Stephen D. Bittinger
Member
Admitted in OH

June 29, 2018

Educational Information

Bill Finerfrock, Executive Director
National Association of Rural Health Clinics
1009 Duke Street
Alexandria, VA 22312
Via email only: bf@capitolassociates.com

Re: Palmetto GBA Demands to RHCs re Improper Payment of Medicare Advantage Plan Claims

Dear Mr. Finerfrock:

Thank you for speaking with Jeanne Born and me on June 27, 2018, regarding the Palmetto GBA demands[1], dated June 15, 2018 (Demand), that were sent to numerous Rural Health Clinics (RHC) across the country. As discussed, Ms. Born has experience with Rural Health reimbursement issues, and I have represented providers nationally in defense of The Centers for Medicare and Medicaid Services (CMS) auditors, including Palmetto GBA (PGBA), in their contracted capacity as a Medicare Administrative Contractor (MAC). We are glad to provide the educational information in this letter to assist your members with understanding the process and some of the key areas of the law involved. Please note that since our firm does not represent the National Association of Rural Health Clinics (NAHRC), this letter is expressly for educational and informational purposes and should not be construed as legal advice for any specific RHC.

On May 7, 2018, PGBA issued a Claims Payment Issues Log (CPIL), which was revised on May 15, 2018, that identified potential overpayments for claims processed prior to February of 2018, related to Part A Jurisdiction J claims that were paid for Medicare beneficiaries covered under a Medicare Advantage (MA) plan. PGBA listed the limited scenarios that would warrant the claim being submitted to Fee For Service (FFC) Medicare that are bulleted on the first page of the Demand.

[1] Redacted PGBA Demand enclosed.

Charleston
Charlotte
Columbia
Greensboro
Greenville
Hilton Head
Myrtle Beach
Raleigh

205 King Street
Suite 400 (29401)
PO Box 486
Charleston, SC 29402
www.nexsenpruet.com

T 843.720.1703
F 843.414.8210
E SBittinger@nexsenpruet.com
Nexsen Pruet, LLC
Attorneys and Counselors at Law

While we understand that the Demands have issued specific overpayment amounts, a complete audit of these claims appears not to have been performed. We understand that PGBA has informed NARHC that an exception process will be permitted for RHCs to produce evidence that PGBA's findings are incorrect on specific claims,[2] which would support the conclusion that PGBA's findings may not be conclusive.

From our team's experience, we believe there are three potential points of system error in the reimbursement process that could have caused portions of the universe of improperly paid claims, which we would call front-end, scrub, or payor errors. Front-end errors under these circumstances would include RHC staff improperly registering patients under the traditional Medicare financial class in lieu of a Medicare Advantage financial class, which would cause the misrouting to Cahaba (prior MAC)/PGBA. A scrub error could have been caused by clearinghouses working for RHCs failing to present pre-billing edits that would have informed the RHC staff of any registration errors that occurred on the front end. A payor error appears to have occurred when Cahaba failed to have a proper edit in place to identify claims that were submitted for beneficiaries enrolled in MA plans. From our experience, these types of system audits (across a multitude of practices) are precipitated primarily due to a payor error, but front-end and scrub errors are highly likely to have occurred to permit the system error to perpetuate the improper payments.

To fully determine the scope of the current situation, a sampling of claims and remittance advice from each RHC would have to be audited. RCHs would then have to determine if any of the limited exception scenarios PGBA highlighted are applicable to their beneficiaries' claims and warrant billing under FFS.

I will specifically address the section from the Demand titled, "**Claims Within the Four Year Reopening Period**," which states that:

> [PGBA] plan[s] to reopen Medicare's initial determination of claims erroneously paid within four year of the date of when this problem was identified and notice was posted of the issue (May 7, 2018). The decision to reopen for good cause is in accordance with 42 CFR 405.986 and based on evidence that an obvious error was made at the time of the initial determination.[3]

Medicare improperly paying MA claims would appear to be an "obvious error" that warrants "good cause" for reopening claims. PGBA's decision to reopen these claims based on the obvious error is not appealable. See 42 CFR 405.926(l) and 405.980(a)(5).

[2] See NARHC email of June 27, 2018, to RHCs re Palmetto's anticipated posting of a valid exception request process.
[3] Demand p2.

However, all demands for repayment of overpayments by CMS contractors are eligible for appeal:

> When any determination or decision is reopened and revised as provided in § 405.980, the contractor, QIC, ALJ or attorney adjudicator, or the Council must mail its revised determination or decision to the parties to that determination or decision at their last known address. In the case of a full or partial reversal resulting in issuance of a payment to a provider or supplier, a revised electronic or paper remittance advice notice must be issued by the Medicare contractor. An adverse revised determination or decision must state the rationale and basis for the reopening and any right to appeal.

