PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

Hearing on the Record

2019-D2

PROVIDER - The University of Texas Southwestern Medical Center

RECORD HEARING DATE – May 10, 2018

Provider No.: 45-0044

Cost Reporting Period Ended – August 31, 2008

vs.

MEDICARE CONTRACTOR – Novitas Solutions, Inc.

CASE NO. 13-1053

INDEX

Page No.

Issue Statement **2**

Decision **2**

Introduction **2**

Statement of Facts **2**

Discussion, Findings of Facts and Conclusions of Law **3**

Decision and Order **5**

ISSUE STATEMENT:

Whether the Medicare Contractor's audit adjustments to remove Medicare Usable Organs (Heart & Kidney) were fair and proper?

DECISION:

The Provider Reimbursement Review Board ("Board") finds that, in connection with the Provider's cost report for fiscal year ("FY") 2008, the Medicare Contractor properly removed two organs from the Medicare Usable Organs count where Multiplan and Cigna were the primary payors, but improperly removed one organ from the Medicare Usable Organ count where Aetna was the primary payor. Accordingly, the Board remands this case to the Medicare Contractor to determine the Provider's reimbursement for FY 2008 by including in the Medicare Usable Organ count the organ at issue where Aetna was the primary payor.

INTRODUCTION:

The University of Texas Southwestern Medical Center – St. Paul Hospital ("Provider") is located in Dallas, Texas. The Provider is a general acute care hospital and is certified as a transplant center. During the cost reporting period at issue, Novitas Solutions, Inc. served as the Provider's Medicare Contractor.[1] The Medicare Contractor removed three organs (two kidneys and one heart) and the related Medicare reimbursement from the Provider's FY 2008 cost report because it determined that Medicare was the secondary payor and the Medicare program had no obligation to pay for these organs. Specifically, the Medicare Contractor contends that the beneficiaries of these three organs had third-party insurance plans under which the Provider had accepted payment from these plans as payment in full for the transplantation services, thereby negating the Medicare program's obligation to pay under the Medicare Secondary Payer provisions. The Provider is appealing the removal of the three organs from the Medicare Usable Organ count and the resulting elimination of Medicare payment of the acquisition costs for these organs. The Provider has met the jurisdictional requirements for a hearing.

The Provider is represented by Manie W. Campbell, of Campbell Wilson, LLP. The Medicare Contractor is represented by John Hamada, Esq., of Federal Specialized Services.

LEGAL BACKGROUND AND STATEMENT OF FACTS:

The Medicare program has established policies which support organ transplantation by providing an equitable means of payment for the variety of organ acquisition services required to support quality transplant programs. There are two payment components to a hospital which is designated as a Certified Transplant Center ("CTC") for organ transplantation - a prospective payment system rate based on a Diagnostic Related Groups ("DRG") and an acquisition payment for the reasonable and necessary costs associated with acquiring the organ (*i.e.*, organ acquisition costs).[2]

---

[1] Medicare Contractor Final Position Paper at 2.
[2] 42 C.F.R. § 412.2(e)(4).

Medicare reimburses CTCs for the reasonable costs of Medicare Usable Organs. Medicare Usable Organs include, among other criteria, organs transplanted into Medicare beneficiaries (excluding Medicare Advantage beneficiaries), and organs that were partially paid by a primary insurance payer in addition to Medicare. Medicare Usable Organs do not include, among other criteria, organs that were totally paid by primary insurance other than Medicare.[3] CTCs include the organ acquisition costs and the count of Medicare Usable Organs on their Medicare cost reports.

Most of the facts of this case are not disputed. The Medicare Contractor removed three Medicare recipients' organs (two kidneys and one heart) from the Medicare Usable Organ count during the Provider's FY 2008 cost report audit.[4] The three organ recipients were each beneficiaries of separate third-party insurance plans (Multiplan, Aetna, and Cigna) whose benefits, per 42 C.F.R. § 411.32(a), were primary to Medicare benefits.[5] In connection with the two kidney transplants, Multiplan paid $35,889.97 to acquire one of the kidneys at issue and Aetna paid $29,445.42 for the other kidney at issue. The Provider's standard organ cost for kidneys during the time at issue was $125,701.90. Similarly, Cigna paid $29,092.70 to acquire the heart at issue. The Provider's Standard organ cost for hearts is $99,179.18.[6] For each of the three organs at issue, the Provider claimed the difference between the third party insurer payment for that organ and its standard organ cost on its FY 2008 cost report. The Medicare Contractor removed the three organs from the Medicare Usable Organ count, thereby removing the costs associated with those organs from the Provider's reimbursement.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

The Medicare Contractor explained that upon audit, it discovered the agreements between the Provider and the third-party insurers, Multiplan, Aetna and Cigna, contained provisions that either indicated the agreed payment schedule for covered services represented "payment in full" or precluded the Provider from seeking payment from the patients.[7] The Medicare Contractor's position is that 42 C.F.R. § 411.32(b) prohibits Medicare secondary payment if the provider is either obligated to accept, or voluntarily accepts, as payment in full, a primary payment that is less than its charges.[8] Additionally, the Medicare Contractor acknowledged that the Cigna third-party insurer agreement did not include the specific phrase "payment in full." However, the Medicare Contractor determined that, because this agreement prohibits the Provider from billing the patient for coinsurance and deductibles, it therefore equates to a "payment in full" provision.[9]

