PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D3

PROVIDER -
Allegany County Department of Health
Belmont, NY

Provider No.: 33-7089

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
United Government Services, LLC - WI

DATE OF HEARING -
August 4, 2005

Cost Reporting Period Ended -
December 31, 2000

CASE NO.: 04-0372

INDEX

ISSUE:

Whether the Intermediary's adjustment to reconcile the fiscal year ended (FYE) 12/31/00 home health agency aide charges to the Provider Statistical & Reimbursement Report (PS&R) was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due a provider of medical services.

The Medicare program provides health insurance to aged and disabled persons. 42 U.S.C. §§1395-1395cc. The Secretary of the Department of Health and Human Services (Secretary) is authorized to promulgate regulations prescribing the health care services covered by the program and the methods of determining payments for those services. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with the program's administration. CMS has entered into contracts with insurance companies known as fiscal intermediaries to maintain the program's payment and audit functions. Intermediaries determine payment amounts due providers of health care services (e.g., hospitals, skilled nursing facilities, and home health agencies) under Medicare law and interpretative guidelines issued by CMS.

At the close of its fiscal year, each provider submits a cost report to its intermediary showing the costs it incurred during the period and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The intermediary reviews the cost report and determines the total amount of Medicare reimbursement due the provider, and notifies the Provider in a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's determination may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

42 C.F.R. §413.13(b) requires Medicare to reimburse providers the lesser of the reasonable costs or customary charges for services rendered to Medicare beneficiaries. Customary charges are defined as the regular rates that providers charge both beneficiaries and other paying patients for services rendered. 42 C.F.R. §413.53(b)(2)(ii)

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Alleghany County Department of Health (Provider) provides a variety of health services to the citizens of Allegany County, New York. One of these services is home health aide services that are provided through the Department's home health agency. This dispute involves home health aide visits that were performed from January 1, 2000 through September 30, 2000. The Provider claims these were erroneously billed by

Allegany County to Medicare at the home health agency's one-hour rate ($30/hour) rather that at the per-visit rate ($62.10).

During its review process, the Intermediary decreased Medicare charges on the Provider's Medicare cost report to reflect charges reported on the Provider Statistical and Reimbursement Report (PS&R). This report interfaces with the billing form the Provider uses for patient claims. Providers must use the reports in preparing costs reports and must be able to explain any variances between the PS&R and the cost report. Intermediaries are to furnish PS&R reports to the Provider on or before 120 days after the close of the cost reporting period.[1] The Provider alleges that it was during this PS& R reconciliation process that it first discovered that it had billed its home health aide charges to Medicare incorrectly and it requested the Intermediary to increase the charges to reflect its customary charges. The Intermediary asked the Provider to submit schedules of the visits and rates actually billed and the visits and the rates that should have been billed. Upon submission of the requested information to the Intermediary,[2] the Provider was informed that the PS&R could only be corrected by rebilling the home health aide services at the correct rate. However, the deadline to rebill the services had expired. The Intermediary therefore settled the cost report using the PS&R data. The adjustment resulted in a reduction of Medicare reimbursement of approximately $206,400.

The Provider appealed the adjustment to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835- 405.1841. The Board made a determination that it had jurisdiction over the issue in a decision dated August 2, 2005. The Provider was represented by Ross P. Lanzafame, Esquire, of Harter, Secrest & Emery, L.L.P. The Intermediary was represented by Arthur E. Peabody, Jr., Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends the home health aide services should have been billed at the per-visit rate because it takes longer than one hour to perform each visit. It blames a clerical error for the incorrect billing of the home health aide visits asserting that a change in its software billing tables incorrectly reflected the home health aide per-visit rate as $30, when in fact it was the Provider's per-hour rate for home health aide services that was $30. The Provider asserts that the average length of a home health aide visit furnished by the Provider is over two hours, and the usual and customary charge for home health aide services provided by the Provider was $62.10 a visit.

The Provider contends that the Medicare Intermediary Manual §2242 requires the Intermediary to settle cost reports based on PS&R data unless there is evidence that the PS&R report is inaccurate. The Provider cites several PRRB cases to support its contention. The Provider asserts that testimony at the hearing established that the Provider, due to a clerical error, incorrectly billed a per-hour charge for home health aide

[1] Provider Reimbursement Manual (CMS Pub. 15-2) §104.A.3.
[2] See Provider Position Paper, Exhibit 8 for the schedule submitted to the Intermediary.

visits to Medicare but completed its cost report using the correct per-visit charge. The Provider claims that it has furnished sufficient documentation to prove that the charges reported in the PS&R for home health aide services are inaccurate.

