PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2001-D22

PROVIDER -
Campbell's Personal Care, Inc.
Chicago, IL

Provider No. 14-7483

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/
Blue Cross Blue Shield of Illinois/
Palmetto Government Benefits
Administrators

DATE OF HEARING-
September 27, 2000

Cost Reporting Period Ended -
December 31, 1995

CASE NO. 98-0229

INDEX

ISSUE:

Was the Intermediary's adjustment to skilled nursing and HHA visits proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Campbell's Personal Care, Inc. ("Provider") is a proprietary home health agency located in Chicago, Illinois. The Intermediary reconciled Medicare settlement data recorded on the Medicare cost report to the latest Intermediary Provider Statistical and Reimbursement ("PS&R") report. Based on the work performed, visits were adjusted to agree with the audited data.[1] The adverse effect of this adjustment is that the Provider's Medicare utilization is lower thereby decreasing Medicare reimbursement. The Intermediary issued a Notice of Program Reimbursement on July 29, 1997.[2] On November 10, 1997, the Provider filed a timely request for an appeal[3] with the Provider Reimbursement Review Board ("Board"), and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider estimates the Medicare reimbursement effect in dispute to be approximately $40,000.

The Provider was represented by Charles F. MacKelvie, Esquire, of MacKelvie & Associates, P.C. The Intermediary was represented by Mr. Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

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1 Intermediary Exhibit I-1.

2 Provider Exhibit 2.

3 Provider Exhibit 3.

The Provider's Administrator asserts that the Intermediary failed to process the Provider's claims in a timely manner. This was confirmed by the Intermediary witness who stated that not all claims were processed in a timely manner.[4] The Provider contends, and it was not refuted, that the Intermediary completely suspended the claims processing for the Provider when it became aware that the Provider was an active participant in the Home Health Prospective Pay Demonstration Program. However, the Provider was not notified of the suspension until August 1997. The Provider also contends that the Intermediary was removed from the Medicare program as a Part A contractor after it was found to have destroyed thousands of provider claims.[5] Based on these factors, the Provider believes that the presumption established under HCFA Pub. 13-2 §§ 2243 and 2244 (that the burden of proof to verify data used in computing allowable costs rests with the provider) is without merit in the instant case.

The Provider contends that the general HCFA instructions require that the Payment Reconciliation Report ("PRR") must be supplied to the Provider within 60 days of the end of the cost report year. This report should be used to resolve discrepancies between the Provider's data and PS&R log. There was no evidence that this or any PRR report was ever supplied to the Provider. Moreover, the Intermediary's staff could have completed an analysis to determine if the Provider's records were correct, but they failed to do so.

The Provider concedes that it bears the initial burden of proof as to whether its claims records were more accurate than the Intermediary's PS&R. However, the Provider contends it has met that burden of proof because its internal records recorded each patient from the time the patient was referred to admission, to the time they were discharged. Specifically, the Provider kept its Medicare records separate from its Medicaid and other records. Also, its claims and billing documentation was handled by an experienced individual, one that had been employed by the Provider since 1989.[6]

As the Provider's Exhibit 15 indicated, the Provider contemporaneously and in the ordinary course of business listed by payor each Medicare patient's name, the patient record number, the date the bill was transmitted to the Intermediary and the date returned, the number of visits by discipline, the amount billed to and received from Medicare, the Medicare voucher and date, the type of claim (new patient, readmission, lengthy time of service, etc.) Exhibit 15 was internally consistent because it was cross-checked against the 1995 billing statistics and the individual patient information files. The Provider contends that this gives credence to the argument that it did in fact provide services for 7,344 Medicare visits in 1995.

The Provider further contends that the reason for the discrepancy between the Provider's records and the Intermediary's PS&R is that not all of the visits by discipline were paid by the

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[4] Tr. at p.116.

[5] Tr. at p. 12 & 13.

[6] Tr. at p. 3.

Intermediary. As Provider Exhibit 12 indicates, the outstanding claims that were submitted but not paid by Medicare were first submitted May, 30, 1995 and resubmitted on October 18, and December 6, 1995 and January 9, 1996. Testimony at the hearing indicated that the Intermediary apparently ignored the follow up letters.[7] The Provider contends that it never received notice that any of the 1,569 claims were not covered by Medicare.

The Provider asserts that contrary to the assumptions of the Intermediary that the Provider's claims records were incorrect, the failure of the Intermediary to reconcile the Provider's patients records against the PS&R log makes the exclusion of claimed visits improper.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends it properly adjusted the as-filed data to the PS&R dated March 31, 1997. The PS&R Report or the Payment Summary and Payment Reconciliation Reports show the best available information for cost report settlement purposes. Using these reports for cost reporting purposes is in accordance with HCFA Pub. 13-2, Sections 2242 and 2243.

HCFA Pub. 13-2, Section 2242 states in part:

> A. Provider Summary Report.- Use information about charges, Medicare patient days, coinsurance days, etc., from the provider summary report in the cost settlement process unless the provider furnishes proof that inaccuracies exist.
>
> B. Payment Reconciliation Report.- The payment reconciliation report provides detailed data which supports the provider summary report. Use this report to resolve discrepancies between the provider's data and the summary report.

