PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D16

PROVIDER –
Yale-New Haven Health Services Group
Appeals

Provider Nos.: 07-0010, 07-0022, 07-0018

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services

DATE OF HEARING -
May 28, 2008

Cost Reporting Periods Ended -
September 30, 1998; September 30, 1999;
September 30, 2000; September 30, 2001

CASE NOs.: 05-1296G, 05-1315G,
05-2197G, 06-1668G

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ISSUE:

Whether the Intermediary properly disallowed direct graduate medical education (DGME) and indirect medical education (IME) payments with respect to discharges of Medicare beneficiaries who were enrolled in the Medicare + Choice or other Medicare risk plans in fiscal years ending September 30, 1998, 1999, 2000 and 2001.

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. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and 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 insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal 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). 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 issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §§405.1835 - 405.1837.

42 U.S.C. §1395ww(h) prescribes the Medicare payment method for direct graduate medical education (GME) costs. In summary, the direct GME payment is the product of a hospital's average per resident amount, derived and updated from a 1984 base period, multiplied by the hospital's number of interns and residents in approved GME programs during the payment year, multiplied by the hospital's Medicare patient load.

42 U.S.C. §1395ww(d)(5)(B) provides that teaching hospitals that have residents in approved GME programs receive additional payments to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals. Regulations at 42 C.F.R. §412.105 establish how the additional payment is calculated. The additional payment, known as the indirect medical education (IME) adjustment, is based on the indirect teaching adjustment factor, calculated using a hospital's ratio of full-time equivalent (FTE) residents to beds.

Prior to the enactment of the Balanced Budget Act of 1997 (BBA '97), the numerator of the Medicare patient load fraction included only the number of patient days attributable to the Medicare beneficiaries who were entitled to have payment made under the Medicare Part A

fee-for-service program. CMS did not include inpatient days attributable to enrollees in Medicare risk plans (i.e., Medicare Health Maintenance Organizations (HMOs) or Competitive Medical Plans (CMPs) with risk sharing contracts under 42 U.S.C. §1395mm. In 1989, when CMS promulgated the regulations implementing the prospective payment method for GME, the agency determined that these Medicare managed care plan days would not be counted as Medicare days in the Medicare patient load that is used to calculate Medicare payment for GME.[1]

Section 4624 of BBA '97 amended the DGME statute by adding a new provision in 42 U.S.C. §1395ww(h)(3)(D) for an additional GME payment with respect to patient days attributable to services furnished to Medicare beneficiaries enrolled in a Medicare + Choice(M+C) plan or any other Medicare managed care plan with a risk sharing contract under 42 U.S.C. §1395mm. The regulations implementing this provision were codified at 42 C.F.R. §413.86. Similarly, BBA '97 amended the IME statute by adding a new provision in 42 U.S.C. §1395ww(d)(11). The regulations implementing this provision are set forth in 42 C.F.R. §412.105(g). In addition, CMS issued Program Memorandum (PM) Transmittal No. A-98-21 which implemented the provision and mandated the same claims filing practices as used for all other claims. Accordingly, the hospital is to submit a "no-pay" claim for each managed care enrollee in UB-92 format with appropriate condition codes.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Yale-New Haven Health Services Group includes Bridgeport Hospital, Yale-New Haven Hospital and Greenwich Hospital (the Providers). All are acute care, not-for-profit facilities located in Connecticut and all received payment from the Medicare Program for hospital inpatient services provided to Medicare beneficiaries pursuant to the Inpatient Prospective Payment System (IPPS) (42 CFR Part 412). During fiscal years 1998 through 2001, the Providers included in their DGME/IME calculations Medicare beneficiaries who were enrolled in Medicare risk plans i.e. health maintenance organizations or competitive medical plans with risk sharing contracts under section 1876 of the Act or a M+C plan under part C of the Act. The claims data for services provided to Medicare managed care beneficiaries from July 1, 1998 through September 30, 2001 were not fully reflected in the Providers' Provider Statistical and Reimbursement (PS&R) reports. National Government Services (Intermediary) adjusted the cost report settlement data to match the statistics reflected on the PS&R reports and issued NPRs for each of the four cost reporting periods. The parties executed an extensive stipulation of facts and there is no dispute that the Intermediary's PS&R reports for each year did not include all of the Providers' claims data for beneficiaries who were enrolled in Medicare managed care plans. At issue is whether the Intermediary properly disallowed the claims data (i.e., days, discharges, DRG amounts) that were not reflected in the PS&R reports.

