PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2012-D12

PROVIDER -
Research Medical Center
Kansas City. Missouri

Provider Nos.: 26-0027

vs.

INTERMEDIARY –
Wisconsin Physicians Service

DATE OF HEARING -
January 26, 2010

Cost Reporting Period Ended -
December 31, 2001

CASE NO.: 06-0269

INDEX

ISSUE:

Whether the Intermediary's determination of additional amounts paid to the Provider for nursing and allied health (N&AH) education costs associated with Medicare + Choice (M+C) enrollees was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. *See* 42 U.S.C. § 1395 *et seq*. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FIs) and Medicare administrative contractors (MACs). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS. *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. The cost reports show the costs incurred during the fiscal year and the portion of those costs allocated to Medicare. *See* 42 C.F.R. § 413.20. The intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). *See* 42 C.F.R. § 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the receipt of the NPR. *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835 (2008).

The Medicare statute consists of several parts, two of which (Medicare Part A and Medicare Part C) are relevant to this case. Medicare Part A provides health insurance to Medicare beneficiaries. *Id.* §§ 1395c, 1395d. Regulations governing claims for payment under Part A are set forth at 42 C.F.R. § 424.30 *et seq.* That Subpart begins by describing its scope, providing that "[c]laims 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)." For claims that do not fall under the exceptions described, the regulations in the Subpart go on to set forth billing requirements.

The provision at 42 C.F.R. § 424.32 requires hospitals to submit claims for payment via a specific form, the Uniform Institutional Provider Bill, also called CMS-1450 or UB-92. The regulation at 42 C.F.R. § 424.44 sets time limits for filing claims with the intermediary. According to this section of the regulations, a hospital must submit bills by "December 31 of the following year for services that were furnished during the first 9 months of a calendar year" or by "December 31 of the second following year for services that were furnished during the last 3 months of the calendar year." *Id.* § 424.44(a). A hospital may receive a six-month extension of

[1] FIs and MACs are hereinafter referred to as intermediaries.

these deadlines if the failure to timely file claims "was caused by error or misrepresentation of an employee [or] intermediary" acting on behalf of the Secretary. *Id.* § 424.44(b). The billing requirements do not apply "when services are furnished . . . by a health maintenance organization . . . ." 42 C.F.R. § 424.30.

Medicare Part C, also called M+C, allows Medicare beneficiaries to receive benefits through health maintenance organizations (HMOs). 42 U.S.C. § 1395w-21 *et seq.* Under Part C, when hospitals provide services to M+C enrollees, the hospitals send bills directly to, and receive payments directly from, HMOs. 42 U.S.C. §§ 1395w-23, 1395mm(a). Hospitals do not receive payment from Medicare fiscal intermediaries for the provision of Part C services.

Medicare Part A reimburses teaching hospitals for the cost of training graduate medical students, including interns and residents, in the course of providing services to Medicare beneficiaries. There are two types of such payments: direct graduate medical education (DGME) and indirect medical education (IME) costs. 42 U.S.C. §§ 1395ww(h), 1395ww(d)(5)(B). In addition, Medicare pays teaching hospitals for the cost of training nursing and allied health (N&AH) students in the course of providing services to Medicare beneficiaries. 42 C.F.R. § 413.85.

Medicare Part A originally reimbursed hospitals for DGME, IME, and the N&AH only in connection with Medicare patients enrolled under Medicare Part A. Payment was not made for M+C enrollees. In Sections 4622 and 4624 of the Balanced Budget Act of 1997 (BBA), however, Congress authorized the payment for DGME and IME costs associated with M+C enrollees. Pub. L. No. 105-33, 111 Stat. 477 and 478 (Aug. 5, 1997). Effective January 1, 1998, the BBA directed that, over a 5 year period, Medicare would begin making payment for the DGME (Section 4624) and IME (Section 4622) associated with M+C enrollees. *Id.* CMS implemented these provisions in Program Memorandum A-98-21 dated July 1, 1998.[2] Hospitals were required to submit to their intermediaries "encounter data," or "no-pay bills," regarding services provided to M+C enrollees. Program Memorandum, CMS Pub. 60A, Transmittal No. A-98-21 (July 1, 1998) (PM A-98-21).[3]

In Section 541 of the Balance Budget Refinement Act of 1999 (BBRA), Congress expanded the payment to cover N&AH. Section 541, provides, effective January 1, 2000, for additional payments to hospitals for N&AH program costs associated with M+C enrollees. Pub. L. No. 106-113, § 541, 113 Stat. 1501, 1501A-391-92 (1999).[4] Under the BBRA, for Calendar Year (CY) 2000, the additional payment was calculated based on the provider's costs of operating N&AH programs as shown on cost reports ending in the federal fiscal year that was two years prior to the current period. The payments for CY 2000 (the year prior to the year under appeal) were *not* based on individual hospital's M+C days. 42 C.F.R. § 413.87(d) (2001, 2002)[5]

Section 512 of the Benefits Improvement and Protection Act of 2000 (BIPA) revised the N&AH payment formula further to specifically account for each hospital's M+C utilization, effective January 1, 2001, the beginning of the cost year under appeal. Pub. L. No. 106-554, § 512, 114

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[2] Exhibit P-12.
[3] *Id.*
[4] Exhibit P-3 at 3.
[5] Exhibit P-4.

Stat. 2763, 2763A-463, 2763A-533-34 (2000).[6] The payment under BIPA is based on a hospital's M+C utilization – that is, the number of patient days attributable to M+C enrollees – during the cost reporting period ending in the federal fiscal year that is two years prior to the current period.

Section 512 of BIPA was initially implemented by Program Memorandum, CMS Pub. 60A, Transmittal No. A-01-148, issued December 27, 2001 (PM A-01-148).[7] This transmittal did not provide any instruction to the hospitals as to the source of the M+C inpatient days data for purposes of calculating the N&AH M+C payments, or suggest that providers were to have submitted "no pay" bills to their fiscal intermediaries to document those days.

On February 3, 2003, CMS issued Program Memorandum, CMS Pub. 60A, Transmittal No. A-03-007 (PM A-03-007),[8] to allow non-IPPS providers to submit no-pay bills for M+C enrollees to receive payment for DGME payments for M+C enrollees. Of significance here, the transmittal also stated:

> In addition, this transmittal also applies to *all* hospitals that operate a nursing or an allied health (N&AH) program and qualify for additional payments related to their M+C enrollees under 42 CFR §413.87(e). These providers would similarly submit their M+C claims to their respective intermediaries to be processed as no-pay bills so that the M+C inpatient days can be accumulated on the PS&R (report type 118) for purposes of calculating the M+C N&AH payment through the cost report. (The instructions for calculating this payment will be explained in a separate transmittal.)

(Emphasis added).[9] The February 2003 transmittal stated, for the first time, that in order for hospitals to receive N&AH payments for M+C enrollees, they must submit no-pay bills for the M+C enrollees to their fiscal intermediaries. The transmittal explicitly stated that it applied prospectively beginning July 1, 2003.

