

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DEPARTMENTAL APPEALS BOARD

**DECISION OF MEDICARE APPEALS COUNCIL**  
**Docket Number: M-10-321**

**In the case of**

Michael King, M.D.  
and Kinston Medical  
Specialists, P.A.  
\_\_\_\_\_  
(Appellant)

**Claim for**

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

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

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

CIGNA Government Services  
\_\_\_\_\_  
(Contractor)

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(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision, partially favorable to the appellant, dated September 29, 2009. The ALJ's decision concerned a Medicare overpayment assessed against the appellant for various diagnostic services provided by the appellant between July 1, 2004, and June 30, 2006. The ALJ first determined that the underlying sampling methodology and associated extrapolation were valid. The ALJ then found that Medicare coverage was warranted for claims associated with thirty-two of the beneficiary-specific claims at issue, but denied coverage for some or all of the claims associated with thirteen beneficiaries. The ALJ directed the Medicare contractor to recalculate the overpayment accordingly and found that the appellant's liability for the remaining overpayment could not be waived. The appellant has asked the Medicare Appeals Council to review this action as it applies to the general sampling issues and specific coverage findings for twelve beneficiaries.

The appellant's request for review (December 1, 2009) is entered into the record as Exhibit (Exh.) MAC-1. The appellant's letter (March 30, 2010), offered as an explanation of good cause for submitting new evidence, earlier with its request for review,

and later with the March 30, 2010 letter, is entered into the record as Exhibit MAC-2.<sup>1</sup> The appellant's brief (August 12, 2010) is entered into the record as Exhibit MAC-3.

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).

As set forth below, the Council upholds the sampling and extrapolation underlying the overpayment, but reverses, in whole or in part, the ALJ's decision as it pertains to certain beneficiary-specific claims for coverage.

### BACKGROUND

On November 28, 2007, AdvanceMed, a Center for Medicare & Medicaid Services (CMS) program safeguard contractor (PSC), provided the appellant with preliminary notification that it had received a Medicare overpayment projected to total \$919,644 for claims associated with services provided by the appellant between July 1, 2004, and June 30, 2006. Exh. 1 at 164. The PSC indicated that:

To determine the overpayment amount due, AdvanceMed used RAT-STATS (a software tool developed by the Office of Inspector General to assist in performing random samples and evaluating the results), to select a sample of claims from a list of all relevant claims paid or partially paid to you. An average overpayment was then calculated and multiplied by the total number of relevant paid and partially paid claims to reach a point estimate. Using the standard statistical formulas found in RAT-STATS, a confidence interval was built around the point estimate. AdvanceMed used the lower limit of the 90% two-sided confidence interval to establish the amount of the overpayment.

Exh. 1 at 164-165.

The PSC also provided the appellant with a CD containing "the sampling methodology and supporting documents." Exh. 1 at 165.

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<sup>1</sup> The Council rules on the admissibility of new evidence, below.

In an associated internal memorandum, the PSC indicated that it had reviewed a "total of 90 claims, 80 medical records, and 399 CPT line items." Exh. 1 at 252.

On December 3, 2007, the Medicare contractor formally notified the appellant of the overpayment. Exh. 1 at 159. The appellant requested redetermination. The Medicare contractor issued an unfavorable redetermination. See Exh. 1 at 115-128. The Medicare contractor indicated that the PSC audit had resulted in a denial or down coding of 276 services provided to 74 beneficiaries resulting in an actual overpayment of \$13,210.52, extrapolated to \$919,644. Exh. 1 at 116.

The appellant requested reconsideration by a Qualified Independent Contractor (QIC). The QIC issued a partially favorable reconsideration, finding coverage for claims for twenty-nine beneficiaries and upholding overpayments for the remaining forty-five. See Exh. L, Item I.

The appellant requested a hearing before an ALJ. The ALJ conducted a hearing over the course of two days, March 6 and July 22, 2009. Both the appellant and the PSC provided expert testimony on the statistical sampling/extrapolation issues, as well as testimony on the unresolved coverage issues. See Dec. at 2. The decision which followed first addressed the overarching issues on appeal. Based on consideration of the evidence and a comparative analysis of expert testimony, the ALJ determined that the underlying statistical sampling was valid. The ALJ found the universe was clearly defined; the sample size adequate; the sample capable of replication (noting that the appellant's expert had not attempted replication of the sample and extrapolation); and the use of the Central Limit Theorem appropriate. Dec. at 10-11.

The ALJ also found the appellant liable for the overpayment and that the appellant "could not avail itself" of the Social Security Act (Act) provisions pertaining to waiver of liability for recoupment of the overpayment. Dec. 12; see, also, sections 1870(b) and 1879(a)(1) of the Act. The ALJ directed that the case be "remanded to the carrier to recalculate the extrapolation based on . . . [the ALJ's] decisions" on beneficiary-specific claims. In so doing, the ALJ denied the appellant's request that the overpayment be limited to the non-covered claims actually sampled and not be extrapolated to the universe of claims. Dec. 12.

The ALJ then addressed the coverage issues presented in the forty-five beneficiary-specific claims before him. The ALJ issued thirty-two fully favorable and thirteen partially favorable or fully unfavorable, beneficiary-specific "decisions." *See, generally*, ALJ Decision, Attachment A at 1-74; *see, also*, Dec. at 2.

In its brief to the Council, the appellant takes exception to the ALJ's universal findings regarding sampling and extrapolation. Generally, the appellant asserts that -

- AdvanceMed (the PSC) has not met the requirements to use extrapolation;
- AdvanceMed's sample results do not achieve acceptable precision;
- AdvanceMed did not verify the correct amount of Medicare claims paid to the appellant for the audit period;
- AdvanceMed's sampling methodology was statistically invalid because it failed to consider the variability in population;
- AdvanceMed did not verify that it correctly determined the overpayments because it failed to address "nonsampling error" resulting in the application of the wrong sampling protocol and production of an "unfair and inaccurate" overpayment estimate;
- AdvanceMed has not shown that it applied all generally recognized procedures for statistical sampling; and
- AdvanceMed has not proven that "its errors are wiped clean" by its practice of choosing the lower limit of extrapolated overpayments.

Exh. MAC-3 at 12-20.

The appellant also challenges the ALJ's coverage findings for twelve of the thirteen partially or fully unfavorable beneficiary-specific decisions. The appellant presents specific exceptions for six of those "decisions" and relies upon its

prior submissions of record for the remaining six "decisions."  
Exh. MAC-3 at 3-10.

The Council sets out the appellant's sampling and coverage arguments in more detail in the analysis below.

