

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-27

In the case of

The Endocrine Clinic, P.C.
(Appellant)

(Beneficiaries)

CIGNA Government Services
(Contractor)

Claim for

Supplementary Medical
Insurance Benefits (Part B)

(HIC Numbers)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a "partially favorable" decision dated July 31, 2009,¹ concerning Medicare's recovery of an overpayment arising from the appellant's claims for physician evaluation and management services and diagnostic testing furnished to multiple beneficiaries on certain dates in 2004 and 2005. In that decision, the ALJ determined: 1) he had no authority to review the contractor's decision to reopen the claims at issue; 2) some of the services at issue were reasonable and necessary for the beneficiaries, and thus, are covered by Medicare; 3) some of the services at issue were not reasonable and necessary as billed, but are reimbursable at a lower, or "downcoded," rate; 4) some of the services at issue were not reasonable and necessary, and thus, are not covered by Medicare; 5) the contractor's decision to utilize statistical sampling is not subject to ALJ review; 6) the contractor's statistical sampling and extrapolation procedures and methods were valid; 7) an overpayment exists; 8) the appellant is not entitled to a limitation on liability pursuant to section 1879 of the Social Security Act (Act); and, 9) the appellant is not without fault in causing the overpayment at issue, and thus, is not entitled to a waiver of Medicare's recovery pursuant to

¹ The ALJ's Notice of Decision, or cover letter, is dated August 7, 2009.

section 1870 of the Act. Dec. at 25-42; see also Appendices A-1 through A-77. The appellant, through counsel, 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 review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c).

The Council enters the following exhibits (Exhs.) into the record:

- Exh. MAC-1 Appellant's initial Request for Review dated October 8, 2009
- Exh. MAC-2 Appellant's letter dated March 22, 2010, including the Affidavit of a hearing witness (Carolyn Avery) and attachments
- Exh. MAC-3 Appellant's supplemental Request for Review dated April 29, 2010 (filed via a series of separate facsimiles on April 29, and April 30, 2010)
- Exh. MAC-4 Appellant's April 30, 2010, Motion to Permit Filing of AdvanceMed Recalculation Spreadsheet for Good Cause Shown
- Exh. MAC-5 Appellant's June 30, 2010, emails regarding AdvanceMed's recalculation of the extrapolation and overpayment amount

The Council has considered the record and the appellant's exceptions.² As explained more fully below, we hereby modify the ALJ's decision only to vacate the decision as it applies to three claims arising from two beneficiaries whose claims were not properly before the ALJ. We otherwise conclude that the appellant's exceptions present no basis for changing the ALJ's action.

² In its April 29, 2010, supplemental request for review, the appellant stated that it is "substituted for the statement of reasons previously filed." Exh. MAC-3 at 3. The Council accepts this substitution and will therefore only address the supplemental, substituted request for review.

BACKGROUND

In this case, the appellant billed Medicare for physician evaluation and management services and diagnostic testing furnished to multiple beneficiaries on certain dates in 2004 and 2005. The affiliated contractor paid these claims initially. However, AdvanceMed, the Program Safeguard Contractor (PSC), conducted a post-payment audit and identified a "pattern of over-utilization." Exh. 28 at 2; see also Exh. 19(A)(1).³ On this basis, the PSC performed a statistical sample of 90 claims, arising from 87 beneficiaries and 292 CPT line items, and found that overpayments had occurred in 227 of the CPT line items.⁴ Exh. 19(C)(1). The results of this statistical sample were then extrapolated to the universe of claims to calculate Medicare's overpayment. The appellant challenged Medicare's overpayment assessment and received partially favorable determinations from both the affiliated contractor and the Qualified Independent Contractor (QIC), granting coverage for some of the services at issue, either as billed or at a downcoded level. Exhs. 3, 10.