On May 23, 2003, CMS issued Program Memorandum, CMS Pub. 60A, Transmittal No. A-03-043 (PM A-03-043)[10], with an effective date of January 1, 2001. This transmittal required that the intermediary determine, for each eligible hospital, the total M+C inpatient days based on data from the settled cost reports for the period(s) ending in the fiscal year that ends in the federal fiscal year that was two years prior to the current calendar year.[11] The transmittal instructed intermediaries to obtain the number of M+C inpatient days from the provider's Provider Statistical and Reimbursement Report (PS&R). It also stated that, "subject to the rules concerning time limitation for submitting provider claims at §3600.2 of the Intermediary Manual

[6] Exhibit P-5 at 3.
[7] Exhibit P-6.
[8] Exhibit P-7.
[9] *Id.*
[10] Exhibit P-8.
[11] For the Provider in this case, that meant that its N&AH M+C payments for its FY 2001 would be based on its M+C days in FY 1998.

[MIM], additional documentation to revise the FI's determination [on the number of M+C days] may be submitted by the provider, but will be subject to audit by the FI."[12] PM A-03-043 requires that fiscal intermediaries rely on the providers' PS&R reports from 1998 to determine their N&AH payments in 2001. PM A-03-043 allows providers to submit additional "days data," but only if that data were submitted to the fiscal intermediary prior to December 31, 2000, consistent with 42 C.F.R. § 424.44 and MIM § 3600.2. No other data would be acceptable, according to the transmittal.[13]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Research Medical Center (Provider) is an acute care hospital located in Kansas City, Missouri. Prior to 2005, the Provider was a multi-campus teaching institution with a small GME program and a large N&AH education program. During fiscal year (FY) 1998, the Provider submitted UB-92 claim forms directly to its MCOs for services furnished to its M+C enrollees, and it was then paid.[14] In addition to filing claims with the MCOs, the Provider also timely filed certain "no-pay" UB-92s with its Intermediary for services supplied to M+C enrollees during the fiscal year 1998.[15] The purpose of submitting these no-pay bills was to obtain payments from Medicare for DGME and IME for the M+C enrollees, as authorized by the BBA and CMS transmittal A-98-21.[16]

The Provider encountered problems in getting its 1998 UB-92 claims associated with the M+C enrollees processed by the Intermediary.[17] Due to the cost and difficulty of processing the no-pay bills and the low DGME and IME payments, the Provider did not continue to submit these claims for FY 1998.[18]

As noted above, Congress subsequently changed the law to allow payment for N&AH for M+C enrollees. CMS issued instructions to providers to submit their M+C claims directly to their fiscal intermediaries so that their M+C days data could be accumulated in the providers' PS&R reports for purposes of the N&AH calculation. CMS issued PM A-03-043, informing providers that in calculating the M+C days for purposes of a hospital's N&AH payment in 2001 (the year under dispute here), the fiscal intermediaries were to rely on the providers' PS&R.[19] The transmittal allowed fiscal intermediaries to accept other days data to supplement the PS&R, but only if that data were submitted within the timely filing limits of the Intermediary Manual § 3600.2 and 42 C.F.R. § 424.44, that is, by December 31, 2000 for the 2001 year in question.[20] Following the issuance of PM A-03-043, the Provider sought to submit additional days data to its Intermediary.[21] The Provider's fiscal intermediary, Mutual of Omaha (now Wisconsin

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[12] *Id.* at 2.
[13] Exhibit P-8.
[14] Transcript (Tr.) 61.
[15] Tr. 63.
[16] Exhibit P-12.
[17] Tr. 64-65.
[18] Tr. 65.
[19] Exhibit P-8; Tr. 80-81.
[20] Tr. 82.
[21] Tr. 90-91.

Physicians Service) (Intermediary), rejected that data on the grounds that the data was not submitted within the timely filing limits specified above.[22]

On May 24, 2005, the Intermediary issued an NPR for the Provider's cost report period ending December 31, 2001 (FYE 2001), adjusting downward the number of M+C days claimed. Subsequently, the Intermediary issued a Revised NPR (RNPR) dated May 18, 2007. In the RNPR, the Intermediary further adjusted the count of M+C days. The Intermediary based the Provider's final FY 2001 N&AH payments for M+C enrollees on 2,864 M+C days from the Provider's FY 1998 PS&R (which includes 122 M+C days attributable to RMC's IPPS exempt rehabilitation unit[23]) reflecting only that portion of the 1998 days associated with the Provider's M+C patients.[24] The Provider indicated that it had difficulties reporting "no-pay" bills in 1998 and discontinued due to the low payment for DGME and IME at that time.[25] With the addition of payments for N&AH, the Provider sought to submit additional M+C day data to the Intermediary, however, the Intermediary rejected the data because it was not timely submitted.[26]

The Provider has appealed the determination and met the jurisdictional requirements of 42 U.S.C. § 1395oo(a). The Provider was represented by Thomas W. Coons, Esquire and Leslie Demaree Goldsmith, Esquire, of Ober, Kaler, Grimes & Shriver, PC. The Intermediary was represented by Marshal Treat, Specialist Cost Report Appeals, and Stacy Hayes, Specialist Cost Report Appeals, of Wisconsin Physicians Service.

PARTIES' CONTENTIONS:

The Provider contends that the BBRA and BIPA amendments to the Medicare statute mandate that the Secretary "shall" provide for additional N&AH payments for providers' Medicare M+C patients, for cost reporting periods beginning on or after January 1, 2000. BBRA § 541; BIPA § 512. Neither the statutory provision nor the implementing regulation at 42 C.F.R. § 413.85 (2001, 2002) restrict the calculation of that reimbursement to data received on a particular form or in a particular report. The Provider asserts that it furnished services to M+C patients and the days should be included in the N&AH education payment calculation for the 2001 cost year.

The Provider further contends that there is no statutory or regulatory authority or guidance that either requires a Provider to submit no-pay claims to receive N&AH payment for M+C enrollees or requires an intermediary to use a provider's no-pay claims for purposes of calculating that payment. CMS PM A-01-148, issued in December 2001 to implement the BIPA changes to the N&AH payment methodology, provides a general discussion of the BIPA payment methodology and does not require that providers submit no-pay bills or that the PS&R would be the sole source of data to show its M+C utilization.[27] The Provider refutes the Intermediary's suggestion that PM A-98-21 imposed an obligation on the Provider to submit no-pay bills in 1998. The

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[22] Tr. 91.
[23] This data was apparently obtained by Mutual from CMS itself. (Exhibit P-17); (Tr. 91).
[24] Exhibit P-43; Tr. 99.
[25] Tr. 64-65.
[26] Tr. at 90-91.
[27] In fact, according to the regulations in the Medicare Claims Processing Manual, it was the MCO's responsibility to submit the M+C days data to the Intermediary for the period at issue. 42 C.F.R. §§ 422.257(a), (b) (Exhibit P-20).

Provider points out that PM A-98-21 implemented the BBA provision allowing for payment for DGME and IME expenses associated with M+C enrollees. The authority for making N&AH payments for M+C enrollees came about as a result of provisions in the BBRA and BIPA, enacted long after cost year 1998 had passed. The first mention of no-pay bills in conjunction with N&AH payments is outlined in PM A-03-007, issued February 3, 2003, and effective July 1, 2003, long after the period for submitting claims for FY 1998 had expired and it was not until the issuance of PM A-03-043 in May 2003, that CMS addressed N&AH payment for FY 2001. In the May 23, 2003 memorandum, CMS stated that the intermediary was to obtain the number of M+C inpatient days from the provider's PS&R report and that the provider could submit "additional documentation to revise the FI's determination," but only within the time limitations specified in Section 3600.2 of the Medicare Intermediary Manual and 42 C.F.R. § 424.44. Thus, the Provider was informed in 2003 – that if it were to seek N&AH payments in 2001, it must have submitted, in 1998, days data for M+C enrollees through no-pay claims, and that, it could supplement the days data, but that it could do so only if that data were submitted within the timely filing limits that, in the case of 1998 claims, expired on December 31, 2000.

