DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

ORDER OF MEDICARE APPEALS COUNCIL
REMANDING CASE TO ADMINISTRATIVE LAW JUDGE
Docket Number: M-11-318

In the case of	**Claim for**
Charles Stockwell, O.D. (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
TrailBlazer Health Enterprises, LLC (Contractor)	**** (ALJ Appeal Number)

The Medicare Appeals Council has decided, on its own motion, to review the Administrative Law Judge's (ALJ's) decision dated September 20, 2010, because there is an error of law material to the outcome of the claim. This case arose as a result of an overpayment determination regarding ophthalmology services provided to multiple beneficiaries over multiple dates of service in 2002 (see attached).[1] The ALJ determined that the provider was without fault in causing the overpayment under section 1870 of the Social Security Act (Act). Consequently, the ALJ held that a review of the individual claims in the sample was not necessary to the determination of an overpayment since the appellant's entitlement to a waiver of recovery under section 1870 of the Act was dispositive.

The Council has carefully considered the record before the ALJ as well as the Centers for Medicare & Medicaid Services (CMS) memorandum and the appellant's response, which have been entered into the record as Exhibit (Exh.) MAC-1 and Exh. MAC-2, respectively. For the reasons set forth below, the Council

[1] The Council has attached a copy of the beneficiary list to this decision with the names, HIC numbers, and dates of service for each of the claims at issue.

hereby vacates the hearing decision and remands this case to an ALJ for further proceedings, including a new decision. *See* 42 C.F.R. § 405.1110(d).

BACKGROUND

The appellant submitted claims to Medicare for ophthalmology services (dacryocystorhinostomy (CPT[2] code 68720), ophthalmological services (CPT codes 92004, 92012, 92014), and ophthalmoscopy (CPT codes 92225 and 92226) he provided to nursing home residents in 2002. On April 21, 2003, and July 8, 2003, the CMS program safeguard contractor (PSC), TriCenturion, notified the appellant it was conducting a review of these previously paid services. Exh. 1 at 146, 150. On October 23, 2003, the PSC completed its medical review and determined a projected overpayment amount of $289,779. *Id*. at 136-145, 134-135.

By letter dated September 26, 2008, the PSC issued an initial determination of overpayment in which it explained that the PSC's "review of 55 claim[s] found that 55 were fully or partially denied resulting in a 100% error rate. The 55 claims (the 'sample') reviewed were randomly selected from a total of 3,726 (the 'universe')." *Id*. at 130. The letter further stated that the projected overpayment was "based on the lower limit of the one-sided 90% confidence interval." *Id*. According to the October 23, 2003, Post-Pay Medical Review Summary, the audit was initiated "as a result of a review to determine top billing providers with specialty 41. Dr. Stockwell was number two on the list. An SRS was requested after a cursory review, of limited records, revealed several aberrancies."[3] *Id*. at 136. Among the examples of aberrancies were:

- though Dr. Stockwell includes a chief complaint on the resident documentation, the services he provides, as reflected in the documentation, cannot be distinguished from a routine eye exam;

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[2] The Centers for Medicare and Medicaid Services (CMS) established the Healthcare Common Procedure Coding System (HCPCS) to ensure that Medicare claims are processed in an orderly and consistent manner. The HCPCS is based upon the American Medical Association's (AMA) Physicians' Current Procedural Terminology, Fourth Edition (CPT-4). Medicare Claims Processing Manual (MCPM), (CMS Pub. 100-04), Ch. 23, § 20. In this case, the Council has provided the CPT codes for the services provided unless otherwise specified.

[3] We presume that "SRS" is an abbreviation for a statistically valid random sample.

- the majority of the patients examined did not require treatment of any kind. The medical necessity for billing these high level ophthalmological codes is suspect;

- for established patients, the requirement that a new complication, either a new diagnosis or management problem be identified was never met; and

- all of the beneficiaries were examined in a nursing facility (POS 32), however the claims were submitted with POS 11, indicating physician office.

Id. at 139.

On October 27, 2008, the contractor, TrailBlazer Health Enterprises, requested a refund of the overpayment. *Id*. at 125. The appellant requested a redetermination on November 20, 2008. *Id*. at 119-122. On July 31, 2009, the contractor upheld the overpayment, finding that the services at issue were not covered by Medicare and that the PSC's assessment of the overpayment was correct. *Id*. at 114. Accompanying the redetermination decision was a document titled, "TrailBlazer's Validation of TriCenturion's Statistical Sampling and Overpayment Extrapolation at Redeterminations" that, despite the title, mostly addresses the appellant's arguments regarding the reopening and waiver under section 1870 of the Act. *Id*. at 114-117.

