

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DEPARTMENTAL APPEALS BOARD

ORDER OF MEDICARE APPEALS COUNCIL  
REMANDING CASE TO ADMINISTRATIVE LAW JUDGE

In the case of

Claim for

Breton L. Morgan, M.D.  
\_\_\_\_\_  
(Appellant)

Supplementary Medical  
Insurance Benefits (Part B)  
\_\_\_\_\_

\*\*\*\*  
\_\_\_\_\_  
(Beneficiaries)

\*\*\*\*  
\_\_\_\_\_  
(HIC Numbers)

Palmetto GBA  
\_\_\_\_\_  
(Contractor)

\*\*\*\*  
\_\_\_\_\_  
(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued an Order, dated April 17, 2009, dismissing the appellant's request for an ALJ hearing in a multi-beneficiary overpayment determination assessed against the appellant by the Centers for Medicare and Medicaid Services (CMS).<sup>1</sup> The ALJ based the dismissal on jurisdictional grounds finding that, since the appellant had been excluded from participation in Medicare, Medicaid and all other federal health care programs, the appellant's claims were not eligible for Medicare reimbursement. The appellant has asked the Medicare Appeals Council to review this action. The appellant's request for review has been entered into the record as Exhibit (Exh.) MAC-1.

The Council may deny review of an ALJ's dismissal or vacate the dismissal and remand the case to the ALJ for further proceedings. 42 C.F.R. § 405.1108(b). The Council will dismiss a request for review when the party requesting review does not have a right to a review by the Council. The Council may also dismiss the request for a hearing for any reason that the ALJ could have dismissed the request for hearing. 42 C.F.R.

<sup>1</sup> Although the current condition of the case record precludes certainty, it appears that there are 195 beneficiaries and 266 claims at issue. See attached Beneficiary List.

§ 405.1108(c).

As explained below, the Council vacates the ALJ's April 17, 2009, Order of Dismissal and remands this case to an ALJ for further proceedings including a hearing and new decision.

#### **BACKGROUND**

The case history below is drawn from the record in this case. As discussed below, the state of the record forwarded from the ALJ precludes specific citation to documents in the record.

#### ***Appellant's Claims History***

Between January 1, 2004, and March 7, 2006, the appellant, then a licensed physician in West Virginia and Ohio, provided a variety of medical services to numerous patients. The appellant submitted claims for Medicare coverage of those services under the following, generally identified, HCPCS/CPT<sup>2</sup> billing codes --

**99213, 99214 and 99215** - Office or other outpatient visit for the evaluation and management of an established patient;

**99222 and 99223** - Initial hospital care, per day, for the evaluation and management of a patient;

**99231, 99232 and 99233** - Subsequent hospital care, per day, for the evaluation and management of a patient;

**99238** - Hospital discharge day management; 30 minutes or less;

**99311**<sup>3</sup> - Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient; and

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<sup>2</sup> CMS created the Healthcare Common Procedure Coding System (HCPCS) to develop uniform national definitions of physician services, codes for those services and payment modifiers, to process, screen, identify, and pay Medicare claims. See 42 C.F.R. §§ 414.2 and 414.40. The Current Procedure Terminology (CPT) is an American Medical Association publication of billing codes for medical services. The HCPCS incorporates the CPT coding system and includes additions of its own.

<sup>3</sup> Code 99311 was deleted for 2006. See HCPCS 2006, page 788 (Nov. 28, 2005).

**99315** - Nursing facility discharge day management; 30 minutes or less.

Medicare initially paid the appellant's claims. However, following a post-payment audit of those claims, on June 6, 2007, Advancemed, a Medicare Program Support Contractor (PSC), notified the appellant that he had been over-paid by \$614,222.95. On June 12, 2007, the Medicare contractor (Palmetto) downcoded or denied payment for these claims. Palmetto issued a redetermination decision on October 15, 2007, followed by a partially favorable, revised redetermination decision, dated September 17, 2008. As a result of the revised redetermination decision, the overpayment was reduced by approximately \$300,000 to \$315,914.40.