The Provider indicates that the Intermediary is not required to use PS&R reports that are inaccurate. Under Section 2242 of the MIM, intermediaries are permitted to rely on the PS&R Report in settling a provider's cost report unless the provider establishes that inaccuracies exist. MIM § 2242. Courts and administrative agencies have consistently upheld the MIM's direction regarding the use of PS&R report data in the cost settling process, *absent a showing of inaccuracies*.[28] Thus, while generally the PS&R report is to be relied upon in the cost report settlement process, the report is not controlling when the provider can demonstrate that it has data that is more accurate. Here, the Provider attempted to submit more accurate data to the Intermediary, but the Intermediary refused to accept it. The data that the Provider sought to submit to the Intermediary consists entirely of paid claims data that the MCOs themselves furnished the Provider. More specifically, the data is from claims that the Provider submitted to the MCOs and that the MCOs themselves, acting as agents of the Secretary, vetted and then paid, reflecting services that had been furnished by the Provider to the MCO's M+C enrollees for the days in question. Given this, there can be no question that this data is far more accurate than the partial data relied upon by the Intermediary. The Provider asserts that this refusal is arbitrary and unreasonable in light of the fact that CMS has accepted data other than "no-pay" claims from non-PPS hospitals and units to reflect N&AH days from 1998 into 2003.[29]

The Provider also contends that because CMS already had access to the Provider's number of M+C days for 1998, no-pay bills were not required in order to establish the hospital's M+C utilization in that year. To be paid for its inpatient hospital services to M+C beneficiaries in FY 1998, the Provider timely submitted UB-92 forms directly to the MCOs, and the MCOs paid the Provider directly. On December 24, 1997, CMS issued Operational Policy Letter (OPL) No. 64 titled, *Hospital Encounter Data Requirements from the Balanced Budget Act of 1997*.[30] In this OPL, CMS stated that M+C organizations must submit inpatient hospital encounter data for discharges on or after July 1, 1997. This obligation on the part of the M+C organizations was

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[28] *See* Provider's Post Hearing Brief at 22-25.

[29] Indeed, the Intermediary furnished such data to the Provider to reflect the days spent by M+C enrollees in its IPPS-exempt rehabilitation unit. (Exhibit P-17); (Tr. 91).

[30] Exhibit P-18.

further memorialized in regulations at 42 C.F.R. § 422.257.[31] In subsection (b) of that section, CMS states that M+C organizations "must submit . . . inpatient hospital care data for all discharges that occur on or after July 1, 1997." Hospitals were required to provide encounter data to the MCOs in UB-92 format, which the Provider did in this case, and that data was to include the health insurance claim (HIC) number.[32] The M+C organizations were then required to submit data to CMS "that conform to the requirements for equivalent data for Medicare fee-for-service when appropriate, and to all relevant national standards." 42 C.F.R. § 422.257(d).

In short, at the time of the Provider's fiscal year 2001 cost report and its settlement, CMS and its contractors already had access to information of the Provider's total number of M+C days for 1998 in determining the M+C utilization. That data could have been used by the Intermediary in calculating the number of M+C enrollee days furnished by the Provider in 1998.

The Provider notes that once it became clear that the Intermediary would not include the proper M+C data in its calculations of the Provider's N&AH reimbursement, it submitted MCO paid claims information, as well as no-pay bills, to the Intermediary. The Intermediary, however, refused to accept this information, claiming that the information was not timely because it was submitted beyond the dates specified in the Medicare claims filing deadlines at MIM § 3600.2[33] and 42 C.F.R. § 424.44.[34]

The Provider asserts that the Intermediary was wrong for a number of reasons. The time limits of the MIM and 42 C.F.R. § 424.44 do not apply to these facts. The cited provision, 42 C.F.R. § 424.44, is part of Subpart C of 42 C.F.R. Part 424. The provisions at 42 C.F.R. § 424.30 specifies that Subpart C "sets forth the . . . time limits for claiming Medicare payments" and that claims must be filed consistent with these provisions and time limits "except when services are furnished on a prepaid capitation basis by a health maintenance organization (HMO) . . . ."[35] All of the services at issue here were for M+C enrollees and provided on a prepaid capitation basis through Medicare MCOs.

That 42 C.F.R. § 424.44 does not apply here is also supported by the Medicare Claims Processing Manual (MCPM) (Pub. 100-04), Chapter 1 at section 70, which states that the "Medicare regulations at 42 CFR 424.44 define the timely filing period for *Medicare fee-for-service claims*." MCPM, Chapter 1, § 70 (emphasis added) (Exhibit P-31). The claims here were not "Medicare fee-for-service claims." Furthermore, as MCPM Chapter 1, § 70 states, 42 C.F.R. § 424.44 addresses payment for individual fee-for-services claims. By contrast, the Provider in this case would not be submitting the UB-92s to the Intermediary in order to receive direct payment for its individual claims or discharges. Rather, the purpose of UB-92s would be to allow the accumulation of patient days data, which would later be used on the cost report to calculate allowable N&AH reimbursement – not to obtain payment for a fee-for-services claim.

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[31] Exhibit P-20.
[32] Exhibits P-18, P-20.
[33] Exhibit P-27.
[34] Exhibit P-28.
[35] Exhibit P-29.

Finally, the Provider asserts this case falls within the exception in § 424.44 that grants an extension to providers if their failure to meet the required deadline was caused by error or misrepresentation of CMS or of an intermediary. 42 C.F.R. § 424.44(b) (2001). The communication from CMS and its intermediary in May 2003 of the need to file no-pay claims in 1998 in order to obtain N&AH payments in 2001 was quite untimely.

The Provider also asserts that the 2003 policy is impermissibly retroactive. In 1998, and indeed in 2001, there was absolutely no guidance from CMS that hinted that no-pay bills would be required or that the claims would have to be submitted to the fiscal intermediary for purposes of M+C N&AH reimbursement. In fact, it was not until the May 2003 transmittal, that CMS stated that intermediaries were to rely on PS&R reports and only PS&R reports in calculating days, and that the only source of the data for the PS&R reports would be the no-pay bills. CMS, acknowledged that providers could go back and claim days for prior periods, but then stated that providers could not do this unless they satisfied the timely filing requirements of 42 C.F.R. § 424.44, however, it was already too late for them to comply with this requirement and CMS would accept no other data.