The appellant requested a reconsideration and on November 3, 2009, the Qualified Independent Contractor (QIC) issued a partially favorable decision, determining that some services were payable, but at a lower level of service. *Id*. at 12-31. The QIC denied some services because the documentation did not meet the local medical review policy (LMRP) requirements or because the appellant had not furnished documentation demonstrating that the services were medically necessary or performed as billed. *Id*. Further, the QIC found that the PSC was authorized to reopen the claims at issue, records from the PSC "contained all the elements to perform a valid statistical overpayment calculation," and the appellant was liable under sections 1879 and 1870 of the Act. *Id*.

In its request for an ALJ hearing, the appellant contended that the reopening of claims by TriCenturion was prohibited and that, because the recoupment occurred more than the third calendar

year after the year of payment, the appellant was deemed to be without fault. *Id*. at 1-11. The appellant also furnished a summary sheet for each patient identifying the dates of service, CPT code billed, the chief complaint, diagnosis, treatment and standard of care for follow-up. *Id*. at 10 (citing Tab 4 in documentation submitted to the ALJ).

The ALJ held a hearing on July 19, 2010, at which the appellant was represented by counsel. Dec. at 1. The ALJ determined that the contractor's decision to reopen is final and not subject to review. *Id*. at 5. The ALJ noted that the audit began on April 21, 2003, when the PSC informed the appellant that it was reviewing claims for services provided in 2002, and that the PSC completed its review on October 23, 2003, but did not notify the appellant of its findings until September 26, 2008. *Id*. The ALJ found this fact "instrumental, and ultimately dispositive, of this appeal because special rules apply when an overpayment is 'discovered' subsequent to the third year following the year in which notice was sent that the amount was paid." *Id*. at 6.

The ALJ found that the QIC incorrectly "entangled the Act's section 1879 standard for fault with the section 1870 standard for fault." Unlike the "presumed knowledge" standard of section 1879, analysis under section 1870 inquires "whether the provider made full disclosure of all material facts and whether . . . it had a reasonable basis for assuming that the payment was correct." The ALJ faulted both the PSC and the QIC for not addressing this issue sufficiently. Regardless, he determined:

> the documentation present in the record on appeal is insufficient to substantiate the conclusion that the provider was at fault in causing the overpayment, nor does it rise to the level of evidence of fault, which is required under a § 1870 analysis. Consequently, even if an individual review of the claims at issue resulted in an overpayment determination, the provisions of § 1870 shield the appellant and the beneficiaries from liability for the overpayment. Therefore, an analysis of the individual claims in the sample is not necessary to the determination since the appellant's entitlement to a waiver of liability under § 1870 of the Social Security Act is dispositive of this appeal.

Id.

CMS referred the ALJ's decision for Council review. 42 C.F.R. § 405.1110(b). CMS' position is that the ALJ erred in waiving recoupment under section 1870 of the Act without making a decision on the merits to determine whether an overpayment exists. Exh. MAC-1 at 7-9. Specifically, CMS asserts that an analysis regarding whether a provider is without fault in causing an overpayment necessarily depends on whether an overpayment exists and the circumstances under which the overpayment occurred. *Id*. at 8-9 (noting that the PSC identified multiple reasons for denial that were not addressed by the ALJ; citing Medicare Financial Management Manual (MFMM), (CMS Pub. 100-06), Ch. 3, §§ 70, 70.3)). Further, CMS contends that the ALJ erred in providing an insufficient notice of hearing to the parties that did not meet the requirements set forth in 42 C.F.R. § 405.1022(b). *Id*. at 9-10. Finally, CMS asserts that the ALJ erred to the extent that he relied upon "concerns of equity and good conscience" as a basis for waiving recoupment because that phrase derives from section 1870(c) of the Act, which is not applicable in this case. *Id*. at 9.

The appellant responded to CMS' referral to the Council. The appellant asserts that the ALJ properly waived recoupment under section 1870 of the Act and that the sections of the MFMM relied upon by CMS are not binding on an ALJ or the Council. Exh. MAC-2 at 1-3 (citing 42 C.F.R. §§ 405.1062(a), 405.1062(b); *Beechwood Sanitarium*, DAB No. 1824 (2002); *Holy Cross Hospital* (2009)). The appellant also contends that because considerations of "equity and good conscience" were not determinative, there is no express or implied reference to section 1870(c) of the Act. *Id*. at 4. Finally, the appellant contends that the ALJ provided notice of the April 26, 2010, hearing in accordance with 42 C.F.R. § 405.1022(b) because participation by the PSC was not required and the AdQIC had notice of the issues to be presented at the hearing. *Id*.

