PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D34

PROVIDER –
Northern Utah Healthcare d/b/a St. Mark's Hospital

Provider No.: 46-0047

vs.

MEDICARE CONTRACTOR –
Wisconsin Physicians Services

HEARING DATE –
February 25, 2016

Cost Reporting Period Ended –
December 31, 2015

CASE NO.: 15-3197

INDEX

Page No.

Issue Statement 2

Decision..... 2

Introduction 2

Statement of Facts…….. 2

Discussion, Findings of Facts, and Conclusions of Law..... 4

Decision and Order 6

Concurring/Dissenting Opinion of Charlotte F. Benson..... 8

ISSUE STATEMENT:

Whether the Provider is entitled to the full Outpatient Prospective Payment System ("OPPS") market basket rate for Calendar Year ("CY") 2015 based on its reported Hospital Outpatient Quality Reporting ("HOQR") validation data?[1]

DECISION:

After considering the Medicare law and regulations, the parties' contentions and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds the "assign physician" verbiage used in St. Mark's medical records documents the time the physician greets the patient, and, therefore, should be used for validating the OP-20 measure. The Board majority also finds the OP-6 and OP-7 measures were incorrectly scored in CMS' validation process. Based on these findings, the Board majority finds that the Provider meets the 75% validation score and is entitled to the full market basket rate for CY 2015.

INTRODUCTION:

Northern Utah Healthcare d/b/a St. Mark's Hospital ("St. Mark's" or "Provider") is an acute care hospital located in Salt Lake City, Utah. In December 2014, the Centers for Medicare & Medicaid Services ("CMS") notified the Provider that it failed to meet the requirements of the CY 2015 HOQR Program.[2] St. Mark's requested that CMS reconsider this decision. On May 1, 2015, CMS upheld its decision that St. Mark's failed to meet the validation requirements of the HOQR Program reporting requirement, and reduced its CY 2015 market basket update.[3] St. Mark's timely appealed this issue to the Board[4] and met the jurisdictional requirements for a hearing.

The Board conducted a hearing on February 25, 2016. Michael Herron and Marie Prothero of Northern Utah Healthcare represented St. Mark's Hospital. Joe Bauers, Esq. and Ed Lau, Esq., of Federal Specialized Services, represented the Medicare Contractor.

STATEMENT OF FACTS AND RELEVANT LAW:

Medicare pays hospitals for outpatient services under OPPS.[5] CMS provides financial incentives to hospitals that report quality data for multiple settings of care if hospitals comply with reporting requirements "in a form and manner, and at a time, specified by the Secretary…."[6] For hospitals' outpatient care, quality data is reported through the HOQR Program.

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[1] Transcript ("Tr.") at 5-6.
[2] *See* Medicare Contractor's Final Position Paper at 2.
[3] *See* St. Mark's Hospital's Appeal Request (Aug. 10, 2015) at 5; Medicare Contractor's Final Position Paper, Exhibit I-1.
[4] *Id*.
[5] 42 U.S.C. § 1395*l*(t).
[6] 42 U.S.C. § 1395*l*(t)(17)(B).

The HOQR Program requirements are communicated to hospitals through multiple sources including federal registers, regulations and the QualityNet website.[7] One of the requirements of submitting outpatient quality data is compliance with "validation" requirements.

In a November 24, 2010 Final Rule, CMS required 800 randomly selected HOQR-participating hospitals to submit medical documentation for up to 48 self-reported cases from the total number of cases that the hospital had successfully submitted to the OPPS Clinical Data Abstraction Center ("CDAC").[8] The hospital had 45 days to submit paper copies of medical documentation for selected cases to the Medicare Contractor. Upon receipt of the requested documentation, CDAC independently re-abstracts the same quality measure data elements that the hospital previously abstracted to determine whether the two sets of data match. If the hospital achieved a validation score of at least 75%, CMS would pay the hospital the full annual payment update. If it failed validation, the hospital would receive a 2% reduction to their OPD fee schedule increase factor for the applicable payment year.[9]

Finally, the regulation at 42 C.F.R. § 419.46(f) (2015) allows a provider that fails the HOQR validation requirements to request that CMS reconsider its decision. A provider dissatisfied with the result of CMS' reconsideration decision may file an appeal with the Board under 42 C.F.R. Part 405, Subpart R.[10]

