BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

ATHENS REGIONAL MEDICAL CENTER/ PIEDMONT HEALTHCARE,	:	
Petitioner,	:	
	:	**Docket No.: 2300240**
	:	**2300240-OSAH-CMO-P_DEN-33-Schroer**
v.	:	
	:	
CARESOURCE,	:	
Respondent.	:	

FINAL DECISION

I. INTRODUCTION

Petitioner, Athens Regional Medical Center/Piedmont Healthcare ("Athens Regional" or "Piedmont"), appealed the decision of Respondent CareSource to disallow certain charges for healthcare services provided by Piedmont to Patient A.K.[1] The hearing was held in-person before the undersigned administrative law judge at the Office of State Administrative Hearings ("OSAH") on February 8 and 9, 2023, and by two-way video conferencing on March 2, 2023. The record remained open to allow the parties to submit post-hearing briefs. Piedmont was represented by James W. Boswell, Esq. and Jennifer S. Lewin, Esq. CareSource was represented by Christina M. Baugh, Esq. and John M. Moye, Esq.

After careful consideration of all the evidence of record, the Court finds by a preponderance of the evidence that CareSource's decision was in violation of the contractual agreement between the parties. Accordingly, CareSource's decision is hereby **REVERSED**.

[1] For privacy reasons, the patient will be referred to by his initials only.

II. FINDINGS OF FACT[2]

A. The Parties

1.

The Georgia Department of Community Health ("DCH") is the state agency that oversees the Medicaid program in Georgia. Georgia Families is DCH's statewide program designed to deliver health care services to Medicaid members through private care management organizations. (Ex. P-18, at p. PHC 8256.)

2.

CareSource Network Partners, LLC ("CareSource") is a Care Management Organization ("CMO") serving Georgia Medicaid recipients through a contract with DCH. (Ex. R-1; Ex. P-1, at p. 1.)[3]

3.

Athens Regional, Inc., a Georgia non-profit corporation, is one of several hospitals operated by Piedmont Healthcare, Inc. Patient A.K. was admitted to Athens Regional on January 24, 2021, and was discharged on March 30, 2021, after a 65-day stay. (Provider Agreement, at p. 1; Ex. P-16; Testimony of M. Woodall.)

B. The Provider Agreement

4.

In May 2018, Piedmont and CareSource entered into the Provider Agreement, which sets forth the terms and conditions governing Piedmont's participation in CareSource's network of providers

[2] To the extent that certain findings of fact are more appropriately classified as conclusions of law, they should be so construed. To the extent that certain conclusions of law are more appropriately classified as findings of fact, they should be so construed.

[3] The Provider Agreement was tendered by both parties as Petitioner's Exhibit P-1 and Respondent's Exhibit R-1. Both exhibits appear to be identical, with the exception of Bates-numbering, highlighting, and topic captions, which do not alter the substance of the document. Hereinafter, citations will be to the "Provider Agreement, at p. ___."

and Piedmont's reimbursement for the provision of health care services for Medicaid recipients. The Provider Agreement consists of a Base Agreement, a Reimbursement Rate Schedule, attached to the Provider Agreement as Schedule 1.35, and two Exhibits: the State-Specific Provisions for Georgia, attached to the Provider Agreement as Exhibit A-1, and State-Specific Provisions, Georgia Medicaid Addendum, attached as Exhibit A-2.[4] The Base Agreement contains a Covenant of Good Faith and Fair Dealing and a requirement that the parties comply with all applicable laws and regulations. In addition, the Base Agreement provides that any amendments must be mutually agreed to in writing by the parties, with the exception of an amendment arising out of a regulatory requirement. (Testimony of M. Woodall, M. Berry, M. Nichols; Provider Agreement, at pp.1, 13, 15.)

1. Claims and Reimbursement Provisions

5.

Under Section 4.1 of the Base Agreement, Piedmont must submit claims for covered services[5] on a standardized claim form. If the claim is a "Clean Claim," CareSource must pay the amount due to Piedmont under the Reimbursement Rate Schedule within 15 business days for electronic claims and within 30 calendar days for paper claims.[6] For inpatient covered services, the Reimbursement

[4] Under both Exhibit A-1 and A-2 to the Provider Agreement, in the event of a conflict between the Base Agreement and the State-Specific Provisions for Georgia, the State-Specific Provisions shall control. (Provider Agreement, at pp. 21, 22.)

[5] "Covered Services" are defined in the Base Agreement as those health care services provided to a Medicaid member that are reimbursable under the Provider Agreement and under CareSource's agreement with DCH. Under the Georgia Medicaid Addendum, Exhibit A-2 to the Provider Agreement, "Covered Services" are defined as medically necessary health care services that are within the normal scope of services provided by Piedmont, and include those health care services covered by Georgia Medicaid's Fee-for-Service program. (Provider Agreement, at pp. 2-3, 23.)

[6] A "Clean Claim" is defined under Section 4.1(b) of the Base Agreement as a claim that meets applicable HIPAA standards and that can be processed without obtaining additional information from Piedmont. Under the Georgia Medicaid Addendum, a "Clean Claim" is defined as a claim "received by CareSource for adjudication, in a nationally accepted format in compliance with standard coding guidelines, which requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by CareSource." Norman Reid, CareSource's Director of Payment Integrity, testified that CareSource promptly reviews submitted claims to determine whether they are Clean Claims, and then proceeds to determine the amount of reimbursement. (Testimony of N. Reid; Provider Agreement, at pp. 8, 23.)