DISCUSSION

The Council has limited its review of the ALJ's action to those exceptions raised by CMS. 42 C.F.R. § 405.1110(c)(2). The Council has determined that remand is appropriate so that the ALJ can address the merits of the underlying appeal prior to determining whether the appellant was without fault in causing the overpayment. *See* 42 C.F.R. §§ 405.1110(d), 405.1126(a).

The ALJ made no substantive determinations on the merits of the claims at issue, reasoning, incorrectly, that such a determination was obviated by the waiver provisions at section 1870(b) of the Act. *See* Dec. at 5-7. The Council finds, however, that the ALJ should have first determined whether services provided to the beneficiaries in each case met the coverage provisions of the Act and were otherwise medically reasonable and necessary under section 1862(a)(1) of the Act. If the ALJ determined that the services at issue were not covered because they did not fall under a benefit category or were otherwise excluded, did not meet technical requirements for coverage, or were not medically reasonable and necessary, his next step of analysis should have been to apply the provisions of sections 1879, 1870, or both, as applicable, based on the reason for denying the services at issue.

Under section 1879, if applicable to the reason the claim was determined to be overpaid, an adjudicator determines whether payment may be possible, or liability limited, (despite findings of non-coverage) on the grounds that neither the provider nor beneficiary knew or could reasonably have been expected to know that the services would not be covered because they are found not medically reasonable and necessary. Only after these analyses are made concerning those claims that were denied for reasons that invoke section 1879 should the ALJ consider waiver of recovery under section 1870. In this regard, the QIC did not err in applying of section 1879 prior to that of section 1870(b). Exh. 1 at 28-30.

Thus, in summary, the Council finds that the ALJ erred in applying section 1870 without first having made determinations concerning whether the services at issue were actually covered and, thus, not overpaid at all. In the event that the ALJ found that some or all of the claims were overpaid on the merits, he should have applied the provisions of sections 1879 and 1870, as applicable, to first determine the liability of the appellant and beneficiaries, as applicable, and then determine whether any portion of the overpayment may be waived. This conclusion is compelled not just by the provisions of Medicare manuals, as the appellant suggests, but by the plain language of the Act and regulations. The circumstances that cause an overpayment, if any, including consideration of liability under section 1879, must be determined first before considering waiver of recovery of an overpayment under section 1870(b) of the Act. This

consideration is integral to determining whether there is "evidence to the contrary," which rebuts the presumption of without fault applied here by the ALJ.

Moreover, to the extent that the ALJ reached section 1870, the ALJ erred by referring, although implicitly, to section 1870(c) of the Act in support of waiving the overpayment. The appellant in this case was a provider of services, not an individual beneficiary. Thus, only section 1870(b), and not section 1870(c), was applicable to determining the provider's responsibility, if any, for the overpayment.

Finally, the general provisions of section 1870 of the Act and chapter 3 of the MFMM make it clear that the specific provisions of section 1870(b) establish only a *rebuttable presumption* that an appellant is without fault if more than three years since the year of payment on the claim have passed. There is no absolute bar to finding that an appellant is with fault or that recovery of an overpayment is appropriate *solely* on the basis of such passage of time. The guidelines of MFMM contemplate that "different rules apply" after the passage of the three-year period. The MFMM provides guidelines for determining whether fault has, in fact, occurred, regardless of whether fault is assessed within or beyond the three-year period. The ALJ erred in finding that the passage of time was "instrumental and ultimately dispositive" on this issue.

The appellant reasons that the MFMM does not compel either an ALJ or the Council to "conduct a complete step-by-step analysis that mirrors manual instructions to guide Medicare carrier and fiscal intermediary operations." Exh. MAC-2 at 3. *See* Exh. MAC-2 at 2 (citing 42 C.F.R. §§ 405.1062(a), 405.1062(b)). The appellant supports his assertion by referencing a 2002 Departmental Appeals Board (DAB) case, *Beechwood Sanitarium*, as well as a 2009 Council decision, *Holy Cross Hospital*. *Id*. at 3. The Council disagrees with the appellant's reliance on these cases.

The Council is not persuaded by the appellant's assertion that the ALJ and the Council should not apply the sequential analysis in the MFMM in this case. First, *Beechwood* was not a case decided by the Medicare Appeals Council, did not involve an overpayment determination, and is not dispositive on the issue of whether the Council should decline to give substantial

deference to CMS program guidance in this case.[4] In the *Beechwood* language cited by the appellant, the DAB found that an "ALJ should [not] be required to make more findings than is necessary to support the remedies imposed."

