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STATE OF NEW JERSEY
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DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES

MONOC, PETITIONER, v. DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, RESPONDENT.	**ADMINISTRATIVE ACTION** **ORDER OF REMAND** **OAL DKT. NO. HMA 12658-2014**

As Assistant Commissioner of the Division of Medical Assistance and Health Services, I have reviewed the record in this case, including the Initial Decision, the OAL case file and the documents filed below. Neither party filed exceptions in this matter. Procedurally, the time period for the Agency Head to render a Final Agency Decision is January 30, 2020 in accordance with an Order of Extension.

This case stems from claims submitted by Monmouth Ocean Hospital Services Corporation (MONOC) in 2009 and 2010. MONOC provides transportation services to individuals by ambulance or paramedic transport. These services are reimbursable by the Division of Medical Assistance and Health Services (DMAHS) for Medicaid recipients through the claims processing system. In 2009 and 2010, some 1,400 submissions for MONOC's services were denied. ID at 2. In January of 2010, Penny Brown the assistant

head of patent accounts for MONOC spoke with DMAHS staff about the denials. After making changes to the claims processing system, DMAHS agreed to have the claims reprocessed. In New Jersey, claims are processed by a fiscal agent which at the time of this case was Molina Medicaid Solutions. See N.J.A.C. 10:49-81. Normally, claims are submitted electronically and the provider received a Remittance Advice (RA). N.J.A.C. 10:49-8.2. Each type of provider has its own manual to explain the processing of claims and the RA it receives. MONOC's Proposed Findings of Facts Exhibit B, Attachment 1.

DMAHS waived the timely filing requirements for MONOC to have its claims reprocessed after the error was removed. Generally speaking all claims must be billed within 12 months of the date of service. N.J.A.C. 10:49-7.2 (e). If additional information is needed, a provider must supply that information "as soon as possible but not more than 30 days after the end of the timely submission period." N.J.A.C. 10:49-7.2 (g). Additionally claims that are denied may be resubmitted "30 days of the date of adjudication as indicated in the Remittance Advice Statement." N.J.A.C. 10:49-7.2 (h). Here, the majority of the claims were timely filed within a year of the service but denied. The denial of the 1,400 claims led to the discovery that an edit in the claims processing system had improperly removed a procedure code that should have been paid any properly submitted claims.

DMAHS makes the characterization that the errors discussed at the hearing were provider related rather than processing related. Certification of Benjamin Kurtis, Esq. Exhibit H. While the parties disagree with the reason the 1,400 claims were originally denied, there is agreement that these first denials stemmed from how the claims were processed. It was at that point that DMAHS worked with MONOC to have the claims, which were outside the 30 day adjudication period, reprocessed. The processing error was corrected and MONOC was instructed to resubmit those denied claims to be processed in ordinary course. As mentioned in an email dated July 2, 2013, claims on the Excel spreadsheet would be reprocessed and MONOC would "track the claims through

processing and correct any other error that might delay/prevent the claim from adjudication." Exhibit P353.

The Initial Decision found that all the claims should be resolved without regard to any timeliness claim advanced by DMAHS. In requiring that DMAHS turn square corners, the Initial Decision fails to acknowledge that MONOC agreed to a time frame of 30 days to resubmit claims and was cautioned to correct any error that would cause the claim to be denied. See P353. The 2013 agreement by the parties centered on reprocessing claims that would have been outright denied for timeliness and the waiver of timeliness permitted those claims to be reprocessed. Under the agreement, MONOC's claims from 2009-2010 were to be submitted using a 30 day time frame. After those claims were submitted multiple times through 2014 well beyond the original 30 days, 211 claims continued to be denied for reasons unrelated to the original processing error permitted the waiver of the timely filing requirements. Those 211 claims were finally denied in September 2014, more than a year after the written agreement to resubmit the claims. I FIND no basis in any of the emails between the parties to support a finding that MONOC could resubmit the claims ad infinitum or that MONOC was absolved of the requirement to file clean claims. See 42 CFR § 447.45 and N.J.A.C. 10:49-7.1, et seq.

