DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-452

In the case of	**Claim for**
Home Care 4 U, Inc. (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiary)	**** (HIC Number)
Palmetto GBA (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued, under the single ALJ Appeal Number identified above, eleven substantively similar decisions, each dated October 29, 2009.[1] The ALJ's decisions concerned a Medicare overpayment determination assessed against the appellant in connection with twenty-three claims for home health services provided to the eleven beneficiaries between January 9, 2007, and November 6, 2007. The beneficiaries are identified in the Attachment to this decision. The ALJ concluded that Medicare did not cover these home health claims because the beneficiaries were not homebound and because the appellant had not documented that home health services were actually provided. Additionally, the ALJ found that the appellant was liable for the cost of the non-covered services and that the appellant's liability could not be waived. The appellant, through counsel, has asked the Medicare Appeals Council to review this action. The appellant's request for review is entered into the record as Exhibit (Exh.) MAC-1.

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

[1] Each decision is identical save for beneficiary-specific information. Below, the Counsel cites to the ALJ decision in the case of Beneficiary M.A.

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).

As set forth below, the Council has determined that the ALJ erred in expanding the issues to be considered at the ALJ hearing without proper notice to the appellant. Further, the overpayment is not supported by probative evidence in the record. Accordingly, the Council reverses the ALJ's decisions.

RELEVANT LEGAL AUTHORITY

In pertinent part, the Medicare program regulations provide –

> (a) *General rule*. The issues before the ALJ include all issues brought out in the initial determination, redetermination or reconsideration that were not decided entirely in a party's favor. . . .
>
> (b) *New Issues – (1) General*. The ALJ may consider a new issue at the hearing if he or she notifies all of the parties about the new issue any time before the start of the hearing. . . .

42 C.F.R. § 405.1032.

"[T]he ALJ will issue a written decision that gives the findings of fact, conclusions of law, and reasons for the decision. The decision must be based on evidence offered at the hearing or otherwise admitted into the record." 42 C.F.R. § 405.1046(a).

BACKGROUND

TriCenturion, a Medicare Program Safeguard Contractor (PSC), conducted a post-payment review of the appellant's twenty-three claims for Medicare coverage of home health services provided to eleven beneficiaries. On September 8, 2008, TriCenturion issued a preliminary report to the appellant, identifying a $278,276.81 overpayment for those claims. TriCenturion found that "the physician identified on the claims . . . certified that the patient was not under his or her care during the period specified, or the patient was under his/her care, but no home health was ordered for the time period billed." ALJ Master File Exh. 1 at 20. This finding was based on an August 18, 2008, Memorandum from a TriCenturion Investigator, which appears in

the claim files for six of the beneficiaries at issue.[2] The Investigator's memorandum recounts an August 18, 2008, conversation between the TriCenturion Investigator and "Dr. W*** S***," the physician whose signature purportedly appears on the beneficiaries' plans of care. The Investigator's memorandum states that Dr. S*** identified, for the Investigator, the plans of care in which his signature was not authentic. An October 3, 2008, Memorandum from an individual at TriCenturion to the Medicare contractor (Palmetto GBA) restates the content of the August 18, 2008, Memorandum and identifies, as affected, all eleven beneficiaries at issue here.[3]

On September 11, 2008, Palmetto formally notified the appellant of the overpayment. ALJ Master File Exh. 1 at 15. The appellant requested redetermination. Palmetto issued eleven unfavorable redeterminations. In each, Palmetto referenced the unauthentic physician's signature as the basis for invalidating the beneficiary's plan of care.

The appellant requested reconsideration by a Qualified Independent Contractor (QIC). The QIC issued a single unfavorable reconsideration finding that the "physician signature" on each plan of care was not authentic. ALJ Master File Exh. 1 at 5.