Rate Schedule requires CareSource to pay Piedmont an amount equal to 105% of the reimbursement Piedmont would have received had the services been paid by Georgia Medicaid. At the time of the execution of the Provider Agreement, Georgia Medicaid paid an 11.88% "add on" for services provided by acute care hospitals, such as Athens Regional. (Testimony of M. Woodall, M. Berry, N. Reid; Provider Agreement, at pp. 1, 5, 8, 19-20, 32.)

6.

Georgia Medicaid billing and reimbursement is a complicated and technical process, and DCH has set forth its reimbursement methodology in the Part II Policies and Procedures for Hospital Services Manual ("DCH's Manual"). As explained by Matt Woodall, Piedmont's Manager for Denials and Payer Recovery, when Georgia Medicaid pays inpatient hospital claims for health care services, it uses a classification system based on diagnosis-related groups or DRGs. The DRG system classifies inpatient services into groups and then assigns a weighted payment or "case rate" to each DRG based on the average cost to treat patients with the medical conditions that fall into that DRG. Georgia Medicaid uses a formula to calculate payment on a claim, which involves multiplying the applicable DRG payment weight times the "hospital-specific base rate." The claim based on DRG codes is referred to as the "inlier" claim. (Testimony of M. Woodall, M. Berry, L. Willis, M. Nichols; Ex. P-18, at p. PHC 8140.)

7.

According to DCH's Manual, in some cases, "a hospital may have an inpatient claim that falls outside of the expected range of cost for the DRG." For example, when a patient is hospitalized for congestive heart failure, the inlier claim using only the DRG code for congestive heart failure would result in the same reimbursement amount whether the patient was hospitalized for one day or one year. Thus, Georgia Medicaid provides for an additional payment, referred to as an "outlier claim," when the costs for services meet or exceed an established threshold. The formula for calculating the

amount of an outlier payment is not based on DRG codes; rather, it is calculated based on the percentage of allowable charges that are over the outlier threshold. (Testimony of M. Woodall, M. Berry, L. Willis, M. Nichols; Ex. P-18, at PHC 8140.)

8.

If CareSource believes that a claim is not a Clean Claim, Section 4.1(c) of the Base Agreement and Section 3.01 of the Georgia Medicaid Addendum require CareSource to pay the portion of the claim that is a Clean Claim, if any, and to notify Piedmont within fifteen business days after receipt of an electronic claim of the specific basis for its belief that some or all of the claim does not meet Clean Claim standards. CareSource must also specify any additional information that is reasonably necessary to process the claim.[7] Once it receives such information, CareSource has 15 business days to process the claim, and either pay or deny it. Under Section 4.1(d) of the Base Agreement, CareSource may not exclude a claim from Clean Claim status solely due to CareSource's "decision to audit, validate or otherwise review Claim based on Plan criteria, including predetermined charge threshold amounts. In the event that [CareSource] subjects a Clean Claim to such audit, validation or review process, then [CareSource] shall not delay payment and shall pay the Claim in accordance with the Clean Claim requirements set forth within this Agreement." (Testimony of M. Woodall; Provider Agreement, at pp. 8-9, 32.)

2. Network Notifications

9.

The Base Agreement provides a means for CareSource to officially communicate non-material changes to the Provider Agreement that relate to claims or reimbursement through "Network

[7] Section 4.1(c) also requires CareSource to comply with Georgia Code Section 33-24-59.5(c), which provides that an insurer must pay 12% interest on any portion of a claim that it fails to pay unless the insurer complies with procedures for prompt notice of the reasons for non-payment, including a written itemization of information needed to process the unpaid claim, and timely review and processing of such information upon receipt. See O.C.G.A. § 33-24-59.5(b) & (c).

Notifications." Section 1.25 of the Base Agreement defines "non-material changes" as "those changes related to Claims and/or reimbursements that will not decrease Piedmont's payment or compensation or will not change the administrative procedures in a way that may reasonably be expected to significantly increase Piedmont's administrative expense." Examples of non-material changes are "new coding edits, documentation requirements, accepted modifiers or other billing issues." Under Section 1.25, Network Notifications must be published on CareSource's website at least thirty days in advance of the change, and Piedmont is obligated to regularly monitor the website for such notifications under Section 3.14. Piedmont reserved the right to reject a Network Notification, but it is required to provide CareSource a detailed, written explanation for the rejection before the effective date of the proposed change. Any material changes to the Provider Agreement must comply with the amendment provisions in Section 9.11 of the Base Agreement. (Testimony of M. Woodall, M. Nichols; Provider Agreement, at pp. 3, 8.)

3. Provider Appeals

10.

Section 1.46 of the Georgia Medicaid Addendum defines a "Provider Appeal" as "CareSource's formal reconsideration of (1) the denial or nonpayment of reimbursement for Clean Claims or (2) the determination of the amount of reimbursement Provider received for Clean Claims paid by CareSource." Article IV of the Georgia Medicaid Addendum sets out the procedures for Provider Appeals, as well as requests for either an Administrative Law Hearing or Arbitration. Under Section 4.01, Piedmont must request a Provider Appeal in writing and within thirty calendar days of CareSource's Notice of Action. Section 4.01 also provides that the request must include all grounds for the appeal and all supporting documentation, and if it does not, the request "will not be accepted or considered by CareSource." Further, failure to comply with these requirements "shall constitute a

waiver of any and all further appeal rights, including the right to an Administrative Law Hearing or Arbitration." (Testimony of M. Woodall; Provider Agreement, at pp. 26, 32-33.)

11.