The Provider further contends that requiring it to submit claims to both the MCO and the Intermediary violates the Paperwork Reduction Act of 1995 (PRA), Pub. L. No. 104-13, 109 Stat. 163 (1995),[36] amending 44 U.S.C. Chapter 35, which requires the Office of Management and Budget (OMB) to adopt rules that minimize administrative duties imposed on the public arising from the burdensome collection of information by government agencies, including CMS. 5 C.F.R. § 1320.1 (2001, 2002). Under the PRA, CMS was required to obtain OMB approval prior to requiring the providers to submit no-pay UB-92s to the intermediary. This is because the added submission of no-pay UB-92s amounts to the provision of "duplicative . . . information otherwise accessible to the agency." *Id.* Providers had already submitted UB-92 claims to the MCOs, which, in turn, submitted this information to CMS. There is no evidence that CMS obtained OMB approval to require providers to submit no-pay UB-92s to intermediaries for N&AH M+C enrollees.

Finally, the Provider asserts that case law supports the Provider's position. While this is a case of first impression concerning the imposition of CMS's 2003 requirements made retroactive to M+C N&AH payments in 2010, the Board has previously held that the retroactive imposition of new documentation standards is improper. The Board reviewed a similar issue in *Children's Hospital & Regional Medical Center v. Blue Cross and Blue Shield/Trispan Health Services*, PRRB Hearing Dec. No. 2004-D28, [1998-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 81,178 (July 14, 2004).[37] In that case, the provider participated in a new program, the Children's Hospital Graduate Medical Education program. The issue on appeal was whether the provider submitted its FTE documentation in a timely manner. The Board recognized that "GME documentation is generally complex and extensive" and that the difficulties in sifting through the documentation were exacerbated because the program was new. *Id.* at 203,708. As in our case at issue, "[t]he Provider furnished information responsive to the Intermediary's initial requests for documentation, but there was disagreement or misunderstanding as to what the Intermediary's documentation requirements were." *Id.* The Board concluded that the

[36] Exhibit P-32.
[37] Exhibit P-13.

intermediary could not reject the provider's documentation based on the intermediary's timeliness requirements because "[t]here are no regulations . . . that address timelines for furnishing documentation . . . [and the government agency] has only issued guidelines governing [the program] that do not have the force of law." *Id.* at 203,709. The Board's conclusion was also based on the fact that the provider did actually submit the requested information in response to the intermediary's request and that such information was reliable.

In addition to the *Children's Hospital* case, numerous cases have been decided by the Board in which providers challenged the documentation standards imposed by CMS on providers seeking to obtain additional DGME and IME reimbursement for M+C days as authorized under the BBA. Those cases begin with the *Santa Barbara Cottage Hospital v. Blue Cross and Blue Shield Ass'n/Nat'l Gov't Servs.*, PRRB Hearing Dec. No. 2007-D78, [2007-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 81,789 (Sept. 28, 2007)[38] decision and include *Bayfront Medical Center v. BlueCross BlueShield Ass'n/First Coast Serv. Options, Inc.*, PRRB Hearing Dec. No. 2008-D3, [2008-1 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 81,682 (Oct. 12, 2007);[39] *Sparrow Health 98-99 IME Managed Care Group v. BlueCross BlueShield Ass'n/United Gov't Servs.*, PRRB Hearing Dec. No. 2008-D17, [2008-1 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 81,882 (Feb. 12, 2008);[40] *Loma Linda University Medical Center v. BlueCross BlueShield Ass'n/United Gov't Servs.*, PRRB Hearing Dec. No. 2008-D26, [2008-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 81,926 (May 9, 2008),[41] *UPHS 99 Medicare + Choice Beneficiaries Group and UPHS 00 Medicare + Choice Beneficiaries Group v. Mut. of Omaha Ins. Co.*, PRRB Hearing Dec. No. 2008-D29, [2008-3 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 82,101 (June 3, 2008), [42] *Yale-New Haven Health Services Group Appeals v. BlueCross BlueShield Ass'n/Nat'l Gov't Servs.*, PRRB Hearing Dec. No. 2009-D16, [2009-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 82,303 (Apr. 2, 2009),[43] and *Henry Ford Health Sys. Managed Care GME/IME Payments Group v. BlueCross BlueShield Ass'n/Nat'l Gov't Servs.*, PRRB Hearing Dec. No. 2009-D20, [2009-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 82,306 (Apr. 16, 2009)[44].[45] In each of

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[38] Exhibit P-37.
[39] Exhibit P-48.
[40] Exhibit P-49.
[41] Exhibit P-50.
[42] Exhibit P-51.
[43] Exhibit P-52.
[44] Exhibit P-53.
[45] In each of those cases, the CMS Administrator reversed the PRRB. *Santa Barbara Cottage Hosp. v. Blue Cross and Blue Shield Ass'n/Nat'l Gov't Servs.*, CMS Adm'r Dec., [2008-1 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 81,859 (Nov. 16, 2007) (Exhibit P-37); *Bayfront Med. Ctr. v. BlueCross BlueShield Ass'n/First Coast Serv. Options, Inc.*, CMS Adm'r Dec., [2008-1 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 81,874 (Dec. 10, 2007) (Exhibit P-48); *Sparrow Health 98-99 IME Managed Care Group v. BlueCross BlueShield Ass'n/United Gov't Servs.*, CMS Adm'r Dec., [2008-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 81,946 (Apr. 14, 2008) (Exhibit P-49); *Loma Linda Univ. Med. Ctr. v. BlueCross BlueShield Ass'n/United Gov't Servs.*, CMS Adm'r Dec., [2008-3 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 82,107 (July 7, 2008) (Exhibit P-50); *UPHS 99 Medicare + Choice Beneficiaries Group and UPHS 00 Medicare + Choice Beneficiaries Group v. Mut. of Omaha Ins. Co.*, CMS Adm'r Dec., [2008-3 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 82,108 (July 31, 2008) (Exhibit P-51); *Yale-New Haven Health Servs. Group Appeals v. BlueCross BlueShield Ass'n/Nat'l Gov't Servs.*, CMS Adm'r Dec., [2009-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 82,332 (May 20, 2009) (Exhibit P-52); *Henry Ford Health Sys. Managed Care GME/IME Payments Group v. BlueCross BlueShield Ass'n/Nat'l Gov't Servs.*, CMS Adm'r Dec., [2009-2 Transfer Binder] Medicare and

these cases, the intermediary had disallowed DGME and IME payments with respect to discharges of M+C enrollees during FY 1998. These cases are not identical to one another in that different providers have presented different arguments. In all of the cases, however, the Board has consistently held that the intermediaries' attempts to reduce DGME and IME reimbursement associated with the M+C enrollees violated the law. The Board has rejected the intermediaries' position that, in order to claim additional DGME and IME reimbursement for M+C enrollees, providers were required to directly bill their intermediaries, as opposed to their MCOs, and that they were required to do so within the timeframe specified in 42 C.F.R. § 424.44. The Board has held that CMS's rules at the time required that providers submit their M+C claims to the MCOs themselves. The Board has further ruled that 42 C.F.R. § 424.30 is specifically applicable to claims involving M+C enrollees and that this regulation – not the regulation at § 424.44 – applies. Further, in the DGME/IME cases, the intermediaries did not dispute that the providers had timely submitted their claims to the MCOs, and the Board therefore held that the data contained in those claims reflected proper payment and had to be considered by the intermediaries in determining the appropriate DGME and IME reimbursement due. The refusal by the intermediaries to do this, the Board held, was improper. The Board also held that the fact that the providers' M+C data were not captured on the PS&R reports was of no consequence. The providers had submitted information regarding their M+C enrollees (information previously submitted to the MCOs) to the intermediaries, and this information should have sufficed according to the Board. The Provider contends that all of these grounds for rejecting the Intermediary's "no-pay" claim position in the DGME and IME context, apply to this case.