The appellant requested a hearing before an ALJ. On August 17, 2009, the ALJ issued a Notice of Hearing which identified the issues to be considered as "the application of Medicare laws and regulations to your appeal. The more specific issue(s) to be addressed will include: **Home Health Services.**" ALJ Master File Exh. 2 at 2 (emphasis in original).

On September 11, 2009, the ALJ conducted a hearing by telephone. As had been the case throughout the earlier appeals process (and now before the Council as well), the appellant was represented by counsel. Before the ALJ, appellant's counsel made a "global opening statement" and then "requested . . . that the . . . ALJ decide each beneficiary's case on the record." Dec. at 1. The appellant's opening statement went to the "alleged statement" by Dr. S*** questioning the validity of his signature in the

[2] Claim Files for Beneficiaries I.D., C.M., E.M, M.P., J.G. and H.A., Exh. 1 at (respectively) 40, 37, 39, 38, 39 and 19.

[3] Claim files for beneficiaries I.D., C.M., E.M and M.P., Exh. 1 at 16; Beneficiary J.G., Exh. 1 at 17; and Beneficiary H.A., Exh. 1 at 15.

various beneficiary records. The appellant asserted – that in spite of a Freedom of Information Act request, it had been denied access to Dr. S***'s statement; that Dr. S***'s statement was not in the record; and that its effect was countermanded by the general content of each claim file which supported the need for home health care for these beneficiaries. *See* ALJ Hearing CD (September 11, 2009).

The ALJ then issued the decisions before the Council. In the "Findings of Fact" for each decision, the ALJ found –

> The appellant states that the beneficiaries, which are part of this overpayment, were treated by W*** E. S*** M.D. who ordered their home health care. This fact is proven through Home Health Care 4 U Care's (*sic*) home health records, including but not limited to, physician prescription, Home Health Plan of Care and Certification and Recertification Order.

Dec. at 2.

The ALJ went on to deny coverage, concluding that "the medical record does not show that the beneficiary was homebound in order to determination (*sic*) whether the services were reasonable and necessary. In addition, there is insufficient documentary evidence submitted to support that the home health services was (*sic*) indeed provided to the beneficiary." Dec. at 6. The ALJ also concluded that the limitation of liability provisions, contained in section 1879 of the Act, were not applicable to the appellant. Additionally, the appellant's liability for the overpayment could not be waived pursuant to section 1870 of the Act. *Id.*

In the request for review, counsel for the appellant does not challenge the propriety of the reopening, nor the ALJ's determination on the limitation of liability (section 1879 of the Act) or waiver of recovery of the overpayment (section 1870 of the Act). Rather, the appellant asserts that this "case from its inception has always been about whether Dr. S*** ordered these home health services." The appellant takes exception to that aspect of the ALJ decision(s) questioning the beneficiaries' "homebound" status, whether the services at issue were medically reasonable and necessary for purposes of Medicare coverage, and whether the services were actually provided. The appellant asserts that Dr. S*** certified that each of these

beneficiaries was homebound. Further, the appellant contends that it can, upon request, document that these services were provided. Exh. MAC-1 at 2.

ANALYSIS

As the appellant notes in its request for review, from the outset, the authenticity of the physician's signature has been the only issue raised in these cases. *See* ALJ Master File Exhibit 1 at 5 (QIC reconsideration) and 18-19 (TriCenturion Claims Review Worksheet); *see, also*, beneficiary-specific redeterminations in each claim file. As discussed above, the legitimacy of the physician's signature on each plan of care, and thus the plan of care itself, was called into question based on the report of a TriCenturion Investigator alleging that the physician identified plans of care where his signature was not authentic. ALJ Master File Exhibit 1 at 20; *see, also*, notes 2 and 3, *supra.*

Before the ALJ, counsel for the appellant recounted his unsuccessful efforts to obtain the physician's statement which served as the basis for the PSC's findings, including a Freedom of Information Act request. *See, also, e.g.*, ALJ Master File Exhibit 1 at 10 and 13. Counsel also noted that the medical necessity of these home health services was otherwise well-documented in each beneficiary's claim file.

