CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Bayfront Medical Center **Provider** **vs.** **BlueCross BlueShield Association/ First Coast Service Options, Inc.** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: June 30, 1998, June 30, 1999 and December 31, 1999** **Review of:** **PRRB Dec. No. 2008-D3** **Dated: October 12, 2007**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period mandated in § 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. The CMS' Centers for Medicare Management submitted comments. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

The Provider is a Medicare certified teaching hospital located in St. Petersburg, Florida. For the cost reporting periods ending June 30, 1998, June 30, 1999 and December 31, 1999, the Intermediary issued Notices of Program Reimbursement (NPR) adjusting the Provider's indirect medical education (IME) and direct graduate medical education (DGME) payments for Medicare beneficiaries enrolled in Medicare risk plans. For the cost reporting periods ending June 30, 1999 and December 31, 1999, the Intermediary made adjustments to the cost report settlement data to match the statistics reflected in the Provider Statistical and Reimbursement Report (PS&R). However, the PS&R for each cost reporting period in question did not include all of the statistics for discharges the Provider alleged were related to beneficiaries enrolled in Medicare risk plans. For the cost reporting period ending June 30, 1998, the Intermediary made adjustments to the cost report settlement data to match the statistics reflected in the PS&R, and also added additional days from the Provider's log for the purpose of DGME payments only.

ISSUE AND BOARD'S DECISION

The issue was whether the Intermediary's disallowance of the discharges not reflected in the PS&R was proper.

The Board Majority noted that, prior to the Balanced Budget Act of 1997 (BBA '97)[1], IME and DGME payments for services provided under risk HMO contracts were not available. These payments were added by the BBA '97 for cost reporting periods occurring on or after January 1, 1998. Specifically, § 1886(d)(11) of the Social Security Act (the Act) mandates that the Secretary provide additional payments for each applicable discharge of any subsection (d) hospital that has an approved medical residency training program, and § 1886(h)(3)(D), provides that the Secretary make additional payments for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under § 1876 and who are entitled to Medicare Part A, or with a Medicare + Choice organization under part C.

The Board Majority then examined the conditions which must be met to entitle a hospital to payment for this benefit. The Board Majority found that the regulations at 42 CFR § 424.30, *et seq.*, governed this issue. This section requires that claims for payment must be filed in all cases except when furnished on a prepaid capitation basis. The Board Majority noted that, prior to the BBA '97, hospitals filed claims directly with Medicare intermediaries. However, if the hospital was a member of a risk HMO which had been prepaid by Medicare, it filed its claim with the HMO, not the Intermediary. Thus, the Board Majority concluded, the claims at issue in this case are "specifically exempt from the requirements, procedures and time limits noted in 42 CFR § 424.30, *et seq.*" Additionally, the Majority noted, any information that would be needed by an intermediary to process such a claim would be contingent upon the Medicare HMO plans' payment processing methods, which is disparate from the fee-for-service plan.

The Board Majority also noted that, prior to the BBA '97, hospitals were required to file "no pay" bills for tracking or utilization purposes, despite the process for filing claims for payment for services furnished. The data from these "no pay" bills was referred to as "encounter data". The BBA '97 shifted the burden for filing this encounter data to the risk HMOs. Additionally, the interim final rule published in June 1998 at 42 CFR § 422.257(a) stated that each Medicare + Choice organization must submit to CMS all data necessary to characterize the context and purpose of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner.

The Board Majority asserted that, despite these changes, no changes were made to 42 CFR § 424.30, nor to the regulations implementing the new IME or DGME payment. No other regulation gave notice that hospitals would now be required to file separate IME and

[1] *See* Pub. L. No. 105-33.

DGME claims with the intermediary, even though the claim was virtually identical to the one filed with the HMO to recover for inpatient services. The Board claimed that the IME and DGME payments arise from "services…furnished on a …capitation basis…" for which filing a claim with the intermediary is excepted under 42 CFR § 424.30.

The Board Majority found that, while the Secretary has been given broad authority to implement procedures for payment, once a 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 an Administrative Bulletin is insufficient to deprive a provider of its statutory right to payment. The Board Majority pointed out that the Administrative Bulletin issued by the Intermediary on August 6, 1998[2] stated that teaching hospitals "may" submit bills for inpatient stays by managed care enrollees for payment of IME, but did not address DGME payments, and did not specify a definite date when this billing should begin or make any reference to CMS Program Memorandum (PM) A-98-21 for further guidance. The Board did not find any directive to the Provider stating that in order to receive IME and DGME payments, a provider must bill the intermediary.