Under Section 4.02 of the Georgia Medicaid Addendum, as well as Georgia Code Section 33-21A-7(b), after exhausting CareSource's internal Provider Appeal procedures, Piedmont has the right to request either an administrative hearing before OSAH or binding arbitration. If Piedmont requests an administrative hearing, Section 4.02 requires Piedmont to file a written request within 30 days of CareSource's response, identifying the disputed issues and the requested relief. Section 4.02 requires CareSource to transfer the request to OSAH within fifteen business days. (Provider Agreement, at pp. 32-33.)

4. Audits

12.

Section 9.5 of the Base Agreement requires Piedmont to provide access to its records to allow CareSource to conduct audits, evaluations, or inspections. Under Section 9.5, as well as Section 4.2 of the Base Agreement, CareSource is authorized to make adjustments if it discovers an overpayment, and may recoup, and in some circumstances, offset, the overpayment.[8] At the end of Section 9.5, the Provider Agreement states that "[f]or any/all processes (whether referred to as 'audit' or not) that lead to disallowed charges on billed Claims, [CareSource] or its third party designee must review disallowed charges with Piedmont and have mutual agreement before charges are actually removed

[8] Mr. Bearden described the process of paying a Clean Claim and then attempting to recoup or offset an overpayment following a post-payment audit or review as "pay and chase," which is "hard" and "a lot of work" for CareSource. CareSource's new system, described in more details *infra*, of conducting pre-payment reviews and making adjustments to the bill before it pays the claim, is CareSource's new approach to outlier claims processing. The process described by Mr. Bearden effectively shifts the burden to the provider to initiate an appeal to resolve disputes between the parties regarding the appropriate amount of reimbursement for services, but Mr. Bearden testified that this was an appropriate change because it allows CareSource to better meet its obligation to DCH to only pay valid claims. (Testimony of J. Bearden.)

from the bill." According to Piedmont, the provision in Section 9.5 is essentially a "meet and confer" requirement, and applies any time CareSource undertakes an action that leads to a disallowed charge. CareSource interprets this provision to relate primarily to retrospective audits conducted after a claim has been adjudicated and paid by CareSource, and argues that pre-payment reviews are more in the nature of "claim edits," similar to deleting duplicate charges, and do not trigger Section 9.5. (Testimony of M. Woodall, M. Berry, M. Nichols, J. Bearden; Provider Agreement, at pp. 9, 14.)

C. July 15, 2019 Network Notification

13.

On July 15, 2019, CareSource issued a Network Notification regarding Inpatient Hospital Pre-Payment Claims Reviews ("2019 N.N."). In the 2019 N.N., CareSource notified its providers that it had contracted with Equian, LLC to conduct itemized bill reviews for inpatient outlier claims. CareSource hoped that Equian's new pre-payment review process, which involved "sophisticated technology and data analytics," would identify errors and compliance issues, such as unbundling,[9] experimental drugs, and billing errors, before such claims are paid. Melissa Nichols, CareSource's Vice President for Network Strategies, testified that CareSource has a fiduciary duty to the State of Georgia to be "fiscally responsible with state funds," and both Ms. Nichols and James Bearden, CareSource Georgia's Market President, testified that use of third party vendors to conduct pre-payment outlier reviews is standard practice among managed care organizations. According to Ms. Nichols, DCH approved the 2019 N.N., which notified providers that they might receive requests for itemized bills from Equian after August 1, 2019. It also stated that a report of Equian's claims review

[9] According to Piedmont's witness, Lamon Willis, an expert in medical coding, "unbundling" is typically referred to in the industry in relation to outpatient claims, not inpatient claims. Nevertheless, based on the evidence in the record, the Court finds that the term "unbundling" in the 2019 N.N. referred to the practice of separately billing for procedures that, in CareSource's opinion, are customarily and appropriately billed together in order to increase the amount of reimbursement paid to a provider.

findings would be delivered to the providers, and "billing adjustments will be made accordingly." (Testimony of M. Nichols; Ex. R-2.)

14.

Piedmont's witnesses at the hearing testified that they were unaware of the 2019 N.N. at the time it was issued. Michelle Berry, Piedmont's Director of Managed Care, testified that she did not see the 2019 N.N., nor was she aware of anyone at Piedmont reviewing or responding to it. According to Ms. Berry, Georgia Medicaid does not use a third-party vendor like Equian to conduct pre-payment reviews, and Georgia Medicaid would not have used such a process to disallow charges before calculating and paying an outlier claim. Ms. Nichols testified that although Piedmont has objected to Network Notifications in the past, it did not object to the 2019 N.N. (Testimony of M. Woodall, M. Berry, M. Nichols.)

D. <u>Claim for Covered Services Provided to Patient A.K.</u>

15.

On January 24, 2021, Patient A.K., age 41, was admitted to Athens Regional. He was critically ill, and was diagnosed with COVID-19, as well as type 2 diabetes and other serious medical conditions. On January 31 2021, about a week after his admission, A.K. developed acute respiratory distress syndrome. He was transferred to the Intensive Care Unit ("ICU"), where he was intubated. While in the ICU, A.K. experienced various complications, including sepsis. His physicians ordered numerous blood tests to measure his glucose levels and monitor other medical concerns. In all, A.K. was intubated for 20 days and spent a total of 38 days in the ICU. He was discharged to a rehabilitation center on March 30, 2021. (Testimony of M. Woodall, L. Willis; Exs. P-2, P-16.)

16.