The reasoning that an ALJ or the Council following CMS program guidance is akin to "mak[ing] more findings than is necessary to support the remedies imposed" is flawed. The applicable regulation states that an ALJ and the Council, while not bound by CMS program guidance, will "give substantial deference to these policies *if they are applicable to a particular case*." 42 C.F.R. § 405.1062(a) (emphasis added). Further, if an ALJ or the Council declines to follow a policy in a particular case, the ALJ or Council must explain the reasons why the policy was not followed and the "decision to disregard such policy *applies only to the specific claim being considered and does not have precedential effect*." 42 C.F.R. § 405.1062(b) (emphasis added). Therefore, if CMS program guidance is applicable in a particular case, which it is in this case, then an ALJ and the Council will give substantial deference to it or provide reasons for not doing so.[5] The fact that the DAB in *Beechwood* concluded that an ALJ made unnecessary findings relating to the civil remedies at issue in that case is separate and apart from an ALJ or the Council deciding whether to follow CMS program guidance when it applies. Further, the ALJ in *Beechwood* was not subject to Medicare appeals regulations set forth in 42 C.F.R. Part 405, Subpart I.

The Council also disagrees with the appellant's reliance on *Holy Cross Hospital* to support the proposition that the presumption of no fault based on the passage of time can be made once the ALJ determined that three years had passed and did not identify any evidence to rebut the presumption that the provider was not

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[4] The title Departmental Appeals Board ("DAB") refers both to the Board Members (collectively the "Board") that the Secretary appoints and to the larger staff organization. The DAB provides impartial, independent review of disputed decisions in a wide range of Department programs under more than 60 statutory provisions. The DAB includes the Board itself (supported by the Appellate Division), Administrative Law Judges ("ALJs") (supported by the Civil Remedies Division), and the Medicare Appeals Council (supported by the Medicare Operations Division). Thus, the DAB has three adjudicatory divisions, each with its own set of judges and staff, as well as its own areas of jurisdiction. *See* http://www.hhs.gov/dab.

[5] In fact, the ALJ's decision reflects that the ALJ did consider and apply the MFFM guidelines, in part. *See,* Dec at n. 4-9 and accompanying text.

without fault in such instances. Exh. MAC-2 at 3. The Council determined in that case that the appellant was *not* without fault in causing the overpayment, largely because of factors enumerated in the MFMM. The Council notes that its decisions, like decisions of ALJs, are not precedent. Moreover, each decision is based on case-specific facts, which require an individual determination as to whether the Medicare medical necessity requirements are met.

For the reasons discussed above, it is necessary for the Council to remand the case to an ALJ for further proceedings. The ALJ shall hold a hearing (unless waived by the appellant) and will issue a decision discussing whether the Medicare Part B services provided to each beneficiary were covered and otherwise medically reasonable and necessary.[6] If applicable, the ALJ will then address the liability of the appellant and the beneficiaries[7] under section 1879 of the Act.

If the ALJ determines that some or all of the services are not covered and that payment may also not be made under section 1879 of the Act, the ALJ will then apply section 1870(b) of the Act. The ALJ will determine whether the appellant is without fault for the overpayment with regard to each claim. Additionally, the ALJ will consider the guidelines of the MFMM, chapter 3, sections 90 and 90.1 in determining whether the appellant is without fault for the overpayment.

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[6] The Council finds that the notice of hearing was sufficient under 42 C.F.R. § 405.1022(b). The notice of hearing set out the specific issues to be addressed and was sent to the QIC. Exh. 2 at 1-5; 42 C.F.R. § 405.1022(c) (noting that

> The notice of hearing should be sent to all parties that filed an appeal or participated in the reconsideration, any party who was found liable for the services at issue subsequent to the initial determination, and the QIC that issued the reconsideration, advising them of the proposed time and place of the hearing).

See also Medicare Program: Changes to the Medicare Claims Appeal Procedures; Final Rule, 74 Fed. Reg. 65296, 65322 (December 9, 2009) (to be codified at 42 C.F.R. part 405) (noting that "sending the notice of hearing to the QIC that processed the reconsideration provides adequate notice to CMS and its contractors of the pending ALJ hearing, and thus is not necessary to also send notice of the hearing to the contractor that issued the initial determination").

[7] Beneficiary liability is generally not an issue in multi-beneficiary provider audits. *See generally* 42 C.F.R. §§ 405.956(a)(2), 405.976(a)(2) and 405.1046(a).

The ALJ may take further action not inconsistent with this order.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/Constance B. Tobias,Chair
Departmental Appeals Board

Date: February 14, 2011