The Providers appealed the denials to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 - 405.1841. The Providers were represented by Edward D. Kalman, Esq. of Behar & Kelman, L.L.P. The Intermediary was represented by James R. Grimes, Esq., of Blue Cross Blue Shield Association.

[1] 54 Fed. Reg. 40286, 40294-95 (Sept. 29, 1989)

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that it was the Providers' responsibility to submit a timely UB-92 claim form to its Intermediary to be processed through the claims system in order to obtain IME and DGME payment for Medicare managed care enrollees. The Intermediary argues that PM A-98-21 was issued on July 1, 1998 to implement the BBA provision. The PM mandated a specific process to be followed:

> This Program Memorandum outlines intermediary and standard system changes needed to process requests for IME and DGME supplemental payments for Medicare managed care enrollees. Sections 4622 and 4624 of the Balanced Budget Act of 1997 state that hospitals may now request a supplemental payment for operating IME for Medicare managed care enrollees.

The PM goes on to say:

> PPS hospitals must submit a claim to the hospitals' regular intermediary in UB-92 format, with condition codes 04 and 69 present on record type 41, fields 4-13, (form locater 24-30). Condition code 69 is a new code recently approved by the National Uniform Billing Committee to indicate that the claim is being submitted for operating IME payment only.

The Intermediary argues that this PM issued by CMS made clear that the Providers were required to bill their Intermediary if they wanted to receive IME and DGME payments for the Medicare managed care enrollees.

Consistent with the Intermediary's position that the Providers must have submitted a claim to the Intermediary to receive IME/DGME payments for the Medicare+Choice beneficiaries, the Intermediary argues that the Providers' claims had to comply timely with the following filing standards as defined in 42 C.F.R. §424.44:

> (a) *Basic limits*. Except as provided in paragraph (b) of this section, the claim must be mailed or delivered to the intermediary or carrier, as appropriate-
> (1) On or before December 31 of the following year for services that were furnished during the first 9 months of a calendar year; and
> (2) On or before December 31 of the second following year for services that were furnished during the last 3 months of the calendar year.
> (b) *Extension of filing time because of error or misrepresentation*.

> (1) The time for filing a claim will be extended if failure to meet the deadline in paragraph (a) of this section was caused by error or misrepresentation of an employee, intermediary, carrier, or agent of the Department that was performing Medicare functions and acting within the scope of its authority.
> (2) The time will be extended through the last day of the 6th calendar month following the month in which the error or misrepresentation is corrected.

Since the Provider did not submit the UB-92 claim forms to the Intermediary until after the filing deadline had expired, the hard copy submission of the claims to the Intermediary to be manually added to the cost report was insufficient to cure the Providers' failure to bill. Furthermore, without the Providers properly billing the claims to the Intermediary, the claims were not entered into the common working file, were not verified for coverage and eligibility, and did not go through the pricing system. The Intermediary asserts that since the Providers did not properly bill the claims, the late filed hard copy claims were properly rejected and not included in the final settled cost report.

The Intermediary argues that CMS PM A-03-007 issued in 2003 was prospective only and does not stand for the principle that the claims filing requirements of §424.44 would not apply to claims for IME and DGME payments for services to Medicare managed care patients. See Transcript at 31-33.

The Intermediary also notes that for each hospital and fiscal period under appeal, there were claims reported on the PS&R reports for which payments were made. Therefore, it would seem that the Providers knew of the required process for filing the "no-pay bills" and were filing claims, but either missed some or some may have been rejected. For whatever reason, the claims were not timely filed or processed and should be denied.

PROVIDERS' CONTENTIONS:

The Providers argue that the Intermediary has improperly refused to allow the hospitals to submit bills or to consider documentation submitted in support of its claim to receive IME & DGME payments for beneficiaries enrolled in Medicare managed care plans. There is no rule of law, whether by statute or regulation, which imposes a (time) limit on the Providers' submission of claims for payment of amounts which Congress has prescribed are due to them under Sections 4622 and 4624 of BBA'97.

The Providers contend that all of the basic requirements for claims submission set forth in Subpart C of Part 424, including the timeliness provisions at 42 C.F.R. §424.44, do not apply to services provided to Medicare managed care enrollees. Therefore, there is no impediment to the Intermediary processing the Providers' request for DGME payments.