The Intermediary asserts that the BBA establishes the authority for the Secretary to make payments to teaching hospitals for DGME and IME associated with Medicare enrollees in MCOs. The additional payments to teaching hospitals for managed care costs are determined based on the hospital's Medicare managed care utilization. In CMS Pub. 60A, Transmittal No. A-98-21, July 1, 1998, (Exhibit I-6) it outlines the changes needed to process provider requests for this additional medical education payment. The transmittal requires that:

> PPS hospitals must submit a claim to the Hospital's regular intermediary in UB-92 format ...
>
> [T]he intermediary will submit the claim to the Common Working File (CWF). CWF will determine if the beneficiary is a managed care enrollee...

Medicaid Guide (CCH) ¶ 82,330 June 10, 2009) (Exhibit P-53). In three of those cases, however, the United States District Court for the District of Columbia reversed the Administrator. *Cottage Health Sys. v. Sebelius*, 631 F. Supp. 2d 80 (D.D.C. 2009), *reprinted in* [2009-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 302,919 (July 7, 2009) (Exhibit P-47); *Hosp. of Univ. of Penn. v. Leavitt*, Civil Action No. 08-1665, [2009-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 302,922 (July 10, 2009) (Exhibit P-51); *Loma Linda Univ. Med. Ctr. v. Sebelius*, No. 1:08-cv-01520-HHK, 2010 WL 532088 (D.D.C. Aug. 29, 2008). The opinions in those three cases turn on the adequacy of the Secretary's reasoning regarding the application of 42 C.F.R. § 424.44, with the court ruling that the Secretary's reasoning was flawed or incomplete. Therefore, in each of the cases, the court remanded the case to the CMS Administrator for further proceedings.

> [U]pon verification from CWF that the beneficiary is a managed care enrollee the intermediary will make an operating IME only payment with the proper annotation on the remittance advice.

The Intermediary disagrees with the Provider's assertion that the Program Memorandum (PM) A-98-21 is invalid since the Paperwork Reduction Act of 1995 requires that a government agency cannot require the same document twice without prior authorization from the OMB. The Intermediary contends that providers have been required to file claims when reimbursement of the particular service (or claim) is not expected since August 1, 1988. Section 411 of Medicare's Hospital Manual, CMS Pub 10,[46] states:

> The benefit days available to a beneficiary depend upon the status of his/her utilization of services during the benefit period described in §215 and the lifetime reserve days described in §219. Submit bills for all stays, including those for which no program payment can be made. This assists the intermediary and HCFA in maintaining utilization records and determining remaining eligibility. Even though these bills are noncovered, a bill is required because hospitalization could extend a benefit period.

CMS has required hospitals to submit bills for all stays since 1988, therefore, the "no-pay" billing requirement established through BBA specific to additional medical education payments for training associated with M+C enrollees presented little or no additional burden to hospitals.

Providers must submit claims for services provided to enrollees of M+C MCOs to their intermediary to complete the CWF process of verifying if the beneficiary is a managed care enrollee. The days of service verified as provided to managed care enrollees are reported on the PS&R report type 118 and represent the hospital's verified managed care days to be included in the hospital's managed care utilization ratio. The claims processing system performs edits that ensure that only eligible M+C enrollees are included in the managed care reimbursement utilization formula. This process was established specific to managed care enrollees beginning with service dates in 1998. By complying with the BBA claim submission requirements, the managed care enrollee days would be gathered in the PS&R as the "best available data" to be used in determining the M+C utilization in accordance with 42 C.F.R. § 413.87(e).

While the Provider contends that the BIPA does not provide instructions to the hospitals as to how to report their M+C inpatient days, the Intermediary contends that BIPA does not address the must-bill policy specific to the additional reimbursement for hospitals that provide N&AH education, because the must-bill policy had previously been implemented in 1988.

The Intermediary disagrees with the Provider's contention that there is nothing in the law that requires timely filing of "no-pay" bills and that the timely filing regulation at 42 C.F.R. § 424.44 does not apply here. The regulation at 42 C.F.R. § 424.30 indicates claims must be filed in all cases except when services are furnished on a prepaid capitation basis. The Intermediary

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[46] Exhibit I-7.

contends that while the general services to M+C beneficiaries are subject to the prepaid capitation, the teaching portion is not.

BBA provided for DGME and IME payments to teaching hospitals for discharges associated with Medicare managed care beneficiaries for portions of cost reporting periods occurring on or after January 1, 1998. The additional payment is "equal to an applicable percentage of the estimated average per discharge that would have been made for that discharge if the beneficiary were not enrolled in managed care" (62 Fed. Reg. 45966 at 46003) (August 29, 1997).[47] The Secretary provided the methodology for the additional medical education payment based on a July 1, 1998 PM A-98-21. The Intermediary also published a newsletter dated July 1998, as Hospital Newsletter 98-27,[48] which the provider should have received. The text of the instruction is clear in that the additional reimbursement payment for medical education services provided to managed care enrollees is not part of the HMO capitation payment. The timely filing of "no-pay" managed care claims at issue here is applicable because the claims support the payment of additional teaching costs and not for services furnished.

The Intermediary asserts that the Provider was aware of their obligation to submit M+C claims for services as reflected by their submission of some of the M+C claims. The Provider elected not to comply with the regulatory requirement to bill all M+C claims to the intermediary. It wasn't until the Intermediary's audit of the Provider's December 31, 2001 cost report that the Provider realized the material impact of its decision not to comply with the must-bill requirement.

The Intermediary also disagrees with the Provider's contention that neither BBA nor BIPA require that reimbursement data be reflected on a particular form or report. The requirement to submit "no-pay" M+C claims was published in PM A-98-21 in July 1998. The language of the transmittal is clear, "PPS Hospitals must submit a claim to the hospital's regular intermediary in UB-92 format ..." Prior to this, as previously stated, CMS has required hospitals to submit bills for all stays since 1988.

42 C.F.R. § 413.87(e)(1)(i) states, "Medicare payments received for approved nursing or allied health education programs **based on data from the settled cost report** for the period(s) ending in the fiscal year that is 2 years prior to the current calendar year;" (emphasis added.) The Intermediary's determination uses the data from the settled cost report. The cost report was settled using the best available data as reflected in the PS&R. The Intermediary contends that the M+C days supported by the PS&R have been subjected to the necessary edits to ensure that the beneficiary was enrolled in an approved managed care program. The requirement to have the hospitals submit their claims to intermediaries so they are subjected to specific edits ensures the PS&R data is the best available data. Once the patient claim is submitted and successfully processed by the intermediary it is reported on the PS&R. There is no need for additional audit verification.

The Intermediary refutes the Provider's argument it is not required to use the PS&R because it is inaccurate or not the best available data. The Intermediary contends the Provider had every

[47] Exhibit I-12.
[48] Exhibit I-17.

opportunity to submit the claims and make the PS&R accurate, but chose not to do so. The Intermediary relied on the PS&R under CMS' rules.