The Provider argued that Medicare is required to pay for services furnished by the Provider on the basis of reasonable costs for organ acquisitions, and Medicare should accept secondary liability for these costs. The Provider's position is that the "payment in full" clauses contained in the Multiplan and Cigna contracts are intended to limit liability of the primary payor and the beneficiary, and these clauses were not intended to negate Medicare's secondary payment

[3] Provider Reimbursement Manual, Part 1 ("PRM1"), § 3104.
[4] Stipulations ¶¶ 1, 2.
[5] Stipulations ¶¶ 3, 4.
[6] *See* Stipulations ¶¶ 12-14; Exhibit I-3.
[7] Medicare Administrative Contractor's Final Position Paper at 4.
[8] *Id.* at 4-5.
[9] *Id.* at 8-9.

obligations.[10] With regards to the Aetna agreement, the Provider argued there is no "payment in full" language in the agreement, nor is there anything that negates Medicare's obligations under the Medicare Secondary Payment rules.[11]

Additionally, the Provider asserted that federal regulations mandate Medicare secondary liability in this case and the Medicare Contractor's audit adjustments do not support disallowance of Medicare's secondary payment obligations.[12]

After consideration of Medicare law and guidelines, the parties' contentions and stipulations and the evidence contained in the record, the Board finds that the audit adjustments to remove the Medicare Usable Organs related to the two beneficiaries covered by the Multiplan and Cigna third-party insurers were fair and proper, but the audit adjustment to remove the Medicare Usable Organ related to the beneficiary covered by the Aetna was improper.

Under Medicare payment policy for organ transplantation costs, reimbursement is available to CTCs for reasonable costs related to Medicare Usable Organs.[13] Medicare Usable Organs do not include, among other criteria, organs that were totally paid by primary insurance other than Medicare.[14] In particular, 42 C.F.R. § 411.32(b) specifically states that "Medicare does not make a secondary payment if the provider or supplier is either obligated to accept, or voluntarily accepts, *as full payment*, a primary payment that is less than its charges."[15] CMS gave the following explanation for this regulation concurrent with its promulgation in 1989:

> The law intends that Medicare supplement the amount paid by the primary payer only in an amount that, combined with the primary payment, equals the charges for the services, or the amount the provider or supplier is obligated to accept *as full payment*. (When a provider or supplier is obligated to accept as full payment an amount less than its charges, HCFA [CMS] considers that lower amount to be the provider's or supplier's charges.)[16]

Thus, when a CTC has accepted payment in full from a primary insurer, leaving Medicare no payment obligation for the transplantation costs, the organ at issue is not considered a Medicare Usable Organ, and the costs related to acquiring that organ are not reimbursable by Medicare.

The Board finds the Multiplan and Cigna agreements required the Provider to accept as payment in full the amount paid by the relevant third party insurer. The Multiplan agreement states "[w]hen a Client is a primary payor, Facility shall accept from Client as payment in full for Covered Services the amounts established…"[17] Similarly, the Cigna agreement states "[s]ubject to the terms of the Agreement, the rates set forth in the Payment Appendix shall be payment in

---

[10] Provider's Final Position Paper at 8-9.
[11] *Id.* at 9.
[12] *Id.* at 10-11.
[13] PRM1 § 3104.
[14] *Id.*
[15] (Emphasis added).
[16] 54 Fed. Reg. 41716, 41728 (Oct. 11, 1989) (emphasis added).
[17] Exhibit P-5 at 3.

full for all Covered Services provided by Hospital and Group's Represented Physicians."[18] Therefore, under the terms of the Multiplan and Cigna contracts with the Provider, the Provider agreed contractually to accept the Multiplan and Cigna payments as full satisfaction of the organ transplantation charges for the covered beneficiaries, and further agreed not to bill any other entity for amounts in excess of the amount they were paid by Multiplan and/or Cigna. In these two instances, pursuant to 42 C.F.R. § 411.32(b), Medicare is not obligated to make a secondary payment to the Provider.

With regards to the Aetna agreement, the Board finds that there is no payment in full language in this agreement, and therefore the Provider is not required to accept the Aetna payment as payment in full.[19] While the Aetna agreement prohibits billing the patient for coinsurance and deductibles, it does not prohibit billing the patient's secondary insurers.[20] In this instance, Medicare is the secondary payer and is obligated to reimburse the Provider for the organ transplantation costs remaining after the Aetna payment, in accordance with the provisions of the regulations and manual.

DECISION AND ORDER:

The Board finds that, in connection with the Provider's cost report for FY 2008, the Medicare Contractor properly removed two organs from the Medicare Usable Organs count where Multiplan and Cigna were the primary payors, but improperly removed one organ from the Medicare Usable Organ count where Aetna was the primary payor. Accordingly, the Board remands this case to the Medicare Contractor to determine the Provider's reimbursement for FY 2008 by including in the Medicare Usable Organ count the organ at issue where Aetna was the primary payor.

BOARD MEMBERS PARTICIPATING:

Clayton J. Nix, Esq.
Charlotte F. Benson, C.P.A
Gregory H. Ziegler, C.P.A., CPC-A
Robert Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

/s/
Clayton J. Nix, Esq.
Chair

DATE: October 31, 2018

---

[18] *See* Provider's Final Position Paper at 9; *see also* Stipulations ¶¶4-5.
[19] *See* Exhibit P-6.
[20] *Id.*