42 CFR 405.982. Here, PGBA, contractor, fully reversed the initial determination and sent the RHCs an adverse determination with rationale. See Demand. However, the Demand did not include a statement of appeal rights. Id. Obviously, the operative word from the regulation above is "any," and whether the RHCs have the right to appeal.

While appealing may not overturn the overpayment where Medicare legitimately paid an MA claim, it is important to note that appealing can stop the automatic recoupment process of a period of time. 42 CFR 405.379.

Under 42 CFR 405.906(a)(3), the RHCs are the "provider of services who file[d] a claim for items or services furnished to a beneficiary" and have standing to appeal PGBA's overpayment demand for a redetermination. Id. at (b). See 42 CFR 405.940. The appeal process is lengthy, which I will just briefly summarize:

- Redetermination is the first level of appeal. 42 CFR §§ 405.940-958. Providers have 120 days from the date of receipt of the notice. Id. at 405.942(a). However, in order to stop automatic recoupement, the request for redetermination must be received by generally within 30 days of the date of the demand, as PGBA has authority to automatically begin recouping 41 days after the date of the demand (June 15, 2018). Recoupment can be prevented until after the Qualified Independent Contractor (QIC) has made a decision on the reconsideration level as set forth below. 42 CFR 405.379(f).

- Reconsideration is the second level of appeal. 42 CFR §§ 405.960-405.978. The QIC "reconsideration consists of an independent, on-the-record review of an initial determination, including the redetermination and all issues related to payment of the claim." 42 CFR 405.968(a)(1). In this instance, for payment demands made by PGBA that are not resolved through PGBA's exception

request process[4], outside evidence of correct payment could be presented to overturn the denial of the claim. Although, for the bulk of the claims that were improperly paid MA claims by Medicare, this step would only prevent recoupment until after the affirming decision.

- Appeal to an Administrative Law Judge (ALJ) at the Office of Medicare Hearings and Appeals (OMHA) is the third level. 42 CFR §§ 405.1000-405.1058. This is a complicated process that I would be glad to expand upon if any RHC ever were to reach this step, but it is the first opportunity for an appellant to set forth legal arguments in front of a judicial officer.

- The Medicare Appeals Council review is the fourth step, which can then be taken to federal district court. 42 CFR §§ 405.1100-405.1140.

The appeal process has been dramatically overtasked, as the wait time to reach the ALJ level now exceeds 1,000 days, despite the regulations requiring it to occur within 90 days, which promoted CMS to create the Settlement Conference Facilitation (SCF) process.[5] Many of the RHCs may want to explore this option, as they determine options for potentially billing to the claims to MAs.

Most importantly, RHCs need to be aware of the law as it related to the section of the Demand titled, "**Claims Outside of the Four Year Reopening Period**."

PGBA's letter does correctly state that all CMS enrolled providers have a duty to return identified overpayments within 60 days. 42 CFR 405.305(a)-(d)(1). The important deadline to understand is that PGBA/CMS has expressly stated that as of the date of the overpayment notice, all RHCs now have a maximum of 180 days to clearly "identify" the overpayment, which means quantification of the total amount owed based on the type of error set forth in the Demand, and only 60 days after that by which CMS must have confirmed receipt of repayment. Id. This is critical, because under 42 CFR 405.305(e), improper retention of an overpayment is a legal obligation that can be enforced under 31 U.S.C 3729 – The False Claims Act (FCA). Potential liability under the FCA includes treble damages and penalties in excess of $10,000 per claim civilly and criminal prosecution. Essentially, PGBA's letter has put all the RHCs on notice that they could be liable under FCA if they do not self-audit for all overpayment on this matter and return overpayments within the six-year lookback period. 42 CFR 405.305(e)-(f).

---

[4] See NARHC email of June 27, 2018, to RHCs re Palmetto's anticipated posting of a valid exception request process.

[5] https://www.hhs.gov/about/agencies/omha/about/special-initiatives/settlement-conference-facilitation/index.html

We understand that there are numerous other factual scenarios with individual RHC's situations, such as being no longer credentialed as an RHC and being able to bill MAs correctly, individual reopening terms under MA contracts, and others, which complicate this matter even further, and we are grateful to continue to be a resource in this difficult matter. Thank you for the opportunity to provide this information.

Sincerely,

Stephen D. Bittinger

enclosure