The appellant sought reconsideration by a Qualified Independent Contractor (QIC). On December 12, 2008,<sup>4</sup> the QIC issued a partially favorable reconsideration decision resulting in fully favorable findings on eighteen claims and partially favorable findings on two others. The appellant requested a hearing by an ALJ.

### ***Appellant's Professional History***

In March 2006, the appellant surrendered, to the West Virginia Board of Medicine (Board of Medicine), his West Virginia medical license. Following treatment for chemical dependency, on December 7, 2006, the appellant again appeared before the Board of Medicine where he signed a Consent Order resulting in his license being reinstated and placed in "inactive" status. The Board of Medicine placed the appellant on three years probation.

In March 2007, the appellant appeared in the United States District Court for the Southern District of West Virginia, where he entered a guilty plea to one count of obtaining a Schedule III controlled substance by fraud. The remaining twenty-eight counts in the indictment against the appellant were dismissed. The appellant's conviction resulted in a May 14, 2007, revocation of his West Virginia medical license and a December 12, 2007, suspension of his Ohio medical license.

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<sup>4</sup> The ALJ identified the date of the unfavorable QIC decision as November 3, 2008. However, that is, in fact, the date of the QIC's acknowledgment letter to the appellant notifying the appellant that the QIC had received his request for reconsideration and explaining the ensuing process.

Based upon the appellant's conviction related to health care fraud, on May 30, 2008, the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services excluded the appellant from participation in Medicare, Medicaid and any other federal health care program for a period of five years. See Section 1128(a)(3) of the Social Security Act (Act).<sup>5</sup>

Consequently, on July 21, 2008, the appellant signed another Consent Order with the Board of Medicine whereby his license was reinstated and then revoked, the revocation stayed and the appellant placed on probation for five years.

### ***The ALJ's Analysis***

#### **Evidence**

The ALJ first excluded evidence from the record noting that the appellant's:

Request for ALJ Hearing of February 6, 2009 and documents in the file mention 1400 or 1500 pages of evidence. To the extent any of these documents are newly submitted evidence, I find no good cause provided to allow them to come into evidence at this juncture. Under the authority of 42 C.F.R. §405.1028, good cause is not found to admit into evidence any new materials provided by . . . [the appellant] with the Request for ALJ Hearing or afterward.

Dec. at 7 (footnote omitted).

#### **The Dismissal**

In the analysis underlying his dismissal, the ALJ determined that the appellant --

has been and should have been excluded from participation in the Medicare program. The remaining question for the OIG to answer is should the exclusion last longer and start earlier; since there is evidence he was using controlled substances from November 2, 2004 through September 6, 2005.

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<sup>5</sup> On appeal, the appellant's exclusion has been upheld in an ALJ decision issued by an ALJ in the Civil Remedies Division (CRD) of the Departmental Appeals Board (DAB). See Breton Lee Morgan, M.D., DAB CR1913 (2009). The ALJ decision was then affirmed by a Panel in the DAB's Appellate Division. See Breton Lee Morgan, M.D., DAB No. 2264 (2009). The Council takes judicial notice of those decisions and incorporates them, by reference, here.

Should Medicare really pay for him to perhaps be on a controlled substance due to his personal addiction and then treat patients? The undersigned suggests the answer is no, an Excluded Provider is entitled to no payment.

Dec. at 7 (footnote omitted).

### ***The Appellant's Request for Review***

In his request for review, the appellant asserts, without further expansion of these arguments, that: (1) the ALJ refused to consider his new evidence, contrary to 42 C.F.R. § 405.1028; (2) the ALJ incorrectly found that the appellant was an excluded provider under section 1128(a)(3) of the Act; (3) the ALJ improperly found that the appellant was not entitled to payment rendered for service prior to March 12, 2007; (4) the ALJ improperly relied upon an unsubstantiated and inaccurate statistical sample; and (5) the ALJ improperly dismissed the appeal contrary to 42 C.F.R. § 405.1052. Exh. MAC-1 at 1-2.