The Board Majority found that, despite the short timeframe that CMS had to implement the provisions of the BBA '97, the Administrative Procedures Act (APA) should have been followed, and regulatory notice of the obligation to file a claim with the intermediary for payment of IME and DGME claims should have been required. Additionally, the Board Majority noted, there was no dispute that the Provider timely filed claims for payment for inpatient services with the HMO. Thus, the Intermediary could have used that data to determine the IME and DGME payments due to the Provider.

Finally, the Board Majority found the Intermediary's refusal to audit the data made available to support the Provider's claim to be a misuse of its discretion, because from January 1, 1998 until the date of notice, the option to bill and receive an interim payment was not available. The use of an alternate method was necessary to allow providers to make a claim for these payments. Thus, the Board Majority found 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, was without basis.

One member of the Board dissented. The Dissent found that PM A-98-21 was an appropriate means of implementing the program payments provided for in the applicable IME and DGME statutes and regulations. The Dissent noted that the required claims were not exempt under 42 CFR § 424.30 because they were not claims for services "furnished on a prepaid capitation basis by a health maintenance organization." Instead, they were claims for additional payment due to the Provider because of its medical education activities, and thus were subject to the timely filing requirements of 42 CFR § 424.44.

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[2] *See* Provider's Consolidated Supplemental Brief in Support of Provider's Position Exhibit P-31.

The Dissent stated that CMS has broad authority to carry out its responsibility for ensuring proper program payments to providers, and that this broad authority includes issuance of regulations, manual instructions, program memorandums, and transmittals. CMS notified intermediaries and the public regarding the availability of the additional reimbursement for Medicare managed care enrollees when it formally modified the IME and DGME regulations in 62 Fed. Reg. 45,965 (August 29, 1997). The publication of PM A-98-21 instructed intermediaries to notify their hospitals of the right to request the additional payments and the means by which the payments could be secured. The Dissent found no need for publication of a new regulation with the required notice and comment period, because the PM was an efficient way of notifying the necessary parties.

The Dissent argued that the fact that the Provider actually filed UB-92 claims for many of its Medicare Managed care patients during each of the three fiscal periods at issue is clear evidence that it knew of the requirement to bill for the additional IME and DGME payments, and that it was attempting to do so. The Provider's position paper discussed the system difficulties it experienced in filing these claims. However, the Dissent found, it is not clear from the record why the Provider did not follow up when the billed claims did not process as expected. The Provider argued that it did not receive remittance advice from the Intermediary for the claims that could not be processed, however, the Dissent noted that remittance advice is not usually generated unless a claim is accepted for processing by the claims system. Claims that are not processed are "returned to the provider" (RTP'd) on an RTP report, and the provider is given 60 days to follow up. If the claims are not addressed within the 60 days, it is as though they were never filed because the RTP'd claims are purged. Thus, the Dissent pointed out that if the UB-92 claim forms filed by the Provider did not contain the data required for the claims processing system to accept the claims, and if the Provider did not follow up on the RTP'd claims, no remittance advice would have been generated.

Finally, the Dissent noted that the Provider ignored the Program's claims filing requirement to its detriment, and that the Provider's numerous arguments were merely aimed at shifting the burden for ensuring accurate IME and DGME payments to the Intermediary. The Dissent found that the Provider was responsible for claiming all the reimbursement to which it was entitled, and that it received timely notification of the manner in which that reimbursement was to be claimed. The Intermediary's refusal to accept the Provider's logs and compute the additional IME and DGME reimbursement from the logs was proper.

COMMENTS

The CMM's Provider Billing Group (PBG) submitted comments stating that the timely filing rules apply to these claims.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions.

Until 1983, Medicare paid for covered hospital inpatient services on the basis of "reasonable cost." Section 1861(v)(1)(A) of the Act defines "reasonable cost" as "the cost actually incurred," less any costs "unnecessary in the efficient delivery of needed health services." While §1861(v)(1)(A) does not prescribe specific procedures for calculating reasonable cost, it authorizes the Secretary to promulgate regulations setting forth the methods to determine reasonable cost and the items to be included in reimbursable services.