In Santa Barbara Cottage Hospital vs. Blue Cross Blue Shield Association/National Government Services, LLC-CA, CMS Administrator's Dec., Medicare and Medicaid Guide CCH ¶81,859, November 16, 2007, the CMS Administrator found that:

> while the statute did not set forth in detail that the Provider was to submit data directly to the Intermediary, the provision for this payment for managed care enrollees is within framework of a pre-existing methodology for IME/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 May 1998 preamble language published in the Federal Register anticipated this requirement. In addition, the PM A-98-21 explicitly stated that a "hospital must submit a claim to the hospital's regular intermediary." Moreover, the July 13, 1998 Bulletin 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 . . . Risk Members: teaching hospitals to submit bills to regular intermediary for IME payment ....

The Intermediary also notes that the CMS Administrator also did not believe that the Administrative Procedure Act required CMS to publish a new regulation under these circumstances. As a result, the Board should find that the Intermediary should use the PS&R and reject the Provider's request to use other data.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law, regulations and guidelines, the parties' contentions, and evidence presented, finds and concludes as follows:

Findings of fact:

1. RMC is a multi-campus facility that participates in the Medicare program. Prior to 2005, the two campuses of the facility were Research Medical Center, a 536-bed hospital, and Research Belton Hospital, a 70-bed suburban facility. At all times relevant, both Research Medical Center and Research Belton Hospital operated and billed under the same Medicare provider number. For purposes of this case, the two hospitals are collectively referred to as RMC.

2. RMC is a teaching institution. During the periods at issue (FYs 1998 and 2001), the Provider had a minor GME program through which it rotated six to eight resident FTEs from outside programs. More significantly, however, the Provider had a robust nursing and allied health education program. That program comprised a nursing school, a radiology school, a nuclear medicine school, and a clinical pastoral education school.

3. The nursing and allied health education programs were recognized under Medicare rules, and Medicare reimbursed their costs for all applicable periods pursuant to the regulations at 42 C.F.R. § 413.85.

4. Prior to 1998, the Medicare program made no direct payment to providers for DGME, IME or N&AH expenses associated with Medicare enrollees of MCOs. Congress began to change this approach, however, with the 1997 BBA.

5. In the BBA, Sections 4622 and 4624, Congress provided for the payment for DGME and IME associated with M+C enrollees, phased in over a five-year period. The BBA provision, however, allowed for payment for M+C enrollees only for purposes of DGME and IME reimbursement. The BBA provision made no allowance for payments for N&AH payments associated with M+C enrollees.

6. CMS issued instructions to implement the BBA provision for DGME and IME reimbursement through PM A-98-21, which was issued July 1, 1998. In PM A-98-21, CMS states that, pursuant to Sections 4622 and 4624 of the BBA, "hospitals *may* request supplemental payments for operating Indirect Medical Education (IME)" as well as DGME for M+C enrollees (emphasis added). The transmittal further states that "for IME and DGME supplemental payments for Medicare and managed care enrollees . . . PPS hospitals must submit a claim to the hospitals' regular intermediary in UB-92 format, with condition codes 04 and 69 present . . . ."

7. Seeking additional DGME and IME reimbursement, RMC submitted UB-92 claims to its Intermediary consistent with the language of PM A-98-21 for services furnished to Medicare M+C enrollees in 1998. RMC, however, encountered significant problems in getting the claims properly processed by its Intermediary, then Mutual of Omaha. A significant number of claims were denied due to various edits, such as coordination of benefits. Providers other than RMC, also serviced by Mutual of Omaha, experienced similar problems in getting their DGME and IME claims associated with M+C enrollees processed.

8. After its unsuccessful attempts to get its claims processed, RMC ceased pursuing those claims. It did this because in 1998 there were very small DGME and IME payments at stake for M+C enrollees. This was due, in part, to the low number of resident FTEs at RMC and was further due to the fact that 1998 was the first year of a five-year period phase-in for payment, meaning that payments were quite low in 1998.

9. Nothing on the face of PM A-98-21 suggested that its documentation and claims submission requirements applied to the submission of claims necessary to obtain additional N&AH expenses for M+C enrollees. Medicare did not begin paying for N&AH education expenses associated with M+C enrollees until January 1, 2000.

10. In Section 541 of the 1999 BBRA, Congress authorized additional payments for N&AH education expenses associated with M+C enrollees. The BBRA payment methodology authorized additional payments calculated using the provider's cost of operating N&AH programs as reflected on cost reports ending in the federal fiscal year two years prior to the current period. The payments made under the BBRA in calendar year 2000 were not based on individual hospitals' M+C days.

11. Congress amended the N&AH payment methodology in Section 512 of the 2000 BIPA. This provision, which was effective January 1, 2001, revised the N&AH payment formula to account specifically for each hospital's M+C utilization during the cost reporting period ending in the federal fiscal years two years prior to the current period.

12. CMS initially implemented Section 512 of BIPA through PM A-01-148, issued on December 27, 2001. The transmittal acknowledged the change in the methodology for the

calculation of the N&AH education expenses and gave general examples of the payment formula. The transmittal, however, did not provide any instruction to hospitals as to how they were to report their M+C inpatient days for purposes of calculating the N&AH M+C payments.

13. Subsequently, on February 3, 2003, CMS issued PM A-03-007. In that transmittal, CMS stated that hospitals that operated N&AH programs and wished to qualify for additional payments related to their M+C enrollees would be required to submit M+C claims to their Medicare fiscal intermediaries, to be processed as no-pay bills, so that the M+C inpatient days could be accumulated on the PS&R for purposes of calculating the M+C N&AH payment through the cost report. This transmittal explicitly applied prospectively, beginning July 1, 2003.

14. Following this, on May 23, 2003, CMS issued PM A-03-043, stating, first, that for each eligible hospital, the total number of M+C inpatient days was to be based on data from the cost report for the fiscal year that was two years prior to the current calendar year and, second, that intermediaries were to obtain the number of M+C inpatient days from the PS&R report for that year. The transmittal also provided that, "subject to the rules concerning time limitation for submitting provider claims at §3600.2 of the Intermediary Manual, (MIM) additional documentation to revise the FI's determination [of the number of M+C days] may be submitted by the provider, but will be subject to audit by the FI." This transmittal, issued on May 23, 2003, had an effective date of January 1, 2001, nearly two and one-half years earlier, and applied to data collected two federal fiscal years prior to 2001, which in this case was 1998.

15. Under the time limitations specified in the MIM § 3600.2, the Provider would have had to have submitted revised data to the Intermediary no later than December 31, 2000, before Section 512 of BIPA was in effect, in order to supplement its data for the 2001 N&AH M+C reimbursement year.

16. The Provider attempted to submit additional 1998 data to its Intermediary in 2003, after it learned of the requirements set forth in PM A-03-043. The Intermediary, however, rejected the additional data as time barred.

17. The additional data that the Provider sought to submit consisted of paid claims data that RMC obtained from the MCOs themselves. This data reflected claims that were submitted to the MCOs by RMC and which the MCOs had paid after review. The paid claims data was not complete. The MCOs were able to retrieve only some paid claims files for 1998. Those retrieved paid claims files, however, showed that the Provider had furnished at least 9,545 days to M+C enrollees. By comparison, the Provider's PS&R report reflected only 2,742 M+C days.