On appeal, as noted above, the ALJ determined: 1) he had no authority to review the contractor's decision to reopen the claims at issue; 2) some of the services at issue were reasonable and necessary for the beneficiaries, and thus, are covered by Medicare; 3) some of the services at issue were not reasonable and necessary as billed, but are reimbursable at a lower, or downcoded, rate; 4) some of the services at issue were not reasonable and necessary, and thus, are not covered by Medicare; 5) the contractor's decision to utilize statistical sampling is not subject to ALJ review; 6) the PSC's statistical sampling and extrapolation procedures and methods were valid; 7) an overpayment exists; 8) the appellant is not entitled to a limitation on liability pursuant to section 1879 of the Act; and, 9) the appellant is not without fault in causing the overpayment at issue, and thus, is not entitled to a waiver of Medicare's recovery pursuant to section 1870 of the Act. Dec. at 25-42; see also Appendices A-1 through A-77.

Before the Council, the appellant seeks review of limited portions of the ALJ's action and asserts that: 1) the statistical extrapolation was "inappropriate and flawed," and should be invalidated for several reasons; 2) the appellant

³ Unless otherwise indicated, all citations to exhibits in this action refer to those contained in the ALJ Master Files.

⁴ The American Medical Association (AMA) publishes its listing of Current Procedural Terminology (CPT) codes annually.

should be found without fault for the denied or downcoded diagnostic testing billed separately rather than as a panel; 3) the ALJ incorrectly downcoded evaluation and management codes for three beneficiaries based on incorrect assessment of medical decision making; 4) in the alternative, the appellant maintains that the presence of co-morbidities increased the complexity of these three instances and/or the appellant should be found without fault for these billing errors because it used Medicare contractor scoring methods; 5) the ALJ incorrectly downcoded the consultation claims for four beneficiaries based upon history and examination; and 6) the ALJ issued unfavorable decisions on claims arising from two beneficiaries whose claims were not actually before him because the QIC had ruled favorably. Exh. MAC-3. We will address each of the appellant's contentions in the course of our discussion below.

DISCUSSION

Appellant's Challenges to the PSC's Recalculation

Before the Council, the appellant contends that the PSC erred in recalculating Medicare's overpayment following the ALJ's decision. Exh. MAC-3 at 6. Specifically, the appellant asserts that although the ALJ issued fully favorable coverage determinations for beneficiaries B.W. and C.F. (citing Dec. Appendices A-21 and A-71), the PSC's recalculation indicates that no decisions were received for these two beneficiaries and treats their claims as though coverage was denied. *Id.* at 6-7.

The record reveals that appellant's counsel attempted to remedy the alleged effectuation error with the PSC directly via a series of emails. Exhs. MAC-3 at Tab D; MAC-5. In the course of this exchange, the PSC's representative appears to have suggested that the perceived error arose from a problem with the ALJ decision itself and, therefore, should be addressed by the Council. Exh. MAC-3 at Tab D.

The regulations contemplate that an ALJ's decision is not final for the purposes of determining the amount of payment due. The regulations provide: "The amount of payment determined by the contractor in effectuating the ALJ's decision is a new initial determination under § 405.924." 42 C.F.R. § 405.1046(c); see also 42 C.F.R. § 405.924(b)(12). Thus, if the appellant wishes to challenge the amount of payment (or, in this case, overpayment) determined by the PSC in effectuating the ALJ's decision, it must do so by requesting a redetermination in

accordance with the regulations at 42 C.F.R. section 405.940, *et seq.*

The appellant also reasons that the PSC's alleged error in effectuating the ALJ's decision constitutes a non-sampling error, which should invalidate the extrapolation. *Id.* at 7. However, the appellant has not cited any statutory or regulatory authority, or program guidance, to support this contention. And, the Council is not aware of any authority that would invalidate the extrapolation itself based on alleged contractor error in effectuating a decision. Moreover, as explained above, the appellant's contentions regarding the effectuation of the ALJ's decision are appropriately addressed through the claims appeal process.

As the appellant has not sought review of the PSC's recalculation through the established administrative process, its contentions on this issue are not properly before the Council. We therefore have no authority to consider the PSC's effectuation of the ALJ's decision at this time.

