PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D35

PROVIDER -
Mid-City Home Health
Los Angeles, CA

Provider No.: 55-7729

vs.

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

DATE OF HEARING -
July 16, 2004

Cost Reporting Period Ended -
September 2, 1997

CASE NO.: 99-1345

INDEX

ISSUE:

Whether accrued liabilities claimed by the Provider are reimbursable under the Medicare principles.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. 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 administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

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

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mid City Home Health Care (Provider) is a home health agency located in Los Angeles, California. It filed its Medicare cost report for the period October 9, 1996 to September 2, 1997 claiming various legal and accounting fees. The amount claimed were accruals, i.e., amounts incurred but not yet paid.

United Government Services, LLC, (Intermediary) disallowed $39,406 of these accrued legal and accounting fees[1] for lack of documentation and for non-payment of accrued liabilities in the time required by Medicare regulations and program instructions.

The Provider appealed the Intermediary's determination to the Board and has met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was

[1] The original amount of contested legal and accounting fees was $52,209. During prehearing activity $12,803 of these costs ($1,303 of legal expenses and $11,500 of accounting expenses) were reviewed and accepted by the Intermediary. However, no formal revised NPR was issued.

represented by C. Chike Amobi, Esquire, of Amobi and Lane. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

FINDING OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and program instructions, evidence submitted, and parties' contentions, finds and concludes that the Intermediary properly denied reimbursement of the accrued legal and accounting fees claimed by the Provider.

The Provider was a new home health agency. As a new agency, before its claim for services were paid, the claims and supporting documentation of the medical services provided were reviewed by medical personnel. Depending on the findings, the advance review may be maintained at 100% review; it may be modified so that only a portion of the claims are held for medical review; or it may be lifted so that claims are promptly paid.[2] In this case, the Provider's medical review was maintained at 100%, in part because the State licensing agency raised questions of potential falsification of records even before the Provider began billing for services.[3] The medical review process meant that payments were delayed as much as six weeks.[4] The State licensing agency eventually "shut down" the agency in August 1997, a few months after its Medicare certification. During that time, the Provider was never taken off 100% medical review.[5] According to the Provider, about 15% of the Provider's claims were denied.[6]

Because Medicare reimbursement principles require accrued expenses to be liquidated within one year after the end of a provider's cost reporting period in which they were accrued, on March 11, 1998, the Provider asked for an extension of time to pay the accrued liabilities.[7] The Intermediary refused, citing the fact that the Provider was no longer a going concern and, therefore, could not demonstrate an ability to pay the accrued liabilities or to repay the Medicare program if a liability existed.[8]

The Provider alleges that the Intermediary's action placed it in a "Catch 22" in that the Intermediary withheld payments due the Provider for processed claims, then would not extend the time frame to liquidate the liabilities.[9]

The Board finds the following to be undisputed:

(1) The above accrued liabilities were not paid in accordance with 42 C.F.R. §413.100(c)(2)(i)(A).

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2 Transcript (Tr.) at 39:21-40:15; 119:5-121:11; 147:4-24.
3 Tr. at 141:5-25; 245:6-146:17.
4 Tr. at 33:23-34:13.
5 Tr. at 38:16-39:5.
6 Tr. at 52: 19-53:53.
7 Tr. at 35:11-37:19.
8 Tr. at 126:11-127:8.
9 Provider's final position paper.

(2) The Provider filed a timely request for an extension of payment of accrued liabilities for up to three years because it believed it had good cause for late payment of these expenses. This met the requirement of 42 C.F.R. §413.100(c)(2)(i)(B).

(3) The Provider did not pay the accrued liabilities in question within the three year regulatory window.

(4) The Provider has never paid the accrued liabilities still being questioned.

Medicare is designed to reimburse providers for costs actually incurred and paid; it does not pay for costs incurred but not paid. The overriding fact in this case is that the Provider's accrued liabilities were never paid, thus making moot the Provider's contentions that the Intermediary acted in bad faith in withholding reimbursement payments and refusing to grant an extension of time for Provider to pay its accrued liabilities.

The Board finds that the actions of the Intermediary were warranted, as they were taken as the result of surveys that had been conducted by the State Department of Health Services which revealed serious patient treatment and record-keeping deficiencies that ultimately resulted in the Provider being ordered to terminate its business as of September 2, 1997.[10]

DECISION AND ORDER:

The Intermediary properly denied reimbursement of accrued legal and accounting fees. The Intermediary's adjustments are sustained.

BOARD MEMBERS PARTICPATING:

Suzanne Cochran, Esquire
Martin W. Hoover, Jr., Esquire
Gary B. Blodgett, D.D.S
Elaine Crews Powell, CPA
Anjali Mulchandani-West

FOR THE BOARD:

DATE: April 12, 2005

Suzanne Cochran
Chairperson

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[10] Intermediary's Supplemental Exhibit I-4, Provider Exhibit P-2; Tr. at 40.