## **APPLICABLE LEGAL STANDARDS**

### ***Statistical Sampling***

In the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress established the Medicare Integrity Program (MIP), under which "the Secretary shall promote the integrity of the Medicare program by entering into contracts in accordance with the section with eligible entities to carry out the activities" listed. Section 1893(a) of the Act. Congress specified that those activities include review of activities by providers and other entities and individuals furnishing items or services covered and/or paid for by Medicare, including medical and utilization review and fraud review. Section 1893(b)(1) of the Act. Congress also authorized the Secretary to enter into such contracts without having promulgated final rules. Section 1893(d) of the Act.

Under the MIP, Congress authorized the Secretary to enter into a plan with providers or suppliers for repayment of overpayments. Section 1893(f)(1)(A) of the Act. Congress also circumscribed the authority of the Secretary to recoup overpayments during the appeals process. Section 1893(f)(2) of the Act. With respect to extrapolation, Congress stated:

LIMITATION ON USE OF EXTRAPOLATION. - A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless the Secretary determines that -

(A) there is a sustained or high level of payment error; or

(B) documented educational intervention has failed to correct the payment error.

There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of

determinations by the Secretary of sustained or high levels of payment errors under this paragraph.

Section 1893(f)(3) of the Act.

CMS (formerly HCFA) Ruling 86-1 describes the agency's policy on the use of statistical sampling to project overpayments to Medicare providers and suppliers. The Ruling also outlines the history and authority, both statutory and precedential, for the use of statistical sampling and extrapolation by CMS in calculating overpayments. We incorporate that discussion by reference here. The Ruling provides, in part:

Sampling does not deprive a provider of its rights to challenge the sample, nor of its rights to procedural due process. Sampling only creates a presumption of validity as to the amount of an overpayment which may be used as the basis for recoupment. The burden then shifts to the provider to take the next step. The provider could attack the statistical validity of the sample, or it could challenge the correctness of the determination in specific cases identified by the sample (including waiver of liability where medical necessity or custodial care is at issue). In either case, the provider is given a full opportunity to demonstrate that the overpayment determination is wrong. If certain individual cases within the sample are determined to be decided erroneously, the amount of overpayment projected to the universe of claims can be modified. If the statistical basis upon which the projection was based is successfully challenged, the overpayment determination can be corrected.

CMS Ruling 86-1 at 9-10.

CMS's sampling guidelines are found in chapter 3, section 3.10 of the Medicare Program Integrity Manual (MPIM), CMS Pub. 100-08. Neither an ALJ, nor the Council, is bound by CMS program guidance, but will give substantial deference to such policies if they are applicable to a particular case. 42 C.F.R. § 405.1062(a).

The MPIM guidelines reflect the perspective that the time and expense of drawing and reviewing the claims from large sample sizes and finding point estimates which accurately reflect the estimated overpayment with relative precision may not be

administratively or economically feasible for contractors performing audits. Instead, the guidelines allow for smaller sample sizes and less precise point estimates, but offset such lack of precision with direction to the carriers to assess the overpayment at the lower level of a confidence interval - generally, the lower level of a ninety-percent one-sided confidence interval. This results in the assumption, in statistical terms, that there is a ninety-percent chance that the actual overpayment is higher than the overpayment which is being assessed, thus giving the benefit of the doubt resulting from any imprecision in the estimation of the overpayment to the appellant, not the agency. See MPIM, ch. 3, § 3.10.5.1. As a result of the above policy decision, the question becomes whether the sample size and design were sufficiently adequate to provide a meaningful measure of the overpayment, and whether the provider/supplier is treated fairly despite any imprecision in the estimation.

The MPIM provides guidance to contractors in conducting statistical sampling for use in estimating overpayment amounts. The instructions are intended to ensure that a statistically valid sample is drawn and that statistically valid methods are used to project overpayments where review of claims indicates that overpayments have been made. The MPIM describes the purpose of its guidance as follows:

These instructions are provided so that a sufficient process is followed when conducting statistical sampling to project overpayments. Failure by the PSC or the ZPIC BI unit or the contractor MR unit to follow one or more of the requirements contained herein does not necessarily affect the validity of the statistical sampling that was conducted or the projection of the overpayment. An appeal challenging the validity of the sampling methodology must be predicated on the actual statistical validity of the sample as drawn and conducted. **Failure by the PSC or ZPIC BI units or the contractor MR units to follow one or more requirements may result in review by CMS of their performance, but should not be construed as necessarily affecting the validity of the statistical sampling and/or the projection of the overpayment.**

MPIM, ch. 3, § 3.10.1.1 (emphasis added).

The MPIM further provides that a contractor may employ any sampling methodology that results in a "probability sample." The MPIM explains:

[The contractor] shall follow a procedure that results in a probability sample. For a procedure to be classified as probability sampling the following two features must apply:

- It must be possible, in principle, to enumerate a set of distinct samples that the procedure is capable of selecting if applied to the target universe. Although only one sample will be selected, each distinct sample of the set has a known probability of selection. It is not necessary to actually carry out the enumeration or calculate the probabilities, especially if the number of possible distinct samples is large - possibly billions. It is merely meant that one could, in theory, write down the samples, the sampling units contained therein, and the probabilities if one had unlimited time; and
- Each sampling unit in each distinct possible sample must have a known probability of selection. For statistical sampling for overpayment estimation, one of the possible samples is selected by a random process according to which each sampling unit in the target population receives its appropriate chance of selection. The selection probabilities do not have to be equal but they should all be greater than zero. In fact, some designs bring gains in efficiency by not assigning equal probabilities to all of the distinct sampling units.

For a procedure that satisfies these bulleted properties it is possible to develop a mathematical theory for various methods of estimation based on probability sampling and to study the features of the estimation method (i.e., bias, precision, cost) although the details of the theory may be complex. **If a particular probability sample design is properly executed, i.e., defining the universe, the frame, the sampling units, using proper randomization, accurately measuring the variables of interest, and using the**

correct formulas for estimation, then assertions that the sample and its resulting estimates are "not statistically valid" cannot legitimately be made. In other words, a probability sample and its results are always "valid." Because of differences in the choice of a design, the level of available resources, and the method of estimation, however, some procedures lead to higher precision (smaller confidence intervals) than other methods. A feature of probability sampling is that the level of uncertainty can be incorporated into the estimate of overpayment as is discussed below.

