DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
Robert Markman M.D. (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
National Heritage Insurance Company (NHIC) (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated April 24, 2009, concerning an overpayment stemming from a claim billed for physician services furnished on June 29, 2005. The ALJ found that the contractor's overpayment demand was appropriate, and that the appellant was not entitled to waiver of recovery under section 1870 of the Social DSEcurity Act (Act). The appellant has asked the Medicare Appeals Council to review this action.

The Council reviews the ALJ's decision *de novo.* 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's action to the exceptions raised by the party in the request for review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c).

The Council has considered the full record, including the recording of the hearing held on October 31, 2008, and the exceptions in the appellant's request for review, which has been admitted into the record as Exhibit MAC-1. The Council finds no basis for changing the ALJ's decision for the reasons explained below and, therefore, adopts the ALJ's decision.

BACKGROUND

On February 6, 2006, EDS Medicare Integrity Program (EDS), a Centers for Medicare & Medicaid Services (CMS) program integrity contractor, issued a "Final Notice of Post Payment Audit" letter. Exh. 15 at 1-8. In this letter, CMS notified the appellant that claims submitted under a provider identification number (PIN) affiliated with the appellant resulted in an overpayment of $253,123.16. *Id*. at 2. A total of $249,684.29 had been stopped for payment, seized by law enforcement or held in a suspense account; resulting in a balance of $3438.87. *Id*. EDS found that the appellant was responsible for the balance and identified the specific claims, by check number and internal control number (ICN), which were subject to the overpayment. *Id*. at 9.

On September 5, 2007, National Heritage Insurance Company (NHIC) issued a demand for repayment for services claimed for the beneficiary on June 29, 2005. Exh. 4 at 1. The appellant requested a redetermination of the overpayment claiming that he had been a victim of identify fraud and that he was not liable for Medicare payments made for claims billed with a Medicare PIN then associated with the appellant. Exh. 1 at 18. The appellant stated that on the date of service at issue he was not practicing medicine and did not provide services to the beneficiary. *Id*. Further, the appellant stated that he had already reimbursed Medicare for the $479.28 NHIC requested on September 5, 2007. *Id*. NHIC denied coverage of the services at issue upon redetermination finding that Medicare payment had been made under the appellant's PIN and that the appellant did not provide medical documentation to support coverage. Exh. 1 at 21-22. The appellant then requested reconsideration by the Qualified Independent Contractor (QIC). In his request for reconsideration, the appellant again claimed that he was not in practice during the date of service, did not provide services to the beneficiary at issue, and was not affiliated with the PIN to which the services were billed. *Id*. at 10. Further, the appellant contends that NHIC's fraud unit was aware of the identify theft. *Id*. On reconsideration, the QIC found that the record lacked medical documentation to substantiate payment for the claim. Exh. 6 at 3.

In response to the reconsideration, the appellant requested a hearing. Exh. 7 at 1. The appellant again argued that he had worked with the Internal Revenue Services' (IRS) fraud unit and

Federal Bureau of Investigations (FBI) as well as NHIC's fraud unit in a "sting operation" to prevent further Medicare fraud using the Medicare PIN that he neither requested nor used to treat beneficiaries. *Id.* The appellant requested relief from the overpayment associated with the beneficiary's claim billed to Medicare for services on June 29, 2005, stating that he had already paid the amount requested.

The appellant requested a hearing on this matter and also requested that the ALJ subpoena various individuals at the FBI, IRS, and NHIC, among others. Exhs. 9, 10. The ALJ denied the appellant's request to issue subpoenas after allowing the appellant an opportunity to explain why he felt subpoenas were necessary in this case. Exh. 10 at 1-8; *see also* Exh. 11. The appellant then asked the ALJ to reconsider his denial using arguments similar to those he made in his initial request. Exh. 12. After consideration, the ALJ again denied the appellant's request to have subpoenas issued. Exh. 13.

The ALJ held an in-person hearing on October 31, 2008, and issued a decision on April 24, 2009. Dec. at 1. During the hearing, the appellant testified that he had already satisfied the overpayment for the beneficiary at issue, that he did not provide the services to the beneficiary at issue, that he did not bill Medicare for the services, and that he was not paid for the services at issue. *Reference* Hearing CD at 02:05:10-02:05:40. On April 24, 2009, the ALJ issued an unfavorable decision finding that the appellant was not entitled to waiver of recovery of the overpayment at issue.

DISCUSSION

Waiver of Recovery

Neither during the hearing nor at any time during the adjudication process does the appellant claim to have provided medical services for the beneficiary at issue. *Reference* Hearing CD at 01:57:57-01:58:48; *see also* Exh. 1 at 10-12, 14 and Exh. 7. Further, the appellant does not argue that his liability for the $3438.87 overpayment should be waived as payment not due. The appellant instead insisted that the sole issue at the hearing, and now before the Council, is whether the overpayment at issue has already been satisfied by previous payments made by the appellant to Medicare. Exh. MAC-1; *reference also* Hearing CD at 02:14:43-02:18:53. Thus, the Council adopts the ALJ's findings regarding Medicare coverage for the services at issue. *See generally* Dec. at 3. Therefore

the Council will limit its evaluation to whether there is sufficient evidence to show that the appellant has satisfied the $479.28 owed Medicare according to NHIC's September 5, 2007, demand letter, and whether waiver of recovery is appropriate. *See* Exh. 4 at 1.