The Provider asserts that Intermediary refused to look beyond the information in the PS&R report. The Intermediary advised the Provider that the only remedy available to the Provider was to rebill the home health aide charges to Medicare. However, the Provider maintains that due to the delay in the Intermediary's issuance of accurate PS&R information during the changeover from the Interim Payment System to the Prospective Payment System and the consequent delay of the Intermediary's tentative settlement, the time for rebilling the services had lapsed.

Specifically, the Provider claims that had a timely final PS&R been issued within the typical five month period after the fiscal year end, and had the Intermediary reviewed the cost report and issued adjustments within the typical 1-year time frame from the end of the cost reporting year, the error would have been caught within the re-billing window and the claims could have been re-billed. The Provider claims they were disadvantaged by the delay in the PS&R and the filing of the FY 2000 cost report in that these delays resulted in its being unaware of the error until at least November 2002, long after the deadline for billing.[3]

The Intermediary asserts that its adjustment to the Provider's Medicare charges accurately reflect what the Provider billed Medicare for services rendered, and that the PS&R properly reflected the claims billed to Medicare; it does not contain errors. The Intermediary also asserts that the alleged "error" was made by the Provider in the billing of home health aide charges, and that the error could have been corrected if it had been identified within the timely period. 42 C.F.R. §424.44, requires a provider to bill within prescribed time limits, in this case, December 31, 2001. The Intermediary contends that it was a lack of diligence on the Provider's part and the Provider's failure to review information provided to it that caused the "error" to go undetected until after the time limit for billing had passed. First, a review of remittance advices and original claims would have identified the problem. The Intermediary states that the reconciliation of remittance advices to the claim forms is a common practice which the Provider failed to follow. Second, since this issue was also present in FY 1999, a comparison of the FYE 2000 adjustment report to the Provider's FYE 1999 amended cost report would have also indicated that the Provider was charging $30 per-visit for home health aide services. Third, a review of other cost reports and/or adjustments would have identified the problem. The Intermediary asserts that a revised adjustment report dated April 2001 reduced the Provider's charges for home health aide services by approximately $650,000, and this should have alerted the Provider of a potential issue with total HHA service charges.

The Intermediary contends that while the Provider and the Intermediary did engage in discussions regarding the issue in an attempt to determine if other avenues existed to

[3] Transcript p. 148.

correct this problem, the discussions took place after the timely billing deadline had expired; therefore, those discussions did not prejudice the Provider in any way.

The Intermediary further asserts that a determination of accurate charges for home health aide services is precluded by irregularities in the Provider's own fee schedules. Although the Provider claims that $62.10 is the accurate charge for its home health aide services during the relevant cost year, the Intermediary argues that Provider has supplied no evidence to support this fact. The Intermediary notes that while it is clear that the Provider billed the visits at $30, the record reflects that the Provider first asserted its charges to be $57 and then $62.10. The Provider's fee schedules reflect that the charge was both $57 and $30 on two different charts, signed by the same person on the same day.

The Intermediary also asserts that the Provider's $62.10 charge for home health aide services appears to be a charge ascertained by the Provider "after the fact;" i.e., after the end of the cost report year at issue rather than being a "customary charge." This charge of $62.10 was "backed into" by the Provider once total cost for aide services and total visits were compiled at year-end. The Intermediary asserts that $62.10 could therefore, not be the correct charge for services performed during the cost reporting year, as the charge was developed using year-end data and could not have been in effect during the year in question.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and program instructions, evidence and the parties' contentions, finds and concludes as follows:

Medicare Intermediary Manual (MIM) 13-2 §2242 identifies how the Intermediary should use the PS&R system reports (both the Provider Summary Report and the Payment Reconciliation Report) in the cost report settlement process. MIM 13-2 §2242 A and B instruct the Intermediary to:

> 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 finishes 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.

