DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

ACTION AND ORDER OF MEDICARE APPEALS COUNCIL
Docket Number: M-2010-263

In the case of	**Claim for**
Idaho Falls Chiropractic Clinic, P.L.L.C. (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiaries)	**** (HIC Numbers)
CIGNA Government Services (Contractor)	**** (ALJ Appeal Number)

The Medicare Appeals Council (Council) received the above-captioned case on a memorandum of referral from the Centers for Medicare and Medicaid Services (CMS). The CMS referral memorandum is entered into the record in this case as Exhibit (Exh.) MAC-3.[1] As explained more fully below, we have decided not to review the Administrative Law Judge's (ALJ's) decision dated September 28, 2009.

The case involves an overpayment derived from a probe sample review of chiropractic services provided to multiple beneficiaries. The ALJ found that the services did not meet Medicare coverage requirements, that the appellant was liable for the non-covered services, and that the overpayment pertaining to the individual claims could not be waived. The ALJ further found that the sampling methodology the contractor has used was invalid and, therefore, the portion of the overpayment that was derived via extrapolation was invalid.

The Council has carefully considered the record that was before the ALJ, as well as CMS' memorandum. As explained below, CMS

[1] In our May 7, 2009, remand to the ALJ (ALJ Appeal No. 1-327963941), the Council admitted CMS' referral memorandum, dated March 4, 2009, and the appellant's exceptions, dated March 17, 2009, into the administrative record as Exhs. MAC-1 and MAC-2, respectively. *See* Exh. 18 at 825-833.

has referred the case to the Council because it challenges the ALJ's conclusion concerning the validity of the extrapolation at issue.

BACKGROUND

By correspondence dated November 22, 2006, the Program Safeguard Contractor (PSC), Western Integrity Center, requested documents from the appellant in order to conduct a post-payment medical review of chiropractic services that the appellant had provided. Exh. 8 at 184-182. Thereafter, the PSC issued a "Final Medical Review Findings" in correspondence dated January 4, 2008, also referencing a "Part B Probe Review." Exh. 8 at 260. The Medicare contractor subsequently issued an overpayment demand letter, dated January 17, 2008. *Id.* at 265. The contractor upheld the extrapolated overpayment in a redetermination dated March 27, 2008. Exh. 2 at 61. The appellant requested reconsideration by the Qualified Independent Contractor (QIC), arguing that it had passed annual reviews conducted by an independent certified professional coder, pursuant to a Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) in effect since 2004. Exh. 3 at 66.

The QIC discussed overpayments determined by "statistically valid random sampling." *Id.* at 76-75. The QIC found that the documentation did not meet the coverage requirements in local coverage determination (LCD) L9474 and that an overpayment had occurred. *Id.* Through counsel, the appellant then filed a request for ALJ hearing, dated September 8, 2008. Exh. 4 at 94-92. The appellant disagreed with the QIC's reconsideration because "Idaho Falls Chiropractic Clinic has rendered reasonable and necessary services to its patients and has conformed with all legal requirements. A brief further detailing our position will be sent 30 days before the hearing." *Id.* at 92; *see* Exh. 8 at 316-299 (brief, dated November 5, 2008).

The ALJ conducted a hearing on September 25, 2008. ALJ Appeal No. 1-327963941, Dec. at 2. The ALJ found that the "spinal chiropractic manipulation treatments [the appellant provided] were not necessary because the treatments were simply maintenance therapy which are not covered services." *Id.* at 3. The ALJ found the appellant liable for the non-covered services under section 1879 of the Social Security Act (Act) and liable

for the overpayment under section 1870 of the Act. *Id.* at 17. The ALJ also found that the statistical sample and extrapolated overpayment were not valid, because neither the QIC nor the Medicare contractor had reviewed the sampling methodology used to extrapolate the overpayment and that the PSC's "entire case is not included in the records on the case." *Id.* at 17.

In a memorandum dated March 4, 2009, CMS asserted that the ALJ erred in invalidating the extrapolation for three reasons: 1) the validity of the sampling methodology had not been challenged by the appellant at any prior level of appeal or during the ALJ hearing itself; 2) the ALJ failed to fully develop the administrative record; and 3) the ALJ failed to provide proper notice of the hearing. *See* Exh. 18 at 823A-823K. The appellant refuted CMS' arguments stating that the statistical sample had been an issue at all levels of appeal and that the ALJ gave proper notice of the September 25, 2008, hearing to all parties. *Id*. at 824A-824C and 823L-823Z.

On May 7, 2009, the Council decided, on its own motion, to vacate the ALJ's January 5, 2009, decision and remanded the case to an ALJ for further proceedings, including a new decision based on CMS' exceptions. The ALJ was instructed to offer the parties and "CMS and/or one or more of its contractors" the opportunity for a new hearing, develop a complete record for the claims at issue, determine if the extrapolation at issue was valid, determine if the appellant had done a probe review as the basis for the overpayment extrapolation, and make findings on whether the underlying chiropractic services were medically reasonable and necessary. *Id*. at 825-831.