On or about June 1, 2021, Piedmont used an electronic claim form to submit its bill for services to CareSource. According to Mr. Woodall, the bill, referred to as a UB04, did not include every band

aid or basin used to treat A.K. Such routine items are considered "floor stock" and are not included as a separate charge on the UB04. Rather, Piedmont's bill listed charges by individual hospital departments or "cost centers," such as pharmacy, ICU, or the operating room, and identified the number of units and the total charge for each cost center based on Piedmont's Hospital Charge Master.[10] For laboratory charges, the UB04 for A.K. has a general laboratory charge category, as well as specialty laboratory categories, such as immunology, hematology, and urology. The total bill for all goods and services provided to A.K. was $988,865.72. (Testimony of M. Woodall, N. Reid; Ex. P-2.)

17.

On June 23, 2021, Equian requested an itemized bill for A.K. from Piedmont. Equian did not request A.K.'s medical record, and there is no evidence that Equian contacted Piedmont before issuing its findings. On July 15, 2021, CareSource issued a Remittance Advice (RA"), notifying Piedmont that it had approved reimbursement of $71,981.41 on A.K.'s claim.[11] This included full payment of the inlier claim based on A.K.'s DRG codes, but a reduced reimbursement for the outlier payment. Specifically, the RA stated that CareSource had disallowed a total of $106,319.50 in charges based on a report prepared by Equian that found that a number of charges on Piedmont's bill were for routine

[10] The Hospital Charge Master is a list of fees for goods and services that Piedmont uses for all payors. Piedmont did not expect CareSource to pay the full amount of the bill reflected on the UB04. Rather, Piedmont expected to receive the reimbursable amount for the inlier DRG claim of $41,703.01 and the outlier claim of $49,536.57, as initially calculated under the Provider Agreement and the Reimbursement Rate Schedule. CareSource does not dispute that Piedmont was entitled to the inlier payment, as calculated, nor does it dispute that Piedmont was entitled to an outlier payment in some amount for Patient A.K. The parties' dispute arises over whether certain line-item charges should have been included in the calculation of the outlier payment. (Testimony of M. Woodall, M. Berry.)

[11] Notwithstanding Section 4.1(c) of the Base Agreement, Section 3.01 of the Addendum, and applicable state law, which require CareSource to pay any portion of a claim that constitutes a Clean Claim, CareSource's practice at that time was to hold the inlier payment until Equian completed its review of the outlier, and then release the inlier and adjusted outlier payments together. After discussions with Piedmont in mid-2022, however, CareSource changed its policy and began issuing the inlier payment while the outlier claim was still under review. Mr. Bearden admitted that the practice of holding the inlier payment was not consistent with the Provider Agreement or state law. (Testimony of M. Nichols, J. Bearden.)

goods or services that should have been included in the daily room and board charge, and therefore were not separately billable.[12] When the disallowed line-item charges were removed from the bill, the total outlier payment, which is a percentage of allowed charges, decreased by $26,543.69. (Testimony of M. Woodall, N. Reid; Exs. P-3, P-4, P-7.)

E. Piedmont's Provider Appeal

18.

On September 21, 2021, more than 60 days after CareSource issued the RA, a nurse auditor for Piedmont sent a letter to CareSource disputing the disallowance of $106,319.50 billed charges. The letter stated that Piedmont disagreed with Equian's denial of charges associated with laboratory processing of blood samples. Piedmont asserted that "it is commonly accepted practice that different tests and biochemical assays require varying types of collection tubes, analyzer instruments and time; all which represent incremental costs." Piedmont requested specific information from CareSource that identified the alleged unbundled charges and the authority for its conclusions that unbundling was not appropriate. The letter did not dispute Equian's findings line-by-line, and it did not attach any supporting documentation. (Testimony of M. Woodall; Ex. R-25.)

19.

On October 20, 2021, CareSource responded to Piedmont's September 21, 2021 letter, declining to consider the appeal of A.K.'s claim because it was submitted beyond the 30-calendar day filing deadline, which was August 13, 2021. (Testimony of M. Woodall; Ex. R-26.)

20.

After receiving CareSource's letter, Piedmont put A.K.'s claim on an "escalation sheet," which was shared with the CareSource Network Claims Manager on or about November 10, 2021.

[12] Equian also disallowed line item charges for other reasons, including numerous charges related to blood tests that "appear to be for blood monitoring results that were obtained from the same sample and included in a separately reimbursed charge. These charges do not appear to constitute an incremental cost." (Ex. P-4.)

According to Mr. Woodall, the A.K. claim "languished" for several months, and Piedmont did not receive an official response from CareSource after A.K.'s claim was escalated.[13] Consequently, Piedmont filed a demand letter on April 19, 2022, seeking immediate payment. Piedmont alleged that CareSource had breached the Provider Agreement, specifically Section 4.1(d), which prohibits CareSource from excluding a claim from Clean Claim status as a result of an audit or review. Piedmont also cited to Section 9.5's "meet and confer" requirement and the provision requiring mutual agreement to remove charges from a bill.[14] Piedmont requested that the $26,543.69 reduction in the outlier payment be paid, but Piedmont again did not respond line-by-line to Equian's report or request an administrative hearing or for arbitration at that time.[15] (Testimony of M. Woodall; Ex. P-5.)

21.

On May 4, 2022, CareSource sent a letter to Piedmont in response to the April 19, 2022 letter, which it described as an "appeal letter." CareSource stated that it was unable to approve the appeal because they received insufficient documentation, citing prior Network Notifications. According to the letter, two Network Notifications were posted to CareSource's website, which notified providers that CareSource had partnered with Equian to review itemized statements and medical records for

[13] Michelle Berry, Melissa Nichols, and James Bearden all testified about informal discussions between Piedmont and CareSource in early to mid-2022 regarding Equian's pre-payment reviews and CareSource's new practice of disallowing claims without first conferring with Piedmont. The discussions did not address A.K.'s claim specifically; however, according to Ms. Berry, CareSource acknowledged generally that they had not sought mutual agreement before disallowing claims after pre-payment review and that they had delayed the release of the inlier payments, even though the inliers constituted Clean Claims and should have been paid timely. Ms. Nichols testified that CareSource values its relationship with Piedmont, and these discussions regarding the Equian review process were undertaken by CareSource in the "spirit of collaboration." (Testimony of M. Berry, M. Nichols, J. Bearden; Exs. P-9, P-10, R-10 - R-19.)

