Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

State Teachers Retirement System of Ohio
Docket No. A-12-20
Decision No. ER1
February 7, 2012

DECISION

State Teachers Retirement System of Ohio (Plan Sponsor) appeals the Centers for Medicare & Medicaid Services' (CMS) determination denying several reimbursement requests under the Early Retiree Reinsurance Program (ERRP). Specifically, CMS issued adverse reimbursement determinations in regards to multiple Revenue Codes and National Drug Codes (NDCs) that the Plan Sponsor included in its ERRP claim list.

For the reasons discussed below, I uphold CMS's adverse reimbursement determinations.

Applicable Regulations and Guidance

Established by the Patient Protection and Affordable Care Act (Affordable Care Act), ERRP provides reimbursement to participating employment-based plans for a portion of the cost of health benefits for early retirees. Affordable Care Act § 1102; *see also* 45 C.F.R. Part 149. Pertinent regulations provide:

> Health benefits means medical, surgical, hospital, prescription drug, and other benefits that may be specified by the Secretary. . . . Such benefits include benefits for the diagnosis, cure, mitigation or prevention of physical or mental disease or condition with respect to any structure or function of the body.

45 C.F.R. § 149.2.

CMS issued several program guidance documents addressing what items and services are eligible for reimbursement under ERRP.[1] According to the guidance documents, "ERRP will not credit the program's cost threshold or reimburse for items and services [], which are generally excluded from Medicare coverage." *See* Claims Ineligible for Reimbursement Under the Early Retiree Reinsurance Program (Claims Ineligible

[1] The program guidance documents are publicly available at http://www.errp.gov.

Guidance) (Sept. 28, 2010). Furthermore, regarding prescription drugs, the guidance states that "drugs that are not covered by a standard Medicare Part D plan (unless covered under Parts A or B)" will not be reimbursed under ERRP. *Id.* at 2. However, the guidance provides that "[i]f a plan sponsor can show, through appeal, that the procedure code could be acceptable under at least one Medicare setting, the cost for the procedure will be reimbursed . . . ." *See* Supplemental Guidance: Additional Coding Details for Ineligible Items and Services (Additional Coding Details) at 2 (Nov. 11, 2011).[2]

The applicable regulations provide that "a sponsor may request an appeal of an adverse reimbursement determination." 45 C.F.R. § 149.500(b). The regulations further provide that a request for appeal "must specify" the sponsor's "reasons for the disagreements" with the adverse reimbursement determinations. 45 C.F.R. § 149.510. The Secretary's decision on the appeal must be based on "the determination at issue, the evidence and findings upon which it was based, [and] any written documents submitted to the Secretary by the sponsor and the Secretary's designee. . . ." 45 C.F.R. § 149.520(b).[3]

Case Background and Analysis

On October 12, 2011, CMS issued adverse reimbursement determinations on the basis that certain revenue codes and NDCs that the Plan Sponsor included in its Claim List were ineligible for reimbursement under ERRP. The Plan Sponsor filed an appeal with the Board stating that in regard to the excluded codes, it "believe[s] these services are clearly Medicare-eligible benefits." *See* Request for Appeal (Oct. 27, 2011). The Plan Sponsor indicated that supporting documentation would be forthcoming. *Id.* On November 28, 2011, the Plan Sponsor timely submitted supporting documentation, which it described as "supporting detail records" of the revenue codes and NDCs excluded from its Claim List. These records consisted of computer printouts listing rejected Revenue Codes, including "Code 0180 Leave of Absence – General," "Code 0941 Other Therapeutic Services" and "Code 0917 Behavioral Health Treatments/Services-Extension of 090X." The records also included a report listing several rejected NDCs, such as "Code 49999048730 Zetia" and "Code 596760360D1 Orthovisc." On January 26, 2012, CMS filed its response stating that the Plan Sponsor failed to provide any evidence that the excluded codes are for Medicare eligible benefits. *See* Response at 2-3.

---

[2] CMS also issued a guidance document that provides a list of revenue codes that are generally considered to be ineligible for reimbursement under ERRP. *See* Supplemental Guidance: Revenue Codes Ineligible for Reimbursement in the Early Retiree Reinsurance Program (Revenue Codes Guidance) (Nov. 11, 2011). The Revenue Codes Guidance, however, was published after the Plan Sponsor filed its appeal in this case on October 27, 2011. Therefore, because the Plan Sponsor in this case did not have notice of the Revenue Codes Guidance, it is not a guidance document on which I rely in rendering my decision.

[3] The Secretary has delegated "[t]he authority to accept and review appeals of adverse reimbursement determinations under the reinsurance program . . . to the Chair of the Departmental Appeals Board, Office of the Secretary, who will designate one or more Board Members to decide each appeal." 76 F.R. 53,903 (Aug. 30, 2011).

I agree with CMS that the items and services at issue in this case are not eligible for reimbursement. The Plan Sponsor had notice through the Claims Ineligible Guidance that ERRP will not cover items and services generally excluded from Medicare. The Plan Sponsor has the burden to show that procedures claimed could be covered by Medicare under at least one Medicare setting and that the drugs claimed are covered by a standard Medicare Part D plan or covered under Parts A or B. The Plan Sponsor has failed to submit any evidence whatsoever that shows that the disputed procedures are eligible for coverage under Medicare. Similarly, the Plan Sponsor has failed to provide any evidence that the NDCs at issue in this case are covered by Medicare under any standard Part D plan or, alternatively, under Medicare Parts A or B. Instead, the Plan Sponsor merely contends that it believes "these services are clearly Medicare-eligible benefits." Without any evidence to support a finding that the items and procedures are indeed eligible for coverage under Medicare, the Board has no basis to reverse CMS's initial determinations.

Conclusion

Based on the foregoing, I uphold CMS's initial determinations.

/s/
Constance B. Tobias
Chair, Departmental Appeals Board