18. The data from the MCOs, which the MCOs submitted to the Provider and the Provider attempted to submit to its intermediary, reflect the same data that the MCOs were supposed to submit to the CMS. This data was relied upon by CMS. Indeed, the Intermediary furnished the Provider with some 122 days associated with M+C enrollees serviced by the hospital's IPPS-exempt rehabilitation unit in 1998. The Intermediary had obtained the data for these 122 days from CMS, which in turn had obtained the data from the MCOs directly. The Intermediary counted those 122 days as "paid days" for purposes of calculating RMC's N&AH education payments for 2001.

19. The difference between the number of days that the Provider has established are due it (data obtained from the MCOs themselves), and the number of days that the Intermediary has allowed (the PS&R reported days of 2,742 plus the 122 days associated with the distinct part rehabilitation unit, totaling 2,864 days) reflects a difference of 6,681 days.

Based upon these facts, the Board finds and concludes that the Intermediary's calculation of the Provider's N&AH education reimbursement amount for 2001 was improper.

The Intermediary's calculation relies exclusively on days contained in the Provider's PS&R report for 1998. That report, in turn, includes only days for which the Provider had submitted and the Intermediary properly processed no-pay claims for 1998 discharges, in order to obtain DGME and IME reimbursement as authorized by Sections 4622 and 4624 of the BBA and CMS PM A-98-21. The evidence clearly shows, however, that those days are significantly understated. Unrebutted testimony establishes that the Provider encountered significant difficulties in getting its no-pay claims processed by the Intermediary for 1998, with claims being repeatedly rejected for a variety of reasons that indicated that the Intermediary was unable to process the claims. Under those circumstances, the Provider ultimately concluded that the cost of pursuing these claims in 1998 exceeded the amount of reimbursement that it would ultimately receive.[49] Given that in 1998 there was no information that Medicare would make N&AH payments for M+C enrollees and certainly no hint that those payments would be based on no-pay bills submitted by providers in 1998, the Provider made a business decision not to bill. Indeed, it was not until 2000 that Medicare began paying for N&AH education associated with M+C enrollees; it was not until 2001 that the payment methodology for N&AH payments associated with M+C enrollees was changed by Congress to reflect hospitals' utilization; and it was not until 2003, that CMS stated that providers would have to submit no-pay bills to reflect that utilization.

Plainly, the Provider was not on notice in 1998 of a need to submit no-pay claims for M+C enrollees in 1998 in order to receive N&AH education payments. Rather, the CMS regulation at that time, 42 C.F.R §417.584, simply informed providers that in order to receive reimbursement for M+C enrollees, they were required to submit claims directly to their MCOs, which they did, and that *if* they wished to receive additional DGME and IME payments, guidance[50] indicated they could submit no-pay claims to their fiscal intermediaries to receive those additional payments. The Provider complied with this guidance in effect in 1998. It submitted UB-92s to its Intermediary to receive addition DGME and IME payments, but after encountering processing roadblocks, elected not to pursue claims they could not get approved and paid. It also sought and received reimbursement from the MCOs themselves for the services it furnished in 1998 to M+C enrollees.[51]

Nothing in the statute or the regulations required N&AH education payments for M+C enrollees to be supported by no-pay claims. The BBRA and BIPA amendments to the Medicare statute mandate that the Secretary "shall" provide for additional N&AH payments for providers' M+C patients for cost reporting periods ending on or after January 1, 2000, BBRA § 541; BIPA § 512,

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[49] Under the BBA, DGME and IME payments for M+C enrollees were phased in over a five-year period. During 1998, only 20% of the reimbursement was, in fact, paid to the Provider.

[50] *See* Board fact no. 6, *supra*.

[51] Without question, the data submitted by the Provider to its MCOs, upon which the MCOs relied in making payments, were accurate claims data. Again, the MCOs vetted that data and, upon verifying the content of that information, made payment to the Provider for the services furnished to the M+C enrollees. Thus, to the extent that this 1998 data now becomes necessary to calculate RMC's M+C N&AH payments, the Intermediary cannot reasonably state that this data – the very claims data upon which the MCOs relied and made payment – is somehow not reliable data.

without specifying the source of documentation. Nor does the implementing regulation at 42 C.F.R. § 413.87, restrict reimbursement to instances where the N&AH reimbursement is supported by no-pay claims or by particular reports. Instead, the only requirement that there be no-pay claims for N&AH payments in 2001 is found in PM A-03-043, promulgated in May 2003, well past the dates the providers could have submitted the no-pay claims under CMS' interpretation and contrary to prior instructions that informed providers that they were to submit claims for M+C enrollees to the MCOs themselves. Moreover, the Intermediary interpreted the 2003 transmittal as expressly barring providers from submitting any supplemental data, unless that data were submitted no later than December 30, 2000, the last day permissible under the claims filing limitations deadline found in 42 C.F.R. § 424.44. If the Intermediary interpretation is correct, these requirements were new requirements, imposed on the Provider for the first time in 2003 but made applicable to 1998. However, the Board finds that CMS' own guidance contradicts that position. CMS Pub. 100-4, Chapter 1, 70.7.1, provides that where an administrative error prevents timely filing of the claim, the provider will have until the end of the 6th calendar month from the month in which the provider received notification that the error or misrepresentation occurred. Situations in which failure to file within the usual time limit will be considered to have been caused by administrative error include the failure resulting from excessive delay by Medicare, or the Medicare contractor in furnishing information necessary for the filing of the claim. CMS erred in not giving notice until May 2003 and providers should have been given an extra amount of time to file.

The Intermediary maintains that CMS requires it to use the PS&R reports, and only the PS&R reports, to determine the number of days for purposes of M+C N&AH calculation. But again, the Board finds CMS guidance to the contrary. Under § 2242 of the MIM, in place at the time these costs were incurred, intermediaries were permitted to rely on the PS&R report in settling a provider's cost report unless the provider was able to establish that inaccuracies existed. The courts and administrative agencies have consistently upheld § 2242's direction regarding the use of PS&R report data in the cost report settlement process, *absent a showing of inaccuracies. See, e.g., Girling Healthcare, Inc. v. Shalala*, 85 F.3d 211, 216 (5th Cir. 1996); *Med. Rehab. Servs., PC v. Shalala*, 17 F.3d 828, 835 (6th Cir. 1994); *Carepoint Home Health Agency South v. Blue Cross and Blue Shield Ass'n/Blue Cross and Blue Shield of Cal.*, HCFA Adm'r Dec., [1994-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 42,445 (May 10, 1994) (Administrator found that, under the circumstances presented, the provider's cost report provided the best data available for determining the number of visits for the provider in each of the three modalities where variances in the PS&R data had been identified). This point was also made by CMS in PM A-02-081 (Aug. 28, 2002), in which the agency stated that it was issuing the transmittal to modify earlier language and "remove any inference that the provider must use only the PS&R to prepare a cost report." Thus, while it is generally true that the PS&R report is to be relied upon in the cost report settlement process, the report is not controlling when the provider can demonstrate, as it has done here, that its data is more accurate. The Board rejects the Intermediary's contention that it must rely on indisputably imperfect data reported in the PS&R report when, as here, the Provider has offered more accurate data to be used in the cost report settlement process, data validated by CMS.