In the present case, the Provider asserts that in February 2013 it transitioned to a new electronic medical record system, known as EPIC. During the beta testing phase in March 2013, the Provider received notice that it would be subject to a validation audit in which it was required to validate its original data by sending paper medical records to CDAC.[11] CDAC requested medical records to validate three measures: OP-20, measuring the time between the patient entered the emergency room to the time that a diagnostic evaluation was done by qualified medical personnel; OP-6, timing of antibiotic prophylaxis and OP-7, prophylactic antibiotic selection for surgical patients.[12]

There is no dispute that St. Mark's submitted paper medical records within the required 45-day period.[13] The dispute in this case seems to turn on whether the medical records adequately validated the original quality measures and whether the additional documentation that the Provider submitted during the Board hearing could be used to validate the quality measures.

Specifically, regarding the OP-20 quality measure, St. Mark's electronic medical records used the terminology "assign physician" to indicate when the diagnostic evaluation began, instead of

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[7] *See* http://www.qualitynet.org. QualityNet was also known as QualityNet Exchange or QNet Exchange.
[8] 75 Fed. Reg. 71800, 72103-05 (Nov. 24, 2010).
[9] 78 Fed. Reg. 74826, 75108 (Dec. 10, 2013); *see also* 42 U.S.C. § 1395*l*(t)(17)(A). By 2012, CMS amended its regulation to reduce the number of hospitals whose quality data was subject to a validation audit to 400. *See* 77 Fed. Reg. 53258, 53551-52 (Aug. 31, 2012).
[10] 42 C.F.R. § 419.46(f)(3). *See also* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835 (2008).
[11] Tr. at 40-41.
[12] Medicare Contractor's Final Position Paper, Exhibit I-3 at 5.
[13] Neither CMS nor CDAC could produce the original paper medical records submitted for the validation audit. The Medicare Contractor did not submit the CDAC's original written request to St. Mark's regarding the validation audit. *See* Provider's Post Hearing Brief at 1. Medicare Contractor's Post Hearing Brief at 10.

the terminology used in the CDAC audit, "physician greets." The Provider asserts that the transition to a new electronic medical record system required physicians to elect the phrase "assign physician" when greeting the patient for the first time in the emergency room. CDAC's validation auditors failed to recognize the term "assign physician" as matching the terminology "physician greets," which it used to validate this measure. St. Mark's pointed out that while CDAC rejected the "assign physician" terminology to validate some records, it allowed it in others.[14]

Regarding the OP-6 and OP-7 measures, the Provider asserted that when it printed the paper medical record from EPIC, the printout inexplicably left off the "manner," or "route," by which the antibiotics were administered, i.e., intravenously or by mouth.[15] As a result, because the data from the original electronic record submission and the paper medical record printout did not match, CDAC denied validation of these measures.

St. Mark's submitted a reconsideration request,[16] and upon reconsideration, CMS upheld its decision to impose a reduction in its "Market Basket Update for CY 2015."[17]

These facts, as asserted by the Provider, are not refuted by the Medicare Contractor which, in its final position paper, argues that while mistakes in the validation record may have been made, the Provider has not determined that, if corrected, the Provider would have met the 75% validation score.[18] In response to the Board's request for additional documentation during the hearing, the Medicare Contractor argued that the Board is limited to considering only those records that were considered by CMS during the reconsideration process.[19]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

Validation of OP-20

With regard to the OP-20 quality measure, it is clear that the validation auditor generally did not accept the term "assign physician," in the documentation. The Provider's witness testified at the hearing that "when they go in and greet the patient, that 'assign physician is what shows in the electronic medical record."[20] The Provider's witness also testified that "when the physician goes into the room and actually clicks onto that patient and greets the patient," the computer software enters "assign attending" and "assign physician."[21] The Board majority finds support for these statements in the medical records where "assign physician" is frequently followed by an order for x-rays or labs within a very short time frame.[22] Further, the Board majority finds that the CDAC auditor accepted the medical records in Provider Exhibits P-21 and P-25, which contain

[14] Tr. at 53.
[15] Tr. at 71-73.
[16] The parties agree that a reconsideration request was timely filed, but neither party has a copy of this request.
[17] Medicare Contractor's Final Position Paper, Exhibit I-1.
[18] Medicare Contractor's Final Position Paper at 6.
[19] Medicare Contractor's Post Hearing Brief at 8-9.
[20] Tr. at 23, 25.
[21] Tr. at 25.
[22] *See* Provider's Final Position Paper, Exhibit P-4 at 6, Exhibit P-6 at 7 and Exhibit P-9 at 7.

the term "assign physician" in validating data from the fourth reporting quarter of January 1, 2014 through March 31, 2014.

