PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D5

PROVIDER -
Unique Care Home Health
Hammond, LA

Provider No.: 19-7717

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Palmetto Government Benefits
Administrators, LLC

DATE OF HEARING -
July 10, 2008

Cost Reporting Periods Ended -
May 31, 1998; March 17, 1999

CASE NO.: 05-2270

INDEX

ISSUES:

Whether the Provider Statistical and Reimbursement Reports (PS&Rs) used to settle the Provider's cost reports for the fiscal years ended May 31, 1998 and March 17, 1999 are accurate.

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 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 to organizations 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. §1395h, 42 C.F.R. §§413.20 and 413.24.

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:

Unique Care Home Health (Provider) was a Medicare certified home health care provider that was located in southern Louisiana. The Provider ceased operations on March 17, 1999. Palmetto Government Benefits Administrators (Intermediary) reconciled the data from the Provider's cost reports for FYE 5/31/98 and FYE 3/17/99 to the Provider Statistical & Reimbursement Reports (PS&Rs)[1] and effected settlement based upon those reconciliations. The Provider challenged the accuracy of the PS&Rs and appealed the Intermediary's settlement amounts. At issue is the accuracy of the PS&R data used in the settlement process.

The Provider timely filed its appeal and met the jurisdictional requirements of 42 C.F.R §§405.1835 - 1840. The Provider was represented by Michael Bermes, Owner, Unique Care Home Health. The Intermediary was represented by James Grimes, Esq., of Blue Cross Blue

[1] The PS&R summarizes statistical and reimbursement data applicable to processed and finalized Medicare Part A claims.

Shield Association.

PROVIDER'S CONTENTIONS:

The Provider claims that the payments per the PS&R reports do not match the actual payments or cash transfers received from the Intermediary, and that the PS&Rs do not match that which was actually billed.[2] The Provider asserts that the discrepancies caused by a focused medical review caused the Provider's billings to be non-sequential and unprocessed.[3]

A focused medical review is a method of targeting and directing medical review efforts on claims where there exists the greatest risk of inappropriate program payment. The review procedure consists of analysis of reports on processed claims to determine patterns of utilization and areas of potential improper payment. Once an aberrancy is identified with a provider's utilization, a prepay provider specific medical review edit is entered into the claims system that selects a percentage of the provider's claims for medical review each time that it bills. The medical review is performed by registered nurses who have knowledge of Medicare regulations and accepted standards of practice. The review ensures that covered services are medically reasonable and necessary and determines if the claim can be paid based on the documentation submitted by the provider.

Once a claim is selected for review, it is removed from the provider's claims submission. The selection interrupts the submission's sequential order which remains disrupted until the selected claims are returned to the provider's original submission. Until the selected claims are returned and the submission's sequential order is restored, the claims cannot be processed. In this case, the focused medical review resulted in the denial of 40% of the Provider's claims

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that CMS Pub. 13-2, §2242 directs intermediaries to use the PS&R in the settlement of the cost report.[4] The Intermediary argues that it reconciled the Provider's "as filed" cost reports to the PS&R and adjusted visits on the 1998 and 1999 costs reports to agree with the visits shown to have been allowed and paid in the summary report.[5] The Intermediary argues that, despite its challenges to the calculations, the Provider offered no documentation that demonstrated that the PS&R was inaccurate or that claims submitted were not processed.

Further, the Intermediary asserts that the Provider expected reimbursement based on its billings. However, records of monies received cannot be expected to agree exactly with the PS&R because the PS&R reflects claims adjudicated and paid. The Provider may have been credited with payment on the PS&R but actual payments to the provider also include adjustments for

[2] Transcript, pp. 16-20.
[3] Transcript, pp. 13-14, 44.
[4] Transcript, p.25.
[5] Transcript, pp.36-37.

offsets, withholdings and overpayments. Therefore, the figures from the PS&R differ from the amounts received and recorded by the Provider.[6]

The Intermediary agreed that claims would be rejected if they were not submitted sequentially. In this case, the sequential billing problems were the result of the Provider being placed on medical review. However the Intermediary argues that, once the medical review was completed, the claims in question and all subsequent claims would have been processed through the system.[7] The Intermediary contends that there is no evidence in the record that claims were not finally processed and either paid or denied.[8] Further, no proof of inaccuracies in the PS&R has been provided to the Intermediary that would justify the use of any other settlement statistics. Accordingly, the Intermediary argues that it properly used the PS&R reports and that its adjustments should be affirmed.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and the evidence included in the record, the Board finds and concludes as follows:

The primary issue before the Board was whether the PS&R reports that the Intermediary used to settle the Provider's cost reports were accurate. The Board examined all the evidence in the record to establish the facts and circumstances of the Provider's case. The Board recognizes that detailed PS&R reports were not timely provided pursuant to the Provider's initial challenge to the validity of the PS&R data.[9] The Board also notes that the Provider experienced significant delays within the claims process due to the collective impact produced by a focused medical review, sequential billing requirements and difficulties within the Florida Shared System (the financial system used by the Intermediary). Those delays are evidenced by the accelerated payment request granted to the Provider in November, 1998.[10]

However, these circumstances above are insufficient to establish inaccuracies within the PS&R reports. The identification of inaccuracies within the PS&R reports requires a claim by claim analysis of amounts billed, approved and paid.[11] The Provider asserts that such reconciliation was supplied both to the Intermediary and to the Board.[12] However, the evidence in the record offered no such reconciliation.[13] Rather, the only reconciliation the Provider offered was a comparison of the PS&R data to a brief summary of the check registery that was prepared by the Provider.[14] The comparison attempts to use payment data as the measure of PS&R accuracy.

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[6] Transcript, p.42.
[7] Transcript, pp.45-46.
[8] Transcript, p.48.
[9] Provider Position Paper, Exhibits 1.
[10] Transcript, P. 51-53; See also Exhibit P-4.
[11] Transcript, pp. 122, 138,139
[12] Transcript, pp.161-163.
[13] Id.
[14] Exhibit P-1.

The comparison did not account for program offsets due to prior accelerated payments, overpayments or denied claims and left unaddressed the Provider's assertion of inaccuracies in the PS&R visits and charge data. Accordingly, the Board finds that the Provider has not established the existence of inaccuracies in the PS&R data used by the Intermediary to effect settlement for fiscal periods 1998 and 1999. Absent such evidence, the Board finds the PS&R data accurate and concludes that the Intermediary's use of that data was proper.

DECISION AND ORDER:

The Provider did not meet the burden of proof necessary to establish inaccuracies in the PS&R data. The Intermediary's use of the PS&R data was proper.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Keith E. Braganza, C.P.A.
J. Gary Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: October 25, 2010