The ALJ conducted a new hearing on August 19, 2009. ALJ Appeal No. 1-434277532, Dec. at 2. The ALJ concluded that, based on the testimony and findings of the "court appointed expert," Dr. Haller, the underlying universe of claims upon which the overpayment was extrapolated incorrectly included zero-pay claims. *Id.* at 12. The ALJ found that the appellant conducted a probe review, not a statistical sample review, and that, pursuant to the Medicare Program Integrity Manual (MPIM), probe reviews cannot be used for the purpose of extrapolation.[2] *Id*. The ALJ further issued unfavorable findings for each of the underlying claims. However, the ALJ did not analyze the appellant's liability for the overpayment or the underlying claims at issue.

[2] Manuals issued by CMS can be found at http://www.cms.hhs.gov/manuals.

CMS again challenged the ALJ's findings and, on November 20, 2009, requested that the Council review the ALJ's September 28, 2009, decision on its own motion. Exh. MAC-3. Relevant to the case now before the Council, CMS argues, in essence, that the extrapolation was valid whether it was a "probe review" or "statistical sample." *Id*. at 13.

DISCUSSION

By correspondence dated November 22, 2006, the PSC requested documents from the appellant in order to conduct a post-payment medical review of chiropractic services that the appellant had provided. Exh. 8 at 184-182. The PSC's letter states that "[a] computer-generated probed sample of claims was selected from the universe of your claims" for the period January 1, 2004, through June 30, 2006. *Id.* at 184. A "Medical Review Sample Selection Summary," dated November 6, 2006, suggests that the contractor subsequently conducted a statistical sampling for claims processed during the period October 1, 2003, through September 30, 2006. Exh. 12 at 652, 651-645.

Thereafter, the PSC issued a "Medical Review Findings Letter," dated July 31, 2007, referencing a "Part B Probe Review" for the "review period" of October 1, 2003, through September 30, 2006. Exh. 8 at 254, 250. The PSC enclosed a provider summary of medical review findings as well as "probe sampling methodology." *Id.* at 252. The summary indicates that the PSC conducted a "coordinated comprehensive provider review," reviewed 77 claims billed under Current Procedural Terminology (CPT) codes 98940 and 98941, and found a 100% "service error rate" due to insufficient/illegible documentation. *Id.* at 258. The letter included information on probe sampling methodology and an extrapolated overpayment amount of $41,496. *Id.* at 254-247, 251.

Upon reconsideration, the QIC found that the documentation did not meet the coverage requirements in local coverage determination (LCD) L9474 and that an overpayment had occurred. *Id.* The QIC noted the authority of the CMS to extrapolate overpayments based upon statistical sampling, "when claims are voluminous and reflect a pattern of erroneous billing or over utilization and a case-by-case review is not administratively feasible." *Id.* Upon further appeal, the ALJ found that the "spinal chiropractic manipulation treatments [the appellant

provided] were not necessary because the treatments were simply maintenance therapy which are not covered services." ALJ Appeal No. 1-327963941, Dec. at 3. The ALJ also found that the statistical sample and extrapolated overpayment were not valid, because neither the QIC nor the Medicare contractor had reviewed the sampling methodology used to extrapolate the overpayment and that the PSC's "entire case is not included in the records on the case." *Id.* at 17.

CMS then requested that the Council take own motion review of the ALJ's decision. Upon own motion review, the Council remanded the case, noting that the record was incomplete concerning whether the PSC engaged in a "probe review" or a "statistical sample" as the basis of the overpayment extrapolation. Exh. 18 at 826, the Council's May 7, 2009, Remand Order to the ALJ. The Council instructed the ALJ to develop the record to ascertain the basis of the overpayment extrapolation as "the distinction is significant, in that the authorities cited above suggest that an overpayment resulting from a probe sample, may not be extrapolated to the universe of claims." *Id*.

In the ALJ's new decision, the ALJ relied upon the evidence in the record and testimony by the PSC and Dr. Haller concerning whether the overpayment extrapolation was based on a probe review. *See* ALJ Appeal No. 1-434277532, Dec. at 12.

CMS has established procedures for Medicare contractors to use in verifying potential billing errors and taking corrective actions. MPIM Ch. 3. CMS distinguishes between Medicare overpayments determined via "probe review" and statistical sampling extrapolation. *Compare id.* § 3.2.A. (error validation (probe) review) and § 3.8.2, *cross-referencing* § 3.10 (statistical sampling extrapolation). A probe review "does not allow projection of overpayments to the universe of claims reviewed. In this type of review, contractors collect overpayments only on claims that are actually reviewed . . . ." *Id.* § 3.2.A. Statistical sampling, on the other hand, "is used to calculate and project (i.e., extrapolate) the amount of overpayment(s) made" to the universe of claims. *Id.* § 3.10.1.2.

The Council finds that the record and testimony of the PSC indicates that the PSC engaged in, and intended to engage in, a probe review. Exh. 5 at 184; *reference also* Hearing CD.

The PSC provided the appellant with information concerning the probe sampling methodology, which states:

> The objective of probe sampling is to examine a representative sample of beneficiaries and claims from a provider or group of providers showing a potentially aberrant billing pattern. The sample is used to determine whether any further action is warranted, such as provider education, pre-payment review, *a more comprehensive statistical sample*, or referral for a special investigation.

Exh. 5 at 256 (emphasis added).

Thus, the Council finds no reason to disturb the ALJ's findings that the sample probe review upon which the PSC based its overpayment extrapolations was invalid. Accordingly, the Council will not take own motion review of this case. The ALJ's September 28, 2009, decision is binding. We refer the case to Q[2] Administrators for effectuation of the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

Date: February 22, 2010