Based on this evidence, the Board majority concludes that the "assign physician" verbiage used in St. Mark's medical records accurately documents the time the physician greets the patient, and should be used for validating the OP-20 measure. The CDAC auditor's refusal to consistently "credit" the Provider's medical record as substantiation that "physician greets" and "assign physician" mean the same thing was arbitrary and capricious and the Board majority reverses this determination.

It should be noted that the Board majority's finding on this quality measure may result in the Provider meeting the 75% validation score. According to the Provider's calculation, if the Board majority reverses the validation finding for this quality measure, St. Mark's validation score increases to 74.70%.[23] The Board requested, and the Medicare Contractor provided, CMS' Hospital Reporting Requirements "rounding" rules, [24] which appear to indicate that a 74.70% would be "rounded up" to 75%. The Provider would be entitled to the full market basket update without considering the validation of OP-6 and OP-7. If the validation score of 75% is not achieved, the Board majority decides the question of the validation of OP-6 and OP-7 as follows.

Validation of OP-6 and OP-7

Regarding measures OP-6 and OP-7, the Provider explains that its electronic patient records contained the required antibiotic timing and route information,[25] but they had difficulty getting this information to print in the paper records submitted to the CDAC for validation. [26] The Provider's witness testified that it began using the new electronic medical record system, the "EPIC System," one month prior to its HOQR validation audit and it found getting EPIC to produce medical records in a printable format particularly challenging.[27] The Provider asserts that the validation failures were the result of these printing difficulties[28] and would like the records provided by St. Mark's for this hearing to be accepted for review.[29]

The Medicare Contractor asserts that the Board is obligated to follow the applicable statutes, regulations and CMS Rulings and cannot consider Provider's supplemental evidence to demonstrate compliance with these quality measures because the Board is limited in its review to only the evidence which CMS reviewed on reconsideration and presumably that the Provider submitted to CDAC for the validation audit.[30]

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[23] Tr. at 42-43. Provider's Post Hearing Brief at 3.
[24] Medicare Contractor's Post Hearing Brief, Exhibit I-6.
[25] Provider's Final Position Paper, Exhibits P-13 to P-18. Tr. at 51, stating the column on the anesthesiologist record showing that the medication was provided intravenously was blank on the version sent to the CDAC.
[26] Tr. at 8-9.
[27] Tr. at 55-56, 71-73.
[28] Tr. at 11-12, 37.
[29] Provider's Post Hearing Brief at 2.
[30] Medicare Contractor's Post Hearing Brief at 8, 10.

The Board majority disagrees with this position for the following reasons. CMS reconsideration regulations outline the CMS procedure for conducting its reconsideration, limiting its review to the medical record submitted to CDAC for the validation audit.[31] While these regulations may limit CMS' reconsideration of CDAC's validation, the Board is not required to follow this provision. Instead, if dissatisfied with the reconsideration decision, a different subsection of this regulation, (f)(3), directs the provider to "file an appeal with the Provider Reimbursement Review Board *under part 405, subpart R of this chapter.*"[32] It is this subsection which the Board must consider in reviewing the validation process and CMS' reconsideration. Part 405, Subpart R of the federal regulations places no limit on what the Board may consider.

Federal statute establishes the Board's authority to review agency decisions and gives the Board authority to issue its decisions that "shall be based upon the record made at such hearing, which shall include the evidence considered by the [Medicare Contractor] *and such other evidence as may be obtained or received by the Board.*[33] The Board's statutory authority also extends to establishing its own rules and procedures to, among other things, issue subpoenas and conduct discovery to further the availability of admissible evidence before a hearing.[34] Finally, the Board has authority to establish its own rules for the conduct of its hearings, including Rule 26, which allows the Board to compel discovery and allows the Board to accept discovery into the hearing record by introducing it as an exhibit or to be read into the record.

The Board majority finds that while 42 C.F.R. § 419.46(f)(2)(vii) limits CMS' reconsideration to the evidence submitted to the validation contractor, the Board's review is not so limited. Therefore, the Board majority concludes that the Board properly exercised its authority to accept the Provider's additional evidence and that this evidence clearly demonstrates the antibiotic timing and "route" sufficient to validate the OP-6 and OP-7 quality measures.