ALJ's Determinations on Claims Not Appealed

Before the Council, the appellant asserts that the ALJ incorrectly considered three claims arising from two beneficiaries that it did not appeal to the ALJ: CPT code 99232 for beneficiary J.B. on November 17, 2004, and beneficiary M.R. on December 4, and December 5, 2004. Exh. MAC-3 at 17-19 (citing Dec. Appendices A-8 and A-52). In addition, the appellant contends that this action constitutes a non-sampling error, which it reasons should invalidate the extrapolation. *Id.* at 19. After reviewing the record, the Council finds that the ALJ should not have considered these three claims, but concludes that this error does not provide a basis for invalidating the extrapolation.

Beneficiary J.B. - November 17, 2004

The QIC issued a favorable determination on the claim arising from beneficiary J.B. identified above. Exh. 10; *see also* Exh. 25 at Attachment 5 (spreadsheet page 2).

The appellant's request for ALJ hearing identifies the beneficiaries whose claims it would like to appeal in Attachment 3 to its request. Exh. 25 at 2. It includes the following statements: "See attached list of beneficiaries whose services were denied as part of a post-payment statistical audit . . . It

is the intent of the Provider to request an appeal on each of the "Unfavorable Decisions" listed in this QIC Reconsideration Appeal Decision." *Id.* Attachment 3 to the appellant's request for hearing contains a cover sheet identifying it as a "list of beneficiaries and dates of service involved in appeal." *Id.* at Attachment 3. The list of beneficiaries does not contain a November 17, 2004, date of service for beneficiary J.B.. *Id.* Thus, the record supports that the appellant did not seek ALJ review of this claim.

If evidence presented before the hearing causes an ALJ to question a favorable portion of prior determinations, the ALJ may consider that issue at the hearing if he notifies the parties before the hearing. 42 C.F.R. § 405.1032. The Notices of Hearing in this case generally identified the issues to be considered by the ALJ as "the application of Medicare laws and regulations to your appeal." Exhs. 21 at 2, 22 at 13, 23 at 2. These notices did not provide the appellant with any indication that the ALJ would consider the claim arising from beneficiary J.B. on November 17, 2004.⁵

The Council therefore finds that the ALJ erred in considering the November 17, 2004, date of service for beneficiary J.B. because the record does not contain any evidence that the appellant sought review of this claim following the QIC's favorable determination or that the ALJ provided the appellant with advance notice of his intent to consider it at the hearing.

Beneficiary M.R. - December 4, and December 5, 2004

The appellant contends that the QIC issued a favorable determination on the claims arising from beneficiary M.R. identified above. Exh. MAC-3 at 18. However, the record does not support this contention.

The contractor's spreadsheet reflects only one date of service for beneficiary M.R.: December 3, 2004. Exh. 3 at 11 (line 52). Similarly, the QIC did not address the December 4, and December 5, 2004, claims in its reconsideration. Exh. 10; see also Exh. 25 at Attachment 5 (spreadsheet page 10). Before the Council, the appellant explains its belief that the contractors likely grouped the December 4, and December 5, 2004, dates of service with the December 3, 2004, date of service and increased the units billed to three. Exh. MAC-3 at 18. The Council is

⁵ Moreover, the QIC issued approximately 41 coverage determinations favorable to the appellant. The ALJ did not provide any explanation for why he reviewed this one favorable claim as opposed to the others.

not persuaded that this occurred in this case. It would be highly unusual for a contractor to change "group" claims in such a manner, as doing so would effectively change the dates of service billed. Moreover, the record does not contain any claims data to support that the December 4, and December 5, 2004, dates of service, adjudicated by the ALJ and contested by the appellant, were ever at issue in this case. The appellant's own billing summary for beneficiary M.R. does not reflect any charges for services on those dates. M.R. Claim File, Exh. 1 at 1. The appellant's request for redetermination lists only December 3, 2004, as the date of service at issue. M.R. Claim File, Exh. 2 at 1. By contrast, the requests for redetermination in other beneficiary claim files list multiple dates of service and multiple CPT codes. See, e.g., J.B. Claim File, Exh. 1 at 1.