In addition, Medicare historically has paid a share of the net costs of "approved medical education activities" under the reasonable cost provisions.[3] The Secretary's regulations define approved educational activities as formally organized or planned programs of study, usually engaged in by providers to enhance the quality of care in an institution.[4] The activities include approved training programs for physicians, nurses and certain paramedical health professionals. Under the reasonable cost system, the allowable costs of the activities included: the direct costs of salaries and fringe benefits of interns and residents, the salaries attributable to teaching physicians' supervisory time, other teachers' salaries; and indirect or institutional overhead costs, including employee health and welfare benefits, that were appropriately allocated to the proper cost center on a provider's Medicare cost report.[5]

In 1982, Congress modified the Medicare program to provide hospitals with better incentives to render services more efficiently. Pursuant to the Tax Equity and Fiscal Responsibility Act (TEFRA),[6] Congress amended the Act by imposing a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. However, under § 1886(a)(4), graduate medical education costs were excluded from the definition of inpatient operating costs for purposes of the TEFRA base year and, thus, were not included in the hospital's TEFRA base year costs for purposes of determining the hospital's target amount.

In 1983, § 1886(d) was added to the statute to establish an inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital services furnished to Medicare beneficiaries.[7] Under IPPS, providers are reimbursed their inpatient operating costs based on prospectively determined national and regional rates for each patient discharge, rather

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[3] 20 CFR §405.421 (1966); 42 CFR §405.421 (1977); 42 CFR §413.85 (1986).
[4] 42 CFR §413.85(b).
[5] 54 Fed. Reg. 40,286 (Sept. 27, 1989).
[6] Pub. L. No. 97-248.
[7] Section 601(e) of the Social Security Amendments of 1983. Pub. L. No. 98-21 (1983).

than on the basis of reasonableness. Graduate medical education costs continued to be paid on a reasonable cost "pass-through."

However, applicable for all periods beginning on, or after, July 1, 1985, pursuant to §1886(h) of the Act, Congress established a new payment policy for DGME costs. Generally, the DGME payment is a combination of a hospital's per resident amount and the hospital's Medicare patient load. The Medicare patient load means with respect to a hospital's cost reporting period, the total number of hospital inpatient days during the cost reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days. To implement the new payment policy, the Secretary promulgated regulations at 42 CFR §413.86, *et seq.*

Section 1886(d)(5)(B) of the Act also provides that teaching hospitals that have residents in approved graduate medical education programs receive an additional payment for each Medicare discharge to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals. The regulations at 42 CFR §412.105 establish how the additional payment is calculated. The additional payment, known as the IME adjustment, is based on the indirect teaching adjustment factor, calculated using the hospital's ratio of full-time equivalent (FTE) residents to beds. Each hospital's indirect medical education payment under the prospective payment system for inpatient operating costs is determined by multiplying the total diagnosis related groups (DRG) revenue for inpatient operating costs by the applicable indirect medical education adjustment factor.

Prior to the enactment of the BBA '97, for purposes of the DGME payments, 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. The statute did not provide for inclusion of inpatient days attributable to enrollees in Medicare risk plans (e.g. Medicare Health Maintenance Organizations or Competitive Medical Plans with risk sharing contracts under § 1876 of the Act or Medicare + Choice plans) in the Medicare patient load used to calculate Medicare payment for DGME. However, § 4624 of the BBA '97 amended the Act by adding a new provision for DGME payments with respect to patient days attributable to services furnished to Medicare beneficiaries enrolled in a Medicare + Choice plan or any other Medicare managed care plan with a risk sharing contract under § 1876 of the Act. Section 1886(h)(3) of the Act states that:

> (D) Payment for Managed Care Enrollees.
> (i) 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 1876 and who are entitled to part A or with a Medicare + Choice under part C. The amount of such a payment shall equal the applicable percentage of the product of –

> (I) the aggregate approved amount (as defined in subparagraph (B)) for that period; and
> (II) the fraction of the total number of inpatient-bed days (as established by the Secretary) during the period which are attributable to such enrolled individuals.
>
> (ii) Applicable Percentage – For purposes of clause (i), the applicable percentage is -
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> (I) 20 percent in 1998,
> (II) 40 percent in 1999,
> (III) 60 percent in 2000,
> (IV) 80 percent in 2001… [Emphasis added.]