MPIM, ch. 3, § 3.10.2 (emphasis added). The MPIM recognizes that a number of sampling designs are acceptable, including: simple random sampling, systematic sampling, stratified sampling, and cluster sampling, or a combination of these. *Id.* at § 3.10.4.1. Stratified sampling is a design that "involves classifying the sampling units in the frame into non-overlapping groups or strata." The objectives are to "define the strata in a way that will reduce the margin of error in the estimate below that which would be attained by other sampling methods, as well as to obtain an unbiased estimate or an estimate with an acceptable bias." *Id.* at § 3.10.4.1.3.

The MPIM further provides that:

If the decision on appeal upholds the sampling methodology but reverses one or more of the revised initial claim determinations, the estimate of overpayment shall be recomputed **and a revised projection of overpayment issued.**

MPIM, ch. 3, § 3.10.9.2 (emphasis added).

The MPIM further explains that variable precision in sampling design may be accounted for through the use of the lower limit of a one-sided ninety-percent confidence interval, which is a conservative method that works to the financial advantage of the supplier, as follows:

In simple random or systematic sampling the total overpayment in the frame may be estimated by calculating the mean overpayment, net of underpayment, in the sample and multiplying it by the number of units in the frame. In this estimation procedure, which is unbiased, the amount of overpayment dollars

in the sample is expanded to yield an overpayment figure for the universe. The method is equivalent to dividing the total sample overpayment by the selection rate. The resulting estimated total is called the point estimate of the overpayment, i.e., the difference between what was paid and what should have been paid. In stratified sampling, an estimate is found for each stratum separately, and the weighted stratum estimates are added together to produce an overall point estimate.

In most situations the lower limit of a one-sided 90 percent confidence interval shall be used as the amount of overpayment to be demanded for recovery from the provider or supplier. The details of the calculation of this lower limit involve subtracting some multiple of the estimated standard error from the point estimate, thus yielding a lower figure. This procedure, which, through confidence interval estimation, incorporates the uncertainty inherent in the sample design, is a conservative method that works to the financial advantage of the provider or supplier. That is, it yields a demand amount for recovery that is very likely less than the true amount of overpayment, and it allows a reasonable recovery without requiring the tight precision that might be needed to support a demand for the point estimate. However, the PSC or ZPIC BI unit or the contractor MR unit is not precluded from demanding the point estimate where high precision has been achieved.

MPIM, ch. 3, § 3.10.5.1.

### ***Medically Reasonable and Necessary Services***

Section 1862(a)(1)(A) of the Act provides that only items and services that are "reasonable and necessary" for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member are covered under the Medicare program. See, also, 42 C.F.R. § 411.15(k).

Section 1833(e) of the Act prohibits payment "to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due." It is the responsibility of the provider or supplier to furnish sufficient information to enable

the contractor to determine whether payment is due and the amount of the payment. 42 C.F.R. § 424.5(a)(6).

## ANALYSIS

### ***New Evidence***

The Council limits its review to the evidence contained in the record of the proceedings before the ALJ, unless there is good cause for submitting new evidence for the first time at the Council level. 42 C.F.R. §§ 405.1122(a) and (c).

As part of its request for review the appellant submitted twenty-one pages of what the appellant conceded was new documentation pertaining to claims involving seven of the twelve beneficiaries<sup>2</sup> for which the appellant seeks review. There the appellant noted that it was providing this material to fully respond to "issues and concerns which could not reasonably have been anticipated . . . prior to [the appellant's] submission of documents to the QIC and ALJ." See Exh. MAC-1 (transmittal letter) and succeeding pages MBK-MAC 001-021.

By letter dated March 10, 2010, the Council directed the appellant to show cause for submission of this new evidence at this stage of review. In response, the appellant explained that, although it had made a good faith effort to submit all material relevant to questions of claims coverage, submission of this new evidence was warranted as a response to questions posed by the ALJ during the course of the hearing. Exh. MAC-2 at 2-3.

In addition to its statement on "good cause" regarding the new "coverage" evidence, as part of its response, the appellant also submitted seven additional pages (MBK-MAC 022-028) of new evidence pertaining to its arguments on the unreliability (*i.e.*, lack of precision) of the PSC's overpayment calculations throughout the various stages of appeal. The appellant asserts that these "AdvanceMed documents (. . . MBK-MAC 022 through 028) were created after, and as a result of, the ALJ Decision in this matter" and therefore could not have been submitted earlier. Exh. MAC-2 at 1-2.

**The Council excludes from evidence the coverage-related documentation (MBK-MAC 001-021) submitted with the appellant's request for review.** The question of coverage for all claims under review has been an issue since well before the post-

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<sup>2</sup> Those were Beneficiaries R.A., M.F., D.H., A.H., E.N., R.S. and E.W.

payment review and subsequent overpayment determination. A comparison of the "new" documentation to that already contained in the associated beneficiary claim files indicates that the "new" evidence is nothing more than what would reasonably be considered routine medical documentation pertaining to the various beneficiaries' conditions.

An appellant bears the burden of documenting its claims for coverage and payment. See section 1833(e) of the Act. An example of good cause for untimely submission of evidence is "when the new evidence is material to an issue addressed in the QIC's reconsideration and that issue was not identified as material prior to the QIC's reconsideration." See 42 C.F.R. § 405.1028(b), *incorporated by reference* at 42 C.F.R. § 405.1122(c)(3)(ii). The appellant's "new" material is the type of evidence that the Council (as well as the contractor, QIC, and the ALJ) would routinely expect to have been provided at the outset of a claim for coverage. The Council does not find persuasive the appellant's contention that this submission was made necessary based on the ALJ's line of inquiry at the hearing. The appellant has not shown that could not submit, or otherwise was precluded from submitting, this documentation prior to the QIC's reconsideration of the associated beneficiaries' claims.

Even assuming that the appellant saw a need to submit additional argument and/or proffer new documentation in response to the ALJ's questioning during the hearing, then, presumably, the appellant could have asked the ALJ for an opportunity to do so either during the course of the two-day hearing, which commenced on March 6, 2009, and did not conclude until many months later, on July 22, 2009, or sometime between March 6 and July 22, 2009. Alternatively, the appellant could have asked the ALJ for a post-hearing opportunity to submit a brief and/or additional documentation for the ALJ's consideration prior to the ALJ's issuance of a written decision. See, e.g., 42 C.F.R. §§ 405.1030(b) and (c) (an ALJ may accept documents during the hearing, and may temporarily stop the hearing to obtain necessary material evidence); 405.1040 (an ALJ may, *sua sponte*, or at a party's request, hold prehearing and posthearing conferences).