HCFA Pub. 13-2, Section 2243 states in part:

> Two reports are produced from the PS&R System. The first consist of statistical reports showing claim activity. These can be used for accounting and auditing purposes regarding provider remittance. . . . The second show the results of processing and are used for operations control and monitoring of the flow of data through the PS&R system. . . .

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[7] Tr. at p. 88.

Statistical reports produced are:

> A. Payment Reconciliation Reports.- This report shows in detail claims accepted by the PS&R system with totals by provider within report type. All claims processed by the PS&R system will be written to this report on a monthly basis. It serves as an audit trail for monthly activities and for comparison to the summary report . . . .
>
> B. Provider Summary Reports.- Summarizes claim data and other information by revenue code required for cost report settlement and HCFA reporting purposes. . . .

The Intermediary contends that it adjusted the as filed data for visits to the PS&R Summary dated March 31, 1997.[8] The net result was a 1575 reduction in Medicare visits.[9] The Intermediary further contends that its adjustments were made in accordance with prescribed Program regulations, instructions, and guidelines.

The Intermediary points out that the Provider has not furnished a reconciliation between the PS&R data or remittance advice information and its own data. Nor has the Provider demonstrated that the Intermediary's settlement data is incorrect or that the adjustment is inaccurate. In addition, the Provider has not adequately supported its position regarding Medicare visits pursuant to 42 C.F.R. §§ 413.20 and 413.24, and HCFA Pub. 15-1 §§§ 2300, 2304, and 2402.2. Provider participation in the Medicare program requires that the Provider maintain adequate documentation for the reimbursement of costs. This requirement is outlined in 42 C.F.R. 413.24 which provides that:

> Adequate cost information must be obtained from the Provider's's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization . . .

Based on these factors, the Intermediary contends that its adjustments should be affirmed.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Regulations - 42 C.F.R.:

§§ 405.1835.-1841 - Right to a Board Hearing

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[8] Intermediary Exhibit I-12.

[9] Intermediary Position Paper p. 5 & 6.

§ 413.20 - Financial Data and Reports

§ 413.24 - Adequate Cost Data and Cost Finding

2. Program Instructions - Medicare Intermediary Manual (HCFA Pub. 13-2):

§ 2242 - Intermediary Use of PS&R Systems Reports

§ 2243 - Description of Reports Available

§ 2244 - Corrections To Individual Records

3. Program Instructions - Provider Reimbursement Manual Part 1 (HCFA Pub. 15-1):

§ 2300 - Adequate Cost Data and Cost Finding - Principle

§ 2304 - Adequacy of Cost Information

§ 2402.2 - Participating Provider

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board finds that there was evidence presented to the Board by the Provider (Exhibit P-15) consisting of a log that reflected the patient's name, a record number, dates of services, and various billing and payment information. This log was also cross checked with billing statistics and individual patient information files which were presented during the hearing (Provider Exhibits P-22 and P-23, respectively). Testimony by the Provider's witness revealed that Exhibit P-15 was considered by the Provider to be its "best evidence"in that it was reviewed and updated daily.

Provider testimony and documentation at the hearing revealed that there were differences between what the Provider believes is due from the Medicare program and what was actually paid to the Provider, as evidenced by the PS&R. During the hearing, the Intermediary questioned the Provider's witness as to possible explanations for the variances. The Board finds that the witness was unable to offer a precise explanation, nor did the Provider produce a listing of unpaid claims which could be reconciled between its logs and the PS&R.

The Board further finds that the Provider utilized the Florida Shared System for its claims processing. That system provides the opportunity for a Provider to enter the system and check on the status of submitted claims. The Board finds the testimony of the Provider's witness to be

inconclusive as to whether certain claims in question were ever received by the Intermediary. The Provider witness testified that follow-ups were made via the mail (return receipt requested). However, this documentation was not in the record. The Board further notes that the Provider received a replacement Intermediary in August 1988. The record does not indicate what unpaid claims, if any, were transferred to the new Intermediary. The Provider witness was not able to specify what was unpaid at that time.

The Board finds the regulation at 42 C.F.R. § 413.20 states that :

> The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program.

The regulation at 42 C.F.R. § 413.24 adds:

> Providers receiving payment on the basis of reimbursable costs must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors.

The Board finds that the Intermediary produced evidence consisting of a PS&R Report and a Payment Reconciliation Report which consisted of a detailed report of Provider claims submitted and paid through July 31, 2000. In that the evidence and testimony produced by the Provider failed to substantiate that the Intermediary reports were inaccurate, the Board finds and concludes that the best evidence in the record is the Provider Summary Report and Payment Reconciliation Report dated August 2, 2000. That report covers the Provider's year ending December 31, 1995.
The Board also finds that the Provider had ample time to reconcile their claims with the PS&R information but failed to do so.

DECISION AND ORDER

The Intermediary's adjustment to Medicare visits using the PS&R data was proper and is affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman
Martin W. Hoover, Jr., Esq.
Charles R. Barker
Stanley J. Sokolove

Date of Decision: May 02, 2001

For The Board

Irvin W. Kues
Chairman