Similarly, the BBA '97 amended the Social Security Act by adding a new provision at § 1886(d), addressing the IME payment, which states that:

> (11) Additional Payments for Managed Care Enrollees. –
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> (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) hospital that has an approved medical residency training program.
> (B) Applicable Discharge – For purposes of this paragraph, the term "applicable discharge" means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or any individual who is enrolled with a Medicare + Choice organization under part C.
> (C) Determination of Amount. – The amount of payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (5)(B) if the individuals had been enrolled as described n subparagraph (B).[8] [Emphasis added.]

Thus, for discharges on, or after, January 1, 1998, the provisions of the BBA '97 required the recognition of the Medicare managed care enrollees in the IME and DGME payment.

These statutory changes were promulgated in the regulation for the DGME payment at 42 CFR § 413.86 and since recodified at 42 CFR § 413.76 (2004). The regulation at 42 CFR § 413.76 states:

> A hospital's Medicare payment for the costs of an approved residency program is calculated as follows:

[8] The regulations implementing this provision were codified at 42 CFR § 412.105(g).

> (a) Step one. The hospital's updated per resident amount (as determined under Sec. 413.77) is multiplied by the actual number of FTE residents (as determined under Sec. 413.79). This result is the aggregate approved amount for the cost reporting period.
> (b) Step two. The product derived in step one is multiplied by the hospital's Medicare patient load.
> (c) Step three. For portions of cost reporting periods occurring on or after January 1, 1998, the product derived in step one is multiplied by the proportion of the hospital's inpatient days attributable to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act and who are entitled to Medicare Part A or with a Medicare+Choice organization under Title XVIII, Part C of the Act. This amount is multiplied by an applicable payment percentage…….[9]

Likewise, for the IME payment, 42 CFR § 412.105(g) was amended to state that:

> (g) *Indirect medical education payment for managed care enrollees*. For portions of cost reporting periods occurring on or after January 1, 1998, a payment is made to a hospital for indirect medical education costs, as determined under paragraph (e) of this section, for discharges associated with individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act or with a Medicare+Choice organization under title XVIII, Part C of the Act during the period, according to the applicable payment percentages described in. Sec. 413.76(c)(1) through (c)(5) of this subchapter. [Emphasis added.]

The regulation at 42 CFR § 412.105(e) explains:

> (1) *Determination of payment amount*. Each hospital's indirect medical education payment under the prospective payment system for inpatient operating costs is determined by multiplying the total DRG revenue for inpatient operating costs, as determined under paragraph (a)(2) of this section, by the applicable education adjustment factor derived in paragraph (d) of this section.[Emphasis added.]

[9] The regulation at 42 CFR § 413.75(b) defines the Medicare patient load as "*Medicare patient load* means, with respect to a hospital's cost reporting period, the total number of hospital inpatient days during the cost reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days. In calculating inpatient days, inpatient days in any distinct part of the hospital furnishing a hospital level of care are included and nursery days are excluded." [Emphasis added].

The IME and DGME payment for Medicare managed care enrollees was specifically addressed in the May 12, 1998 *Federal Register*[10] which promulgated the IPPS Federal Fiscal Year (FFY) 1998 rule and BBA '97 changes. In response to comments regarding the claims process to be implemented for the DGME and IME payments, the Secretary stated that:

> Under §§ 4622 and 4624 of the BBA '97, teaching hospitals may receive indirect and direct GME payments associated with Medicare + Choice discharges. Since publication of the final rule with comment on August 29, 1997, we have consulted with hospitals, managed care plans, and fiscal intermediaries for purposes of developing a process to implement these provisions.
>
> We anticipate teaching hospitals will need to submit claims associated with Medicare + Choice discharges to the fiscal intermediaries for purposes of receiving indirect and direct medical education payments. When the claims are processed, the fiscal intermediaries will make the IME payment associated with a Medicare + Choice discharge directly to the teaching hospital. Teaching hospitals will also be required to submit bills associated with Medicare + Choice organizations to the managed care plans. The inpatient encounter data from these bills will be submitted by the managed care plans to HCFA for purposes of implementing the risk adjustment methodology. The fiscal intermediary's would revise interim payments to reflect the Medicare direct GME payment associated with Medicare + Choice discharges. However, until the fiscal intermediaries have more experience with paying hospitals for direct GME associated with Medicare + Choice discharges, we believe the fiscal intermediaries will have limited data upon which to base interim payment. We are making adjustments to the Medicare cost report to allow for settlement of the cost report reflective of direct GME payment associated with Medicare + Choice discharges. [Emphasis added]