### **DISCUSSION**

Below, the Council addresses the appellant's arguments in an order more conducive to the presentation of its overall analysis.

### **The Propriety of the Exclusion**

There is no merit to the appellant's argument that the ALJ incorrectly found that the appellant was an excluded provider under section 1128(a)(3) of the Act. As noted above, the appellant's exclusion from participation in Medicare, Medicaid and any other federal health care program for a period of five years based upon his conviction related to health care fraud is a matter of record. The exclusion has been sustained by an ALJ and affirmed by an appellate panel, both within the Departmental Appeals Board. See Breton Lee Morgan, M.D., DAB CR1913 (2009) and Breton Lee Morgan, M.D., DAB No. 2264 (2009). The fact that the appellant may be seeking to overturn his exclusion in federal court is immaterial. The appellant is currently excluded from participation in Medicare, Medicaid and any other federal health care program.

### The Sample

There is no reason to consider, at this time, the appellant's argument that the ALJ improperly relied upon an unsubstantiated and inaccurate statistical sample. The ALJ's sole discussion of a statistical sample was to note its existence as the basis of the PSC's overpayment determination. See Dec. at 2. However, the ALJ did not address the substance of the overpayment determination, which might involve consideration of the statistical sample, but instead dismissed the appellant's case based on jurisdiction grounds.

### The Excluded Evidence

An ALJ is required to make "a complete record of the evidence." 42 C.F.R. § 405.1042(a)(1). The regulation continues to require that:

The record will include marked as exhibits, the documents used in making the decision under review, including, but not limited to, claims, medical records, written statements, certificates, reports, affidavits and any other evidence the ALJ admits. In the record, the ALJ must also discuss any evidence excluded under §405.1028 and include justification for excluding the evidence.

42 C.F.R. § 405.1042(a)(2).

The ALJ was correct in finding that, by regulation, a party seeking to present new evidence, not previously before a QIC, must demonstrate good cause for the submission of that evidence at the ALJ hearing level of review. See 42 C.F.R. § 405.1028.

However, the record in this case is in disarray. In its current state, the record consists of ten large manila folders, secured only by rubber bands, containing unbound documents neither paginated nor more than generically indexed.<sup>6</sup> The documentation itself includes pages which are in no apparent sequential order, folded, upside down, and/or blank side up, envelopes, parts of envelopes as well as a diskette in an unsecured envelope purporting, based on the writing on the diskette, to be a "QIC copy" of a "correction to letter." The ALJ's reference to the

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<sup>6</sup> An unsecured Exhibit List in the record identifies the record as containing one exhibit, described as "All records contained within the captioned Case File" with page numbers "Identified by Appellant Dismissal Issued 4-17-09."

exhibits in his Order is no clearer, simply consisting of twenty-three footnote citations to "Exhs. Appendix A."

Inherent in a reasonable reading of 42 C.F.R. § 405.1042(a)(2) is an understanding that an ALJ should identify, in something more than vague fashion, the documentation which will be excluded from the record. The ALJ's most specific identification of the excluded documentation in the Order is "new and additional evidence with the Request for ALJ Hearing that the QIC may have had or did not consider." Dec. at 3. It is impossible for the Council to identify or locate the "excluded documentation," let alone determine whether it was properly excluded from the record.

**The ALJ's Order of Dismissal and the Appellant's Entitlement to Payment Prior to March 12, 2007**

The ALJ's Order of Dismissal, which is based upon his conclusion that the appellant did not have a right to an ALJ hearing pursuant to 42 C.F.R. § 405.1052(a)(3)), contains an error of law.

As noted above, the ALJ set his analysis in the following context: "The remaining question for the OIG to answer is should the exclusion last longer and start earlier; since there is evidence he [the appellant] was using controlled substances from November 2, 2004 though September 6, 2005." See Dec. at 7.

Generally, section 1128(c) of the Act establishes the requirements relative to the notice, effective date and period of exclusion. Section 1128(c)(1) provides that an exclusion is effective upon reasonable notice to the individual or entity excluded. Section 1128(c)(2)(A) provides that, other than in circumstances not applicable here, "an exclusion shall be effective with respect to services furnished . . . **on or after the effective date of the exclusion.**" (Emphasis Added.)

