SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-2446-20

MELMARK, INC.,

Petitioner-Appellant,

v.

NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES,

Respondent-Respondent.

Submitted November 2, 2022 – Decided January 27, 2023

Before Judges Haas and Gooden Brown.

On appeal from the New Jersey Department of Human Services, Division of Medical Assistance and Health Services.

Fenningham, Dempster & Coval LLP, attorneys for appellant (Christopher P. Coval, on the briefs).

Matthew J. Platkin, Attorney General, attorney for respondent (Melissa H. Raksa, Assistant Attorney

General, of counsel; Jacqueline R. D'Alessandro, Deputy Attorney General, on the brief).

PER CURIAM

Petitioner Melmark, Inc. (Melmark) appeals from the June 1, 2020 final agency decision of the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), adopting the March 4, 2021 decision of an Administrative Law Judge (ALJ). The ALJ determined that DMAHS properly denied Melmark reimbursement on thirty claims for the residential care of seven Medicaid beneficiaries from 2015 to 2017. The unreimbursed claims amounted to $472,902. We reverse.

I.

By way of background, "Medicaid is a federally-created, state-implemented program that provides 'medical assistance to the poor at the expense of the public.'" In re Est. of Brown, 448 N.J. Super. 252, 256 (App. Div. 2017) (quoting Est. of DeMartino v. Div. of Med. Assistance & Health Servs., 373 N.J. Super. 210, 217 (App. Div. 2004)); see also 42 U.S.C. § 1396-1. "Although a state is not required to participate, once it has been accepted into the Medicaid program it must comply with the federal Medicaid statutes and regulations." Ibid. (citing Harris v. McRae, 448 U.S. 297, 301 (1980)).

"New Jersey's participation in the federal Medicaid program was authorized by the enactment of the New Jersey Medical Assistance and Health Services Act (MAHSA), N.J.S.A. 30:4D-1 to -19.5." D.C. v. Div. of Med. Assistance & Health Servs., 464 N.J. Super. 343, 354 (App. Div. 2020). Under MAHSA, "DHS is designated as 'the single State agency to administer the provisions of [the Act],' N.J.S.A. 30:4D-5, and the Director of DHS has the authority to promulgate rules, regulations, and administrative orders necessary to administer the Medicaid program." Ibid. (citing N.J.S.A. 30:4D-17.1(c)). "DMAHS is the agency within DHS responsible for implementing the State Medicaid program." Ibid. (citing N.J.S.A. 30:4D-4).

The pertinent facts giving rise to this appeal are relatively straightforward. Melmark, which is located in Berwyn, Pennsylvania, is an Intermediate Care Facility (ICF) that provides long-term care for individuals with intellectual disabilities. Melmark receives monthly reimbursements from DMAHS for the care of its Medicaid-eligible residents through the claims processing system administered by DMAHS's designated fiscal agent. Between 2015 and 2017, Melmark did not receive payments for thirty of its submitted claims involving seven Medicaid-eligible residents who had resided at Melmark since 2010. Melmark attempted to resubmit the claims for processing pursuant to N.J.A.C.

10:49-7.2(h), which allows providers to resubmit corrected claims no later than one year after the date of service. On September 2, 2020, DMAHS's fiscal agent issued a letter reaffirming the denial of all thirty claims on the ground that Melmark's resubmissions were untimely. The letter also stated that there was no record that some of the claims had ever been submitted. Melmark challenged the determination, and the agency transmitted the matter to the Office of Administrative Law (OAL) for a hearing as a contested case. As a result, an OAL hearing was conducted by an ALJ on February 11, 2021.

At the hearing, Melmark's vice president and chief financial officer, Thomas Crofcheck, provided uncontested testimony explaining how Melmark was reimbursed by DMAHS. According to Crofcheck, Melmark is "a cost reimbursement program," meaning that DMAHS provided Melmark with "cash on a monthly basis" to facilitate the continuous operation of the program. Crofcheck stated that "[a]t the end of the fiscal year," Melmark was "obligated to submit a cost report which [was] audited by independent auditors and then reviewed by [DMAHS]" to ensure that "what was paid . . . during the year" accurately reflected Melmark's "actual cost" of operation. During this reconciliation process, Melmark would refund any overpayment, and DMAHS would reimburse Melmark for any underpayment. According to Crofcheck,

DMAHS's failure to reimburse Melmark for the thirty claims resulted in an underpayment to Melmark that was never rectified.