As for the appellant's argument that there is good cause for the submittal of such new medical documentation to the Council because the ALJ "liberally referenced hearing testimony in support of his conclusions" and, "[o]ften, the analysis and

explanation of his decisions raised and relied upon issues and concerns which could not have been anticipated" (see Exh. MAC-2), by exercising its right to further review before the Council, as is the case here, an appellant is afforded an opportunity for our consideration of the ALJ's "analysis and explanation" in the ALJ's written decision. As for referring to hearing testimony within the ALJ's written decision, it is more than appropriate for any ALJ to do so; indeed, the regulations mandate that an ALJ give, in his or her written decision, "the findings of fact, conclusions of law, and the reasons for the decision," which "must be based on evidence offered at the hearing or otherwise admitted into the record." 42 C.F.R. § 405.1046(a). We further note that the appellant does not specifically contend that the ALJ considered any new issue(s) for which the notice provisions in 42 C.F.R. section 405.1032(b) would apply.

We also are not persuaded that "[i]t was only after the [appellant's] review of [the ALJ's] [d]ecision that [the appellant was] able to identify the additional patient/beneficiary records, as relevant and probative in response to the positions taken by [the ALJ]." Exh. MAC-2. The appellant's argument, by logical extension, could mean that any appellant (i.e., a provider or supplier, or a beneficiary represented by a provider or supplier) may cite as good cause an ALJ's analysis or references to hearing testimony to bootstrap its case for coverage of the underlying claims for further review at the Council's level with new medical documentation that was long in existence and could (and should) have been proffered earlier, before the post-payment review. See 42 C.F.R. §§ 405.1122(c) and 405.1018(a), (c), (d).<sup>3</sup> We do not read the applicable regulations to contemplate the Council's admission of new medical documents of the type the appellant

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<sup>3</sup> As beneficiary-specific explanation of good cause, the appellant explains, for example, that newly offered evidence of lab tests taken prior and subsequent to a date of service responds to the ALJ's comment that there were no signs and symptoms of a urinary tract infection (UTI) and supports the appellant doctor's testimony that the beneficiary had recurrent UTIs that required monitoring. See Exh. MAC-2. This argument is not convincing. As a general matter, records contemporaneous to a particular service, for a particular date of service, is the most probative evidence, in terms of written documentation. More specifically, if the underlying point of a service was that a physician's monitoring was necessary, then the physician should have submitted all the information, data, opinions, etc., needed to support a finding of necessity of such physician monitoring when the claim was filed, even if some of that medical documentation pre-dated the actual date of service.

proffers based on the type of good cause rationale offered herein.

While excluded from consideration as evidence, the appellant's documentation identified as MBK-MAC 001-021 will be retained in the record for the purposes of identification, and in light of the Council's admissibility ruling herein.

**The Council admits into evidence the sampling-related documentation (MBK-MAC 022-028) provided to the Council with its submission identified as Exhibit MAC-2.** Here, the appellant's "new" documentation is being offered in connection with an argument responsive to various changes in the number of claims covered or denied over the course of the appeals process and the ensuing revision of the overpayment recalculations. The Council distinguishes these documents from medical documentation that relates to the coverage of specific underlying claims that would (or could) have been created contemporaneously on or around the dates on which the services in question were furnished (here, between mid-2004 through mid-2006). An appellant would have been charged with the responsibility for early and full presentation of any such documents to Medicare's adjudicators, for the purposes of its claims for coverage, subject to the regulations governing their admissibility at various stages of review. The documentation at issue (MBK-MAC 022-028), in contrast, addresses the appellant's global argument that the overpayment calculation is inherently unreliable, rather than a question of whether a specific claim is, or is not, covered. The Council finds good cause for admission of the documentation at MBK-MAC 022-028 into the record.

### ***Sampling and Extrapolation***

The appellant recounts the Act's basis for using extrapolation to calculate an overpayment, *i.e.*, that there is a determination of a sustained or high level of payment error or a failure of documented educational intervention. The appellant notes that there is no evidence of a documented failed educational intervention. Similarly, the appellant asserts, there is no evidence of a sustained or high level of payment error. The appellant recognizes the ALJ's conclusion that a determination of a sustained or high level of payment error is not appealable. However, the appellant contends that neither the ALJ nor the Council is precluded from reviewing a contractor's decision "to utilize sampling or extrapolation to determine the amount of an overpayment." The appellant generally argues that the record is

devoid of evidence that sampling and extrapolation were appropriate in this instance. Exh. MAC-3 at 12-14.

The criteria in section 1893(f)(3) of the Act, sustained or high level of payment error or a failure of documented educational intervention, are independent requirements. The existence of either criterion provides a sufficient basis for the use of sampling and extrapolation to determine an overpayment. Here, CMS, through its contractor (AdvanceMed), found a sustained or high level of payment error. There is, therefore, no need to ask whether there was "documented educational intervention." By law, the determination of a sustained or high error rate is not an appealable finding. See section 1893(f)(3) of the Act; see, also, MPIM, ch. 3, § 3.10.1.4.

As noted, above, the specific guidelines for Medicare audits can be found at chapter 3, sections 3.10 through 3.10.11.2 of the MPIM. Generally, the MPIM provides that stratification sampling, here, by amounts paid, is permissible and results in greater precision of overpayment estimation than a non-stratified simple random sample. MPIM, ch. 3, § 3.10.11.1.

The Council need not find that CMS or its contractor undertook statistical sampling and extrapolation based on the most precise methodology that might be devised in order to uphold an overpayment extrapolation based on that methodology. Rather, as the above-quoted authorities make clear, the test is whether the methodology is statistically valid. Pursuant to CMS Ruling 86-1, the use of statistical sampling "creates a presumption of validity as to the amount of an overpayment which may be used as the basis for recoupment." The Ruling goes on to state that "the burden then shifts to the provider to take the next step." Thus, the provisions of CMS Ruling 86-1 establish that the burden is on the appellant to prove that the statistical sampling methodology was invalid, and not on the contractor to establish that it chose the most precise methodology.

The appellant challenges the sample's reliability. The appellant asserts that the PSC did not demonstrate that the sample was representative of the patient population or that, in its design, had adequately considered patient population variability. The appellant contends that the PSC had not demonstrated that it correctly determined the overpayments in the specific sampled claims. The appellant asserts that there was no evidence that the sampled claims accurately reflected

actions subsequent to original payment, such as adjustments or reversals. The appellant argues that the sample did not satisfy generally recognized statistical sampling procedures, nor did its results reflect acceptable sampling precision. The appellant maintains that the lack of precision is not overcome by estimating an overpayment based upon the lower bound of the confidence interval. *See, generally, Exh. MAC-3 at 14-20.*

The appellant's arguments largely restate its position before the ALJ. Finding the sample statistically valid and the extrapolation appropriate, the ALJ noted that the appellant's statistical expert had conceded that the sample size was adequate, the universe clearly defined, and that the sample could be recreated by independent means. The ALJ recounted that the appellant had not replicated the sample and extrapolation. Further, the appellant did not dispute that the Central Limit Theorem was appropriate and valid. Dec. at 10-11.