[14] Mr. Woodall testified that Piedmont never conferred with Equian or CareSource about A.K.'s claim or the disallowed charges, and Piedmont did not mutually agree to the removal of the disputed charges from A.K.'s bill. Further, according to Mr. Woodall, prior to A.K.'s claim, CareSource had not disallowed line item charges on a Piedmont claim in connection with a pre-payment review by Equian. (Testimony of M. Woodall.)

[15] At the hearing, Mr. Woodall admitted that this letter "was not as complete as it could be."

inpatient outlier claims. Specifically, CareSource stated that "providers are asked to submit their request indicating the specific lines being disputed," which Piedmont did not do in its appeal letter.[16] The letter further provided that Piedmont could resubmit its request with the specific disputes identified, but that "Timely Filing Will Apply." Finally, CareSource stated that its internal appeal process was now complete, and if the appeal involved denied or underpaid claims, "you may now request an Administrative Law Hearing in accordance with O.C.G.A. § 49-4-153, O.C.G.A. § 50-13-13, and O.C.G.A. § 50-13-15." (Testimony of M. Woodall; Ex. P-6.)

F. Administrative Hearing

22.

On June 3, 2022, approximately eleven months after CareSource issued the RA, Piedmont filed a request for an administrative law hearing. The request included a rebuttal grid, which, for the first time, responded to each disallowed charge by revenue code.[17] For example, Equian had disallowed a charge for Heparin (Revenue Code 250), a drug that can be used both to flush an intravenous ("IV") line and as a drip to aid in blood coagulation. Upon review of A.K.'s medical record, Piedmont agreed that a $3,551.20 charge for Heparin in A.K.'s itemized bill was for use of the drug as a flush only and was not properly billed as a separate charge. Conversely, Piedmont contended that charges related to the use of sodium chloride (Revenue Code 258), totaling $13,080.50, were appropriately billed as separate charges because these were physician-ordered

[16] The Court notes that only one Network Notification was admitted into evidence at the hearing, and that Network Notification did not address how providers were to respond to an Equian report, nor did it require a line-by-line response. (Ex. R-2.) Moreover, Mr. Woodall testified, and Ms. Nichols admitted, that the Provider Agreement does not define the level of detail required in an appeal request, and there is no evidence in the record that proves that CareSource specified the additional information it was seeking in order to process the appeal or that it had previously notified Piedmont of a requirement to identify specific lines in dispute. Moreover, Mr. Reid testified that in his experience Provider Appeals usually do not identify disputes line-by-line, but by categories, although he did testify that such an obligation might be "implied." (Testimony of M. Woodall, M. Nichols, N. Reid.)

[17] According to Mr. Reid, CareSource has not reviewed the rebuttal grid or provided a response to Piedmont's substantive arguments about the disallowance because the appeal was untimely. If the packet had been provided within the deadline, CareSource would have considered the arguments. However, Mr. Reid did acknowledge that CareSource sometimes makes exceptions and considers late appeals. (Testimony of N. Reid.)

supplies prepared by the pharmacy, and were not taken from routine floor stock. Similarly, Piedmont contended that charges for (i) specialty respiratory supplies and services for a patient on a ventilator (Revenue Codes 272 and 410), (ii) venipuncture done by personnel from the laboratory, rather than the nursing staff (Revenue Code 300), (iii) separate blood tests performed by the laboratory, using different assays and machinery, and not included in a comprehensive blood panel (Revenue Codes 301 and 305), and (iv) pulse oximetry outside the ICU (Revenue Code 460), are not routine goods and services provided to all patients in the hospital, and were therefore properly billed as separate charges. (Testimony of M. Woodall; Ex. P-7.)

23.

On July 15, 2022, the Court issued a *Notice of Filing and Order*, requiring the parties to, among other things, file a join status report that included identification of the factual issues in dispute and the controlling statutory or regulatory authority, as well as a description of the "payment or coverage issues." After a number of continuance requests, the parties submitted a *Joint Status Report* on October 20, 2022. In the *Joint Status Report*, CareSource identified the issues in dispute as relating to the pre-payment review done by Equian, which resulted in findings "that certain line items were double-billed and were properly included in other line item charges which were paid as submitted." Piedmont similarly described the issues in dispute as Equian's line-item disallowances, which it contended were improper and a breach of the Provider Agreement. Neither party identified the threshold issue of whether Piedmont was entitled to an administrative hearing on these issues because the initial Provider Appeal was untimely. On October 26, 2022, the Court issued a *Notice of Hearing and Pre-Hearing Order*, setting the hearing for January 19 and 20, 2023, and providing, among other things, that "[a]ll motions must be made in writing and filed with the judge's assistant, with a copy served simultaneously upon all parties of record." Although the Court issued a *Continuance Order* on December 27, 2022, resetting the hearing to February 8 and 9, 2023, the *Continuance Order*

specified that "[a]ll other information contained in the original Notice of Hearing shall remain the same."

24.