Crofcheck explained that the monthly reimbursements were calculated from a patient roster submitted each month as part of the claims processing system. The patient roster, called a turnaround document (TAD), was preprinted by DMAHS's fiscal agent, which, at the time, was Molina Medicaid Solutions (Molina).[1] Molina physically mailed the TAD to Melmark and, upon receipt, Melmark was required to verify the accuracy and add or delete names as necessary to reflect any changes to its patient list. Melmark would then return the updated TAD to Molina, which processed the claims and ostensibly amended subsequent TADs to reflect the updated roster.

Crofcheck testified that in accordance with this procedure, which was delineated in a billing supplement issued by the fiscal agent,[2] Melmark received a TAD from Molina by mail each month. However, the TADs Molina provided

[1] DMAHS's fiscal agent has changed ownership several times. Molina was acquired by DXC Technology in 2018 and is currently owned by Gainwell Technologies.

[2] The parties produced the 2020 edition of the billing supplement, which was published by DXC Technology following its acquisition of Molina. However, Crofcheck gave undisputed testimony indicating that the relevant sections were unchanged in the 2020 publication.

consistently listed "individuals who [were] either deceased or were discharged in 2013 or sooner" rather than the individuals who were actually at Melmark. As a result, Melmark was required to make identical handwritten corrections "every single month," crossing out and inserting the same names on each TAD, before mailing the TAD back to Molina. Crofcheck stated that because the TADs Molina provided were "really grain[y]," they could not be scanned.

Crofcheck explained that this process, somewhat predictably, led to a plethora of clerical errors, primarily by Molina but partly by Melmark, resulting in errors when processing the claims. According to Crofcheck, after repeatedly contacting DMAHS, Molina, and Molina's successors in an attempt to rectify the problem, he was informed that the problem stemmed from Melmark's inability to submit claims electronically. Specifically, because Melmark was "an out of state provider that [could] not bill electronically," Molina was "manually keying [Melmark's] claims," resulting in the processing errors.

DMAHS did not contest these portions of Crofcheck's testimony. Rather, Michael McMullen, a "Program Support Specialist," testified on the agency's behalf and further detailed the claims handling process. According to McMullen, Molina used a "computerized system" to process claims. For claims not submitted electronically, like Melmark's, Molina staff members manually

"keyed" the information from the TAD into the system, at which point "the computer . . . processing system t[ook] over." The system reviewed the information submitted from each TAD and placed a processing hold on any TAD with incomplete or incorrect information, such as an incorrect patient name, admission date, eligibility code, diagnosis code, or identification number.

McMullen stated that TADs flagged by the system were subject to "adjudication." In adjudication, "[o]ne of [Molina's] resolution clerks . . . look[ed] at [the claim] to make sure that it was keyed correctly." If adjudication revealed that the information on the TAD was "keyed incorrectly" and "not based on the claim [information]," then the clerk would manually correct the system entry and "release [the claim] for processing and payment." On the other hand, if the clerk determined the information was "keyed correctly" and there were no clerical errors, the clerk would release the processing hold on the claim, allowing the system to deny the claim.

McMullen further explained that after adjudication, the agency issued a "remittance advice" (RA), which explained the status of each claim, including whether it was "paid," "denied," or "in process." If the claim was denied, the RA provided an error code or "a reason code" for denial. If the error was "correctable," then Molina was required to append a Claim Correction Form

(CCF) to the RA with instructions to the provider to submit any required corrections within ninety days. If the error was "fatal," no further corrective action was contemplated. According to McMullen, if a provider did not receive an RA, agency policy required the provider to contact the fiscal agent for a status update on the claim.

Crofcheck testified that Melmark did not receive an RA for all the disputed claims and never received a CCF for any of the disputed claims. He also confirmed that Melmark had submitted TADs to Molina reflecting all the claims in dispute within thirty days of the date of service. In support, Crofcheck provided the TADs submitted to Molina by Melmark, as well as RAs showing that other uncontested claims submitted in the same TADs had been processed and paid while the contested claims were either entirely omitted or showed that they were "in process." Additionally, Crofcheck verified that in August 2017 and again in January 2018, Melmark had resubmitted the disputed claims and followed up with Molina but received no response. In fact, Melmark did not learn about the issues regarding the claims until the appeal was filed.

