DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-12-1481

In the case of	**Claim for**
Discount Diabetic (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
National Government Services (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated January 12, 2012, concerning an overpayment for diabetic supplies furnished to the beneficiary for dates of service from May 31, 2006, through July 30, 2006.[1] The ALJ found that the Medicare contractor correctly sought to recover the amount it paid for the items under Medicare Part B, because the payment was made in error as the beneficiary was enrolled in a Medicare Advantage (MA) Plan during the dates of service. The ALJ did not allow the appellant to waive recovery of the overpayment pursuant to section 1870 of the Social Security Act (Act). The ALJ ultimately held the appellant "financially liable for the overpayments," but also held the beneficiary "financially liable to Appellant." Dec. at 13-14. The appellant has asked the Medicare Appeals Council (Council) to review this action.

The Council reviews the ALJ's decision *de novo*. 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's action to the exceptions raised by the party in the request for

[1] The ALJ stated that the supplies were furnished on May 31, 2006. *See* Dec. at 1. The record shows that the dates of service for the overpayment were from May 31, 2006, through July 30, 2006. *See, e.g.*, Exhibit (Exh.) 2, at 4; Exh. 6, at 1. We therefore limit our consideration in this decision to that service period.

review, unless the appellant is an unrepresented beneficiary. *Id*. § 405.1112(c). The Council enters the appellant's request for review, dated January 24, 2012, and interim correspondence into the record as Exh. MAC-1.

As set forth below, the Council reverses the ALJ's decision.

BACKGROUND

The record indicates that the appellant submitted a $241 claim to Medicare for the diabetic supplies at issue. Exh. 2, at 4. On July 3, 2006, the contractor paid $88.19 to the appellant for those supplies. *Id*. Over three years later, on December 29, 2009, the contractor informed the appellant that it had overpaid the appellant for multiple beneficiary claims, including the beneficiary claim at issue. *See id*. at 1-5. The contractor stated that the "overpayment occurred because it was determined that the charge was covered by Hospice, Managed Care or Home Health Agency." *Id*. at 5.

For the beneficiary claim at issue, the appellant submitted a request for redetermination and the beneficiary's "Patient Eligibility (271) Report" (Eligibility Report) with a request date of May 15, 2006. Exh. 3, at 1-2. The appellant argued that the Eligibility Report it obtained at the time of service showed that Original Medicare was the primary payor and that there were no other payors. *See id*. at 1. The appellant also argued that, at some later time, Medicare retroactively updated the beneficiary's Medicare record to reflect that the beneficiary was enrolled under an MA Plan from April 1, 2006, through December 31, 2007. *See id*. The appellant therefore essentially asserts that it relied on the accuracy of the Medicare record as provided in the Eligibility Report before submitting its claim to Medicare and before Medicare retroactively updated the beneficiary's Medicare record to indicate enrollment in the MA Plan during the dates of service. *See id*. The appellant further stated that it refunded the overpayment on January 13, 2010. *Id*.

The redetermination contractor affirmed the overpayment determination, finding that the beneficiary was enrolled in an MA Plan and that the beneficiary's claim should have been billed to that plan. Exh. 4, at 1-2. The contractor also held the beneficiary responsible for the overpayment. *Id*. at 2. On reconsideration, the Qualified Independent Contractor (QIC)

affirmed the overpayment determination on the same grounds, but held the appellant responsible for the overpayment. Exh. 6, at 1-2.

Upon further appeal, the ALJ issued an Order of Remand, dated July 14, 2011, which directed the QIC to provide the missing documentation that would indicate that the beneficiary was enrolled in an MA Plan during the dates of service. Exh. 9, at 5-6. Upon remand, the QIC submitted the missing documentation, and the ALJ subsequently reopened the case and issued an "unfavorable" decision. *See* Dec. at 2. As discussed above, the ALJ found that the contractor correctly sought to recover the amount it paid for the beneficiary's claim under Medicare Part B, because the previous payment was made in error as the beneficiary was enrolled in an MA Plan during the dates of service. *See id*. at 11-14. The ALJ did not allow the appellant to waive recovery of the overpayment pursuant to section 1870 of the Act, because the ALJ concluded that the provisions in that section do not apply to "suppliers," such as the appellant, as the language of that section only references "provider of services or other person." *Id*. at 12 & n.4. The ALJ ultimately held the appellant "financially liable for the overpayments," but also held the beneficiary "financially liable to Appellant." *Id*. at 13-14.

Before the Council, the appellant argues that it was without fault in billing Medicare, because the beneficiary had stated that he was enrolled in Original Medicare when he placed the order for the supplies, and that the common working file at the time also showed that the beneficiary was enrolled in Medicare Part B. *See* Exh. MAC-1, at 2-3. The appellant also asserts that it did not receive notice of the overpayment until it was too late for it to correct the error by submitting the claim to the beneficiary's MA Plan. *Id*. at 3.

DISCUSSION

After considering the record and exceptions, the Council finds that the ALJ erred in concluding that the appellant, as a supplier, was not subject to the recovery of the overpayment waiver under section 1870 of the Act. Specifically, section 1870(b) states that a "provider of services or other person" may be waived from recovery of an overpayment if deemed to be without fault in receiving the overpayment. The term "other person" in section 1870(b) is not defined under the Act, but we

find that the term is sufficiently broad to encompass the term "supplier" as defined in section 1861(d).[2] Therefore, we find that that the appellant was subject to the recovery of the overpayment waiver under section 1870(b).

We also find that the appellant was without fault in receiving the overpayment pursuant to section 1870(b) of the Act. The Medicare Financial Management Manual (MFMM) explains that a provider or supplier is considered to be 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 [fiscal intermediary] or carrier's attention.

MFMM, CMS Pub. 100-06, Ch. 3, § 90.[3]

The record shows that the appellant requested the Eligibility Report prior to dispensing the supplies to the beneficiary and submitting the claim to Medicare. *See* Exh. 3, at 2. The Eligibility Report indicates that the beneficiary was actively enrolled in Medicare Part A and B, and does not indicate that the beneficiary was enrolled in an MA Plan. *Id*. We find that the Eligibility Report is consistent with the appellant's argument that Medicare retroactively updated the beneficiary's Medicare record, and that the appellant relied on the accuracy of the beneficiary's Medicare record at the time it submitted the claim.

Therefore, the Council finds that the appellant was without fault in receiving the overpayment because it had exercised

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[2] Section 1861(d) of the Act provides that "the term 'supplier' means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title."

[3] Manuals issued by the Centers for Medicare & Medicaid Services (CMS) can be found at http://www.cms.gov/manuals.

reasonable care in billing for, and accepting, the payment. MFMM, Ch. 3, § 90. Accordingly, pursuant to section 1870(b) of the Act, the appellant is waived from recovery of the overpayment, and thus, the contractor may not recover the $88.19 overpayment made to the appellant for the supplies at issue.

DECISION

The Council reverses the ALJ's decision. The contractor may not recover the $88.19 overpayment made to the appellant. To the extent that the appellant has already refunded that amount to the contractor before receiving notice of this decision, the contractor shall return that amount to the appellant as soon as practicable.

MEDICARE APPEALS COUNCIL

/s/ Stanley I. Osborne, Jr.
Administrative Appeals Judge

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

Date: June 29, 2012