CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

IN THE CASE OF:	CLAIM FOR:
Alacare Home Health Services **Provider** **vs.** **Blue Cross Blue Shield Assn./ Palmetto Government Benefits Administrators** **Intermediary**	**Provider Reimbursement Fiscal Years Ending: 12/31/98, 12/31/99** **REVIEW OF:** **PRRB Dec. No. 2007-D22** **Dated: February 27, 2007**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS). for review of the Provider Reimbursement Review Board (Board) decision. The review is during the 60-day period mandated in §1878(f)(1) of the Social Security Act (Act) [42 USC 1395oo(f)(1)], as amended. Comments were received from the Center for Medicare Management (CMM), requesting reversal. The Administrator notified the parties of the intention to review the Board's decision. Subsequently, comments were received from the Intermediary, requesting reversal. Comments were also received from the Provider, requesting affirmation of the Board's decision. Accordingly, this case is now before the Administrator for final administrative review.

ISSUE AND BOARD'S DECISION

The issue is whether the relevant claims were timely filed by the Provider under 42 CFR 424.44.[1]

[1] The Board denied jurisdiction over the Provider's appeal on December 23, 2002. The Provider appealed the jurisdictional decision to the United States District Court for the Northern District of Alabama. The Court ruled that, in issuing Notices of Program Reimbursement (NPR) which did not include reimbursement for the claims at issue, the Intermediary made a determination subject to the review. Thus, the Court remanded the case to the Board for a determination on the merits of the case.

The Board Majority held that the Intermediary improperly denied the claims at issue as untimely. The Majority remanded the case to the Intermediary for processing of the claims at issue without an "error-free" standard. The Majority observed that the Provider identified three categories of relevant claims. The first category involved claims that were submitted by the December 31, 2000 deadline, were returned to the Provider (RTP'd) due to errors, which the Provider corrected and resubmitted subsequent to the filing deadline. These claims were denied for untimely filing because the Provider did not perfect the claims until after the deadline. The second category involved claims that were also filed prior to the deadline and were returned because of errors, but the Provider failed to cure the errors in these claims. The third category involved claims which were denied as duplicate claims.

Further, the Majority stated that, prior to fiscal year (FY) 2000, the Provider would have been permitted to correct at least some of these claims. However, in a January 5, 2000 Regional Office (RO) letter to a provider not related to this case, the RO explained that claims which are RTP'd due to errors are not considered timely-filed.[2] In addition, the Majority quoted a February 24, 2000 internal memorandum from the Intermediary's claim manager to an unrelated provider, which stated that there continued to be confusion over the issue of timely filing resulting from the Intermediary's historically liberal policies. The Majority also observed that a May 2000 Medicare Advisory Bulletin was the only communication to providers establishing how RTP claims would be handled in the future. The Majority noted that the Bulletin used the term, "error-free."

Moreover, the Majority continued, even after the material issued to providers in 2000, confusion regarding the timely filing policy remained. In an email dated November 7, 2002, RO personnel stated that it found the "error-free" language problematic and directed the Intermediary to use the phrase, "essential data must be complete and accurate" in relation to a timely-filed claim, instead of "error-free." At the Board hearing in this case, the Intermediary's witness acknowledged that CMS did not support the "error-free" standard because it was misleading and subject to misinterpretation when, in fact, intermediary standards did not require perfection.

The Majority further observed that the Medicare Claims Processing Manual indicates that the Intermediary and CMS expect that imperfect claims will be submitted. A process for such claims was set forth in section 3600.1 of the predecessor to the Medicare Claims Processing Manual, i.e., the Medicare Intermediary Manual (MIM). The Majority stated that the clean claim policy was put in place to hold intermediaries to a standard for timely claim processing and to determine the interest amount if an intermediary does not meet the standard. The Intermediary and the Provider in this case agree that the Home Health Agency Manual also does not include the clean claim standard.

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[2] See Intermediary Exhibit No. I-5.