DECISION AND ORDER:

After considering the Medicare law and regulations, the parties' contentions and the evidence submitted, the Board majority finds the "assign physician" verbiage used in St. Mark's medical records documents the time the physician greets the patient and, therefore, should be used for validating the OP-20 measure. The Board majority also finds the OP-6 and OP-7 measures were incorrectly scored in CMS' validation process. The Board majority reverses CMS' reconsideration determination and orders CMS to pay the Provider the full CY 2015 market basket update.

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[31] 42 C.F.R. § 419.46(f)(2)(vii).
[32] 42 C.F.R. § 419.46(f)(3) (emphasis added).
[33] 42 U.S.C. § 1395oo(d) (emphasis added). *See also* 1972 U.S.C.C.A.N 4989, 5309.
[34] 42 C.F.R. § 405.1840. This role was recognized as early as 1987 by the First Circuit in *St. Luke's Hosp. v. Sec'y of Health and Human Servs.* ("St. Luke's"), 810 F.2d 325, 329 (1st Cir. 1987) which stated, "The special features of Board review suggest that its reviewing powers are, if anything, broader, not narrower, that those of the typical reviewing body. For one thing, the Board's authorizing statute contains a special, extra clause specifically stating that it can consider matters not brought to the intermediary's attention. *For another, the Board operates to a degree like an initial factfinder, not simply a reviewing body*…. All this is simply to say that the special circumstances of the reviewing body, as well as general legal principles, support the conclusion that the statute means what it says." (Emphasis added).

BOARD MEMBERS PARTICIPATING:

L. Sue Andersen, Esq.
Charlotte F. Benson, C.P.A. (concurring in part, dissenting in part)
Gregory Ziegler, C.P.A, C.P.C-A

FOR THE BOARD:

/s/
L. Sue Andersen, Esq.
Chairperson

DATE: April 25, 2018

Charlotte F. Benson, CPA, *concurring in part and dissenting in part*

I concur with the Board majority with regard to the OP-20 quality measure. It is clear the validation auditor generally did not accept the verbiage "assign physician" to document the OP-20 measure. However, the Provider testified at the hearing that "when they go in and greet the patient, that assign physician is what shows in the medical record."[35] The Provider also testified that "assign attending" and "assign physician" are entries that happen "when the physician goes into the room and actually clicks onto that patient and greets the patient."[36] This statement is supported by the Provider's medical records that show "assign physician" is frequently followed by an order for x-rays or labs within a very short time frame.[37] Based on this, I concur with the Board majority that the "assign physician" verbiage used in St. Mark's medical records documents the time the physician greets the patient and should be used for validating the OP-20 measure.

However, for the OP-6 and OP-7 quality measures, I respectfully disagree with the Board majority. Although the Board majority correctly points out that 42 U.S.C. § 1395oo(d) allows the Board to base its decision on evidence considered by the Medicare Contractor "*and such other evidence as may be obtained or received by the Board*" (emphasis added), in this case I respectfully disagree with the Board majority's decision to accept additional evidence for validating St. Mark's OP-6 and OP-7 measures for the following reasons.

First, CMS regulations are clear that "[a] hospital must submit the supporting medical record documentation to CMS or its contractor within 45 days of the date identified on the written request"[38] and "[a] hospital meets the validation requirement with respect to a fiscal year if it achieves at least a 75-percent reliability score, *as determined by CMS*."[39] In implementing these regulations, CMS stated in the federal register that "[t]he hospital must ensure a full medical record goes to the contractor for accurate validation"[40] and "*[t]o participate successfully* in the Hospital OQR Program, hospitals must meet administrative, data collection and submission, and *data validation requirements*."[41] St Mark's admits it did not send the required validation information for its OP-6 and OP-7 measures to the CDAC within the 45 day timeframe[42] as required by 42 C.F.R. § 419.46(e)(1). Therefore, the CDAC correctly scored the OP-6 and OP-7 measures. Even if the Board were to accept the new information (as the Board majority agreed to do), that does not change the fact that St. Mark's was *not* compliant with 42 C.F.R. § 419.46(e)(1) as it did not submit its full medical record to the Medicare Contractor for accurate validation within the 45 day time limit. As St. Mark's was *not* compliant with the data validation