As above, the appellant's request for ALJ hearing identifies the beneficiaries whose claims it would like to appeal in Attachment 3 to its request. Exh. 25 at 2. That attachment listing the beneficiaries does not make any mention of beneficiary M.R., regardless of the dates of service. *Id.* at Attachment 3. Thus, the record taken as a whole supports that the appellant did not seek ALJ review of these claims.

The Council therefore finds that the ALJ erred in addressing the December 4, and December 5, 2004, dates of service for beneficiary M.R. because the record does not contain any evidence that claims were properly before the ALJ; specifically, the record contains no evidence that the contractors issued initial determinations, redeterminations, or reconsiderations on these dates of service.

Accordingly, the Council finds that the ALJ should not have considered the three claims discussed in detail above because he lacked jurisdiction to review them. We hereby vacate the ALJ's decision only as it pertains to these three claims. Once again, the appellant has not provided any statutory or regulatory authority, or program guidance, to support its contention that the ALJ's error should invalidate the contractor's use of extrapolation. Exh. MAC-3 at 19. The appellant apparently misunderstands the remedy available to correct the ALJ's error. Instead of invalidating the contractor's use of statistical sampling and extrapolation, the appellant is entitled to have the contractor effectuate the Council's decision, which is subject to further appeal.

Coverage and Overpayment Determination

The ALJ thoroughly addressed global coding and coverage issues in his decision, styled as an "Omnibus Decision." The ALJ also performed individualized coverage analyses for 77 beneficiaries in a series of decisions that are presented as appendices to his omnibus decision. See generally Dec. at 25-32; Appendices A-1 to A-77. Before the Council, the appellant has only raised limited exceptions to the ALJ's action. Exh. MAC-3. Thus, we will limit our discussion accordingly. 42 C.F.R. § 405.1112(c).

Evaluation and Management Consultations

Before the Council, the appellant asserts that the ALJ incorrectly downcoded evaluation and management consultation codes in three instances: beneficiary O.J. (CPT code 99244 billed, downcoded to 99243), beneficiary V.S. (92245 billed, downcoded to 99244), and beneficiary V.T. (99245 billed, downcoded to 99244). Exh. MAC-3 at 13-16. The appellant maintains that the ALJ incorrectly interpreted the "new problem" criteria from Medicare contractor score sheets, which grade the relative complexity of medical decision making. *Id.* More specifically, the appellant asserts that the ALJ should have interpreted the criteria to reflect increased medical decision making complexity where a diagnosis is new to the provider, regardless of whether that diagnosis is new to the patient. *Id.* In support of this position, the appellant submitted an affidavit from a certified professional coder who also testified at the ALJ hearing, Carolyn Avery. Exh. MAC-2. Ms. Avery's affidavit states that she believes the QIC and the ALJ did not properly score the medical decision making at issue to reflect the "new to the provider" scenario described above. *Id.* In the alternative, the appellant asserts that if the ALJ's reasoning stands, the evaluation and management codes at issue should be covered as billed due to each beneficiary's co-morbidities increasing the complexity of medical decision-making. *Id.*

After reviewing the medical documentation in evidence and considering Ms. Avery's affidavit, we find that the ALJ did not err because his coverage determinations in each of these three instances are supported by the evidence of record. See ALJ Dec. Appendices A-36 (O.J.), A-58 (V.S.), A-64 (V.T.); O.J. Claim File at Exhs. 8-9, V.S. Claim File at Exh. 11, V.T. Claim File at Exh. 10.

The ALJ thoroughly considered the appellant's "new to the provider" theory in detail and we concur with his assessment:

This [theory] is not consistent with the 1995/1997 *E/M Guidelines*, which simply set forth the proposition that a diagnosed condition is less complex to treat than an undiagnosed condition. Moreover, as Appellant has essentially recognized, what they are really arguing is that [medical decision making] complexity should be increased in consultation settings. However, the uniqueness of these situations has already been factored into Medicare billing by the use of specialized consultation CPT coding.