The Medicare Program Integrity Manual (PIM) (CMS Pub. 100-08) notes that section 1128 of the Act provides the Secretary the authority to exclude various health care providers, individuals, and businesses from receiving payment for services that would otherwise be payable under Medicare, Medicaid, and all federal health care programs. This authority has been delegated to the OIG. PIM Chp. 4, § 4.19.2. Section 4.19.2 continues providing

that "[p]ayment is not made for items and services furnished by an excluded practitioner or other person."<sup>7</sup>

The OIG's exclusion was not before the ALJ, nor are the OIG past or future actions subject to review by this ALJ in this context. The appellant's exclusion was based upon section 1128(a) of the Act, - "Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs." The ALJ's authority here arises from section 1869 of the Act, - "Determinations and Appeals." Section 1869(a)(1) directing the Secretary to "promulgate regulations and make initial determinations with respect to benefits under [Medicare] part A or part B . . . ." Pertinent here, are the implementing regulations at 42 C.F.R. part 405, subpart I - "Determinations, Redeterminations, Reconsiderations and Appeals Under Original Medicare (Part A and Part B)."

The Act precludes Medicare payment to providers excluded from the Medicare program. However, that preclusion of payment begins upon notice of exclusion and carries forward. The issue before the ALJ in this case was an overpayment determination for services provided during the period January 1, 2004, through March 7, 2006. The appellant was notified of his exclusion in May 2008. Thus, the propriety of the Medicare funding at issue is not affected by the appellant's subsequent exclusion from participation in Medicare.

In addition to being supported by the applicable law and program guidance, the Council's determination is underscored by both the Medicare contractor's revised redetermination decision and the QIC reconsideration decision. To varying degrees, both of these earlier actions found Medicare coverage available for some of the appellant's claims within the timeframe of the overpayment determination, without regard to the appellant's status as an excluded physician.

The ALJ's Order of Dismissal, based upon his conclusion that the appellant did not have a right to an ALJ hearing (see 42 C.F.R. § 405.1052(a)(3)), was erroneous. The appellant had a right to review of the substance of the PSC overpayment determination levied against him. Accordingly, the Council vacates the ALJ's

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<sup>7</sup> The Council recognizes that chapter 4, section 4.18.1.3.3 of the PIM addresses "Recoupment of Overpayments." However, that recoupment speaks to overpayments based upon findings of Medicare fraud as determined by a PSC or its successor entity, the Zone Program Integrity Contractor Benefit Integrity Unit (ZPIC BI). There is no evidence of such a finding in this case.



Order of Dismissal and remands the case to an ALJ for a hearing and new decision consistent with the instructions below. In so doing, at this time, the Council offers no opinion on the propriety of the overpayment determination as that issue has not been considered by an ALJ and therefore is not properly before the Council in this request for review.

#### **INSTRUCTIONS ON REMAND**

On remand the ALJ will:

1. Give the parties the opportunity for a hearing on the merits of the claims remaining at issue in the overpayment determination, or shall obtain a written waiver of the parties' right to appear. 42 C.F.R. § 205.1020(c)(1).
2. Chronologically organize, secure, paginate and index all exhibits admitted as evidence in the record.
3. Identify, organize, secure, paginate and index the documentation submitted with the appellant's request for an ALJ hearing, which the ALJ directed should be excluded.
4. Identify, accurately, the number of beneficiaries and claims in issue.
5. Decide whether the claimed services were medically reasonable and necessary for each beneficiary, as required by section 1862(a)(1)(A) of the Act, citing the reasons for the decision(s), including a summary of any evidence used to make the decision.

6. If necessary, consider whether the overpayment, if any, may be limited or waived pursuant to section 1879 and/or section 1870(b) of the Act.

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

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki  
Administrative Appeals Judge

/s/ Gilde Morrisson  
Administrative Appeals Judge

Date: November 5, 2009