During the hearing, the ALJ repeatedly requested that the appellant show a direct correlation through evidence that payments the appellant claimed he made to the Treasury Financial Management Services Division (Treasury) and a collection agency were related to the overpayment at issue. *Reference* Hearing CD at 2:14:43-2:24:46. The appellant stated that he "did not need [to show] that proof." *Id*. at 2:16:28-2:17:45. The appellant argued that he was not required to prove that he had already paid the debt and that the claims for the beneficiary at issue were part of EDS' initial overpayment calculation. *Id*. The ALJ indicated that even though the overpayment referenced the same beneficiary and date of service, that the appellant would need to show that the overpayment had been satisfied. *Id*. at 2:23:33. The appellant again stated that he should not be required to offer such evidence, that the previously-denied subpoenas would corroborate his claims that this overpayment was based on fraud and that his accountant, if subpoenaed, would offer evidence of payment. *Id*. at 2:24:46-2:33:48. The appellant further stated that he would not offer corroborating evidence himself. *Id*. At the close of the hearing, the ALJ offered the appellant an opportunity to submit additional evidence that he had satisfied the overpayment; and therefore kept the record open for an additional two months, until January 2, 2009. *Id*. at 2:37:05.

On January 2, 2009, the appellant submitted eight pages of additional evidence that he purports was part of a 17-page accounting of the specific claims involved in CMS' demand for overpayment reimbursement. Exh. 16. The record indicates that the Treasury garnished $217.50 monthly from the appellant's Social Security Administration (SSA) checks from April 3, 2008, through September 3, 2008, for a total of $1087.50. *Id*. at 3-9. The appellant also provided a copy of his September 12, 2008, Discover credit card statement which shows a payment of $2726.30 made to a collection agency. *Id*. at 4. The appellant claims that the $3813.80 paid to the Treasury and Fed Debt satisfied the amount Medicare indicated he owed. Exh. MAC-1 at 2.

The record indicates that the $479.28 NHIC requested on September 5, 2007, is identical to the amount identified for

three services billed for the beneficiary on June 29, 2005. Exh. 15 at 9. However, the Council concurs with the ALJ in finding that the record lacks sufficient evidence to show that the payments made to the Treasury and the collection agency were specifically for the overpayment at issue. The appellant indicated that Treasury garnished his SSA checks as a result of a separate legal action. *Reference* Hearing CD at 2:15:55-2:16:25. The appellant does not offer evidence of the legal action to show that the payments were made for the overpayment demand at issue. Further, the Council finds that the record lacks correspondence beyond the initial demand letter recalculating the appellant's liability to the $3813.80 he paid. The appellant claims that Medicare found the appellant responsible for $3813.80, $374.93 above the $3438.87 request. The Council finds that while the ICN and date of service indicate that NHIC's overpayment demand was initiated from EDS' audit, there is no evidence that the appellant reimbursed Medicare for the services at issue. Further, the Council finds that the appellant was given ample opportunity to provide additional evidence and failed to meet this burden of proof.

Subpoena Authority

In this regard, the appellant also alleges that the ALJ erred in not granting requested subpoenas for various individuals at the FBI, IRS, and NHIC, among others. *See* Exh. MAC-1 at 2-3. A party to the hearing has a right to discovery, which can include the issuance of a subpoena, only when CMS through its agents and/or contracted authority (e.g. a Medicare contractor) participate in the hearing as a party. *See* 42 C.F.R. § 405.1037. The governing authorities define "party," as the party who filed the request for hearing and all other parties subject to the QIC's reconsideration. 42 C.F.R. § 405.1008. CMS and/or its contractors can become a party to a hearing by notifying the ALJ in writing of its intent to participate in a hearing. 42 C.F.R. § 405.1012. In this case, CMS neither participated in the hearing nor at the redetermination or reconsideration levels of adjudication. Therefore, there is no right for the appellant to compel discovery from CMS or its contractors.

However, the ALJ does have discretionary authority under the regulations to pursue missing evidence. 42 C.F.R. § 405.1030(c). When it is reasonably necessary for the full presentation of a case, the ALJ may, on his or her own initiative, issue a subpoena. *See* 42 C.F.R. § 405.1036(f). A

parties' written request for a subpoena must indicate why the facts the party wishes to obtain through subpoena cannot be otherwise proven without the issuance of a subpoena. *Id*.

The appellant adamantly maintained that he was not at the hearing to determine his liability for EDS' initial $3438.87 overpayment demand. *Reference* Hearing CD at 02:19:54-02:20:09. The appellant had requested that the ALJ issue subpoenas for various parties to appear to corroborate that he was a victim of identify theft. *Id*. The appellant claims that the identity theft led to the fraudulent usage of a Medicare PIN that had been used to bill Medicare for services that were *not* provided to multiple beneficiaries, including the beneficiary at issue. *Id; see also* Exh. 10. The appellant also maintained that the issue of liability for the $3438.87 had already been adjudicated in a different court. *Id*. The appellant stated that the sole issue at the hearing was whether he was liable for the $479.28 for which, the appellant claims, Medicare had already been reimbursed. *Id*. at 2:20:10.

Given that that the appellant has stated that liability has already been adjudicated in another unnamed forum, and has repeatedly refused to produce evidence already in his possession that is relevant to waiver of recovery of the overpayment, the Council does not find that the ALJ abused his discretion in denying the request for subpoenas. Indeed, among other things, the appellant requested that the ALJ subpoena the appellant's own accountant, without any showing that the appellant could not engage the accountant's testimony on his own, other than that he did not want to incur the expense.

Accordingly, after considering the full record, including the recording of the hearing and the exceptions in the appellant's request for review, the Council finds that the ALJ did not err in finding that the appellant was not entitled to waiver of recovery of the $479.28 overpayment. The Council adopts the ALJ's decision of April 24, 2009.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: October 21, 2009