Dec. at 29 (internal citations omitted). Also, as noted by the ALJ, the appellant has not cited any legal authority which would require the use of the scoring sheets and tools it references in support of its theory. *Id.* at n. 28. Thus, we concur with the ALJ that, "[u]ltimately, however, any scoring tool may not be applied in a manner that is inconsistent with the 1995/1997 *E/M Guidelines*." *Id.*

Similarly, the ALJ considered the appellant's assertions regarding the contribution of comorbidities to the complexity of medical decision making. Generally, the ALJ found:

that such comorbidities would reasonably tend to increase the complexity of diabetes treatment being provided, even where a separate treatment of the comorbidity is not documented. Where appropriate, documentation of such comorbidities has been taken into account . . . as factors which would tend to increase the complexity of [medical decision making].

Dec. at 30. Thus, the ALJ did not discount the presence of comorbidities, but, in these three instances, he simply found that they did not contribute to increased complexity of medical decision-making. The medical documentation in evidence supports the ALJ's findings and we concur with his analysis. See ALJ Dec. Appendices A-36 (O.J.), A-58 (V.S.), A-64 (V.T.).

The appellant also asserts that the ALJ downcoded consultations furnished to two beneficiaries, L.D. and V.S., based upon history and examination. Exh. MAC-3 at 17. Before the Council, the appellant simply identifies the ALJ's action and states: "These were addressed in the testimony at the ALJ hearing. More detailed information may be provided." *Id.* To date, the Council has not received any further briefing from the appellant. Thus, as the appellant has not explained why it

believes the ALJ may have erred in downcoding the consultations furnished to L.D. and V.S., the Council will not consider this issue further.

Blood Glucose Tests

The ALJ determined that, in certain instances, the appellant had not provided sufficient documentation to support which of two possible blood glucose tests was performed. Dec. at 31. The appellant mentions this issue before the Council but states: "Unless further supplemented, this basis for appeal is withdrawn due to the amount in controversy, except as to extrapolation." Exh. MAC-3 at 19. The Council has received nothing further from the appellant regarding this issue and the appellant has not identified any specific claims or beneficiaries affected or any reasons why it disagrees with the ALJ's findings on this topic. We therefore construe this statement to mean that the appellant does not wish for the Council to consider the ALJ's decision as it pertains to blood glucose testing.

Thus, with the limited exceptions noted in the prior section (pertaining to beneficiaries J.B. and M.R.), we adopt the ALJ's coverage determinations, as set forth in Appendices A-1 through A-77 to his decision, and uphold the ALJ's overpayment determination.

Statistical Sampling and Use of Extrapolation

Before the Council, the appellant contends that the ALJ erred in finding the contractor's use of extrapolation proper in this case. Exh. MAC-3 at 4. Specifically, the appellant asserts that the statistical extrapolation was "inappropriate and flawed," and should be invalidated for several reasons, including the contractor's alleged "failure to recalculate extrapolated liability" prior to the ALJ hearing and lack of educational efforts, as well as the premise that no "true level of payment error could be determined." *Id.* The appellant also contends that "[t]he high level of favorable determinations through the appeal process casts doubt upon the use of this audit as the basis for a determination of a 'high level of payment error.'" *Id.* In support of its contentions, the appellant references both the hearing testimony of its expert Will Yancey, Ph.D., and a letter from M. Suzanne Moody, Ph.D., the PSC's Chief Statistician. Exh. MAC-3 at 5.

However, section 1893(f)(3) of the Act states that "[t]here 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." Act at § 1893(f)(3). The implementing regulations further provide that determinations of sustained or high levels of payment errors in accordance with section 1893(f)(3)(A) of the Act are not initial determinations subject to the appeals process. 42 C.F.R. § 405.926(p). Therefore, neither the ALJ, nor the Council, may review any aspect of a contractor's determination that a sustained or high payment error rate exists, which extends to the contractor's decision to perform extrapolation.

