DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
Holy Cross Hospital (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiary)	**** (HIC Number)
First Coast Service Options (Contractor)	**** (ALJ Appeal Number)

On February 3, 2009, the Administrative Law Judge (ALJ) issued a hearing decision concerning the overpayment of a claim based on inpatient hospital admission of the beneficiary to the Holy Cross Hospital on February 6, 2004. The ALJ found that the inpatient admission and related services were not medically reasonable and necessary for the beneficiary; upheld the overpayment determination; held the appellant liable under section 1879 of the Social Security Act (Act); and concluded that the recovery of the overpayment may not be waived under section 1870 of the Act. The appellant seeks Medicare Appeals Council review of the ALJ's decision.

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 modifies the ALJ's decision as set forth below.

BACKGROUND AND PROCEDURAL HISTORY

This appeal involves inpatient hospital admission of, and related services provided to, the beneficiary on February 6, 2004. The claim was initially paid in February 2004. In

February 2008, a Recovery Audit Contractor (RAC) informed the appellant that the appellant had been overpaid on this claim because the documentation submitted by the appellant did not support the beneficiary's need for inpatient admission to an acute care hospital and that the appellant was responsible for reimbursement of the overpayment. An unfavorable decision was issued on redetermination. On reconsideration, the Qualified Independent Contractor (QIC) upheld the overpayment determination and found the appellant liable for the non-covered services. The appellant then sought ALJ review.

The ALJ held a hearing on January 28, 2009. Dr. G.P. testified for the appellant. In his February 3, 2009, hearing decision, the ALJ found that the inpatient admission on February 6, 2004 was not medically reasonable and necessary for the beneficiary pursuant to section 1862(a)(1) of the Act. The ALJ further found that the appellant is financially liable for the non-covered services under section 1879 of the Act. Finally, the ALJ concluded that the appellant is not without fault for the overpayment and, therefore, not entitled to a waiver of the overpayment under section 1870 of the Act. Dec. at 7-9.

The appellant filed a timely request for Council review, which is admitted into the record as Exh. MAC-1.

DISCUSSION

Medical Necessity and Overpayment Determination

Having reviewed the record before the ALJ and the appellant's request for Council review, the Council fully agrees with the ALJ's findings and conclusions concerning the medical necessity of the beneficiary's inpatient hospital admission. The beneficiary was admitted with a chief complaint of abdominal pain radiating down to the back. His medical history included human immunodeficiency virus (HIV), AIDS, gastroesophageal reflux, history of bilateral macular degeneration, and hyperlipidemia. Exh. 2 at 54. The appellant argued below that the beneficiary's gallbladder disease, in combination with a compromised system due to HIV and AIDS, called for inpatient admission. However, the medical records indicate that the beneficiary was not in acute distress. In fact, on physical examination on the date of admission, the beneficiary was found to be in "no acute distress." Exh. 2 at 54. And, the beneficiary was admitted for "observation" (Exh. 2 at 56). Although the "admission status" was described as "observation

with intensity of service" (*id.* at 32), radiology results did not show the presence of gallstones (Exh. 2 at 36); and a physician opined that the complaints of pain could have resulted from a combination of medications. Exh. 2 at 44. Moreover, a doctor noted, after a gastrointestinal evaluation, that it would be "OK to proceed as outpatient." Exh. 2 at 34.

The Council therefore concurs with the ALJ that acute care hospital admission was not shown to have been necessary and that care on an outpatient basis would have been appropriate under the facts of this case. Dec. at 2-3, 7-8. The Council adopts the ALJ's findings and conclusions on this issue and concludes that the overpayment determination was valid.