In addition, the Intermediary's position that "no-pay bills" cannot be filed with an intermediary beyond the time periods set forth in 42 C.F.R. §424.44 is contradicted by CMS' PM A-03-007 (2/3/03) issued to address payments to non-IPPS hospitals and units for DGME purposes. In the PM, CMS found it feasible and legally permissible to allow non-IPPS hospitals and units to submit their M+C claims as "no-pay bills" beyond the time period set forth in §424.44 so that the M+C inpatient days could be accumulated in the PS&R report for DGME payment purposes through the cost report. Furthermore, CMS can not simply issue a program memorandum requiring that claims be submitted to the Intermediary for services to Medicare managed care enrollees, when such a directive is contrary to the clear provisions of its regulation at §424.30 that exempts filing a claim with the Intermediary if the payment arises from services provided on a capitation basis. CMS is bound by its own regulation and, under the Administrative Procedures Act, an agency is obliged to engage in notice and comment before repealing or amending a regulation. Therefore, even though the hospitals were allowed to submit the data to the Intermediary, they were under no requirement to do so.

The Providers further assert that they provided a log of the Medicare managed care patients furnished services as part of a reopening request made for each hospital and fiscal year in question, but the Intermediary refused to audit the documentation. The Providers seek ruling that the Intermediary/CMS must accept and review its data that demonstrates entitlement to payments for FYs 1998 through 2001 for the additional days associated with the Medicare managed care patients.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence and the parties' contentions, the Board finds and concludes as follows:

The Board has addressed this issue in recent decisions.[2] In those cases, the Board majority found that CMS did not make a change to the regulation at 42 C.F.R. §424.30 that exempts filing a claim with the Intermediary if the payment arises from services furnished on a capitation basis. Therefore, providers could not be required to file a separate claim for IME/DGME payments with the intermediary. Rather, providers could claim GME payment by providing other documentation that these services were provided. The Intermediary must review the alternative documentation that the Provider presented and, if verified, use it as a basis to approve payment for GME services. In addition, the Board finds that even if CMS had properly implemented the claims mechanism for the GME payment for HMO enrollees, problems with the implementation constitutes good cause to grant provides an exception for late filing of claims. The same rationale is applicable to the instant case.

[2] Santa Barbara Cottage Hospital v. BCBSA/National Government Services, PRRB Dec. No. 2007-D78, September 28, 2007, aff'd in part and reversed in part, CMS Admin., November 16, 2007 (reversed on GME issue). Bayfront Medical Center v. BCBSA/First Coast Service Options, Inc., PRRB Dec No. 2008-D3, Ocotber 12, 2007, rev'd CMS Administrator, December 10, 2007. Sparrow Health 98-99 IME Managed Care Group v. BCBSA/United Governmnet Services, PRRB Dec. No. 2008-D17, February 12, 2008, rev'd CMS Admin., April 14, 2008. Loma Linda University Medical Center v. BCBSA/United Government Services, LLC-CA, PRRB Dec. No. 2008-D26, May 9, 2008, rev'd CMS Administrator, July 7, 2008.

The Balanced Budget Act of 1997 (BBA '97) provided for IME and DGME payments for services provided under risk HMO contracts that, prior to the BBA, had not been available. The Secretary was given broad authority to provide for or devise a way to pay hospitals supplemental payments for DGME and IME. 42 U.S.C. §1395ww(h)(3)(D) entitled "Payment for managed care enrollees" states:

> (i) In general. For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1395mm of this title and who are entitled to part A of this subchapter or with a Medicare + Choice organization under part C of this subchapter.

42 U.S.C. §1395ww(d)(11) entitled "Additional payments for managed care enrollees" states:

> (A) In general. For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) of this section hospital that has an approved medical residency training program.

The question before the Board is what conditions precedent must be satisfied to entitle a hospital to payment for the new additional benefit.

This dispute is also governed by the regulation, 42 C.F.R. §424.30 et seq. Prior to the BBA '97, whether a "claim" (described elsewhere as a form UB-92) filed for each patient stay was required was governed by 42 C.F.R. §424.30 which states:

> This subpart sets forth the requirements, procedures, and time limits for claiming Medicare payments. Claims must be filed in all cases except when services are furnished on a prepaid capitation basis by [HMOs].

42 C.F.R. §424.32 et. seq. furnishes more detail including the "basic requirement" that the claim be filed with the hospital's intermediary and within the time limits specified in section 424.44.

Therefore, prior to BBA '97, if Medicare was responsible for payment of the services furnished to Medicare beneficiaries, the hospital filed its claim for payment directly with its Medicare intermediary. But, if the beneficiary was a member of a risk HMO which had been prepaid by Medicare, the hospital filed its claim for payment for services furnished with the HMO, not the intermediary. The claims in question, for services furnished by and paid for by Medicare + Choice organizations or other

Medicare risk plans, are specifically exempted from the requirements, procedures and time limits under this section. The information that would be needed to process these claims by intermediaries is contingent upon the Medicare HMO plans payment processing methods which may be quite different from those of fee-for-service plans.