On July 1, 1998, the CMS Program Memorandum (PM) A-98-21 was issued consistent with the claims process set forth in the rule. The PM stated that:

> 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. During the period January 1, 1998 through December 31, 1998, providers will receive 20 percent of the fee for service DGME and operating

[10] 63 Fed. Reg. 26,318 (May 12, 1998).

> IME payment. This amount will increase 20 percent each consecutive year until it reaches 100 percent.

Moreover, PM A-98-21 further explained that:

> PPS hospitals must submit a claim to the hospitals' regular intermediary in UB-92 format, which condition codes 04 and 69 present on record type 41, fields 4-13, (form locator 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. [Emphasis added]

The submission of claims to intermediaries for, *inter alia*, Part A payment, is controlled by the regulation at 42 CFR § 424.30. The regulation explains the scope of claims for payment and 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 a health maintenance organization, (HMO), a competitive medical plan (CMP), or a health care prepayment plan (HCPP).

Therefore, while claims for, *inter alia*, Part C and § 1876 managed care services are not controlled by this section, a hospital must submit claims in conformity with 42 CFR § 424.30, *et seq.*, to be able to include managed care enrollees for the Part A IME and DGME payments from its intermediary. The timeframe for filing claims is set forth at 42 CFR § 424.44, which states that:

> (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 days of the 6th calendar month following the month in which the error or misrepresentation is corrected.

As the PM explained, filing a claim with the intermediary using the UB-92 form is required in order to generate data that may be used for payment. The procedures set forth in the PM are consistent with the Medicare Financial Management Manual (Pub. 100-6) which explains the role of the UB-92 form and claims processing in the settlement process. The claims system makes the required determination on eligibility rules and benefits available for Medicare, in contrast to the cost report settlement process. CMS provides each intermediary a standard Provider Statistical and Reimbursement System or the "PS&R" to interface with billing form CMS 1450 (UB-92 form). This system provides reports to be used in developing and auditing provider cost reports and related data accumulation operations. Providers also must use the reports in preparing cost reports and must be able to explain any variances between the PS&R report and the cost report. The intermediary uses information on such items as Medicare patient days (relevant for GME), discharges and DRGs. The statistical reports produced are the Payment Reconciliation Report; Provider Summary Report and DRG Summary Report. Thus, when a provider bills in accordance with the instructions for payment of the DGME and IME for Medicare managed care enrollees, the claims system would compute a simulated DRG payment and charges for patient days and issue a payment, all of which would be summarized on the PS&R. The PM A-98-21 explained that:

> The intermediary will submit the claim to the Common Working File (CWF). CWF will determine if the beneficiary is a managed care enrollee and what their plan number and effective dates are. Upon verification from the CWF that the beneficiary is a managed care enrollee, the intermediary will add the HMO Pay code of 0 to the claim and make an operating IME only payment with the proper annotation of the remittance advice.…
>
> The DGME payments are to be made using the same interim payment calculation you currently employ. Specifically you must calculate the additional DGME payments using the inpatient days attributable to Medicare managed care enrollees. As with DGME payments under fee-for-service, the sum of these interim payment amounts are subject to adjustment upon settlement of the cost report.

Claiming costs on the cost report alone is not sufficient to make a IME and DGME payment for managed care enrollees. If no claim is filed, no IME payment will be made and no data relating to days will be generated on the PS&R that can be reconciled with the claimed cost report amounts.

