PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D22

PROVIDER -
Alacare Home Health Services, Inc.
Birmingham, Alabama

Provider No.: 01-7009

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Palmetto Government Benefits
Administrators

DATE OF HEARING -
January 31, 2006

Cost Reporting Periods Ended -
December 31, 1998 and December 31, 1999

CASE NOS.: 01-0654 and 02-0235

INDEX

ISSUE:

Whether the relevant claims were timely filed by Alacare under 42 C.F.R. §424.44.

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 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 issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

42 C.F.R. §424.32 identifies the basic requirements for all claims. This provision states in pertinent part:

> (a) A claim must meet the following requirements:
>
> 1. A claim must be filed with the appropriate intermediary or carrier on a form prescribed by HCFA in accordance with HCFA instructions.
>
> 2. A claim for physician services . . . must include appropriate diagnostic coding for those services using ICD-9-CM.
>
> 3. A claim must be signed by the beneficiary or the beneficiary’s representative (in accordance with §424.36(b)).

> 4. A claim must be filed within the time limits specified in §424.44.

42 C.F.R. §424.44 governs the timeframes for filing Medicare claims. This provision states in pertinent part:

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

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Alacare Home Health Services, Inc. (Provider) provides a variety of home health services to home-bound patients throughout the State of Alabama. The Provider filed Medicare claims applicable to the first nine (9) months of 1999 and the last three (3) months of 1998 with its Intermediary, Palmetto Government Benefits Administrators (PGBA), prior to or on, December 31, 2000, which was the filing deadline for the claims under 42 C.F.R. §424.44. PGBA refused to accept and process many of the Provider's Medicare claims filed on or near the December 31, 2000 deadline that were not "error-free." The Provider's finalized cost reports for FYs 1998 and 1999 did not include the denied claims. The Provider filed timely appeals with the Board.

The Intermediary filed a challenge to the Board's jurisdiction, stating that the issue was related to the payment of claims, which is not covered under the Board's authority. The

Board denied jurisdiction on December 23, 2002, and the Provider then appealed the decision to the United States District Court for the Northern District of Alabama (Southern Division). The District Court ruled that, in issuing NPRs that did not include reimbursement for the alleged untimely claims, the Intermediary made a determination that was subject to review. Additionally, the Court found that the claims issue was not a coverage matter because the issue of whether the claims were timely filed is not governed by 42 U.S.C. §1395d or §1395y. The case was then remanded to the Board to determine if the claims were timely filed.

The Intermediary's adjustment resulted in a reduction in Medicare reimbursement of approximately $335,476 for the two fiscal years in issue. The Provider was represented by Richard D. Sanders, Esquire, of Balch & Bingham, LLP. The Intermediary was represented by Bernard Talbert, Esquire, of Blue Cross and Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that it timely submitted claims to the Intermediary relying upon the clear language set forth in 42 C.F.R. §424.44 and upon the Intermediary's historical practice of processing timely filed claims. The Intermediary deviated from established Medicare filing standards and practices by refusing to process any adjustments or corrections to the Provider's claims that were submitted after December 31, 2000. The Provider admits that the claims in question contained flaws and they were properly denied payment. However, the claims were filed prior to the December 31, 2000 filing deadline and should be considered timely received, even if the claims contained errors.

The Provider contends that prior to 2000, the Intermediary interpreted 42 C.F.R §424.44 such that erroneous and flawed claims which were filed on or before the timely filing deadline were considered to have been timely filed and were regularly processed even though they were not "error-free." The Provider identified instances in previous years where the Intermediary had worked with the Provider, as well as other providers, to correct errors on claims that were submitted by the filing deadline but flagged by the claims processing system as Return-to-Provider (RTP) claims.[1] Therefore, the Provider asserts that it relied on its previous experience with the Intermediary when it submitted claims at the end of the timely filing period with the belief that if any errors were identified in those claims, the Provider would be allowed to correct the claims after the December 31, 2000 filing deadline.

The Intermediary asserts that in January and February of 2000, it received notice from the Atlanta Regional Office that its claims processing practice allowing providers to cure RTP claims after the filing deadline was an inaccurate interpretation of the timely filing guidelines,[2] and that going forward, RTP claims that were perfected after the filing

[1] Transcript, page 44.

[2] Exhibit I-5, pages 2 and 5. The Intermediary was notified by CMS through a CC on a letter responding to a provider that had claims denied by Palmetto because they were deemed "incomplete or invalid." This letter informs the provider that for an "administrative error" to be proven, the provider would have to document that they submitted ". . . complete and valid claims on a timely basis."

deadline would no longer be considered timely.[3] The Intermediary contends that it published its new policy on timely filing standards in the May 2000 Medicare Advisory Bulletin issued to all providers; therefore, the Provider had notice of this change approximately seven months prior to the filing deadline for the claims in question.