McMullen confirmed that the claims were denied for being untimely and testified that a claim was untimely if an error was not corrected within one year. However, McMullen could not provide documentation to verify that RAs or

CCFs had been sent to Melmark. Nonetheless, McMullen stated if a claim did not appear on an RA, it was the provider's responsibility to resubmit the claim, and it was "hard to believe that one provider out of 30,000 did not receive a[n RA]."

On March 4, 2021, the ALJ issued an Initial Decision affirming Medicaid's denial of Melmark's claims. Although the ALJ did not make specific credibility findings, she adopted the undisputed portions of the witnesses' testimony detailing the claims handling process as part of her factual findings. The ALJ also reviewed in detail the pertinent TADs, the RAs, and the billing supplement. Based on the evidence, the ALJ determined:

> It [was] undisputed that [Melmark] rendered the services to the seven individuals and that the individuals were Medicaid eligible. The amount of the claims [was] also not contested. Rather, the core of this matter is whether Melmark's claims were received by Medicaid's fiscal agent within the time dictated by the applicable regulations.

In that regard, the ALJ found that Melmark submitted "the thirty claims . . . within one month from the date of service," substantiating Melmark's contention "that the claims were filed timely." The ALJ also determined that "Molina continuously submitted TADs with inaccurate data which Melmark had to manually correct." Further, the ALJ found that Molina's "[c]laim [s]tatus

[n]otes detailing why the thirty claims were denied contain[ed] inaccurate data," and that DMAHS provided no "evidence that . . . CCFs were sent to [Melmark]" despite the fact that "it was the fiscal agent's duty to forward the CCFs to [Melmark]." In particular, for the January 2016 billing month, which involved two separate claims, the ALJ found that Melmark received neither an RA nor a CCF despite Molina's receipt of the claims. Additionally, the ALJ found that certain RAs listed specific error codes for some denied claims but indicated only "Claims in Process" or "In Process – CCF" for others, without attaching the relevant CCF or otherwise indicating the reason for the processing hold.

Notwithstanding these factual findings, relying on the pertinent regulations and Lincoln Park Intermediate Care Center (A.B.) v. Division of Medical Assistance & Health Services, 92 N.J.A.R.2d 63 (Div. of Medical Assistance & Health Services), the ALJ determined:

> [E]ven if a CCF was not received, "[i]t is the duty of the provider to follow-up if the claim is not paid, to supply the additional information needed and to supply it in the proper form." [RAs] were issued for many of the claims with "in process" or "in process – CCF." If a claim was not paid, it was incumbent upon [Melmark] to follow up. Even if [DMAHS] failed to issue a[n RA], the lack of payment was sufficient notice that a claim was found to be problematic and should have triggered a prompt response from Melmark. There is no evidence that Melmark followed up with Molina until August 9,

> 2017, when the claims were resubmitted to Molina for processing. This is not timely filing.

Melmark filed exceptions to the ALJ's decision on March 10, 2021. On June 1, 2021, DMAHS's Assistant Commissioner issued a final agency decision adopting the ALJ's decision in its entirety. Relying on the regulations and Lincoln Park Intermediate Care Center, the Assistant Commissioner agreed with the ALJ that "regardless of whether [Melmark] received a[n RA] or a CCF, the lack of payment was sufficient notice that a claim was problematic and required a prompt response." However, the Assistant Commissioner found "no evidence in the record that Melmark timely followed up on the claims at issue." This appeal followed.

II.

"We review a decision made by an administrative agency entrusted to apply and enforce a statutory scheme under an enhanced deferential standard." E. Bay Drywall, LLC v. Dep't of Lab. & Workforce Dev., 251 N.J. 477, 493 (2022). Accordingly, "[a]n administrative agency's final quasi-judicial decision will be sustained unless there is a clear showing that it is arbitrary, capricious, or unreasonable, or that it lacks fair support in the record." Allstars Auto Grp., Inc. v. N.J. Motor Vehicle Comm'n, 234 N.J. 150, 157 (2018) (quoting Russo v. Bd. of Trs., Police & Fireman's Ret. Sys., 206 N.J. 14, 27 (2011)).

