in which the error or misrepresentation is corrected.

Applying the relevant law and program policy to the foregoing facts, the Administrator agrees with the Board's determination that the Intermediary properly excluded the days at issue from both the Medicare and Medicaid fraction of the DSH adjustment calculation. The record shows that the Providers never billed Medicare for the services to generate patient days for the beneficiaries at issue. As

a result, the patient days at issue were not included in the Provider Statistical and Reimbursement (PS&R) used to calculate the Providers' disproportionate patient percentage (DPP). The PS&R reports are generated by a standard system provided by CMS. The PS&R system accumulates Medicare Part A claims data processed on the standard claims processing system (i.e., Fiscal Intermediary Shared System [FISS]. The two primary reports produced by the PS&R are the Provider Summary Report, and the Payment Reconciliation Report. The Provider Summary Report is used by providers when preparing their Medicare cost report, and includes the following information for each provider for a specified period of time: Medicare Part A charges, Medicare patient days, Deductibles, Coinsurance, and Payments, etc. The Payment Reconciliation Report providers detailed claim data that supports the Provider Summary Report. The PS&R is the statement used to reconcile a provider's cost report.

Under 42 C.F.R. §§ 413.20 and 413.24, a provider has the burden of maintaining adequate documentation to support its claimed costs and enable the Intermediary to determine the amount payable. In this case, the Providers have not adequately defined, much less supported their claims with auditable documentation recognizable by Medicare that supports the inclusion of the days at issue in the DPP, as claims were never presented.

Finally, with respect to CMS Ruling 1498-R, the Administrator notes that on April 29, 2010 CMS is issued CMS Ruling 1498-R. CMS Ruling 1498-R addresses three issues pertaining to the calculation of the DPP under § 1886(d)(5)(F)(vi) and 42 C.F.R. §412.106(b). In addition, CMS Ruling 1498-R addresses the jurisdiction of the PRRB or other administrative tribunals over appeals of these issues. The three issues relate to (1) appeals of the data matching process used in calculating the Supplemental Security Income (SSI) fraction; (2) appeals of the exclusion from the DPP of non-covered inpatient hospital days for patients entitled to Medicare Part A and days for which the patient's Part A inpatient hospital benefits were exhausted; and (3) appeals of the exclusion from the DPP of labor/delivery room inpatient days. The Administrator finds that CMS Ruling 1498-R does not apply in this case because the Providers never submitted a Medicare claim on behalf of the patient for the days at issue[2] and, thus, failed to meet a procedural threshold documentation requirement.

Accordingly, the Administrator agrees with the Board's determination that the Intermediary properly excluded the days at issue from both the Medicare and Medicaid fraction of the DSH adjustment calculation. The Administrator finds that

[2] See CMS Ruling 1498-R at page 9.

the Providers failure to file timely claims was not because of lack of notice. In addition, the Administrator finds that the patient days at issue are not for Medicare Part C days per the Providers' position paper. In this case, the Providers were simply unaware that the patients were Part A entitled. Therefore, under the above regulation, as a basic prerequisite for payment, Providers are required to submit claims in a timely fashion to receive any payment related to those services. As the Providers in this appeal failed to file claims timely or otherwise, the days cannot be included in the DSH calculation..

## DECISION

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

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

Date: 6/15/2010

/s/
Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services