The appellant's challenge to this sample is based on its theory as to the manner in which an audit of a Medicare provider should be conducted. While there may well be theories on the "right way" to conduct a sample, there is no formal recognition of "generally accepted statistical principles and procedures." At a practical level, there are a variety of factors impacting Medicare audits, which generally do not exist outside the Medicare arena. The MPIM guidelines reflect the perspective that the time and expense of drawing and reviewing the claims from large sample sizes and finding point estimates which accurately reflect the estimated overpayment with relative precision may not be administratively or economically feasible for contractors performing audits. Instead, the guidelines allow for smaller sample sizes and less precise point estimates, but offset such lack of precision with direction to the carriers to assess the overpayment at the lower limit of a confidence interval - generally, the lower limit of a ninety-percent one-sided confidence interval. This results in the assumption, in statistical terms, that there is a ninety-percent chance that the actual overpayment is higher than the overpayment which is being assessed, thus giving the benefit of the doubt resulting from any imprecision in the estimation of the overpayment to the appellant, not the agency. As a result of the above policy decision, the question becomes whether the sample size and design employed here were sufficiently adequate to provide a meaningful measure of the overpayment, and whether the provider/supplier is treated fairly despite any imprecision in the estimation.

Here, the PSC used the lower limit of a two-sided ninety-percent confidence interval. See Exh. 1 at 165. As the PSC statistical expert explained in more detail:

Furthermore, the RAT-STATS standard statistical formulas for stratified analysis were used to develop a confidence interval around the point estimate associated with the 90% confidence level. AdvanceMed uses the lower limit of the two-sided 90% confidence interval as the amount of overpayment demanded for recovery. These results mean that there is 95% probability that the true overpayment amount is greater than or equal to the requested overpayment amount. In other words, this procedure is a conservative method that works to the financial advantage of the provider because it yields a demand amount for recovery that is very likely less than the true amount of overpayment.

Exh. 2 at 190.

The appellant contends that the relative precision in the original sampling did not meet the PSC's policy guidelines for a 10% or less error rate. Moreover, the appellant argued that the relative precision in the estimation increased, significantly, from 13.66% at the time of the original sampling and extrapolation by the PSC to 21.02% after the QIC reconsideration and to 39.28% after the ALJ decision. Thus, the appellant argued, the sampling results should not be extrapolated and the overpayment should be limited to the sampled claims. Exh. MAC-3 at 15. In support of this argument, the appellant relied upon the opinion of its statistical expert, who stated that "estimating at the lower bound of the confidence interval is not an adequate step to overcoming the failure to achieve adequate precision." Exh. MAC-3 at 15.

However, the guidance found in the MPIM does not require a specific level of sampling precision. The MPIM clearly expresses CMS's policy to trade off time and resources which would be required for obtaining a precise estimate in an overpayment case, in favor of a lower overpayment amount, i.e., an assessment at the lower confidence bound rather than at the point estimate. See MPIM, ch. 3, § 3.10.5.1. Under these guidelines, the Council has upheld the results of many extrapolated overpayment assessments in Medicare cases. As the relative precision in estimating an overpayment decreases as the

result of changes to the overpayment findings in the sampled claims, the confidence interval widens and the lower confidence bound is reduced to a proportionately lower overpayment assessment. The Council finds no fatal flaw in such a process which would compel it to overturn the sample and extrapolation in this case.

As previously noted, the Council is required to give substantial deference to manual instructions in a particular case. The appellant has not demonstrated that the alleged imprecision in the sample and extrapolation invalidates the sample or resulting overpayment calculation. The appellant failed to offer sufficient affirmative evidence to establish that the PSC's sampling methodology and extrapolation did not comport with the guidelines established by CMS Ruling 86-1 and the MPIM.

### ***Beneficiary-Specific Claims***

The appellant provided argument in support of coverage for claims associated with six beneficiaries. The appellant rested on its arguments before the ALJ for the claims associated with the six remaining beneficiaries.<sup>4</sup>

### **Beneficiaries with Additional Arguments for Review**

#### **Beneficiary - J.B.<sup>5</sup>**

**Date of Service - April 13, 2005**

The beneficiary's pertinent medical history included coronary artery disease, heart murmur and a pre-existing placement of a pacemaker. On March 23, 2005, the beneficiary was hospitalized for chest pain. On April 8, 2005, the beneficiary underwent an adenosine cardiolute stress test (identified by the appellant as a SPECT test). See Exh. MAC-3 at 5. On April 13, 2005, the appellant performed a multiple gated acquisition (MUGA) scan on the beneficiary and billed Medicare using CPT<sup>6</sup> codes 78472

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<sup>4</sup> That is to say the appellant attempted to submit new documentation even for the beneficiaries for whom it submitted no additional argument. The exclusion of the untimely submitted evidence had no impact on the Council's consideration of the claims for coverage of involving those beneficiaries.

<sup>5</sup> The beneficiary-specific procedural case histories are presented in abbreviated fashion, beginning with the QIC reconsideration.

<sup>6</sup> CPT (Current Procedure Terminology) codes were designed by the American Medical Association to describe medical and surgical services performed by providers. Based upon the CPT system, CMS developed the Healthcare Common

(Cardiac Blood Pool Imaging/MUGA) and A4641 (Supply of Radiopharmaceutical Diagnostic Imaging Agent). On reconsideration, the QIC denied coverage finding that the April 8<sup>th</sup> SPECT test produced the same information captured in the MUGA performed five days later. Decision, Att. A at 6.

The ALJ denied coverage noting that upon admission (March 23, 2005), the appellant found the beneficiary's chest discomfort to be more musculoskeletal, rather than cardiac. The ALJ reasoned that the April 8<sup>th</sup> test did not identify any definite evidence of ischemia and there was no "clinical indication" identifying the need for a test on April 13<sup>th</sup>. Decision, Att. A at 6-7.