"Where action of an administrative agency is challenged, 'a presumption of reasonableness attaches to the action . . . and the party who challenges the validity of that action has the burden of showing that it was arbitrary, unreasonable[,] or capricious.'" Barone v. Dep't of Human Servs., Div. of Med. Assistance & Health Servs., 210 N.J. Super. 276, 285 (App. Div. 1986) (quoting Boyle v. Riti, 175 N.J. Super. 158, 166 (App. Div. 1980)). Furthermore, "[a]n administrative agency's interpretation of statutes and regulations within its implementing and enforcing responsibility is ordinarily entitled to our deference." A.B. v. Div. of Med. Assistance & Health Servs., 407 N.J. Super. 330, 339 (App. Div. 2009) (alteration in original) (quoting Wnuck v. N.J. Div. of Motor Vehicles, 337 N.J. Super. 52, 56 (App. Div. 2001)).

Nevertheless, our review is "in no way bound by the agency's interpretation of a statute or its determination of a strictly legal issue." R.S. v. Div. of Med. Assistance & Health Servs., 434 N.J. Super. 250, 261 (App. Div. 2014) (quoting Mayflower Sec. Co. v. Bureau of Sec. in Div. of Consumer Affs. of Dep't of L. & Pub. Safety, 64 N.J. 85, 93 (1973)). "Like all matters of law, we apply de novo review to an agency's interpretation of a statute or case law." Russo, 206 N.J. at 27 (emphasis omitted). Moreover, "[w]e do not . . . simply rubber stamp the agency's decision." Paff v. N.J. Dep't of Lab., 392 N.J. Super.

334, 340 (App. Div. 2007) (citing Henry v. Rahway State Prison, 81 N.J. 571, 579-80 (1980)). Instead, we will "intervene . . . in those rare circumstances in which an agency action is clearly inconsistent with its statutory mission or other state policy." In re Musick, 143 N.J. 206, 216 (1996).

On appeal, Melmark contends that DMAHS relied on case law interpreting obsolete Medicaid regulations that have no analogue in the current regulations. Melmark also challenges the ALJ's and the Assistant Commissioner's respective conclusions that Melmark had constructive notice of its claims' deficiencies by virtue of nonpayment alone. In support, Melmark points to the ALJ's factual findings that Molina frequently provided RAs with no error codes and never provided Melmark with any CCFs. Finally, Melmark argues that the "prompt follow-up" rule articulated by the ALJ and adopted by the Assistant Commissioner is overly vague and "a recipe for confusion and possible abuse." In any event, Melmark contends that "[u]nder the circumstances, [its] follow up was reasonable and certainly not in violation of any law or regulation." DMAHS counters that the governing regulations "make clear that the burden lies squarely with the provider to ensure the claims are submitted properly, corrected when necessary, and resubmitted if denied."

In applying the arbitrary and capricious standard of review, our task is to decide:

> (1) whether the agency's decision offends the State or Federal Constitution; (2) whether the agency's action violates express or implied legislative policies; (3) whether the record contains substantial evidence to support the findings on which the agency based its action; and (4) whether in applying the legislative policies to the facts, the agency clearly erred in reaching a conclusion that could not reasonably have been made on a showing of the relevant factors.
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> [A.B., 407 N.J. Super. at 339 (quoting George Harms Constr. Co. v. N.J. Tpk. Auth., 137 N.J. 8, 27 (1994)).]

A review of the governing regulations informs our analysis in fulfilling this task. Under N.J.A.C. 10:49-1.3, the "[f]iscal agent" is the "entity that processes and adjudicates provider claims on behalf of programs administered . . . by [DMAHS]." The fiscal agent is responsible for "processing . . . Medicaid claims" and making "payment[s] to providers." N.J.A.C. 10:49-8.1. An ICF such as Melmark is required to submit "a claim for payment for services" to the "fiscal agent no later than one year after the 'from date of service' as indicated on the claim." N.J.A.C. 10:49-7.2(d)(2). The fiscal agent is required to "process Medicaid claims daily and produce provider payments and associated [r]emittance [a]dvice (RA) statements once each week." N.J.A.C. 10:49-8.2(a).

"The [RA] is the major vehicle for communicating to the provider the status of all Medicaid claims received by the fiscal agent." N.J.A.C. 10:49-8.2(a)(1). "All claims processed . . . fall into one of three classifications: paid; in process; or denied." Ibid.