[35] Tr. at 23, 25.
[36] Tr. at 25.
[37] *See* Provider's Final Position Paper, Exhibit P-4 at 6; Exhibit P-6 at 7; and Exhibit P-9 at 7.
[38] 42 C.F.R. § 419.46(e)(1).
[39] 42 C.F.R. § 419.46(e)(2) (emphasis added).
[40] 77 Fed Reg. 68467, 68486 (Nov. 15, 2012).
[41] 78 Fed. Reg. at 75108.
[42] Tr. at 51, 71-73, stating the column showing the medication was provided intravenously was blank on the version sent to the CDAC.

requirements in 42 C.F.R. § 419.46(e)(1), I conclude that St. Mark's did not *participate successfully* in the HOQR Program for these measures.[43]

Second, CMS regulations require a hospital to include in its reconsideration request "a copy of all materials that the hospital submitted to comply with the requirements of the affected Hospital OQR Program payment determination year."[44] The word *copy* denotes only what was submitted to the CMS contractor during the validation process. The federal register supports this interpretation stating "[i]f CMS has evidence that the hospital received both letters requesting medical records, the hospital would be deemed responsible for not returning the requested medical record documentation and the hospital would not be allowed to submit such medical documentation as part of its reconsideration request so that information not utilized in making a payment determination is not included in *any* reconsideration request."[45] In this case, there is no dispute that the hospital received the medical record request but responded with an incomplete version of its medical record[46] and, therefore, CMS' reconsideration decision was proper. If the Board accepts additional information, the regulations at 42 C.F.R. § 419.46(f)(2)(vii) and 42 C.F.R. § 419.46(e)(1) would become meaningless. As the Board is bound by *all* agency regulations,[47] I decline to take actions that would make the above regulations meaningless.

Finally, the Board majority points out that as early as 1987 the first circuit court in *St. Luke's* stated, "[t]he special features of Board review suggest that its reviewing powers are, if anything, broader, not narrower, than those of the typical reviewing body. For one thing, the Board's authorizing statute contains a special, extra clause specifically stating that it *can* consider matters not brought to the [Medicare Contractor's] attention."[48] While it is clear the court's decision in *St. Luke's* supports the fact that the Board *can* consider matters not brought to the Medicare Contractor's attention, this decision does not mandate that in all circumstances the Board *must* consider matters not brought to the Medicare Contractor.[49] More importantly, the decision in *St. Luke's* does not address whether the Board can accept additional information when CMS regulations specifically limit the time period for submitting information.[50] As St. Mark's did not comply with 42 C.F.R. § 419.46(e)(1), I decline to overlook this non-compliance and accept new information as a means for St. Mark's to meet the HOQR Program validation requirements. If the Board accepts information not submitted in compliance with 42 C.F.R. § 419.46(e)(1), any hospital could simply appeal to the Board to bypass 42 C.F.R. § 419.46(e)(1). It certainly was not CMS' intent to give non-compliant providers a means to bypass the HOQR Program regulations[51] when it allowed HOQR Program reconsideration decisions to be appealed to the Board.

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[43] *See* 78 Fed. Reg. at 75108 stating "[t]o participate successfully in the Hospital OQR Program, hospitals must meet administrative, data collection and submission, and *data validation requirements*."
[44] 42 C.F.R. § 419.46(f)(2)(vii).
[45] 77 Fed. Reg. at 68487.
[46] Tr. at 51, 71-73, 114.
[47] 42 C.F.R. § 405.1867.
[48] *St. Luke's*, 810 F.2d at 329.
[49] *Id.* at 327-28.
[50] Unlike the HOQR Program regulations, CMS' cost report regulations do not limit the time period to submit data related to a cost report audit.
[51] 42 C.F.R. § 419.46(e)(1).

In conclusion, I disagree with the Board majority related to the OP-6 and OP-7 measures and find these measures were correctly scored in CMS' validation process. I agree with the Board majority that the "assign physician" verbiage used in St. Mark's medical records documents the time the physician greets the patient and, therefore, should be used for validating the OP-20 measure. I remand this case back to CMS to re-evaluate the Provider's OP-20 measure based upon the Board's findings, and re-calculate the Provider's validation reliability score to determine if the Provider is entitled to the full market basket rate for CY 2015.

/s/
Charlotte F. Benson
Board Member