PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D38

PROVIDER –
North Carolina Baptist Hospital

Provider No.: 34-0047/34-T047

vs.

MEDICARE CONTRACTOR –
Palmetto GBA c/o National Government Services

HEARING DATE –
August 8, 2017

Cost Reporting Period Ended –
September 30, 2017

CASE NO.: 17-0866

INDEX

ISSUE STATEMENT:

Whether a two percentage point reduction in the Provider's fiscal year ("FY") 2017 annual increase factor, due to failure to meet Inpatient Rehabilitation Facility Quality Reporting Program ("IRF-QRP") requirements, was proper?[1]

DECISION:

After considering the Medicare law and regulations, the arguments presented, and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds that the Centers for Medicare & Medicaid Services ("CMS") properly imposed a two percentage point reduction to the Provider's annual increase factor for FY 2017.

INTRODUCTION:

North Carolina Baptist Hospital ("Hospital") is an acute care hospital located in Winston Salem, NC. The Hospital has various sub-providers, one of which is a rehabilitation unit ("Rehab Unit" or "Provider"). On July 7, 2016, CMS notified the Rehab Unit[2] that it failed to meet the IRF-QRP requirements for FY 2017, and as a result, the Rehab Unit would have its FY 2017 annual increase factor reduced by two percentage points. Specifically, CMS alleged that the Rehab Unit failed to report all required months of complete *Methicillin Resistant Staphylococcus aureus* ("MRSA") and *Clostridium difficile* ("CDI") data.[3] Following the Rehab Unit's request for reconsideration, CMS upheld its decision to reduce t
he Rehab Unit's annual increase factor.[4]

The Provider timely appealed that decision and has met the jurisdictional requirements for a hearing before the Board. The Board conducted a live hearing on August 8, 2017. The Provider was represented by Karin Mendenhall Mabe, Associate Vice President of Revenue and Reimbursement. Palmetto GBA c/o National Government Services, Inc. ("Medicare Contractor") was represented by Joe Bauers, Esq., of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW:

The Medicare program pays rehabilitation facilities[5] for services under the IRF prospective payment system ("IRF-PPS").[6] Under IRF-PPS, the Medicare program pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7] The standardized

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[1] Transcript ("Tr.") at 5-6.
[2] The Rehab Unit's CMS Certification Number ("CCN") is 34-T047.
[3] Provider's Final Position Paper, Exhibit P-1a; *see also* Medicare Contractor's Final Position Paper, Exhibit I-3.
[4] Provider's Final Position Paper, Exhibit P-6.
[5] "Rehabilitation facilities" includes rehabilitation hospitals and rehabilitation units within a hospital. *See* 42 U.S.C. § 1395ww(j)(1)(A).
[6] *See* 42 U.S.C. § 1395ww(j); 42 C.F.R. §§ 412.600, *et seq.*
[7] *See* 42 C.F.R. § 412.624.

amounts are increased each year by an annual increase factor to account for increases in operating costs.[8]

The Patient Protection and Affordable Care Act ("ACA") of 2010[9] amended 42 U.S.C. § 1395ww(j) to establish the IRF-QRP, and required each rehabilitation facility to submit quality of care data "in a form and manner, and at a time, specified by the Secretary...."[10] For fiscal years 2014 and beyond, federal law specifies that a rehabilitation facility that fails to report the required quality data under the IRF-QRP is assessed a one-time two percent reduction to its annual increase factor to the standard federal IRF prospective payment.[11]

The IRF-QRP requires rehabilitation facilities to submit various quality measures, including data regarding MRSA and CDI.[12] CMS instructed rehabilitation facilities to submit MRSA and CDI quality data to the Centers for Disease Control and Prevention ("CDC") through a CDC computer system called the National Healthcare Safety Network ("NHSN").[13] IRF-QRP instructions and deadlines[14] for data submission are posted on CMS' IRF-QRP web site.[15]

Since 2012, the NHSN website has made available manuals for using the NHSN system as well as instructions regarding how providers can internally validate the completeness and accuracy of data entered into the NHSN system.[16] These instructions are referred to as Internal Validation Guidance and Toolkits.