Prior to the BBA '97, in addition to the process for filing claims for payment for services furnished, hospitals were required by the hospital manual to file 'no pay' bills for tracking or utilization purposes only, for example, to set capitated rates. These were referred to as 'no-pay' bills and the data assembled was referred to as 'encounter data.'

> A. No-Payment Situations Where Bills Must be Submitted.-- Situations for which bills are required include the following. If part of the admission will be paid and part not, prepare one bill covering the entire stay.
>
> * * * *
>
> For services provided to an HMO enrollee for which an HMO has jurisdiction for payment. Since HCFA is instructing you to provide this information, negotiate an agreement with the HMO for submitting to it bills it pays. Include in your agreement with HMOs a clear statement of the data elements required for proper identification of Medicare HMO/CMP enrollees and accurate submission to the intermediary.
>
> Where the HMO does not have jurisdiction, prepare a payment bill.

CMS Program Manuals - Hospital (PUB. 10), Chapter IV - Billing Procedures
411. Submitting Inpatient Bills In No-Payment Situations.

The BBA '97 and the Secretary's implementing regulations clearly shifted the burden for filing encounter data squarely on the risk HMOs.

> In order to carry out this paragraph, the Secretary shall require Medicare + Choice organizations (and eligible organizations with risk-sharing contracts under section 1395mm of this title) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998. The Secretary may not require an organization to submit such data before January 1, 1998.

42 U.S.C. §1395w-23(a)(3)(B).

> *Data collection: Basic rule*. Each M+C organization must submit to HCFA (in accordance with HCFA instructions) all data necessary to characterize the context and purposes of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner.

42 C.F.R. §422.257(a) (interim final rule was published in June 1998).

However, no changes were made to 42 C.F.R. §424.30. 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.

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. No where does the Board find a directive to the Provider that states that in order to receive IME and DGME supplemental payments the Provider ***must*** bill.

Even if the Board had found that CMS could implement the claims requirement without regulatory change, the Board agrees with the Provider that it would be entitled to an exception to the deadline for filing claims for the following reasons:

Despite the fact that CMS had a very short timeframe to implement the provisions of BBA '97, specifically, the issue in question, by the effective date of January 1, 1998 the Administrative Procedures Act (APA) prescribes an "informal rulemaking" process that should have been followed by CMS to handle the period from January 1, 1998 until the finalization of the rule. If the regulatory obligation to file a "claim" is to be bifurcated so that a provider has an obligation to file its claim for payment of services to the beneficiary to the HMO and to also file a virtually identical claim to its intermediary, then the Board believes a regulatory notice is required.

The Intermediary does not dispute that the hospital complied with requirements for timely filing its claims for payment for inpatient services with the HMO. In fact, the hospital seeks to rely on those records as proof of entitlement and for calculation of its IME/DGME

additional payment to be claimed (in the generic sense) via its cost report. The expense of graduate medical education that the hospital incurs in providing services furnished on a capitation basis is only one element of many costs properly reported and claimed on the cost report. The data contained in those claims to the HMOs along with the remittance advices reflecting payment is proper evidence and must be considered by the Intermediary to determine the IME/DGME payments due.

Furthermore, for the period from January 1, 1998 through June 30, 1998, the option to bill and receive an interim payment was not available and the use of an alternate method was necessary to allow providers to make a request (or claim) for these payments. For this reason, the Board finds that the Intermediary's disallowance of the subject days, based on the fact that the Provider did not bill and the data was not captured on the PS&R, is without basis. The Provider submitted to the Intermediary a detailed log of the Medicare managed care enrollees it serviced during the periods at issue. The Board finds that the Intermediary's refusal to audit the data made available to support the Provider's claim was a misuse of its discretion and the case should be remanded to the Intermediary to complete the audit. In addition, the Board finds that even if CMS had properly implemented the claims mechanism for the GME payment for HMO enrollees, problems with the implementation constitutes good cause to grant providers an exception for late filing of claims.

DECISION AND ORDER:

The Intermediary improperly disallowed DGME and IME payments with respect to discharges of Medicare beneficiaries who were enrolled in the Medicare + Choice or other Medicare risk plans in fiscal years ending September 30, 1998, 1999, 2000 and 2001. The Intermediary's adjustments are reversed and cases are remanded to the Intermediary to include the days applicable to the Medicare managed care enrollees.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith C. Braganza, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: April 2, 2009

Yale-New Haven Health Services Group Appeals

Schedule of Providers

Case Number	Fiscal Year	Provider Number	Provider Name
05-1296G	09/30/98	07-0010	Bridgeport Hospital
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