Further, the Majority explained that the regulations, at 42 CFR 424.5(a), require a provider to file a claim which includes a payment request. The Majority found that there was no dispute that the Provider had fulfilled these requirements. The Majority noted that, pursuant to the regulation at 42 CFR 424.32(a)(1), a payment request is usually made on a form prescribed by CMS consistent with CMS instructions, but there is an exception which allows the payment request to be made on something else. 42 CFR 424.45 establishes the contents of a claim for purposes of meeting the time limits. Specifically, the regulation states that a "statement of intent" constitutes a claim if certain requirements are met. However, the Majority pointed out that the Provider did not choose the statement of intent option, but rather submitted its claims in the prescribed manner and time frame, in compliance with CMS instructions. The Majority found that the regulation at 42 CFR 424.45 indicates that a clean or error-free claim is not required to meet the timely filing condition, although 42 CFR 424.32(a)(1) states that a claim must be filed "'in accordance with [CMS] instructions.' "

In conclusion, the Majority found that the Intermediary improperly determined that the Provider's claims did not meet an error-free standard. Such a standard is not in the regulations, is not endorsed by CMS, and was not properly communicated to providers.

Two Board members dissented, contending that the Majority ignored the Provider's responsibilities in favor of finding insufficient notice. The Dissenters observed that the notice was adequate, published in the prescribed form, and was issued seven months prior to the deadline for submission of the claims at issue. Notice through a bulletin was the sole way for the Intermediary to communicate a policy change, and the Intermediary did so. The Provider could have asked questions about the deadline for claims, but did not. In addition, the Provider could have used the statement of intent process but chose not to do so. The Dissenters pointed out that the burden of proof in this case is clearly on the Provider.

Further, the Dissenters noted that the category number one claims which were returned to the Provider due to errors were filed prior to the deadline of December 31, 2000, but the Provider failed to correct them before the deadline and electronically resubmit them. The category two claims were also submitted before the deadline but rejected for errors. The Provider, however, chose not to correct the errors and resubmit them for payment. The third group of claims were rejected as duplicate claims because their service dates overlapped service dates for previously-paid claims. The Dissenters found that the Provider could have corrected the errors in the various claims timely.

Finally, the Dissenters stated that, contrary to the Majority and the Provider, it found the "error-free" term insignificant. The requirement that claims be correctly filed and consistent with all CMS instructions amounted to the same standard as "error-free." The Intermediary's use of the term "error-free" may have been a poor choice of words, but it cannot be the ground upon which the Provider is excused from its duty to file accurate

claims in a timely manner, or at least correct the errors in time for the acceptance date to occur prior to the deadline.

COMMENTS

CMM commented, requesting reversal of the Board majority decision. CMM explained that it had always interpreted the regulation at 42 CFR 424.44(a) to mean that a complete claim, as defined at 42 CFR 424.32(a), must be submitted on or before the filing deadline for the claim to be considered timely. This policy is evident on its face, since the regulation states that a "claim" must be filed timely, and a "claim" is defined as meeting certain requirements. Therefore, if a claim is incomplete or contains incorrect information, the completed or corrected claim must be submitted to the Medicare contractor on or before the filing deadline. Were it otherwise, the claim filing deadline would be eviscerated because a provider could submit unacceptable claims and have unlimited time to resubmit an acceptable claim. In addition, CMM noted that CMS' contractors are not budgeted for this type of inefficient work. CMM argued that 15 to 27 months is more than adequate time for providers to submit acceptable claims. Moreover, CMM stated that, although the adequacy of the May 2000 Bulletin notice was not crucial, it agreed with the dissenting opinion that the Bulletin furnished sufficient notice to the provider community of the elements of an acceptable submission.

CMM further argued that, contrary to the Majority's opinion, the Intermediary did not hold the Provider's claims to an incorrect standard. The Intermediary's witness at the hearing testified that, regardless of whether the Intermediary's May 2000 Bulletin stated that claims had to be "error-free" or "all the essential data must be complete and accurate," which was the language preferred by the Regional Office, the claims at issue would have been rejected as incomplete or incorrect.[3]

CMM also noted that the Majority reasoned that the fact that providers are allowed to file statements of intent means that providers are not required to file complete claims. However, the Majority acknowledged that the Provider did not use the statements of intent process. Moreover, CMM added, it does not necessarily follow that, if the Provider had tried to file statements of intent, they would have been accepted because the statement of intent procedures during the cost years at issue required essentially the same data elements for a statement of intent that were required for a true claim.[4]

The Intermediary commented, requesting reversal of the Board majority decision. The Intermediary, incorporating by reference, the opinion of the Dissenters and the comments of CMM, argued that the relevant regulations and program instructions place the burden

[3] CMM cited to the Transcript of the Oral Hearing (Tr.) at 187.
[4] CMM cited to Program Memorandum (PM) AB-00-43 (May 2000), reissued as PM AB-03-061 (May 2003).

on a provider to file claims correctly in order to meet any timely filing requirement. The Intermediary noted that waiting until the deadline before filing, puts the risK on the filing provider. Thus, claims which are properly rejected (i.e., have errors) simply do not count as being filed when transmitted.