> i. A claim that is correctly completed for a covered service provided to a Medicaid beneficiary by an approved provider will be paid. The claim will appear on the RA [c]laims [s]tatus page, or pages, along with all other claims for which a provider is being paid in that payment cycle. If the amount differs from the billed charges, an explanation will appear on the RA.
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> ii. In process claims or processed but unpaid claims are those claims held for prepayment review by [DMAHS] or by the [f]iscal [a]gent. The review will result in a claim or group of claims being paid, denied, or additional information being requested. If additional information is required, a letter and/or a Claim Correction Form (CCF) will be forwarded to the provider. (Additional billing information is provided in the Fiscal Agent Billing Supplement . . .).
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> iii. Reasons for denial of a claim will be provided on the RA in the form of an error/edit code.
>
> [Ibid.]

When a request for additional information is made, "the provider shall supply the information as soon as possible but not more than [thirty] days after the end of the timely submission period." N.J.A.C. 10:49-7.2(g). Once a claim "has been adjudicated and denied, a provider may resubmit the claim within one

year of the date of service or [thirty] days of the date of adjudication as indicated in the [RA], whichever is later." N.J.A.C. 10:49-7.2(h). No reimbursement is permitted "for a claim received outside the prescribed time periods." N.J.A.C. 10:49-7.2(a)(2)(i).

"It is the responsibility of each provider to ensure that each Medicaid . . . claim submitted by that provider is received by the . . . [f]iscal [a]gent within the time periods indicated . . . ." N.J.A.C. 10:49-7.2(a)(2). "Providers shall reconcile their claims submission records with the [RA] they receive from the . . . [f]iscal [a]gent . . . to verify that the . . . [f]iscal [a]gent has received their claims." Ibid. A provider "shall resubmit any claims for reimbursement, which the provider determines have been submitted previously, but which do not appear on the [RA]." Ibid.

Applying this regulatory scheme to the record, we are convinced that Melmark's claims were filed timely and Melmark had no notice, constructive or otherwise, of the purported errors in its claims. The ALJ determined that all thirty claims were timely filed "within one month of the date of service" and Molina's claim status notes explaining "why the thirty claims were denied contain[ed] inaccurate data." The ALJ also found no evidence that Molina sent any CCFs to Melmark, notwithstanding the requirement to do so, and determined

that Molina had failed to issue an RA for two separate claims. Further, according to the ALJ, Molina frequently provided RAs with no error codes or with claims marked "in process" without any accompanying explanation to alert Melmark to the missing information. Additionally, as a cost reimbursement program, Melmark could not be placed on notice of the errors by nonpayment of the claims alone because Melmark's monthly payments were provisional in nature and underpayments were reconciled at the end of each fiscal year.[3]

We also conclude that Melmark had no duty under the regulations to "follow up" with Molina or DMAHS upon nonpayment of the claims. The current regulatory scheme only affirmatively requires providers to ensure that its claims are timely received. See N.J.A.C. 10:49-7.2(a)(2). In concluding that "it was incumbent upon [Melmark] to timely follow up with Molina," DMAHS relied on its decision in Lincoln Park Intermediate Care Center. However, the Lincoln Park decision was predicated on a former version of N.J.A.C. 10:49-1.2 that stated, "[i]t is the responsibility of all other providers to submit a claim,

[3] For the first time on appeal, DMAHS contends that Melmark had actual notice of the required corrections because the Division posts all CCFs on its online portal, which it asserts Melmark used to submit its claims. However, the argument is contrary to the undisputed record that Melmark had no access to the online portal, which was the very reason Melmark submitted all TAD corrections manually and was reportedly the underlying reason for the processing errors.

make a follow-up inquiry, or supply information to the appropriate [f]iscal [a]gent." Lincoln Park, 92 N.J.A.R.2d at 65. Thus, the regulation interpreted in Lincoln Park placed the responsibility of making "follow-up" inquiries squarely on the provider. Ibid. That language no longer appears in the current regulations.

Although "[w]e will defer to an agency's interpretation of both a statute and implementing regulation[] within the sphere of the agency's authority," we are not bound by an interpretation that is "plainly unreasonable." In re Election L. Enf't Comm'n Advisory Op. No. 01-2008, 201 N.J. 254, 262 (2010) (quoting Reilly v. AAA Mid-Atl. Ins. Co. of N.J., 194 N.J. 474, 485 (2008)). We conclude that DMAHS has advanced such an interpretation here.

Reversed.