CareSource did not file a motion to amend the Joint Status Report, to dismiss the case, or for summary determination to raise the issue of Piedmont's failure to file the Provider Appeal within the contractual deadline. Rather, during opening arguments on February 8, 2023, CareSource made an oral motion to dismiss Piedmont's appeal on the grounds that Piedmont had waived its right to an Administrative Law Hearing by failing to file a timely and properly supported Provider Appeal under Section 4.01 of the Georgia Medicaid Addendum to the Provider Agreement. Piedmont opposed the motion, and the Court denied CareSource's request to adjourn the evidentiary hearing in order for the Court to consider and rule on its oral motion before the presentation of evidence. The Court found that CareSource's oral motion to dismiss did not comply with OSAH's rules or the Pre-Hearing Order. The Court took the issue under advisement, however, and allowed the parties to present evidence on whether CareSource's actions constituted a waiver of the provisions of Section 4.01. The hearing proceeded, and the parties presented evidence on the merits. (Provider Agreement, at pp. 32-33, hereinafter "Section 4.01.")

25.

On the first day of the hearing, Piedmont presented evidence from two Piedmont employees – Mr. Woodall and Ms. Berry – as well as Mr. Willis, an expert in medical coding. In addition to the testimony cited in the Findings of Fact *supra*, Piedmont's witnesses acknowledged that Piedmont had billed a few of the disallowed charges in error, and Ms. Berry testified that the total outlier payment originally requested by Piedmont of $49,536.57 was properly reduced by $4,377.20. In addition, Mr. Willis, who had reviewed Equian's report, Piedmont's UB04 bill, and the itemized statement for

Patient A.K., opined that most, although not all, of the disallowed line items were, in fact, customarily and properly billed separately as non-routine items. (Testimony of L. Willis, M. Berry; Ex. R-2.)

26.

On the second day of the hearing, CareSource presented testimony from three witnesses -- Ms. Nichols, Mr. Reid, and Mr. Bearden, all of whom were employees of CareSource. These witnesses were not involved with Equian's review of the A.K. claim, and no one from Equian testified at the hearing regarding the reasons for the disallowances. Instead, Mr. Reid, who is not a certified coder and had not reviewed A.K.'s medical records, testified regarding his understanding of Equian's findings, although he was not certain what outside authority or information Equian relied upon in reaching its findings. For example, Mr. Reid was uncertain what outside guidance Equian used to determine which charges were "routine" and appropriately included in a room and board charge. Similarly, Mr. Reid testified that Equian suspected that some of the blood tests were taken from a single sample and performed as part of panel, but the preponderance of the probative evidence proved that Equian did not have access to sufficient documentation, namely the medical record, to reasonably reach this conclusion. Mr. Reid also did not explain Equian's finding that procedures and supplies associated with endotracheal intubation are routine and customarily included within a standard ICU room and board charge. The Court, having weighed the probative evidence in the record regarding Equian's findings regarding the disallowed charges, finds that Mr. Willis' unrebutted expert testimony on these issues was well-supported, reasonable, and entitled to great weight. (Testimony of N. Reid, L. Willis .)

27.

Finally, at the conclusion of the hearing on February 9, 2023, Mr. Bearden testified that the Provider Agreement was primarily drafted by Piedmont. On February 15, 2023, Piedmont submitted the Affidavit of J. Shannon Glover, the Vice President of Managed Care for Piedmont, who averred

that although both parties contributed proposed language to the Provider Agreement, CareSource drafted and proposed the majority of the contract provisions, particularly the language in Exhibits A-1 and A-2 and the provisions relating to Network Notifications in Section 1.25 in the Base Agreement. On March 2, 2023, Mr. Glover testified on cross-examination via two-way video conference, and acknowledged that the final version of the Provider Agreement was the result of negotiations between the parties. Mr. Glover testified that it was not accurate to refer to the Provider Agreement as "Piedmont's document," as Mr. Bearden had done in his testimony on February 9, 2023, because both parties contributed draft language, which was merged and modified through negotiations between the parties before the agreement was executed. (Affidavit of J. Shannon Glover; Testimony of J. Bearden, J. Glover.)

28.

The parties filed post-hearing briefs on March 17, 2023, and the deadline for issuance of the Final Decision was extended to April 21, 2023.

III. CONCLUSIONS OF LAW

A. General Provisions

1.

Piedmont bears the burden of proof. Ga. Comp. R. & Regs. 616-1-2-.07. The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. 616-1-2-.21(4).

2.

The Provider Agreement is a contract between Piedmont and CareSource, and the principles of contract construction apply. See O.C.G.A. § 13-2-2. The cardinal rule of construction is to ascertain the intention of the parties. Knott v. Knott, 277 Ga. 380, 381 (2003),(citing O.C.G.A. § 13-2-3); McVay v. Anderson, 221 Ga. 381, 385 (1965); Hull v. Lewis, 180 Ga. 721, 724 (1935). If the intention of the parties is clear and it contravenes no rule of law, the contract will be enforced

according to its terms. O.C.G.A. § 13-2-3. Furthermore, where the terms of the written contract are clear and unambiguous, the court will look to the contract alone to find the intention of the parties. Owners Ins. Co. v. Smith Mech. Constrs., Inc., 285 Ga. 807, 808 (2009) (citations omitted). Finally, the custom of a business is only binding when the evidence proves that it is "of such universal practice as to justify the conclusion that it became, by implication, a part of the contract." O.C.G.A. § 13-2-2(3).

3.