The Provider commented, requesting affirmation of the Majority's decision. The Provider argued that CMM was disingenuous when it stated that it "always interpreted" timely filing to mean that a complete claim must be submitted before the timely filing date. In fact, based on testimonial evidence, the Intermediary worked with providers after the deadline to rectify technical errors in claims, as long as the claims had been filed by the deadline. However, the Provider asserted that the Intermediary changed its policy to an "error-free" standard and notified affected providers through an article in its newsletter. This "error-free" policy was arbitrary and capricious because it is not precipitated by a change in regulations. The Provider claimed that, regardless of Intermediary's primary evidence to support the error-free policy, the Provider has demonstrated before the Board that the Intermediary has not sufficiently justified this policy. Thus, the Provider argued that it met the requirement for timely filing pursuant to the regulations.

Further, the Provider noted that CMM claimed that the notice of this change in policy was sufficient. However, the Provider argued that the mere publication of the notice contradicts CMM's argument that it "always interpreted" the timely filing rules consistently. If this were so, no notice should have been necessary. Although the Provider agrees that the issue of sufficiency of notice is not crucial, the Provider pointed out that CMM failed to mention the impact of the policy change. The Provider noted that, unlike previous years, the Intermediary did not conduct seminars and educational events regarding this major policy change.

Moreover, the Provider disagreed with CMM's allegation that "the claims at issue would have been denied or rejected as incomplete or incorrect." First, the Provider has only sought to have the disputed claims processed in accordance with rules in place at the time the claims were filed. The Provider did not contend that the Board should deem the claims valid. However, the Provider presented evidence that the claims in dispute included sufficient information for processing and should have been paid if they had been processed by the Intermediary.

With respect to whether the claims at issue must contain complete and correct information in order to be processed, the Provider argued that the only issue before the Board was whether the Provider submitted its claims timely. The Provider noted that CMM relies on section 3600 of the Medicare Intermediary Manual. However, the Provider argued that these rules only state what constitutes a complete and correct claim, not whether a claim must be complete and correct in order to be considered timely. The Provider also noted that the "sufficient information for process" requirement cited is a claims processing standard imposed by the Intermediary for its internal timeline purposes, and does not

govern provider conduct. The Provider argued that it submitted the claims at issue on or before the filing deadline pursuant to the controlling regulation. The Provider acknowledged that the submitted claims were not completely error-free. However, the Provider asserted that it relied on the clear language of the Medicare claims submission regulations, and the Intermediary's historical practice of processing timely filed claims, even if those claims contained errors.

In sum, the Provider stated that that the Board majority correctly concluded that the Intermediary improperly held the Provider's claims to an unsupported "error-free" standard. A standard of which is neither found in regulations nor endorsed by CMS, and was not properly communicated to the affected providers. Thus, the Provider urged the Administrator to uphold the Majority's decision.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments timely received have been considered and are included in the record.

The regulation at 42 CFR 424.44 establishes the time limits for filing Medicare fee-for-service claims, and reads as follows:

> (a) Basic limits. Except as provided in paragraph (b) of this section,[5] the claim must be mailed or delivered to the intermediary or carrier, as appropriate -
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> (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
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> (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.

In addition, 42 CFR 424.32(a)(1) of the regulations states that "a claim must be filed with the appropriate intermediary ... in accordance with HCFA instructions." [Emphasis added.] The instructions relevant in this case are set forth in the Medicare Claims

[5] Two exceptions in 42 CFR 424.44(b) extend the filing time: if the intermediary or an agent of the Department caused the failure to meet the deadline, or where the deadline falls on a nonworkday. Moreover, during the cost years at issue, the regulation at 42 CFR 424.45 allowed for the submission of statements of intent, to extend the timely filing period for the submission of an initial claim. A statement of intent, alone, did not equal a claim, but rather was equivalent to a placeholder for filing a timely and proper claim if the statement of intent met certain requirements. However, the record reflects that the Provider in this case did not file statements of intent for these claims.