According to MONOC's testimony, the disputed claims were subsequently denied due to technical errors in the claim such as lacking a claim modifier, a missing carrier code, filing of multiple claims in the same submission or lack of Medicaid fee-for-service eligibility. October 25, 2016 Hearing Tr. at 44. Ln. 18-25. See also N.J.A.C.10:49-7. MONOC admits it can now file the claims correctly and seeks to have these claims "reprocessed one final time." See October 24, 2016 Hearing Tr. at 45, Ln. 6-12, at 84, Ln. 7-24 and October 25, 2016 Hearing Tr. at 18, Ln. 25.

The Initial Decision makes specific findings on 187 of the 211 claims at issue. Those 187 claims were divided by the parties into five groupings with the remaining 24

challenged by DMAHS as not part of the original agreement to reprocess. ID at 7. There is no evidence that these 24 claims were part of the agreement or that they were "of the same ilk as the groupings that have been discussed." ID at 7. If that were so, those remaining claims would have been counted in the established groupings. These claims cannot be painted with a broad brush and authorized for payment. MONOC did not demonstrate that the 24 claims were part of the original agreement to reprocess and were timely filed through the RA statements. The fact that the service occurred in 2009-2010 does not necessarily translate to the claim being originally timely filed and denied due to the original processing error. I FIND no basis to pay the 24 undefined claims.

Once the processing function that had denied the 1,400 original claims had been fixed, MONOC was instructed that it was their responsibility to correct errors in the claims. See P-353. At the hearing in October 2016 Ms. Brown testified that if MONOC was allowed to resubmit the claims that had the wrong carrier code or other technical mistakes, it would be able to fix those errors. October 24, 2016 Hearing Tr. at 45; at 84. However, MONOC was already given multiple chances to correct the errors and failed to do so. As such, I FIND that those 16 claims identified as correctable claims were never properly submitted by MONOC as a clean claim despite repeated chances and should remain denied.

The record is silent as to the number of times the claims were adjudicated but Ms. Brown testified that DMAHS denied the claims at issue several times. October 24, 2016 Tr. at 44, Ln. 9-13. She stated the reasons for the claims being denied were for missing a modifier, carrier code or explanation of benefits (EOB). Other claims were denied because "the patient was eligible for an HMO Medicaid or perhaps they had other coverage." October 24, 2016 Tr. at 44, Ln. 21-22. It is now some nine years after the service was provided, after in-person meetings with DMAHS staff and after several denials of the claims by Molina, that MONOC now asserts it is able to submit claims that can be paid. I FIND that these technical errors were properly denied and MONOC presented no evidence that

the other 29 claims were perfected during any of the times the claims were previously submitted.

I do find that the 59 claims where Medicare as primary insurer paid more than Medicaid's allowed rate were incorrectly denied. From July 2008 through June 2010 certain budget language removed the requirement that the Medicaid rate was the ceiling for claims that were first submitted to Medicare. See N.J.A.C. 10:49-7.3 (e). The regulatory probation that prevented those claims from being paid was not a bar for this time period. As such, those claims that fit into that time period and were denied due to Medicare reimbursement amounts should be processed for payment.

With regard to the last group of 83 claims where primary insurance coverage was not verified, I cannot tell from the record whether MONOC would have been entitled to the provisions of N.J.A.C. 10:49-7.3(b) which would allow for payment due to third party liability (TPL) not being established or that third party benefits were not available to pay at the time the provider's claim was filed. Due to the age of these claims, the TPL may not have been present or available at the time the claims were originally filed in 2009-2010. As such, the matter is REMANDED for findings specific to these 83 claims and the timing of the TPL and applicability of N.J.A.C. 10:49-7.3(b).

THEREFORE, it is on this 28th day of JANUARY 2020,

ORDERED:

That the Initial Decision is hereby ADOPTED, in part, and REVERSED, in part, as set forth above;

That the matter is hereby REMANDED for further proceedings on the 83 claims identified above; and

That the 59 claims specifically identified above shall be processed.

Jennifer Langer Jacobs, Assistant Commissioner
Division of Medical Assistance
and Health Services