Liability – Section 1879 of the Act

Medicare is a defined-benefit program. Items and services that fall within a benefit category are covered under statutory and administrative authority. Nonetheless, an item or service may meet Medicare coverage criteria, yet still be excluded from coverage as not reasonable and necessary or as constituting custodial care. Act, sections 1862(a)(1)(A), 1862(a)(9). In that event, section 1879 of the Act may limit the liability of a beneficiary or provider for non-covered items or services based upon whether or not they had prior knowledge of non-coverage. Act, section 1879(a); 42 C.F.R. §§ 411.400(a), 411.404, 411.406. The limitation on liability provisions of section 1879 apply only to denials where the items or services are determined to be not medically reasonable and necessary.

The Medicare program makes payment for non-covered services when neither the beneficiary, nor the provider, practitioner, or supplier knew, or could reasonably have been expected to know, that the items or services would be found non-covered on the grounds that they were not medically reasonable and necessary. Medicare Claims Processing Manual (MCPM), CMS Pub. 100-04, Ch. 30, § 20. A beneficiary is presumed not to know that services are not covered unless the evidence indicates that written notice was given to the beneficiary before the services were provided. *Id.* at § 30.1. The Council sees no error in the ALJ's conclusion that the appellant in this case is held to have "acquired knowledge" that the hospital services it provided to the beneficiary are not covered based on "its receipt of manuals, bulletins and written guidelines from the carrier." Dec. at 8-9; *see* MCPM, Ch. 30, §§ 40.1, 40.1.1. The Council concurs with the ALJ that the appellant knew, or could

reasonably have been expected to know, that the services would not be covered by Medicare. Accordingly, the appellant is liable for the costs of the non-covered services pursuant to section 1879 of the Act.

Waiver of the Overpayment

On the issue of waiver of the overpayment, in its request for Council review, the appellant argues that the ALJ erred by incorrectly calculating the period after the year on which the claim was initially paid and the year on which the overpayment determination was made. The appellant states, in part:

> [The appellant] assert[s] that the [ALJ] made a factual error in determining that this case was reopened within three years from the date of [the] initial claim payment, and therefore the [ALJ] erroneously failed to conclude that the [appellant] should be presumed without fault, and [the ALJ] erroneously failed to waive the determined overpayment.

Exh. MAC-1 at 1.

The appellant argues in Exh. MAC-1 at 1-2, and the Council agrees, that in this case three full calendar years elapsed between the year of the initial determination (2004) and the year on which the overpayment was found (2008). The appellant is correct that the ALJ erred when he stated, in Dec. at 9, that the "reopening was within the three calendar years from the date of payment." The factual error in the ALJ's decision on the calculation of the three-year period after the initial determination affects the analysis of the issue of waiver, but not the ultimate result in this case (in other words, the appellant is still liable for the overpayment), as explained below.

Section 1870 of the Act governs the recovery of overpayments, based upon provider or beneficiary fault. Section 1870(b) of the Act provides for a waiver of recovery of an overpayment to a provider or supplier if it is "without fault" in incurring the overpayment. Section 1870(b) of the Act effectively presumes no fault on a provider's part where an overpayment determination is made "subsequent to the third year following the year in which notice was sent to such individual that such amount had been paid" in the absence of evidence to the contrary.

Section 1870(b) does not define the meaning of the term "without fault"; however, the Medicare Financial Management Manual (MFMM), CMS Pub. 100-06, Ch. 3, section 90, provides guidance. A provider is without fault if it exercised reasonable care in billing and accepting Medicare payment. A provider is considered not "without fault" if, e.g., it did not submit documentation to substantiate that services billed were covered, or billed, or Medicare paid, for services the provider should have known were not covered. *Id.* at § 90.1. The MFMM explains that the provider should have known about a policy or rule if the policy or rule is in the provider manual or in the regulations. *Id.*

The MFMM, CMS Pub. 100-06, provides that fault would not be shown under the following circumstances:

> The FI [fiscal intermediary] or carrier considers a provider without fault, if it exercised reasonable care in billing for, and accepting, the payment; i.e.,
>
> > • It made full disclosure of all material facts; and
> > • On the basis of the information available to it, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or, if it had reason to question the payment; it promptly brought the question to the FI or carrier's attention.