Processing Manual (Manual). Section 70.1 of the Manual contains a table illustrating the timely filing limit for dates of service in each filing month. Section 70.2 establishes three conditions which must be met for a submission to be considered a claim:

> it must be filed with the appropriate Medicare contractor, it must be filed on the prescribed form and it must be filed in accordance with all pertinent CMS instructions.[6] [Emphasis added.]

Notably, section 70.2.3 adds that:

> [s]ervices submitted for payment in a manner not complete and consistent according to these instructions will not be accepted into Medicare's electronic claims processing system and will not be considered filed for purposes of determining timely filing. [Emphasis added.]

In turn, section 70.2.3.1 of the Manual defines "incomplete submissions" as those lacking required information, and "invalid submissions" as containing illogical or incorrect information, or which are not in conformance with required claim formats. Both incomplete and invalid submissions are RTP'd. When claims are made electronically, problems are detected by the intermediary's claim processing system, and are returned to the provider electronically, with the errors notated. Further, section 70.2.3.1 of the Manual adds that "[a]ssistance for making corrections is available in the on-line processing system ... or through the [intermediary]."

Section 70.3 of the Manual goes on to state that:

> A submission, as defined above, 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 described in section 70.2 above and is accepted into Medicare adjudication processes. At this point, the submission receives a permanent receipt date that remains part of the claim record.
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> The receipt date has two functions. It is used for determining whether the claim was timely filed. ... The same date is also used as the receipt date for purposes of determining claims processing timeliness on the part of the intermediary. [Emphasis added.]

Further, section 70.7 establishes that there are only two exceptions to the timely filing requirements: where there is a Medicare program error, or where the provider has filed a statement of intent to file claims.[7]

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[6] Sections 3600.2 of the MIM, setting forth the time limitations for filing fee-for-service claims, was not issued until after the cost years at issue in this case.

In addition, the Medicare Advisory Bulletin, issued in May 2000, addressed filing requirements.[8] On page one of the Bulletin, the relevant heading reads as follows: "Medicare Part A Timely Filing Guidelines for All Bill Types." That section covers four pages of the Bulletin, which sets forth a filing chart, matching dates of service with last filing dates, and states that:

> the claim must be error free. Any claim filed with invalid or incomplete information, and Returned to Provider (RTP'd) for correction is not protected from the timely filing guidelines. ...
>
> If a provider fails to include a particular item or service on its initial bill, an adjustment bill(s) to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing a claim. In addition, the adjustment and late charge bill must be error free. Adjustments and late charge bills filed with invalid or incomplete information, and ... RTP'd ... for correction are not protected from the timely filing guidelines. [Emphasis added.]

An amendment to section 3600.1.A.7 of the Medicare Intermediary Manual was issued on November 16, 2000, with an effective date of October 1, 2000. That section reads as follows:

> Receipt Date -The receipt date is the date you receive a claim subject to the qualifications in subsection C on whether the data are sufficiently complete to qualify as a claim. The receipt date is used to ... determine if a claim was received timely. ...
>
> [C]laims that do not meet the basic legibility, format, or completion requirements are not considered as received for claims processing and may be rejected from the claims processing system. Rejected claims are not considered as received until resubmitted as corrected, complete claims.

In this case, the claims for the last quarter of the 12/31/98 cost year and the first three quarters of the FYE 12/31/99 cost year were postmarked on January 2, 2001. The FYE 12/31/98 and 12/31/99 claims were received by the Intermediary on January 3, 2001. The Intermediary processed all valid and complete claims through its system and included these on the Provider Statistical and Reimbursement (PS&R) report for paid claims. The claims which were RTP'd as invalid or incomplete were considered untimely and were not

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[7] The Administrator notes that, as of May 24, 2004, Medicare no longer accepts statements of intent to extend the timely filing limit.