In this case, the Provider, a teaching hospital, argued that the Intermediary improperly adjusted the settlement data used to determine IME and DGME payments with respect to Medicare managed care enrollees in its cost reports. The Provider claimed and the Board Majority agreed, that nothing in the statute or Office of Management and Budget (OMB) standards required the Provider to submit data directly to the Intermediary and within a specified time. The Board Majority also accepted the Provider's position that the

Intermediary should have used the data contained in the UB-92 which was submitted by the Medicare risk plans relating to Medicare risk plan discharges or the encounter data, both of which were available to the Intermediary before the audits for each of the fiscal years at issue were completed. Finally, the Provider argued and the Board Majority agreed, that it could not be penalized for having failed to meet a requirement to submit claims directly to the Intermediary, as no such requirement was ever approved by the OMB, and thus the Federal Paperwork Reduction Act precluded CMS from applying such a requirement to deny the Provider the benefit of the DGME and IME payments at issue without obtaining OMB approval for the data collection.

The Administrator finds 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 and 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, PM A-98-21 explicitly stated that hospitals "must submit a claim to the hospitals' regular intermediary." Moreover, the Intermediary in this case issued a Medicare Part A Bulletin on August 6, 1998 which detailed the filing requirements for payment to hospitals for direct costs of DGME and IME for Medicare managed care enrollees. This Bulletin stated "PPS hospitals must submit a claim to the hospitals' regular intermediary with condition codes 04 and 69 in form locator 24-30 of the HCFA 1450 (UB-92) claims format." The Bulletin also noted,

> If a provider has an agreement with a managed care plan to submit claims with discharge dates prior to July 1, 1998, for encounter data purposes, another claim must be submitted for this purpose. The additional claim would be similar to the IME only claim but it must not contain condition code 69. Beginning with discharges on or after July 1, 1998, providers may not submit HMO paid claims (no pay bills) to their Medicare contractor.

Thus, the need for encounter data for managed care rate setting purposes was separate and distinct from the claims processing required for the Part IME and DGME payments under §§ 1886(d) and 1886(h). The Bulletin further provided 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, separate bills for IME are only be to be submitted for members of risk HMOs. Currently, hospitals submit (risk) HMO paid bills for these individuals for utilization purposes only.

The Bulletin, the *Federal Register* preamble language and the PM A-98-21 plainly instructed a hospital to bill its intermediary so that the claims could be processed. In fact,

the Administrator finds that providers were informed of the billing policy as early as the May 1998 *Federal Register* publication that hospitals would be required to file claims for payment with their intermediary. The Provider's arguments merely shift the burden for accurate payment of the IME and DGME claims to the Intermediary, which is contrary to basic Medicare rules for payment.[11]

The Provider argued in the oral hearing that it did not receive PM A-98-21, which was directed to intermediaries, and that it did not receive the Medicare Part A Bulletin until the end of August, 1998. The Provider argued that this was not timely notice, as the Program Memorandum had directed intermediaries to alert providers to the new requirements within 3 days of receipt of the Program Memorandum. While the claims period started on January 1, 1998, no guidance for how to make these claims was received until August, 1998. The Provider argued that this guidance was also conflicting, confusing and not very specific.

The Administrator find that the IME and DGME payments for Medicare managed care discharges was effective for cost reporting periods beginning on or after January 1, 1998. The PM A-98-21 was issued by CMS on July 1, 1998. The Intermediary issued a Medicare Part A Bulletin on August 6, 1998 which detailed the requirements of PM A-98-21, which the Provider acknowledged receipt of by at least August 1998. Pursuant to 42 CFR 424.44, the earliest claims were due on or before December 31 of the following year for services that were furnished during the first nine months of the calendar year. The Provider had adequate time to comply with the instructions requiring the submission of the specially coded UB-92 forms. In sum, the Provider had over a year to comply with this requirement after the date it acknowledged receipt of the procedures.

Additionally, the Administrator finds that the Provider's partial success in setting up a system to submit claims for IME and DGME for its Medicare managed care plan beneficiaries shows that the Provider had timely notice of the requirement. The Provider began the process of developing a system to submit IME claims for Medicare managed care beneficiaries to the Intermediary in a UB-92 format, which would include the beneficiary's HIC# and a physician's UPIN. The record indicates that the Provider successfully submitted some claims. The record shows that the Provider was paid for those claims which were properly submitted, but is trying to argue for payment of claims that were never filed, or that were rejected due to errors.[12]

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[11] *See*, e.g. Section 1815(a) of the Act which states, "[N]o such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due…" *See also* Section 1878(a) which states, "[A]ny hospital which receives payments in amounts imputed under subsection (b) or (d) of Section 1886 and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing…"

[12] *See* Provider's Consolidated Supplemental Brief in Support of Provider's Position, pages 4-6.