The "2015 Patient Safety Data Quality Guidance and Toolkit for Reporting Facilities" states:

> Quality validation HAI [health-care associated infections] surveillance require rigorous adherence to standard NHSN specifications; remain up-to-date when changes are made; and commit to using appropriate NHSN methods and definitions to validate HAI data reported to the system.[17]

In April 2015, NHSN made available instructions to inpatient rehabilitation units within acute care and critical access hospitals on how to appropriately designate within the NHSN system

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[8] *See* 42 U.S.C. § 1395ww(j)(3).
[9] Patient Protection and Affordable Care Act § 3004(b), Pub. L. No. 111-148, 124 Stat. 119 (2010).
[10] *Id.* at § 3004(b)(2)(C), 124 Stat. at 369. *See also* 42 C.F.R. § 412.634.
[11] *See* 42 U.S.C. § 1395ww(j)(7)(A)(i); 42 C.F.R. § 412.634(b)(2).
[12] *See* 79 Fed. Reg. 45872, 45911-14 (Aug. 6, 2014). *See also* https://www.cdc.gov/nhsn/training/patient-safety-component/.
[13] *See* 79 Fed. Reg. at 45912-13.
[14] *See* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Data-Submission-Deadlines.html.
[15] *See* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/. The archived instructions for FY 2017 are located at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/FY-2017-Payment-Determination-Measures-and-Deadlines.docx; *see also* Medicare Contractor's Final Position Paper, Exhibit I-1.
[16] https://www.cdc.gov/nhsn/validation/index.html.
[17] *Id.* at 3.

whether their units were separately licensed IRFs.[18] The instructions urge sub-units that have an 'R' or 'T' in the 3rd position of their CCN to "… double check the CCN with the billing/administrative departments at your facility prior to moving forward with location set-up."[19] The instructions also explain that entering the rehab specific CCN allows quality data to be sent to CMS to satisfy quality data reporting requirements.

The NHSN also issues newsletters that contain user information and updates. The June 2015 NHSN Newsletter[20] contained a monthly checklist related to the IRF-QRP (and other CMS quality data programs), as well as a frequently asked questions section regarding mapped locations within NHSN. The newsletter emphasized the importance of keeping facility locations up-to-date, and recommended reviewing location mappings once a year.

For the period under appeal, the Rehab Unit submitted its MRSA and CDI quality data, but the data was inadvertently mapped with the acute care Hospital's CCN.[21] The dispute in this case centers on whether or not the Rehab Unit submitted its MRSA and CDI data in the form and manner, and at the time, specified by the Secretary.

DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The Rehab Unit explained that it submitted the missing quality data timely, however, the data was submitted inadvertently under the Hospital's CCN of 34-0047 rather than the Rehab Unit's CCN of 34-T047.[22] In support of its position, the Rehab Unit argues that the process of reporting quality data is resource intensive, and the newness of the program along with lack of clear instruction lead to the error in reporting the data.[23] The Rehab Unit also states there was no error check or system check process within the NHSN that would alert a provider that its facility was not mapped correctly within the system.[24]

The Board is empathetic to the Rehab Unit's position, but finds there were instructions available during the reporting period. These instructions emphasized the importance of using the correct rehabilitation unit CCN when mapping the location within the NHSN system. The Board points out that NHSN's April 2015 instructions specifically note that rehab units within an acute care hospital will have a different CCN then the acute care hospital and state that it is "essential to double check the CCN with the billing/administrative departments at your facility prior to moving forward with location set-up."[25] The Board notes that the Rehab Unit was able to promptly correct its error upon discovery.[26]

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[18] *See* "Updates to NHSN for IRF Locations within Acute Care & Critical Access Hospitals," found at https://www.cdc.gov/nhsn/pdfs/irf/updating-irf-locations-within-nhsn.pdf.
[19] *Id.* at 1.
[20] *See* https://www.cdc.gov/nhsn/pdfs/newsletters/eNewsletter_June-2015_Final.pdf; *see also* Medicare Contractor's Final Position Paper, Exhibit I-5.
[21] Provider's Final Position Paper at 3.
[22] Tr. at 10-11.
[23] Provider's Post-Hearing Brief at 1.
[24] *Id.*
[25] "Updates to NHSN for IRF Locations within Acute Care & Critical Access Hospitals" at 1.
[26] Tr. at 13-14.

In conclusion, the Board finds that the Rehab Unit failed to submit its data in the form and manner, and at the time, specified by the Secretary.[27] Failure to timely file the required quality data triggers the imposition of a two percentage point reduction to the annual increase factor, and the statute and regulations do not allow for a waiver of that penalty.[28]

DECISION AND ORDER:

After considering the Medicare law and regulations, the arguments presented, and the evidence submitted, the Board finds that CMS properly imposed a two percentage point reduction to the Provider's annual increase factor for FY 2017.

BOARD MEMBERS PARTICIPATING:

Charlotte F. Benson, C.P.A.
Gregory Ziegler, C.P.A., CPC-A
Robert A. Evarts, Esq.

FOR THE BOARD:

/s/
Charlotte F. Benson, C.P.A.
Board Member

DATE: May 25, 2018

[27] ACA § 3004(b)(2)(C), 124 Stat. at 369. *See also* 42 C.F.R. § 412.634.
[28] 42 C.F.R. § 412.634(b)(2).