[8] See Intermediary Exhibits I-7 and I-14, and Tr. at 148-151.

processed. The Intermediary and the Provider discussed the issue of timeliness on several occasions.[9] An NPR for FYE 12/31/98 was issued on September 30, 2000.[10]

No adjustments for PS&R data were included in the 1998 NPR, based upon the parties' agreement that the PS&R to be used at finalization was inaccurate. According to the Provider, a large number of the last quarter of the 1998 claims were in the process of being submitted to the Intermediary for inclusion in the PS&R report.[11] The Intermediary agreed to refrain from including any PS&R statistical adjustments, and to wait until the last quarter of the FYE 12/31/98 claims were processed and included on the PS&R report. The Intermediary reopened, revised, and reissued the 1998 NPR on November 1, 2001, to include the statistical adjustments from the September 30, 2001 PS&R report. The PS&R report used by the Intermediary did not include the FYE 12/31/98 claims which were received on January 3, 2001, and RTP'd to the Provider. Such claims were deemed to be untimely and, thus, not processed.

An NPR for FYE 12/31/99 was issued on September 5, 2001. The Intermediary reopened the FYE 12/31/99 NPR, and issued a revised NPR on October 10, 2001. Both finalized cost reports included PS&R statistical adjustments, but the PS&R report did not include the Provider's FYE 12/31/99 claims which the Intermediary received on January 3, 2001 and returned to the Provider as untimely filed.

Applicable to both cost years, the Provider has argued that, once a claim is furnished to the Intermediary, the receipt date governs whether it is timely-filed per 42 CFR 424.44. Moreover, the Provider contended that the claims it submitted for the final quarter of FYE 12/31/98 and the first three quarters of FYE 12/31/99 which were received by the Intermediary on January 3, 2001 (for both cost years) were timely. In addition, the Provider averred that the RTP'd claims which were corrected and refiled should have been accepted as timely by the Intermediary.

After review of the record and the law set forth above, the Administrator finds the regulation, at 42 CFR 424.44, establishes the time limits which are required to be followed when a provider files a claim. The Provider has argued that it filed its claims in conformance with the regulation. However, the Administrator finds that simply filing a claim by the date it is due as established in the regulations does not satisfy the requirements for a timely filed claim. Notably, the regulation, at 42 CFR 424.32(a)(1), expressly states that claims must be filed not just by the time limits in the regulations, but also in accordance with CMS instructions found primarily in section 70 of the Medicare

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[9] See e.g., email between Provider and Intermediary, including a timeline of events, at Intermediary Exhibit I-4.

[10] See Intermediary's Position Paper for FYE 12/31/98, pp. 4-5, and 12/31/99 Position Paper, p. 4.

[11] See Intermediary Exhibit I-2.

Claims Processing Manual. If those instructions are not followed when a provider files a claim, section 70.2.3 of the Manual states that the claim will not be "considered filed for purposes of determining timely filing." Some of the claims at issue were RTP'd because they contained errors or were incomplete, as defined in section 70.2.3.1 of the Manual, while others were filed so late that there were no days left within the timely filing period for correction. Section 70.3 of the Manual establishes that a claim submission is considered to be filed timely only when it "passes edits for completeness and validity. ..." In addition, some claims were rejected as duplicate services. Regardless of the specific reasons for the Intermediary's rejection of the claims, the Administrator finds that all of the Provider's claims at issue in this case did not meet the regulatory and program definition of a timely filed claim. Thus, the Intermediary properly determined the claims at issue incomplete and, thus, untimely filed.

Further, the Administrator notes that the Provider could have filed the subject claims under the Statement of Intent process, which was an option during the time periods at issue in this case. If the Provider had availed itself of that option, it could have reserved for itself additional time to work through the problems with the claims in order for the claims to have been considered acceptable. Since the Provider did not elect this option, it had only one option, which was to file the claims properly in the first instance.

Finally, with respect to the Board's finding of "confusion," the Administrator finds that the Medicare Advisory Bulletin, issued in May 2000, provided actual notice that, inter alia, RTP'd claims would not be protected from the timely filing guidelines. Moreover, to the extent the Provider argued that the Intermediary had a practice of accepting claims filed in such a manner, there is no authority for an intermediary to ignore regulatory requirements and instructions.[12]

Thus, based on the foregoing opinion, the Administrator concludes that the Majority decision is improper. The Majority's decision in this case is reversed.

[12] Further, in finding jurisdiction in this case, the court has treated these claims as a cost report payment issue. The Administrator notes that sectionS 1815 and 1878(a) of the Act, 42 CFR 413.20 and 413.24 all require a provider to submit auditable and verifiable documentation for proper payment within designated timeframes. The Provider failed to do so in this case.

DECISION

The decision of the Board Majority in this case is reversed consistent with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

Date: 4/30/07

/s/
Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services