DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: Maryland Department of Health and Mental Hygiene
Docket No. 86-30
Decision No. 812

DATE: November 19, 1986

DECISION

The Maryland Department of Health and Mental Hygiene (State) appealed a determination by the Health Care Financing Administration (HCFA or Agency) disallowing $3,189,903 in federal financial participation for operation of the State's Medicaid program between July 1, 1983 and June 30, 1984. The basis for the disallowance was HCFA's determination that the State had not met the requirements of section 1903(s) of the Social Security Act (Act) and implementing regulations, which provides a one percent offset to reductions in Medicaid funding to states for fiscal years 1982 through 1984.

Section 1903(s) of the Act provides for progressive percentage reductions in federal Medicaid funding for each of these years, which could nevertheless be offset by an amount equal to one percent of funding (the "one percent offset") if certain criteria were met. The State here alleged that it met the one percent offset by virtue of its having a system to detect "fraud and abuse" that would "divert" a specified amount of funds which would otherwise be spent in the Medicaid program. The State argued that it had diverted funds attributable to the detection of fraud and abuse by operation of a "two-step prepayment screening process" for all hospital admissions. The Agency determined that the State's system for detecting fraud and abuse was ineligible for the offset under the terms of the applicable regulations.

Specifically, the Agency denied the claim of diverted funds from the first stage of the State's process because stage one occurred before the hospital invoice for services had been submitted to the State Medicaid agency and was not, therefore, in the Agency's view, a "claims processing system of prepayment screens" as required by 42 CFR 433.203. The Agency also objected to stage two of the State's system since, although the screening operations occurred after the invoice had been submitted, they were nonetheless "routine" and "clerical."

As explained below, we reverse the disallowance since we conclude that amounts diverted under both stages of the State's two-stage screening system qualify for purposes of the fraud and abuse offset. We find that the screening process provided by a Professional Standards Review Organization in stage one of the State's system was a part of the State's "claims processing system," as required by regulation, since the PSRO's review occurred after discharge of the patient and, in effect, reviewed the hospital's demand for Medicaid payment for services provided. For stage two of the State's ~~system~~, we reject the Agency's argument that the review was "routine" and "clerical," since we find that the State demonstrated that the stage two review involved an independent appraisal of the claim and only included screens which the regulations specifically provided to be eligible for the fraud and abuse offset. 1/

Statutory and regulatory background

Section 1903(s) of the Act provided for reductions in federal Medicaid funding of 3 percent for fiscal year (FY) 1982, 4 percent for FY 1983, and 4.5 percent for FY 1984. Section 1903(s)(1)(A). The section further provided, however, that these percentages shall be "reduced . . . by one percentage point if the total amount of the State's third party and fraud and abuse recoveries for the previous quarter is equal to or exceeds one percent of the amount of Federal payments that the Secretary estimates are due the State . . . for that previous quarter." Section 1903(s)(2)(C). "Third party and fraud and abuse recoveries" are defined as:

> the total amount that State demonstrates to the Secretary that it has recovered or diverted . . . in the quarter

1/ The State in this appeal had challenged the authority of the Agency to effectuate the percentage reductions of Medicaid funding, incorporating by reference an argument made by Pennsylvania in a related case, Docket No. 85-224. Pennsylvania argued that the Agency could not effectuate the disallowance because it had failed to comply with certain prerequisites provided in section 1903(s). In our decision on the Pennsylvania appeal, we explained why the State's arguments did not cause us to reverse the disallowance; we incorporate by reference the same analysis in this decision. See Pennsylvania Department of Public Welfare, Decision No. 811, November 19, 1986, pp. 4-6.

> on the basis of (I) third-party payments . . . , (II) the operation of its State medicaid fraud control unit . . . , and (III) other fraud or abuse control activities. . . .

Section 1903(s)(5)(A)(i).

"Diverted" amounts or "fraud and abuse control activities" are not defined in the statute. Regulations implementing section 1903(s), however, provide:

> . . . Definitions.
>
> For purposes of this subpart--"Abuse" means provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
>
> "Diverted funds" means program funds not spent because claims were denied or reduced in amount as a result of the following:
>
> * * *
>
> (3) Use in claims processing systems of prepayment screens that are--
>
> (ii) Specifically designed to detect fraud or abuse and applied to all claims submitted by all providers or by a general category of providers.