MFMM, Ch. 3, § 90. Again, absent evidence to the contrary, a provider or supplier is deemed without fault for an overpayment discovered after the third calendar year following the year of payment. MFMM, CMS Pub. 100-06, Ch. 3, § 70.3.A.

The MFMM also provides, for overpayments found after the third calendar year after the year of payment:

> There are special rules that apply when an overpayment is discovered subsequent to the third year following the year in which notice was sent that the amount was paid. **Ordinarily**, the provider or beneficiary will be considered without fault **unless there is evidence to**

> **the contrary**. In the absence of evidence to the contrary, the FI [fiscal intermediary] or carrier will not recover the determined overpayment. (**One example of evidence to the contrary would be a pattern of billing errors**. See PIM, Chapter 3.)

MFMM, Ch. 3, § 80 (emphasis added).

The MFMM also provides guidance on how to calculate the "third year" after the year payment was approved. It states:

> Only the year of the payment and the year it was found to be an overpayment enter into the determination of the 3-year calendar period. The day and month are irrelevant. [For example,] [w]ith respect to payments made in 2000, the third calendar year thereafter is 2003.

MFMM, Ch. 3, section 80.1.

In essence, under Section 1870(b) of the Act and MFMM, there is a rebuttable presumption that providers/suppliers are "without fault" with regard to overpayments discovered more than three calendar years after the year on which the initial determination was made, as was the case in the instant appeal. Therefore, the ALJ should have discussed the applicability of the presumption in this case, and articulated whether the presumption was rebutted, but he did not.

In this case the ALJ concluded that, because the appellant was "aware of the inpatient policy as provided in the manual [referring to relevant sections of the Medicare Claims Processing Manual, CMS Pub. 100-4, in Ch. 1], among other relevant regulations and guidance, "recovery of the overpayment would not defeat the purposes of Title II or Title XVIII [of the Act] or be against equity and good conscience." Dec. at 9.

The MFMM also provides that, generally, a provider's allegation that it was not at fault with respect to payment for non-covered services because it was not aware of coverage requirements is not considered a basis for finding it "without fault" if one of several conditions is met. One such condition is if the provider billed, or Medicare paid for, services the provider should have known were not covered. MFMM, Ch. 3, § 90.1. It was on this condition that the RAC determined that an overpayment occurred in the instant case. *See* Exh. 1 at 18.

Having considered the basis on which the overpayment was found in this case, as discussed above, and Section 1870(b) and MFMM guidance, the Council agrees with the ALJ's ultimate conclusion that the appellant was not without fault in creating the overpayment. The Council modifies the ALJ's decision to the extent that the "without fault" rebuttable presumption should have been, but was not, applied, and finds that the presumption was rebutted in this case. The Council adopts the ALJ's ultimate conclusion that, because the appellant was not "without fault" in creating the overpayment, a waiver of recoupment of the overpayment is not warranted.

The Council has considered the appellant's argument, in Exh. MAC-1 at 2, that because there is no evidence of "fraud or similar fault" in this case (apparently referring to the regulation at 42 C.F.R. § 405.980(b)(3)), such as a pattern of billing errors, that a waiver is proper in this case. As explained above, relevant MFMM guidance provides that where, as here, a provider billed and Medicare paid for services the provider should have known were not covered, the provider may not be found "without fault."

Finally, it is apparent that, based on the ALJ's employment of the term "against equity and good conscience" (Dec. at 9), the ALJ considered, at least in part, section 1870(c) of the Act to conclude that an overpayment waiver is not appropriate in this case, even though he did not specifically cite section 1870(c). As relevant to the instant appeal, section 1870(c) applies to a waiver of overpayments made to beneficiaries, and not providers. On this issue, the Council has held that section 1870(c) is inapplicable to providers and suppliers. This statutory provision is worded such that it is applicable to individual beneficiaries as it pertains to benefits received under Title II and to "equity and good conscience."

The ALJ's February 3, 2009, decision is modified in accordance with the foregoing discussion.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: May 13, 2009