The Provider argues that the notice in the May Advisory Bulletin was included in a lengthy document that included numerous other claims processing updates. The Intermediary did not issue a special bulletin specifically for this change, nor did the monthly bulletin draw special attention to this change. Also, the Provider asserts that in years past, the Intermediary hosted in-person training events to review significant changes in policy over the year, but the Intermediary did not host training sessions in 2000 that highlighted this change. The Provider argues that a shift in policy this extreme should have been widely publicized and not just included as "an aside" on page two of a newsletter.[4] The Provider claims it was unaware of the change in policy when it filed the claims on or shortly before December 31, 2000, and until after the claims were rejected by the Intermediary.

The Provider argues that this change in policy precipitated by CMS' new interpretation of the timely filing guidelines is not supported by the timeliness criteria set forth in the controlling regulation, 42 C.F.R. §424.44. Since the timeliness regulation does not speak to a claim being error-free and speaks only to the date by which a claim must be filed, the Provider contends the Intermediary is applying a standard that is not addressed by the regulation.

The Intermediary contends that 42 C.F.R. §424.44, in conjunction with 42 C.F.R. §424.32 and other existing Medicare authorities, support its position that a claim must be error-free to be considered timely. The Intermediary asserts that 42 C.F.R. §425.5(a)(6), basic conditions for Medicare payment, requires a claim for payment to include ". . . sufficient information . . . to determine whether payment is due and the amount of payment." The Intermediary argues that when reading the above referenced regulations together, a timely claim must meet a qualitative standard as well as a chronological standard. The Intermediary also asserts that Section 3600 of the Medicare Intermediary Manual (MIM) includes strong language which supports the assertion that claims returned because of errors are not considered timely filed. The MIM, CMS Pub. 13-3, §3600.2(B)(3)[5] states in pertinent part:

> In order to constitute a Medicare claim, services submitted for payment must be entered in a claim format in accordance with these instructions. Services submitted for payment in a manner not complete and consistent according to these instructions will not be accepted into Medicare's

[3] Exhibit I-5, pages 1and 4.
[4] Transcript, page 118.
[5] CMS Pub. 13-3 §3600.2(B)(3) has been redesignated as Medicare Claims Processing Manual (Pub 100-04) Chapter 1, §70.2.3.

> electronic claims processing system and will not be considered filed for purposes of determining timely filing.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Provider has identified three distinct "buckets" for the claims in question. The first category includes claims that were submitted by the 12/31/00 deadline, were returned to the Provider due to errors in the claims, and the Provider fixed the errors in the claims. These claims were denied for timely filing, as the Provider "perfected" or fixed the claim after the filing deadline. These claims are reportedly still in the Medicare claims processing system. The second category represents claims that were filed prior to the filing deadline and were also returned because of errors. This batch, however, was not corrected, as the Intermediary had informed the Provider that if changes were made to those claims, they would have been rejected just as those in the first batch had been. This group of claims was purged by the Intermediary's claims processing system 60 days after they were returned and corrections were not made. The third category represents claims that were rejected as duplicate claims, as the service dates on those claims overlapped service dates for claims previously filed, and due to sequential billing requirements, were considered "out-of-order" and therefore rejected as duplicate claims.[6]

It is undisputed that prior to FY 2000, the Provider would have been permitted to correct at least a portion of the claims identified above.[7] The change in policy was triggered by an interpretation made by the CMS Regional Office (RO) in a letter dated January 5, 2000.[8] An internal memo, written by the Intermediary's claim manager and dated February 24, 2000, stated that, "There still seems to be some confusion about timely filing, specifically regarding when it is appropriate to override timely filing. I think part of the confusion is resulting from Aetna's and PGBA's past liberal policies regarding overrides for timeliness."[9] It is also undisputed that the May 2000 Medicare Advisory Bulletin was the only explicit communication to providers on how the Intermediary would be handling RTP claims in the future, and that the memo included the language of "error-free."

Even after the February 2000 memo and the May 2000 advisory were issued to the provider community, the evidence indicates that confusion still remained as to the appropriate interpretation of the timely filing policy. In an email dated November 7, 2002, CMS RO personnel commented on the "error free" language used by the Intermediary in a Medicare Advisory Bulletin dated October of 2002 (which was the

[6] Transcript, pages 32-34.
[7] Transcript, pages 207-208.
[8] Exhibit I-5.
[9] Exhibit I-5.

same language used by the Intermediary in its May 2000 advisory).[10] The CMS RO found the language "problematic" and instructed the Intermediary not to use the term "error-free" language in any future advisories. Instead, CMS "suggested" that the phrase "essential data must be complete and accurate" be used to describe the requirements of a timely filed claim.[11] The Intermediary's witness acknowledged that the "error-free" standard imposed on its providers was not supported by CMS.[12] The "error-free" language was found to be misleading and subject to misinterpretation by the reader to mean that perfect claims must be submitted, when in fact, the intermediary's standards do not require perfection.