42 CFR 433.203 (1982).

The State's screening system

As explained by the State, the first stage of the State's screening process begins when a hospital completes a Department of Health and Mental Hygiene "3808" form. On the 3808 form, the hospital will claim for each admission a certain length of stay for which the hospital believes it is entitled to Medicaid funding. The hospital also includes other relevant information, such as "the patient's admission and discharge dates, the diagnosis, the plan of treatment provided and the procedures performed." State's Opening Brief, p. 4. 2/

2/ The 3808 form is completed for 100 percent of hospital admissions. The State explained, however, that it claimed the diverting of funds attributable to the detection of (continued on the next page)

The hospital sends the completed 3808 form to the State-designated "Utilization Review" agent, which during the time in question was a federally-approved Professional Standards Review Organization (PSRO). The PSRO reviews the 3808 form to determine the medical necessity of the length of treatment provided. In some cases, the PSRO will also review the patient's medical records. The PSRO then certifies on the 3808 form the number of days which it has approved as medically necessary, as well as identifying those days of care for which the hospital is seeking reimbursement but which are being denied by the PSRO. The denied days of treatment are the basis for computing the diversion of funds when the hospital next submits the actual invoice for the service, which must be accompanied by the 3808 form itself.

The second stage of the State's system begins when the hospital submits to the State the 3808 form along with the invoice for services rendered. At the State agency, the invoice and accompanying 3808 are reviewed by "a team of medical and professional personnel," which analyzes the invoice and 3808 form for three types of fraud and abuse: "Fraudulent billing, overutilization and fragmented claims." State's Opening Brief, p. 5. Fraudulent, or "erroneous," billing, according to the State, is detected by examining whether the hospital's claim was based on some misrepresentation or whether the information provided on the invoice differs from information earlier provided to the PSRO. Id.; Tr., p. 23. "Overutilization" is apparently also detected by examining whether there have been misrepresentations. Tr., p. 24. "Fragmented" claims is a technical term, referring to "multiple billings for the different components of a single admission." State's Opening Brief, p. 5, n. 6. The State also examines whether the hospital is billing for a "non-covered service," but the State does not include any amounts detected by this screen in its calculation of diverted funds, since the State conceded that the regulation's preamble specifically excluded such screens from the definition of "diverted funds." State's Reply Brief, p. 5; 47 Fed. Reg. at 43344 (September 30, 1982).

2/ (continued from the previous page)
fraud and abuse for only those admissions for which the 3808 form is completed after discharge, about 75 percent of the total. According to the State, these admissions are for "non-elective, urgent or emergency procedures and the admissions where the patient is determined to be retroactively eligible after discharge." State's Opening Brief, p. 3, n. 2.

The Agency's basis for the disallowance

The Agency had independent objections to both stages of the State's two-stage screening process. The Agency in its written briefs, however, focused its objections on the first stage of the system, the review of the form 3808 by the PSRO. According to the Agency, "the issue [in this appeal] is whether the PSRO's activities can be construed as a prepayment screen used in a claims processing system," quoting the regulatory definition of "diverted funds" provided by 42 CFR 433.203. Agency's Brief, p. 4. The Agency argued that stage one of the State's system cannot qualify as a prepayment screen in a claims processing system since the PSRO's review occurs before a "claim" is ever submitted by the hospital to the State. The Agency defined the term "claim" to mean the hospital's "invoice" or "bill."

Although the term "claim" is not defined by the regulations implementing the fraud and abuse offset provision, the Agency cited a definition of "claim" appearing in a section of the Medicaid regulations which implement section 1902(a)(37) of the Act, establishing deadlines for the submission and processing of "claims" by a provider. See 42 CFR 447.45. One definition of a claim in that regulation is a "bill for services." 3/

As well as drawing significance from the fact that the State's system was "pre-invoice," the Agency argued that the State's system was part of its system for "utilization control" which was intended to fulfill other statutory and regulatory requirements, including 42 CFR Part 456 ("Utilization Control"). The Agency maintained, therefore, that the State's system was ineligible for the fraud and abuse offset since the system was not "[s]pecifically designed to detect fraud and abuse." 42 CFR 433.203; see Agency's Brief, pp. 5-6.

The Agency also argued that stage two of the State's system failed to meet the requirements of the offset regulations. In the Agency's view, the stage two screening was "a clerical function and not a prepayment screen specifically designed to detect fraud and abuse." Agency's notice of disallowance dated January 13, 1986, p. 2. The Agency further described stage two of the system as merely "a screen designed to determine if the services received the medical reviewer's [the PSRO's] approval." Id.