The appellant recounts its hearing testimony to be that while information from the SPECT test might have eliminated the need for the MUGA scan, the MUGA ("the gold standard test for heart function") would not necessarily have ruled out the need for the SPECT test. The appellant ordered both tests at the same time knowing, from professional experience, that there would be a delay in obtaining the isotope needed for the MUGA test. The appellant reasoned that if the SPECT test results were acceptable, the MUGA could be canceled. However, if the tests were not ordered simultaneously, and the MUGA later determined to be necessary, there would be an additional delay encountered waiting for the isotope. See Exh. MAC-3 at 5. Characterizing SPECT test results as "difficult to interpret," because the beneficiary had moved during the procedure, the appellant asserts that the SPECT test did not rule out the need for the MUGA. Consequently, the appellant conducted the MUGA scan. *Id.* Asserting that the measure of medical necessity should be the greater accuracy obtained with a MUGA scan, rather than the ultimate similarity of the SPECT-MUGA test results, the appellant characterizes questions regarding the MUGA's necessity as "Monday-morning quarterbacking." Exh. MAC-3 at 6.

The Council has considered the appellant's arguments in the context of the applicable legal authority, the evidence of record, particularly this beneficiary's medical records. In spite of the appellant's contentions, the Council finds no error in the ALJ's denial of coverage for the April 13, 2005, MUGA scan. The appellant concedes that the MUGA test is more accurate, yet acknowledges that the MUGA results would not

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Procedure Coding System (HCPCS) for processing, screening, identifying, and paying Medicare claims. See 42 C.F.R. §§ 414.2 and 414.40. For our purposes here, the coding systems are identical and the Council simply cites the CPT code.

necessarily have eliminated the need for the SPECT test. The tests results, however, are essentially repetitive. In spite of the beneficiary's medical history, his medical records from admission up to the April 13<sup>th</sup> date of service do not show the medical necessity for the MUGA testing provided on that date.

**Accordingly, the Council finds that the appellant's April 13, 2005, claim for Beneficiary J.B., billed under CPT codes 78472 and A4641, is not covered by Medicare.**

**Beneficiary - M.F.**

**Date of Service - May 22, 2006**

The beneficiary's medical history included multiple sclerosis and edema. On May 22, 2006, the appellant performed an echocardiogram on the beneficiary, subsequently billing Medicare under CPT codes 93307, 93320 and 93325. The QIC denied coverage for this claim essentially finding that the beneficiary's shortness of breath (SOB) was not adequately documented throughout the pertinent medical history. The ALJ denied coverage, adopting the QIC's reasoning that the beneficiary's SOB had not been clearly documented, principally because of the physical area in the medical records where the SOB was noted. Decision, Att. A at 16.

The appellant restates its hearing testimony that the beneficiary experienced SOB, and reasserts that the echocardiogram was medically reasonable and necessary. Further, the appellant notes that the PSC witness at the hearing testified that had the beneficiary's SOB been better identified in the medical records, the PSC would have conceded the medical necessity of this service. The appellant argues that there is no actual dispute as to the existence of the beneficiary's SOB. Rather, coverage has been denied because of the manner in which this information was recorded in the beneficiary's medical records. The appellant also asserts that the beneficiary's "pedal edema" is a causal factor in ordering the echocardiogram, but this acknowledged condition was not considered by the ALJ in denying coverage. Exh. MAC-3 at 3-4.

The Council has considered the appellant's arguments in the context of the applicable legal authority, the evidence of record, particularly this beneficiary's medical records. The Council finds that the beneficiary's medical record adequately identifies the presence of SOB in her May 12, 2006, examination (as well as being noted in the May 22<sup>nd</sup>

Echocardiographic report) and the existence of lower extremity edema. There is no question that the SOB, standing alone, would justify coverage of the echocardiogram.

**Based upon our review of the medical records in this case and the totality of the beneficiary's condition, the Council finds that the appellant's May 22, 2006, claim for Beneficiary M.F., billed under CPT codes 93307, 93320 and 93325, is covered by Medicare.**

**Beneficiary - D.H.**

**Date of Service - February 16, 2005**

The beneficiary presented to the appellant on February 2, 2005, with a heart murmur, sore throat, low potassium, high cholesterol and a "Syncope [fainting] episode in the past." On February 16<sup>th</sup> the appellant performed an echocardiogram and carotid Doppler on the beneficiary. The appellant sought Medicare coverage for the echocardiogram, under CPT codes 93307, 93320 and 93325-59 and the carotid Doppler, under CPT code 93880. The QIC denied coverage for the echocardiogram because the date of the fainting episode was not identified in the beneficiary's medical history.<sup>7</sup>

Based on the general nature of the beneficiary's medical history, as well as the unknown date of the beneficiary's fainting episode, the ALJ denied Medicare coverage for the echocardiogram. Decision, Att. A at 19-20.

The appellant concedes that it has no further information regarding the date of the beneficiary's fainting episode. However, the appellant contends that the ALJ failed to consider the evidence in its entirety, citing the appellant's notation in a subsequent "patient summary" that "the echocardiogram was obtained to evaluate the heart murmur" for underlying idiopathic hypertrophic cardiomyopathy.

The Council has considered the appellant's arguments in the context of the applicable legal authority, the evidence of record, particularly this beneficiary's medical records. The Council finds that the beneficiary's medical record adequately identifies the presence of heart murmur in her

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<sup>7</sup> The QIC also denied coverage for the carotid Doppler. However, at the ALJ hearing the PSC conceded that Medicare coverage for the carotid Doppler was appropriate. Decision, Att. A at 19.

February 2, 2005, examination, as well as being noted in the related February 16<sup>th</sup> Echocardiographic report.

**Read in conjunction with the remainder of the beneficiary's Medical history, the Council finds that the appellant's February 16, 2005, claim for Beneficiary D.H., billed under CPT codes 93307, 93320 and 93325-59, is covered by Medicare.**

**Beneficiary - A.H.**

**Date of Service - November 4, 2005**

The beneficiary's medical history included implantation of a pacemaker, uncontrolled hypertension, arteriosclerotic heart disease, diabetes and dizziness with palpitations.

On November 4, 2005, the appellant performed a transcranial Doppler study on the beneficiary. The study was inadequate for the appellant's purposes and was repeated on November 17, 2005. The appellant billed Medicare for a transcranial Doppler study (CPT code 93886), a noninvasive physiological study of the lower extremity (CPT code 93923) and an arterial Doppler study (CPT code 93925).

The QIC denied coverage for the November 17<sup>th</sup> transcranial Doppler testing because there was "no indication when recent carotid noted in chart was done. Unsure why doing this testing." The QIC denied coverage for the noninvasive physiological study of the lower extremity (CPT code 93923) based on the lack of signs & symptoms justifying its necessity. The QIC denied coverage for the arterial Doppler study (CPT code 93925) based on the absence of a "report for lower extremity doppler found in the file, have report for upper extremity arterial duplex study." Exh. L, Item I, Attachment to QIC Reconsideration at 7.