Under Georgia law, "a provider of medical assistance may request a hearing on a decision of a care management organization . . . with respect to a denial or nonpayment of or the determination of the amount of reimbursement paid or payable to such provider on a certain item of medical or remedial care of service rendered by such provider by filing a written request for a hearing in accordance with Code Sections 50-13-13 and 50-13-15. . . ." O.C.G.A. § 49-4-153(e)(1). A provider's request for hearing must identify the CMO, the issues under appeal, and specify the relief requested. Id. Requests for hearings under Code Section 49-4-153(e) are referred to OSAH for hearing and issuance of a final decision. Id.

4.

Under OSAH's Administrative Rules of Procedures ("ARP"), the Court may, among other things, establish the time for filing motions and other submissions, including dispositive motions. See Ga. Comp. R. & Regs. 616-1-2-.22(1)(h), (i). Under ARP 16, requests made to the Court must be made by motion, and unless made during the hearing or otherwise provided, all motions must be made in writing and filed at least ten calendar days prior to the hearing "unless the need or opportunity for the motion could not reasonably have been foreseen." Ga. Comp. R. & Regs. 616-1-2-.16(1). In the case of motions for summary determination, the deadline for filing the motion is thirty calendar days before the hearing. Ga. Comp. R. & Regs. 616-1-2-.15(1)(b).

5.

Hearings before OSAH are "de novo," and the Court must make "an independent determination on the basis of the competent evidence presented at the hearing." Ga. Comp. R. & Regs. 616-1-2-.21(1), (3).

B. Piedmont is Entitled to an Administrative Hearing on the Merits of Its Appeal.

6.

The Court concludes that Piedmont is entitled to an administrative hearing on issues it raised in its administrative hearing request, notwithstanding its untimely Provider Appeal. First, the Court concludes that the issue of the untimely Provider Appeal was not properly raised by CareSource under either the ARPs or the pre-hearing orders of the Court. The contested issues for adjudication during an administrative hearing before OSAH under Code Section § 49-4-153(e)(1) are first identified by the provider in its request for hearing. Piedmont, perhaps understandably, did not raise the issue of its untimely Provider Appeal in its June 3, 2022 request for an administrative hearing. Shortly thereafter, the Court provided CareSource an opportunity to identify its position on the issues in dispute between the parties in the *Joint Status Report*, which the parties were required to file under the July 15, 2022 *Notice of Filing and Order*. However, CareSource, like Piedmont, identified the disputed issues as Equian's pre-payment review and the disallowance of line item charges. Neither party mentioned the untimely Provider Appeal as an issue to be resolved in the administrative hearing.

7.

CareSource had ample opportunity, from July 2022 through January 2023, to raise the issue of Piedmont's untimely initial appeal through filing a motion to amend the *Joint Status Report*, a motion to dismiss, or a motion for summary determination. The only restriction on CareSource's right to request that the Court rule on this issue was the obligation that such request be made through a written motion, served on Piedmont and filed with the Court at least ten days prior to the hearing

date. CareSource simply did not comply with the procedures designed to provide the Court and the opposing party reasonable notice of the factual and legal issues to be addressed during the administrative hearing, and CareSource presented no evidence during the hearing that "the need or opportunity for the motion could not reasonably have been foreseen." Ga. Comp. R. & Regs. 616-1-2-.16(1). Consequently, the Court concludes that the issue of Piedmont's untimely Provider Appeal was not properly brought before the Court.

8.

In the alternative, even if the Court were to consider this issue, the preponderance of the evidence in the record supports a finding that CareSource waived the timely appeal provisions in Section 4.01 of the Georgia Medicaid Addendum by (1) accepting Piedmont's second appeal request filed on April 19, 2022 and not denying it on timeliness grounds, (2) notifying Piedmont that it could request an administrative hearing on May 4, 2022, (3) accepting Piedmont's June 3, 2022 request for an administrative hearing and referring it to OSAH, and (4) failing to raise the issue of the untimely Provider Appeal for six months while the case was pending before OSAH. In addition, in considering whether CareSource waived the timely appeal provisions, the Court has taken into account Mr. Reid's testimony that CareSource sometimes accepts and processes late Provider Appeals, as well as Ms. Nichols' testimony that CareSource, on a high level, was working with Piedmont around the time Piedmont filed its second appeal letter in an effort to reach consensus regarding Equian's pre-payment reviews. See generally Edwards v. McTyre, 24 Ga. 302, 303 (1980) (time is of the essence provisions in contract can be waived either before or after the contractual deadline).

C. CareSource Did Not Breach the Provider Agreement by Using Equian to Conduct Pre-Payment Reviews, but Equian's Pre-Payment Review was Not Grounds to Disregard CareSource's Obligation to Promptly Pay Clean Claims.

1. Pre-Payment Reviews are permissible under the Provider Agreement and were properly noticed under the 2019 N.N.

9.

Pre-payment reviews of claims are not specifically mentioned in the Provider Agreement, and, as a general matter, are not prohibited under any provision. For example, under Section 9.5 of the Base Agreement, CareSource or its designees are authorized to "audit, evaluate and inspect" Piedmont's records without any limitation as to when during the claim process such audit may be conducted. Similarly, the claim processing provisions in the Provider Agreement do not prohibit pre-payment review of claims, although, as discussed *infra*, such review would not be grounds to delay processing and paying a Clean Claim, which by definition is a claim that requires no further information or adjustment to be processed and paid.[18] Finally, as Piedmont pointed out, Section 9.5 encompasses both pre- and post-payment reviews of provider bills in the "meet and confer" provision requiring mutual agreement before removal of charges.

10.