Despite the recognition that it did not submit the required claims, the Provider maintains that the Intermediary should be able to use the Provider's records and logs to determine discharges, rather than relying on the PS&R. The Provider noted that the Intermediary used the provider's log in order to calculate DGME payments for the June 30, 1998 cost report. The Administrator finds that the Intermediary was incorrect in applying the PM only on the period after June 30, 1998. The Administrator finds that the Intermediary was correct to only allow those days and discharges which were included in the Provider's PS&R, and should not have used the Provider's records and logs to determine discharges for any period after January 1, 1998.

Requiring a standard claim format, which determines whether the claim belongs in the calculations, is a reasonable method of implementing the requirements of the BBA '97 for submitting information. The Administrator finds that PM A-98-21 was an appropriate means to implement program payments pursuant to the applicable IME and DGME statutes and regulations. The Secretary has the responsibility of ensuring proper program payments to providers of services, and utilizes various processes such as the issuance of regulations and manual instructions, as well as program memorandums. CMS notified its intermediaries and the public regarding the claims processing instructions for the Medicare managed care enrollees IME and DGME payments.[13] The standard claim format is reasonably required as the claims must be reflected in the PS&R as the PS&R is the necessary mechanism for the intermediaries and providers to reconcile the cost report settlement.[14]

The requisite claims were required to be submitted to the Intermediary pursuant to 42 CFR §424.30. The only exception to the claims processing requirements at 42 CFR §424.30 is for services furnished on a prepaid capitation basis to the beneficiary by a managed care plan, which is not at issue here. The claims in the instant case were claims for an established reimbursement methodology for hospitals' costs associated with being a teaching hospital and not for the services furnished to a managed care enrollees.

The Administrator also finds that the APA does not require CMS to publish a new regulation under these circumstances. CMS is allowed to promulgate interpretive rules and guidance. In addition, contrary to the Board Majority's finding, this process did not

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[13] *See* 62 Fed. Reg. 45, 965 (August 29, 1997).

[14] The Provider asserted that the Medicare risk plans (not providers) submitted UB-92 data relating to Medicare risk plan discharges to the Intermediary before the audits of each of the fiscal years at issue were completed and the Intermediary did not include that data in the settled cost reports, which the Board Majority accepted as relevant. However, the "encounter data" required by the BBA '97 to be submitted to CMS is related to the risk adjustment methodology and not to a claims determination process required of the IME/DGME payment methodology. Thus, the submission of this data to CMS is not relevant to the discussion here.

implement a new payment methodology. Rather, the payment of IME and DGME claims was an already established payment methodology for teaching hospitals that was already linked to the claims processing system. In addition, consistent with the APA, the proposed claims processing methodology was published in the May 1998 *Federal Register* subject to notice and comment. Thus, the claims processing instructions implementing the IME and DGME payments did not violate the requirements of the APA. The Provider received adequate published notice of its right to claim the reimbursement, but did not follow the procedures for doing so.

Finally, the Federal Paperwork Reduction Act does not preclude CMS from requiring providers to submit claims directly to the intermediary for DGME and IME payments with respect to discharges of patients enrolled in Medicare risk plans. The Paperwork Reduction Act states,

> Notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information that is subject to this subchapter if (1) the collection of information does not display a valid control number assigned by the Director in accordance with this subchapter…

However, the UB-92 was an existing form which already had a valid control number assigned by OMB (OMB #0938-0279). Additionally, the information requested was similar to information already being supplied by the Provider for fee-for-service Medicare beneficiaries and the related IME and DGME payments. Finally, the issue here is not that the Provider is being subject to a "penalty," rather the issue is that the Provider has not submitted sufficient information for reimbursement under § 1886 of the Act because it failed to submit the necessary UB-92 form to its Intermediary.

Accordingly, the Administrator finds that the Intermediary properly used the PS&R in disallowing DGME and IME payments with respect to discharges of Medicare beneficiaries who were enrolled in the Medicare + Choice or other Medicare risk plans. Thus, the Administrator reverses the Board's decision.

DECISION

The Administrator reverses the decision of the Board in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

Date: **12/10/07** **/s/**

Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services