The Medicare claims processing manual indicates that both CMS and the Intermediary have an expectation that claims that are not "clean" will be submitted. A process was put into place for those claims in CMS Pub. 13-3 §3600.1. The clean claim standard, as it is described in §3600.1.A.3, was instituted to hold the Intermediary to a standard for timely processing of claims and also to determine the amount of interest due or payable if the standard was not met by the Intermediary. Both the Intermediary and the Provider agree that the clean claim standard is not included in the Home Health Agency Manual (CMS-Pub. 11), the manual for home health providers on submission of claims.

The Intermediary argues that all of 42 C.F.R. §424 (including §424.5 and §424.32) is relevant in order to determine whether or not a payment is due from Medicare. This section details all of the conditions and requirements necessary to reach this determination. However, the question of whether or not the subject claims met all such conditions is not before the Board; rather, whether or not the Provider's request for payment was timely filed in accordance with the regulations is the issue to be decided. To answer this question, the Board must look at the regulations to determine the conditions that must be met regarding the timely filing of a claim for payment.

The regulation establishing the basic conditions for Medicare payment at 42 C.F.R. §424.5(a) states, in part, that:

> (5) Claim for payment. The provider, supplier, or beneficiary, as appropriate, must *file* a claim that includes or makes reference to a *request for payment*, in accordance with subpart C of this part. (emphasis added)

There is no dispute that the Provider (1) filed a claim and (2) made a request for payment. The request for payment is usually made on a form prescribed by HCFA in accordance with HCFA instructions. See 42 C.F.R. §424.32(a)(1). However, there is an exception to this procedure that allows the request for payment to be made on something other than

[10] Exhibit P-12.
[11] The Board speculates that confusion still exists on this issue, as the advisory states that adjustments to claims are subject to timely filing deadlines, but CMS Pub. 13-3 §3600.1 states that there is no longer a timely filing period for adjustments.
[12] Transcript, page 183.

HCFA-approved forms. In fact, the regulations at 42 C.F.R. §424.45 state what constitutes a claim for purposes of meeting the time limits as:

> A written statement of intent (SOI) to claim Medicare benefits constitutes a claim if –
>
> (a) The statement is filed with HCFA or any carrier or intermediary within the time limits specified in §424.44;
>
> (b) The statement indicates the intent to claim Medicare payment for specified services furnished to an identified beneficiary; and
>
> (c) A claim that meets the requirements of §424.32(a) is filed within 6 months after the month in which the intermediary or carrier, as appropriate, advises the claimant to file that claim.

It is undisputed that the Provider did not avail itself of this option but chose to gather all the necessary information and submit its claims in the prescribed manner and within the established time frame. The Board majority finds that by all indications, the Provider complied with, according to its understanding, all HCFA/Intermediary requests and instructions. The regulation at 42 C.F.R. §424.45 is a good indication that a "clean" or "error-free" claim is not required to satisfy the timely filing condition for payment, although under §424.32(a)(1), a claim must be filed " . . . in accordance with HCFA instructions."

In addition, the Provider has argued that it relied on the previous guidance and history with the Intermediary in submitting the claims in dispute. The Board majority finds that based on the previous actions of the Intermediary, the Provider placed legitimate reliance on the fact that RTP claims would be considered timely by the Intermediary if received prior to time limits outlined at 42 C.F.R. §424.44(a). The Board majority finds that the change in "interpretation," even if the interpretation was used by only one intermediary, represented such a significant shift in policy that, at the least, formal notice should have been provided to all providers who were affected. The Board majority finds that the brief discussion of the new interpretation amongst numerous other topics in the Medicare Advisory Bulletin issued by the Intermediary in May of 2000, without any emphasis on the impact of the change, was inadequate notice to providers of this significant change in claims processing policy.

The Board majority concludes that the Intermediary improperly held the Provider's claims to an unsupported "error-free" standard. This standard is neither found in the regulations nor endorsed by CMS,[13] and was not properly communicated to the affected providers.[14]

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[13] It is noted that CMS has clarified its timely filing requirements in the Medicare Claims Processing Manual, Pub 100-04, Chapter 1, 70.2, 70.3 and 70.4 effective 6/13/2003 with transmittal #1887, dated 5/30/2003. §70.2 clarifies the components of a claim which are required and therefore are needed in

DECISION AND ORDER:

The Intermediary improperly applied an "error-free" standard to the claims in question. The case is remanded to the Intermediary to process the $335,476 of claims outlined in Provider Exhibit P-6 without applying the "error-free" standard.