There is no question that the Provider offered data to the Intermediary of M+C days that was more accurate and reliable than the incomplete data reflected in the Provider's PS&R report. There is also no question that the Intermediary rejected this data. Although the Intermediary

now contends that the MCO paid claims data was not the "best available data," the Board notes that the Intermediary relied upon this very type of paid claims data – data that the MCOs had reported to CMS and that CMS had forwarded to the Intermediary – in determining the number of days to which the Provider was entitled for N&AH payments associated with M+C enrollees in RMC's IPPS-exempt rehabilitation unit. Plainly, then, the Intermediary considered this data to be reliable and accurate in making some of the N&AH payments, and it cannot now suggest that the PS&R, which lacked this data, is the more reliable document. This is particularly so given that the regulations at 42 C.F.R. § 422.257 required that the providers submit claims data related to their M+C enrollees directly to the MCOs themselves and that the MCOs report that data to CMS.

The Intermediary further maintains, again relying on the May 2003 transmittal, that the Provider may not supplement the PS&R unless it does so within the time frames set forth in MIM § 3600.2 and 42 C.F.R. § 424.44. In other words, the Intermediary maintains that the Provider must have submitted claims related to its M+C enrollees directly to the Intermediary no later than December 31, 2000, *before reimbursement by Medicare for N&AH education payments was even authorized*. Here, again, the Intermediary's argument misses the mark. The services at issue were all provided on a pre-paid capitation basis through Medicare MCOs. The applicable regulation at 42 C.F.R. § 424.44 is part of 42 C.F.R. Part 424, Subpart C. Subpart C at 42 C.F.R. § 424.30 states expressly that the provisions of Subpart C, including the timely filing requirements, are to be applied "except when services are furnished on a prepaid capitation basis." This point is reinforced by CMS' own Medicare Claims Processing Manual, Pub. 100-04, Chapter 1, § 70, which states that the regulations at 42 C.F.R. § 424.44 define the timely filing period for "Medicare fee-for-service claims." Consequently, the timely filing requirements of 42 C.F.R. § 424.44 do not apply to the claims at issue here.

In similar circumstances the Board has rejected the intermediaries' position that, in order to claim additional DGME and IME reimbursement for M+C enrollees, providers were required to directly bill their intermediaries, as opposed to their MCOs, and that they were required to do so within the timeframe specified in 42 C.F.R. § 424.44.[52] The Board has held that CMS' rules at the time required that providers submit their M+C claims to the MCOs themselves. The Board has further ruled that 42 C.F.R. § 424.30 is specifically applicable to claims involving M+C enrollees and that this regulation – not the regulation at § 424.44 – applies. Further, in the DGME/IME cases, the intermediaries did not dispute that the providers had timely submitted their claims to the MCOs, and the Board therefore held that the data contained in those claims reflected proper payment and had to be considered by the intermediaries in determining the appropriate DGME and IME reimbursement due. The refusal by the intermediaries to do this, the Board held, was improper. The Board also held that the fact that the providers' M+C data were not captured on the PS&R reports was of no consequence. The providers had submitted information regarding their M+C enrollees (information previously submitted to the MCOs) to the intermediaries, and this information should have sufficed according to the Board.

All of these grounds for rejecting the Intermediary's "no-pay" claim position apply here, just as they applied in the DGME and IME context. When the statutory provisions authorizing N+AH payments based on M+C days were adopted, no changes were made to 42 C.F.R. §424.30.

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[52] *See* Provider's contention, *supra* notes 38-45 and accompanying text.

Furthermore, 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 the HMO to recover payment for inpatient services. 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 with the MCO and to also file a virtually identical claim to the intermediary, then the Board believes that a regulatory notice is required. When 42 C.F.R. §424.30 governing claims filing was implemented, there was no contemplation of or any need for a "claim for payment" other than the claim to obtain payment for the inpatient *services furnished* to the beneficiary. When the additional payment for IME/DGME was authorized by the BBA' 97, it did not change the nature of the payment for "services furnished." Rather, the IME/DGME payment arises 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 Secretary has been given extremely broad authority to implement procedures for payment. However, once 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 guidance in a Program Memorandum is insufficient to deprive a provider of its statutory right to payment. Therefore, the Board finds that the Intermediary improperly denied the Provider's submission of IME/DGME claims for Medicare managed care enrollees due to untimely filing, and the Provider should be given the opportunity to support its claim for payment.

Moreover, even were the timely filing provisions at 42 C.F.R. § 424.44 to apply here, those regulations grant an exception to providers if the failure to meet a required deadline was caused by error or misrepresentation by CMS or an intermediary. The Board concludes that there were errors in the processing of the Provider's 1998 no-pay bills so as to cause a delay in the "timely filing" of those claims. There were also misrepresentations contained in CMS' communication of the requirements for filing no-pay claims, in that it was silent as to the applicability of a timely filing requirement. As a consequence, even if the requirements of 42 C.F.R. § 424.44 were generally to apply here, the Provider would be entitled to an extension in which to submit the additional data that the Intermediary rejected.

In summary, there is no statutory or regulatory requirement that providers submit no-pay claims in 1998 to receive reimbursement for services furnished to M+C enrollees or that intermediaries require no-pay claims to calculate that reimbursement for N&AH education payments in 2001. Instead, in 1998, providers were required to submit claims for services furnished to M+C enrollees directly to the MCOs themselves, not to Medicare fiscal intermediaries. Moreover, although providers could submit claims directly to fiscal intermediaries if they wished to receive reimbursement for additional DGME and IME payments associated with those M+C enrollees in 1998, nothing required that they do so. CMS's transmittal in May 2003 mandates that in order to receive N&AH payments in 2001, providers were required to have submitted no-pay claims in 1998 directly through their fiscal intermediary. The 2003 transmittal contradicts these pre-existing authorities and constitutes a new set of conditions for reimbursement. As such, the Board gives no weight to the new guidance.

Furthermore, the evidence demonstrates that the Provider had already supplied the information necessary to calculate the M+C days by providing beneficiary-specific claims to CMS' contractors, the MCOs themselves, as the rules at the time required. And, once notified of the no-pay claim requirement, the Provider here offered the Intermediary accurate, complete and reliable data in the form of paid claims files from the MCOs, reflecting the M+C days. The Provider sought to furnish to the Intermediary a detailed listing – in the form of paid claims files – of the M+C enrollees and days it serviced during the periods at issue for verification and inclusion in the Medicare cost report. The Intermediary's refusal to accept and audit the data made available to support the Provider's claim was contrary to rules and guidance in effect at the time, was improper, and must be remanded to the Intermediary for audit and payment of N&AH costs based on the data submitted by the Provider.

The Board also notes that the OMB argument has been remanded to the Secretary for further explanation in other cases.[53] A decision on the OMB issue is unnecessary given the Board decision on the other challenges.

DECISION AND ORDER:

The Intermediary improperly disallowed the N&AH payments in the Provider's FY 2001 with respect to the discharges of M+C beneficiaries for the period ending December 31, 1998. The Intermediary's adjustments are reversed and the cost reports are remanded to the Intermediary to include the FY 1998 paid M+C days as reported by the MCOs in recalculating the Provider's allowable N&AH payments for FY 2001.

BOARD MEMBERS PARTICIPATING:

Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.
Michael W. Harty

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: MAR 09 2012

[53] *See Cottage Health, supra n. 7.*