The Court further concludes that the July 2019 N.N., which communicated CareSource's intent to use Equian to conduct pre-payment reviews of outlier claims did not result in a material change to the Provider Agreement, thereby triggering the amendment provisions under Section 9.11. The Court first notes that Piedmont had an obligation under Section 3.14 to regularly monitor CareSource's website for Network Notifications, and Piedmont did not follow the contractual procedures to reject the proposed changes in the July 2019 N.N. Moreover, Piedmont did not present

[18] Section 4.1(d) of the Base Agreement contemplates CareSource's review of a claim during the pre-payment period when it specifically precludes CareSource from delaying payment because it has decided to audit or review a Clean Claim.

sufficient evidence to prove that Equian's possible request for an itemized bill during the pre-payment period, as announced in the 2019 N.N., would "significantly increase Piedmont's administrative expenses." Under Section 9.5, CareSource or its designees have always had the right to request access to such records at any time. Finally, although the July 2019 N.N. stated that "billing adjustments will be made accordingly," this statement does not mean that such adjustments will be made in violation of the Provider Agreement. That is, as discussed *infra*, notwithstanding the announcement of the new Equian pre-payment review process, the July 2019 N.N. does not allow CareSource to delay payment of outlier claims or to remove disallowed charges without complying with the "meet and confer" requirement in Section 9.5. Accordingly, the Court concludes that the change communicated through the July 2019 N.N., so construed, constituted a non-material change under Section 1.25, was permissible under the Provider Agreement, and was not properly rejected by Piedmont.

2. CareSource Was Not Entitled to Delay Payment or Disallow Charges Based on Equian's Pre-Payment Reviews.

11.

The fact that pre-payment review is permissible and was properly communicated by CareSource does not provide a basis for CareSource to violate its obligations to promptly review and pay Clean Claims. The Provider Agreement clearly requires CareSource to pay a Clean Claim within 15 business days for electronic claims. In addition, Section 4.1(d) of the Base Agreement precludes CareSource from excluding a claim from Clean Claim status solely due to its decision to review the claim, including outlier claims. If CareSource directs Equian to perform pre-payment reviews of all outlier claims, such reviews are not a basis for CareSource to delay payment of either the inlier or the outlier as a Clean Claim. In fact, Section 4.1(d) provides that "[i]n the event that [Care Source] subjects a Clean Claim to such audit, validation or review process, then [CareSource] shall not delay payment and shall pay the Claim in accordance with the Clean Claim requirements. . . ." Thus, under the Provider Agreement, even if Equian performs a pre-payment review of an outlier claim, as long

as it is a Clean Claim, CareSource must pay the outlier claim within the time established by the Provider Agreement and in accordance with the Reimbursement Rate Schedule.

12.

If, however, CareSource believes that an outlier claim under pre-payment review does not meet the standards for a Clean Claim, Section 4.1(d) of the Provider Agreement allows CareSource to delay payment on the outlier claim, but CareSource must still make timely payment on the inlier (assuming the inlier meets the Clean Claim standards) and must notify Piedmont within fifteen business days of the specific reasons why it believes that the outlier does not meet Clean Claim standards. CareSource must also identify the specific information that it needs to process the claim, and must process the claim within fifteen business days of receiving such information. In the case of A.K.'s claim, there is no evidence in the record that CareSource believed that either the inlier or the outlier claim did not meet Clean Claim standards or that CareSource ever notified Piedmont of such a finding as required by the Provider Agreement and state law. Accordingly, the Court concludes that Piedmont was entitled to timely payment of both the inlier and the outlier claim related to Patient A.K. under the Provider Agreement, notwithstanding Equian's pre-payment review.

13.

As to the Equian disallowances, the Court agrees with Piedmont that Section 9.5's "meet and confer" provision applies to Equian's pre-payment review of the A.K. outlier claim. That is, under the unambiguous terms of Section 9.5, whether CareSource called Equian's pre-payment review an audit or not, CareSource was required to review the disallowed charges with Piedmont and "have mutual agreement before charges are actually removed from the bill." The evidence in the record proved that Equian did not review the disallowed charges with Piedmont before making its findings, nor did CareSource obtain Piedmont's mutual agreement before removing the disputed charges from the bill and recalculating the outlier payment. The terms of the Provider Agreement on this issue are

clear and unambiguous. Thus, although CareSource was free to engage Equian to conduct pre-payment reviews of outlier claims, it was not permitted under the Provider Agreement to disallow charges and remove them from Piedmont's bill without first complying with Section 9.5's meet and confer requirements. Accordingly, the Court concludes that CareSource breached the Provider Agreement by unilaterally removing the disallowed charges and reducing the outlier payment.

D. Piedmont is Entitled to Payment on the A.K. Outlier Claim.

14.

Under Section 4.1(c) and O.C.G.A. § 33-24-59.5(c), Piedmont is entitled to prompt payment, with interest, of the portion of the outlier claim that was disallowed based on Equian's report. Within one week of the date of this Final Decision, Piedmont shall file and serve a Post-Hearing Report, calculating the amount of the unpaid outlier charge and the interest owed. In making this calculation, Piedmont is hereby **ORDERED** to deduct the charges that its witnesses, Ms. Berry and Mr. Willis, admitted during the hearing were improperly included in Piedmont's bill before it calculates the unpaid outlier payment and interest. Within three business days, CareSource may file a response to the Post-Hearing Report, and the Court will then issue a Post-Hearing Order, and the case will be closed.

IV. DECISION

For the above and foregoing reasons, CareSource's decision to reduce Piedmont's outlier claim relating to Patient A.K. is hereby **REVERSED**. The record will remain open for the filing of the Post-Hearing Report and CareSource's Response, and the issuance of the Post-Hearing Order.

SO ORDERED, this 21st day of April, 2023.

Kimberly W. Schroer

Kimberly W. Schroer
Administrative Law Judge