3/ The Agency also noted that a similar definition of claim is contained in the State's Medicaid state plan, which, under the heading "Timely Claims Payment," provides, "A claim is defined as a bill for services." Agency's Ex. 2.

The Board's analysis

Stage One

We find that the stage one review meets the regulatory requirements of a "prepayment screen" used in a "claims processing system." Before a hospital can receive Medicaid reimbursement for services provided under the State's processing system, the hospital after discharge of the patient is required to submit a statement of the days (form 3808) for which it should receive reimbursement. The hospital then submits an invoice consistent with the PSRO's review of form 3808, which must be accompanied by the 3808 itself. The State has thus functionally broken the billing process into two stages. The process requires an initial review of the medical necessity of the hospital stay by submission of the form 3808 and then consideration of other elements of the claim following submission of an invoice, including further evaluation of medical necessity. Any action taken on the form 3808 review by the PSRO is clearly an action on the hospital's claim for reimbursement. An approval means the requested days were found to be medically necessary and authorizes payment if no further problems are identified through review of the invoice. A denial of days requested by form 3808 effectively denies reimbursement for days of services provided and precludes the possibility of favorable action on those days following a submission of an invoice.

We find that, under its own current regulations, the Agency here places undue weight on the actual submission of an "invoice" in the State's process and does not consider the claims functions served by the form 3808 review. The regulations do not refer anywhere to an invoice and use only the more generic terms "claims" and "claims processing system." The term "claim" is defined in the Webster's Third New International Dictionary as a "demand for compensation." The facts of this case clearly show that the 3808 review, just as the invoice, is an essential part of the processing of a hospital's demand for compensation for days of services actually rendered and, as such, fits within the commonly accepted or plain meaning of "claim" and "claims processing." 4/

4/ The regulation's reference to the "processing" of a claim in a "system" appears to encompass something broader and more flexible than the mere submission and review of an invoice. Webster's Third New International Dictionary provides as one definition of "system": "a complex unity formed of many diverse parts subject to a common plan or serving a common purpose."

The Agency has pointed to program regulations in a different context which define claim as a "bill for services." Again, while the form 3808 is not denominated a "bill" as such, it serves directly and fully as the first step in the claiming or billing process for a service rendered and thus is functionally the same.

The Agency gives the impression that if the 3808 form and the hospital invoice arrived at the same time at the State Medicaid agency and then the 3808 was sent to the PSRO for a medical necessity review, the review could qualify as claims processing. The State gave unrefuted testimony at the hearing that its approach (having a 3808 review precede an invoice) fulfilled the same purpose as a review in which both steps were conducted concurrently and, furthermore, served to make its overall claims processing more efficient. The State's witness explained:

> We had the hospital tell the UR Agency [the PSRO] before it prepared a complex type of bill . . . what it intended to bill and what it was going to put on its bill, tell us if all those days are medically necessary. If we did it any other way, we'd have to . . . look at the invoice, . . . send it back to the hospital if the UR Agency found out that there were medically unnecessary days, and then the invoice would then have to be resubmitted, adding to the amount of time substantially occurring over our present process.

Tr., pp. 10-11.

Accordingly, we conclude that the Agency's objection to the timing of the stage one review is one of form over substance and does not properly take into account the actual claims processing functions being served by the review of the form 3808. 4/

4/ In a companion decision which we also issue today, we concluded that the term "claims processing system" in the offset regulations was not intended to include prior authorization reviews performed before or shortly after the patient's admission to the hospital and before completion of the services and thus before submission of what represents a demand for compensation for services rendered. See Pennsylvania Department of Public Welfare, Decision No. 811, November 19, 1986. The alleged diversion in Pennsylvania was not a denial of payment for actual services rendered (as in the case of Maryland) but rather was a denial of a requested length of stay made by (continued on the next page)

The Agency also argued that the State's stage one or form 3808 review did not represent an additional effort to detect fraud or abuse, which the regulatory preamble identified as the purpose of qualifying screens (47 Fed. Reg. 43340, 43344 (September 30, 1982)), and was instead intended to meet the utilization control requirements of 42 CFR Part 456, which, for the time period relevant here, could be met by contracting with a PSRO. Agency's Brief, pp. 5-6.