In its preliminary report to the appellant (September 8, 2008), the PSC maintained that the physician had "certified" instances in which his signature was not authentic. The PSC did not place the physician's statement in the record. The finding that the signatures are invalid is based entirely upon the PSC Investigator's written assertion that the physician indicated that some, but not all, signatures were not authentic. The record does not include the "attached memo" regarding the background of the "Miami Special Project" referenced by the PSC. ALJ Master File Exhibit 1 at 15. The spreadsheet where the PSC investigator reportedly indicated which cases Dr. S*** indicated he did not sign does not contain a legend for the columns, and is thus bereft of value. *Id.* at 19-20. The investigator's report is unsigned. *Id.* at 19. Further, the evidence admitted by the ALJ does not contain any documents where Dr. S*** reportedly made an "N" mark to denote that the signature was not his. Thus, there is no contemporaneous documentary support for the Investigator's memorandum in the

record. And the PSC has refused to respond to the appellant's Freedom of Information Act request to produce such documentation. ALJ Master File Exhibit 1 at 10 and 13.

The investigator's report is hearsay. To be sure, the formal rules of evidence do not apply to the relatively informal proceedings under which Medicare hearings are conducted. 42 C.F.R. § 405.1036(e). However, concepts of fundamental due process do apply. The PSC, the contractor and the QIC should have considered and based their determinations on all evidence. 42 C.F.R. §§ 405.948, 405.986. In turn, all of that evidence should have been forwarded to the ALJ, and the appellant must be given the opportunity to contest that evidence. The various contractors had the opportunity to participate in the hearing, but did not do so. ALJ Master File Notice of Hearing, Exhibit 2; 42 C.F.R. §§ 405.1010, 405.1012.

The ALJ did not question the authenticity of the physician's signature, either at the hearing or in the decisions which followed. Rather, the ALJ found as a fact that:

> The appellant states that the beneficiaries, which are part of this overpayment, were treated by W*** E. S*** M.D. who ordered their home health care. This fact is proven through Home Health Care 4 U Care's (*sic*) home health records, including but not limited to, physician prescription, Home Health Plan of Care and Certification and Recertification Order.

Dec. at 2.

There is no evidence in the record from Dr. S*** that he did not sign the plans of care and other documents. The overpayment cannot be sustained as a matter of due process when the PSC has failed to provide such evidence.

The appellant is correct that the validity of the physician's signature, and thus orders, was the sole issue considered in the overpayment. The ALJ provided a generalized analysis of medical necessity for home health services. In so doing, the ALJ adjudicated each claim in a context of specific elements for coverage of home health services that were not the basis of the overpayment assessed or considered in the determinations below (*i.e.,* whether the beneficiaries were "homebound" or if home health services were performed). 42 C.F.R. § 405.1032(a). The

appellant did not receive unfavorable determinations on any of these elements of coverage in any earlier aspect of the claims appeal process. These issues were not identified with any specificity in the Notice of Hearing, nor raised by the ALJ during the hearing. Given the consistent basis for the overpayment, the redeterminations and reconsiderations, and absent identification of this potential line of analysis in the Notice of Hearing, the ALJ did not properly notify the appellant that new issues would be considered at the hearing. *See* 42 C.F.R. § 405.1032(b)(1).

DECISION

The Medicare Appeals Council adopts the ALJ's finding that the overpayment assessed for lack of a valid physician's signature in these overpayments is not supported by probative evidence in the record. Accordingly, in the absence of reliable evidence to the contrary, it is the decision of the Council that a physician ordered the care provided. Moreover, the ALJ did not provide the appellant with proper notice of any additional issues to be considered at the hearing. For these reasons, and based on the record before us, the Council reverses the ALJ's decisions, and finds that the appellant was not overpaid.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: May 25, 2010