The ALJ denied coverage for all three codes. The ALJ recounted the appellant's hearing testimony as being that the appellant had not charged for the November 4<sup>th</sup> transcranial Doppler study. The ALJ then referenced an October 31, 2005, progress note which states: "No headaches." Decision, Att. A at 23.

Turning to CPT code 93925, the ALJ noted that the November 4<sup>th</sup> arterial duplex study lists arm weakness, not headaches, as the clinical indication and that the October 31<sup>st</sup> progress notes do not identify arm weakness, but state: "Muscle strength adequate." Decision, Att. A. at 24.

The ALJ then found that the record did not contain "a noninvasive physiological study of lower extremity (93923)." The ALJ acknowledged the appellant's hearing testimony that this claim had been misidentified for billing purposes and that CPT code 93930 (Duplex scan of upper extremities) should have been billed. The ALJ determined that as there had been no preliminary coverage consideration of a billing under CPT Code 93930 he was without authority to assess the merits of coverage for that claim. The ALJ recommended that the appellant resubmit that particular claim for an initial coverage determination. Decision, Att. A. at 24.

**CPT code 93886** - The appellant acknowledges confusion surrounding the performance and billing of November 4<sup>th</sup> and 17<sup>th</sup> transcranial Doppler studies. The appellant restates that the November 4<sup>th</sup> study was inadequately performed and thus was repeated on November 17<sup>th</sup>. The appellant indicates that it only sought and received coverage for a single transcranial Doppler study associated with this beneficiary. The appellant cited evidence in the record (Exhibit D, Third Attachment) demonstrating that it had in fact been paid for a single transcranial Doppler study. The appellant indicates that it is not seeking coverage for another, identical test, but would like the assumption of an unfavorable determination on this claim (*i.e.*, what was in effect, a perceived double-billing), rectified for the purposes of accurate overpayment recalculation. The appellant recounts the PSC hearing testimony to the effect that if evidence supported a finding that the transcranial Doppler had only been billed once, the PSC would treat the November 17<sup>th</sup> test as appropriately billed. Exh. MAC-3 at 7.

The appellant's evidence supports its recitation of the facts. Although it followed a somewhat confusing path, the evidence supports a conclusion that the appellant has sought and received coverage for this testing, but only once. Recalculation of the overpayment should reflect these facts. Based upon the fact of coverage, the Council need not address the issue of the test's medical necessity.

**CPT code 93925** - The appellant concedes that it erroneously billed Medicare for lower extremity testing (CPT code 99352) instead of the upper extremity testing it actually provided (CPT code 93930). The appellant takes issue with the ALJ's conclusion that he was without authority to entertain, for the

first time at his level of review, what was, in effect, a new claim for coverage. The appellant cites testimony from the PSC's witness indicating that the ALJ could "recode" this claim to reflect the correct nature of the service performed. Exh. MAC-3 at 7.

The ALJ is correct in noting that he is generally without jurisdiction to consider an issue for which a party has not received an unfavorable QIC reconsideration. *See, generally*, 42 C.F.R. § 405.1000. Nor may an ALJ add a claim to a pending appeal unless it has been adjudicated at the lower appeals levels. 42 C.F.R. § 405.1032(c). Here, the appellant has not filed a claim for CPT code 93930. Although the Council is unaware of the underlying basis for the PSC's assertion that the ALJ did have the authority to recode the claim, the PSC or contractor may well have that authority under 42 C.F.R. §§ 405.980 and 405.986 or make any necessary allowance for the appellant's resubmission of the claim, properly coded. Again, the Council notes that the PSC or contractor will be recalculating this overpayment to reflect changes brought on by the Council's decision. Having conceded that this claim was not properly coded, as initially submitted, the appellant's claim for coverage remains denied.

**CPT code 93923** - The appellant has added no further argument regarding this code, asserting that it is derivative and if the 93925 claim is reimbursed, reimbursement for this code will follow. Based on the preceding analysis, coverage for the claim submitted under CPT code 93923 remains denied.

**The Council finds that the appellant has submitted and received coverage for one claim associated with CPT code 93886. The record is corrected to reflect a single payment for a single service.**

**The appellant's claim for coverage of CPT codes 93925 and 93923 remains denied due to errors in their initial billing.**

**Beneficiary - A.J.**

**Date of Service - November 30, 2005**

The beneficiary's medical history included chronic obstructive pulmonary disease, diabetes, sleep apnea, high cholesterol and hypertension.

Based on a referral, the appellant performed a CT scan on the beneficiary on November 30, 2005 to determine the cause of her chest discomfort. The appellant billed Medicare for a computed tomographic angiography (CTA), chest, without contrast, under CPT code 71275TC.<sup>8</sup> The appellant also billed Medicare for a computed tomography, thorax, with contrast material(s), under CPT code 71260TC.

The QIC denied coverage for CPT code 71260TC, finding that someone other than the appellant-physician interpreted the procedure, and that there was no indication that the appellant-physician was the supervising physician. The QIC denied coverage for CPT code 71275TC, finding that the "CPT descriptor says with and without contrast. No indication testing was done without contrast. Exh. L, Item I, Attachment to QIC Reconsideration at 9.

The ALJ recognized the appellant's hearing-testimony concession that CPT code 71260TC was billed erroneously. Further, the appellant also testified that it had mistakenly billed 71275TC "without contrast" noting that "without contrast," there would be nothing to see on the scan. The appellant contended that CPT code 71275TC should be paid. Regardless, the ALJ denied coverage, finding that the appellant had not addressed the QIC's rationale for denying coverage.<sup>9</sup> Decision, Att. A. at 31-32.

Before the Council, the appellant reemphasizes that it billed only for the technical component of this service. The appellant recounts that the CT scan was ordered by the appellant-physician and interpreted by the appellant-medical specialist group. The appellant notes that neither the QIC, nor the ALJ, questioned the medical necessity of this diagnostic test. Rather, the QIC based its denial on the absence of any indication that the appellant-physician was the supervising physician and the ALJ, in the appellant's characterization, merely adopted the QIC rationale. Exh. MAC-3 at 9-10.

The appellant argues that the QIC/ALJ reasoning "would make sense" if the appellant "had billed Medicare for the

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<sup>8</sup> The "TC" modifier indicates - **Technical Component**: Certain procedures are a combination of professional and technical components. When only the technical component is reported, the service is identified by adding modifier TC to the procedure code.