In response, the State explained that, while the review by the PSRO did fulfill federal requirements for utilization control, the State's system here went well beyond those requirements. The State explained that federal regulations during the period in dispute required only a review of a sample of admissions for utilization control and did not require the review of 100 percent of admissions, as was done by the PSRO in Maryland. See State's Reply Brief, pp. 2-4; Tr., pp. 46-47. Further, the State could have delegated the review function to the hospitals themselves, rather than contracting with the PSRO. Tr., pp. 59-60. The Agency did not dispute this explanation by the State, but apparently continued to maintain that since the PSRO review fulfilled utilization control requirements, the State was not undertaking an "extra effort" to detect fraud and abuse, as intended by the statute and regulations. See Tr., pp. 55-56.

We conclude that the regulatory requirements regarding utilization control do not preclude the State's system here from qualifying for purposes of the fraud and abuse offset.

4/ (continued from the previous page)
the hospital at the time of admission. The diversion in Pennsylvania was computed, in effect, by estimating the cost of services that would have been provided if the full length of stay had been granted and if the requested services had actually been rendered. (In Maryland, of course, services have already been rendered before medical necessity is reviewed.) We concluded that Pennsylvania's process did not comply with the plain meaning of the regulatory requirements in that the State was not processing a demand for compensation for actual services rendered. We also found that Pennsylvania's process was not authorized as a qualifying screen under the preambles to the interim and final regulations, as the State had specifically argued. Finally, we concluded that the Agency's position furthered an important statutory purpose as identified in the legislative history since it limited diversions to what could be documented as actual, rather than estimated, savings. In the instant case, there is no question that the State would only receive credit for documented actual savings to the program.

The Agency might have a stronger point if the State's system in toto was independently required by regulations other than the fraud and abuse provisions. However, this was clearly not the case here, since, as the State explained, its system went well beyond those other requirements, an explanation which HCFA never sought to dispute. We therefore conclude that insofar as utilization control requirements were concerned, the State's system provided an "extra effort" to detect fraud and abuse.

We also note that the preamble to the final regulations expressly clarified that qualifying prepayment screens may include screens that review overutilization and medical necessity. 47 Fed. Reg. 43344 (September 30, 1982). The stage one process here reviewed overutilization and medical necessity for 100 percent of certain types of hospital stays. As a direct result of these reviews, no payments were made to a hospital for any portion of a stay that was found to be overutilization of services or medically unnecessary.

Accordingly, on the basis of the foregoing, we conclude that these screens meet the regulatory requirements since they functionally were part of the State's claims processing system and since they performed actions specifically recognized by the preamble as being performed by qualifying screens.

Stage Two

The Agency had no objection to the timing of stage two, since it was performed after submission of the invoice, but instead objected that the stage two screens were only "clerical" and "routine" and thus did not fulfill the purposes of the statute and regulations. 5/ The Agency relied specifically upon language in the preamble to the regulations, which excluded from the definition of diverted funds "routine monitoring screens that are required by good business practices," and which instead required that to be acceptable a screen must represent an "additional effort to detect fraud or abuse. . . ." 47 Fed. Reg. 43344 (September 30, 1982).

The Agency provided no substantial support for its description of the second stage function as "clerical" and "a routine business practice." While the Agency in its brief characterized the State's description of the stage two review as

5/ We note that even if the Board were to find stage two unacceptable, the State documented that the amount diverted from stage one alone would qualify it for the one percent offset. See Tr., pp. 12, 30; State's Hearing Exs. A-D.

"conclusory and uninformative" (Agency's Brief, p. 6), the State explained that all of the functions performed by stage two which the State counted as creating diversions were listed as acceptable screens by the regulatory preamble. The preamble specifically authorized reviews for "fragmented claims," "medical necessity of services," "overutilization of services and program benefits," and "false billings." 47 Fed. Reg. at 43344 (September 30, 1982); see State's Reply Brief, p. 5.

At the hearing, the State elicited testimony from its Director of the State Medical Assistance Compliance Administration who substantiated the State's explanation that the stage two review involved only these acceptable activities. The official further explained that the review was conducted by registered nurses and other professional staff. Tr., pp. 21-22. The Agency called no witnesses to rebut this testimony, nor did the Agency provide any specific argument as to why these screens would still not qualify. See Tr., pp. 36-42.

We therefore conclude that stage two of the State's system performed screens which were acceptable under the fraud and abuse regulations.

Conclusion

As explained above, we conclude that the State is eligible for the one percent offset to reductions in Medicaid funding based on the operation of its two-stage screening system and we therefore reverse the disallowance.

Judith A. Ballard

Alexander G. Teitz

Donald F. Garrett
Presiding Board Member