BOARD MEMBERS PARTICIPATING:

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

DATE: February 27, 2007

FOR THE BOARD:

Suzanne Cochran
Chairperson

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order to process the claim submission and those components which are conditional, and therefore must be completed if other conditions exist. §70.3 instructs the Intermediary that any submitted claim which is incomplete (missing those required components) or invalid (contains the required information but is illogical or incorrect or does not conform to required claim formats) is considered to be a filed claim for purposes of determining timely filing on the date that the submission passes edits for completeness and validity and is accepted into the Medicare adjudication process. This clarification does not use the terminology "clean claim" or "error-free."

Dissenting Opinion of Elaine Crews Powell and Anjali Mulchandani-West

We respectfully dissent.

The record indicates that the Provider was notified of the change in the way the Intermediary was interpreting and applying the timely billing standard codified at 42 C.F.R. §424.44 as early as May 2000. We find that the Intermediary's notice in May of 2000 was sufficient and timely, and if the Provider had had questions about the deadline, it should have asked for clarification. The burden here is clearly on the Provider. The Provider had adequate notice of the Intermediary's change in implementing the policy. Notification through a bulletin is the ONLY way that an intermediary can communicate a change in its implementation of policy and the Intermediary did exactly that in this instance. Moreover, the Provider had the opportunity to avail itself of the Statement of Intent to file claims option but chose not to do so.

The Provider knew that it had problems with the claims that were identified at the hearing. The Provider organized these rejected claims into three "baskets."

In Basket #1 were claims that had been returned to the Provider (RTP) for correction because they could not be processed cleanly by the system, i.e., they contained errors that preventing them from being processed for payment. The claims had been filed prior to the deadline of 12/31/00. An electronically submitted claim could be corrected on line by correcting the error, and then pressing F9 to "submit it back for payment." (Tr. 85) The date on the claim would be the date it was accepted for processing, not the date the original incorrect claim was filed. The later date is the one against which the timeliness standard of 42 C.F.R.§424.44 is measured by the Intermediary. These claims were not corrected by the Provider through the on line F9 process until after the deadline had passed and were, therefore, rejected by the Intermediary as untimely.

Another scenario that was discussed by witness Dordick was that the Provider chose not to correct the RTP claims on line but, rather, chose to file new paper claims. By the time the Intermediary input the claims and the system accepted them for processing, the deadline had passed, so the claims were rejected by the Intermediary as untimely. This necessitated a resubmission of the claims.

In Basket #2 were claims that were filed prior to the deadline and had been RTP'd for errors. The Provider's witness testified that the Provider did nothing to correct the errors on the claims. The Provider at that time "made a decision that they weren't going to be able to do anything else to fix them, and they were going to pursue the issue further. They sat in that return-to-provider file, and then in approximately 60 days those claims would be purged from the Medicare system and they're no longer there." (Tr. 87-88) These claims were also rejected as untimely.

In Basket #3 were claims that were filed with the Intermediary but rejected "as a duplicate claim" due to the sequential billing requirement. Some of these claims had paid, but when a different line item service that occurred between two dates on the paid claim needed to be billed on a second claim, the second claim overlapped and was rejected as a duplicate. (Tr. 90) The Provider could have seen that the claim had been paid and done an adjustment bill to the initial claim on line, but it did not do so.

We find that the Provider knew that it had problems with cleaning up some of its claims, but due to other pressures, waited to the last day or two before the deadline to file the rejected claims. However, we also note that while the majority of the claims were filed immediately prior to the deadline, several claims were filed at least 6 months before the deadline and the Provider did not remedy the problems with those bills. This delay, coupled with the Intermediary's tightening of existing CMS policy regarding the timely submission of claims, caused the problem now before the Board.

The majority decision ignores the Provider's responsibility in favor of castigating the Intermediary for the insufficiency of its notice. What form would the majority have the notice take? How much notice is enough? There was clearly a communication process in place and that process was used for this notification. Although not flamboyant, the notice was adequate, timely – seven months before the deadline for submission of the claims at issue, and published in the prescribed forum.

We find insignificant the "error-free" language that so troubled the majority and upon which the Provider wants to focus the decision. We believe the requirement that claims be filed correctly and in accordance with all CMS instructions clearly envisions the same thing. The Intermediary's use of the term "error-free" may have been a poor choice of words, but it cannot be the basis upon which the Provider is excused from its responsibility for filing accurate claims timely, or at least correcting the errors in time for the acceptance date to fall before the filing deadline.

_____ _____

Elaine Crews Powell, CPA Anjali Mulchandani-West