In order for the Intermediary to utilize a provider's charge data instead of the PS&R summary report, a provider must provide proof that inaccuracies exist in the PS&R. The

provider would then submit its own records to resolve the identified discrepancies. In this case, the Provider submitted records in the form of sliding scale fee schedules, charge masters,[4] and summary schedules of visits[5] to prove that discrepancies existed; however those documents also showed internal discrepancies, as one identified the proper charge as $57 and the other as $62. Also, the charge masters were based on the average cost-per-visit at the end of the cost reporting period, rather than being a true charge made concurrent with billing.

The Provider testified at the hearing that although its records identified that home health aide services were billed at $30 per hour, the average visit was more than two hours in length[6]. The Provider also testified that its contract with an outside agency for its home health aides mandated at least two hours per visit, and this further supports its contentions that an aide visit would be longer than two hours and that the $30 charge was understated. The Provider, however, did not submit any patient files or documents to demonstrate that while more than one hour of service was performed, only one hour of service was billed and paid for. Although the Provider claims that it could have proved through patient records that the discrepancies existed, the only evidence presented to the Board was testimony that the errors existed and the summary schedules and charge masters as identified above. Based on those documents alone, the Board is not convinced that home health aide visits exceeded one hour or that a charge discrepancy existed at the time the services were billed.

The Provider claims that it was misled by the Intermediary's assertion that no other process was available to correct the misbilled claims through the claims processing system. Based on the testimony at the hearing, however, it appears that there may have been a process available to the Provider at the time the billing error was discovered of which the Provider was not notified.[7] MIM 13-3, Chapter VIII §3799 allows for the reopening and revision of claims determinations and decisions for errors found in claims after the time for claims appeals has passed. MIM 13-3, Chapter VIII §3799 reads in relevant part:

> When a final determination is made on a claim for payment, both the beneficiary and the provider under Part A and the physician or supplier under Part B should be able to rely on that determination. Occasionally, information disclosing an error in the determination comes to light after the time for appeals has passed. To correct these errors, regulations permit reopening of an otherwise final decision under specific circumstances. A

[4] See Provider Position Paper, Exhibits 7 (Allegany County Department of Health – Sliding Fee Scale effective 11/1/99-12/31/00 with only $30 per hour listed) and Exhibit 15 (Alleghany County Health Dept, Base Rates for Services) and Intermediary Position Paper, Exhibit 10 (Allegany County Department of Health – Sliding Fee Scale effective 11/1/99-12/31/00 with $30 per hour listed and $57 per visit).

[5] See Provider Position Paper, Exhibits 5 (Summary of Actual HHA Billing), 6 (Summary of visits at $57 per visit) and 8 (Summary of visits at $62.10 per visit).

[6] See Transcript, page 32

[7] See Transcript, pages 202-204

> case is open until the last determination becomes final by the losing party's failure to appeal, or appeal rights have been exhausted. Reopen only if the case is closed and the new information is significant and material, or discloses an error on the face of the materials.

In addition, the CMS manual identifies examples of good cause for reopenings. MIM 13-3 Chapter VIII §3799.8 states:

> "Good Cause for reopening" exists where:
>
> - New and material evidence, not readily available at the time of the determination, is furnished;
> - There is an error on the face of the evidence on which such a determination or decision is based; or,
> - There is a clerical error in the claim file.

MIM 13-3 Chapter VII §3600.2E[8] also provides instructions on how to process special claim types, such as adjustments. The Manual states in relevant part that:

> There is no longer a timely filing period for adjustments . . .
>
> And that –
>
> To the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing (See Chapter 29 on Reopenings).

The Intermediary claims that it had no knowledge of other remedies available to the Provider at the time the adjustment was made to reconcile Medicare charges to the PS&R. While the Board finds the Intermediary's failure to properly inform the Provider of other remedies available troubling, the Board has no jurisdiction over claims processing and, therefore, it has no authority to apply any of these remedies. Rather, it must apply the claims determinations made through that process.

DECISION AND ORDER:

The Intermediary's adjustment to the Provider's home health aide charges was proper. The Intermediary's adjustment is affirmed.

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[8] This Manual provision has been redesignated as Pub. 100-04, Chapter 1. Section 70.5 in the new Medicare Claims Processing Manual.

BOARD MEMBERS PARTICIPATING

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: November 7, 2006

Suzanne Cochran
Chairperson