<sup>9</sup> The ALJ also surmised, after acknowledging the appellant's hearing concession that it "was a mistake to bill 71260," that the appellant had conceded 71275TC was "a billing error." Decision, Att. A. at 31.

professional component of the tests. However, . . . [the appellant asserts that it] billed only the technical component." Exh. MAC-3 at 10. The appellant continues to point out some potential confusion in the appellant-physician's testimony. The appellant notes that it is conceding that CPT code 71260TC was billed erroneously and avers that it is not seeking Medicare coverage for that test. Citing the associated test report as support, the appellant contends that "all components of . . . [CPT code 71275] were performed . . . both with and without contrast . . ." and requests payment for that billing. Exh. MAC-3 at 10; see, also, Exh. F at 850.

As with several of the appellant's claims, the factual/billing pattern for this beneficiary is less than clear. However, given the nature of an ALJ's review is *de novo* (see 70 Fed. Reg. 36386 (June 23, 2005)), as well as the content of the appellant's argument, it is reasonable to expect that the ALJ's analysis of this claim would have consisted of more than a mere "adoption" of the QIC reconsideration based on a perception that the appellant failed to address the QIC rationale.

The record supports the appellant's claim. As it argued, the appellant billed (and the PSC reviewed) claims for only the technical components of CPT codes 71260 and 71275. See Exh. L, Item I, Attachment to QIC Reconsideration at 8-9. The appellant has withdrawn its claim for coverage involving code 71260 and clarified that it was seeking coverage for the CPT code 71275TC procedure with contrast.

**In light of the clarified facts of the appellant's claim and the pertinent medical evidence, the Council finds that the appellant's claim for CTP code 71275TC is covered by Medicare.**

**Beneficiary - E.W.**

**Date of Service - March 30, 2006**

The beneficiary's medical history included diabetes, congestive heart failure and arteriosclerotic heart disease. On March 30, 2006, the appellant performed a noninvasive physiologic study of the lower extremity (CPT code 93923) and a duplex scan of the lower extremity arteries (CPT code 93925) on the beneficiary. On reconsideration, the QIC denied Medicare coverage for both codes, reasoning that the beneficiary was "[s]eeing another provider for foot problem. Unsure why this testing is being done . . . [by appellant]. Diagnosis on report is not supported

by office visit notes." Exh. L, Item I, Attachment to QIC Reconsideration at 15.

After recounting the appellant's arguments and pertinent evidence, the ALJ indicated that a "March 21, 2006 progress note does not mention that the beneficiary had problems walking, problems with her legs, vascular problems, or claudication." Consequently, the ALJ found that the services were not "reasonable and necessary" and not covered by Medicare. Decision, Att. A. at 63-64.

The appellant notes that "claudification" was listed on the March 30<sup>th</sup> test report, but concedes, as it had in hearing testimony, that such information was not contained in the March 21<sup>st</sup> progress note. The appellant asserts that any perceived deficiency in the March 21<sup>st</sup> progress note was cured by the appellant's hearing testimony. There, the appellant-physician explained that the testing was predicated on the possibility that the beneficiary's mobility problems were caused by "ischemia (restriction or obstruction of blood flow)." Exh. MAC-3 at 8. The appellant contends that, in the context of "the treating physician rule," its hearing testimony and the documentary evidence support coverage of these claims.

The "treating physician rule" does not provide a basis for changing the ALJ's action. CMS Ruling 93-1 provides that no *presumptive* weight should be assigned to a treating physician's medical opinion in determining the medical necessity of inpatient hospital or skilled nursing facility services. The Ruling provides that "if the medical evidence is inconsistent with the physician's certification, the medical review entity considers the attending physician's certification only on a par with the other pertinent medical evidence." CMS Ruling 93-1. Moreover, the Ruling adds, parenthetically, that the Ruling does not "by omission or implication" endorse the application of the treating physician rule to services not addressed in the ruling. *Id.* Therefore, the Council need not defer to a treating physician's medical opinion, but rather considers it within the context of other pertinent evidence of record. Having done so, and considered the ALJ's rationale for his findings and conclusions, the Council concurs with the ALJ's action.

An appellant seeking Medicare coverage and reimbursement for services is responsible for properly documenting the medical necessity of those services. See section 1833(e) of the Act and 42 C.F.R. § 424.5(a)(6).

There is minimal documentation in the beneficiary's record. The existing documentation largely post-dates the provision of the services at issue and does not demonstrate, clearly, the medical necessity underlying these diagnostic services. **Accordingly, the Council finds that the appellant's March 30, 2006, claim for CPT codes 93923 and 93925 is not covered by Medicare.**

#### **Beneficiaries without Additional Arguments on Review**

The appellant acknowledged that the ALJ issued unfavorable, beneficiary-specific decisions for **Beneficiaries R.A., A.L, E.N., J.R., R.S. and S.W.** However, the appellant rests on its previous arguments of record for those beneficiaries. Exh. MAC-3 at 10. The Council has reviewed the ALJ's findings and conclusions for these six beneficiaries. Based upon the absence of any new argument suggesting why the ALJ's findings and conclusions for these beneficiaries are wrong, the Council affirms them without further comment. See 42 C.F.R. § 405.1112(c).

#### **Liability and Waiver of Recoupment of Overpayment**

The ALJ determined that the appellant was liable for the non-covered costs arising from the overpayment and that the appellant was not eligible for waiver of recoupment of the overpayment. See, Dec. at 13; see, also, sections 1879(a)(1) and 1870(b) of the Act. The appellant did not challenge these findings and the Council affirms them without further comment.

#### **DECISION**

Consistent with the detailed analysis above, it is the decision of the Medicare Appeals Council that:

Medicare coverage is available for the May 22, 2006, claims billed for Beneficiary M.F. (CPT codes 93307, 93230 and 93325);

Medicare coverage is available for the February 16, 2005, claims for Beneficiary D.H. (CPT codes 93307, 93230 and 93325-59);

Medicare coverage is available for the November 17, 2005, claim for Beneficiary A.H. (CPT code 93886); **the claims for CPT codes 93923 and 93925 remain denied;**

Medicare coverage is available for the November 30, 2005, claim for Beneficiary A.J. (CPT code 71275TC); **the claim for CPT**

code 71260 remains denied.

All claims at issue for Beneficiaries **R.A., J.B., A.L, E.N., J.R. R.S., E.W. and S.W.** remain denied.

The appellant is liable for all non-covered costs and is not eligible for waiver of recoupment of the resulting overpayment.

The Medicare contractor is directed to recalculate the resulting overpayment in according with the findings and conclusions above.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim  
Administrative Appeals Judge

/s/Constance B. Tobias, Chair  
Departmental Appeals Board

Date: May 10, 2011