Like the ALJ, we find Dr. Yancey's objections to the use of statistical sampling in this case "to be hypothetical in nature, not supported by application to the data in the instant case, and otherwise insufficient to demonstrate that the overpayment extrapolation procedures and methodology utilized in the instant case should be overturned." Dec. at 34.

Furthermore, Dr. Moody's letter to appellant's counsel - in an entirely unrelated case involving another provider - merely explains that changes in claim determinations made after extrapolation constitute a non-sampling error unless a re-extrapolation is performed on the revised set of findings. Exh. MAC-3 at Tab B (note 6). It does not suggest, much less prove, that any such error occurred in this case.

Thus, the Council concludes that the appellant's objections to the contractor's use of statistical sampling and extrapolation in this case lack merit.

Limitation on Liability

The ALJ determined that the appellant's liability for the denied and downcoded services could not be limited pursuant to section 1879(b) of the Act. Dec. at 40-41. The appellant has not raised any exception to this determination before the Council. Exh. MAC-3. We therefore concur with the ALJ's analysis and adopt his findings on this issue without further comment.

Waiver of Overpayment Recovery

Throughout its brief, appellant's counsel suggests various reasons why the appellant physicians should be found "not at fault" for Medicare's overpayment. Exh. MAC-3. The appellant asserts, *inter alia*, that "none of the claims should have been reopened beyond one year." *Id.* at 8. We disagree.

Section 1870 of the Act governs the recovery of overpayments, based upon provider or beneficiary fault. Section 1870(b) allows for a waiver of recovery of an overpayment to a provider 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. CMS has provided guidance on this issue in its Medicare Financial Management Manual (MFMM). See MFMM, Pub. 100-06, Ch. 3, § 80. In essence, section 1870(b) of the Act and the MFMM allow for a rebuttable presumption that providers are "without fault" for overpayments discovered more than three calendar years after the year in which the initial determination was made. As the ALJ appropriately determined, this rebuttable presumption does not apply in the present case. Dec. at 41-42. Thus, we concur with the ALJ's finding that the appellant-provider is not entitled to waiver of recovery on this basis. *Id.*

The appellant also asserts that its physicians accepted at face value the instruction that diagnostic testing claims could be billed individually or as a panel. Exh. MAC-3 at 8-12. The appellant identifies 19 beneficiaries whose claims are affected. *Id.* at 11-12. Essentially, the appellant reasons that because it was allowed to bill for the tests either separately or as a panel, it was the contractor that erred when it paid the appellant the higher amount for the separately billed tests, and thus, the appellant should be found without fault for these overpayments. *Id.* at 9-10. The appellant also asserts that these claims should not be used to demonstrate that a high level of billing error existed because it did not bill incorrectly. *Id.* at 9. The Council is not persuaded by the appellant's reasoning. Instead, we concur with the ALJ, who explained:

Under Section 1870 of [the Act] a provider is not deemed "without fault" merely because an overpayment resulted from an "error in calculation by the . . . carrier in calculating reimbursement." [MFMM], Ch. 3, § 90.1(D). As such, it is no defense to liability even if the Contractor's calculation error in payment for the tests included in the lipid panel CPT Code 80061 (i.e. CPT 82465; 83718; 84478) may have resulted in the overpayment determination. See *Id.* To be found without fault, not only must the supplier submit accurate documentation, but the supplier must also

promptly bring any overpayment errors to the Contractor's attention. [MFMM], Ch. 3, § 90. There is no evidence that this occurred in the instant case. As such, Medicare will not provide Appellant a windfall, and allow improperly paid amounts to be retained, merely because of a Contractor calculation error.

Dec. at 41 (*italics omitted*). Thus, the Council finds that the appellant is not "without fault" and remains liable for the overpayments arising from the diagnostic testing billed separately but determined to be properly paid as a lipid panel.

The appellant further contends that it is without fault for the difference in downcoded physician evaluation and management consultation services furnished to beneficiaries O.J., V.S., and V.T., because it interpreted the coding guidelines in the same way that other Medicare contractors have, as evidenced by their scoring sheets. Exh. MAC-3 at 17 (citing Affidavit of Ms. Avery). The Council is not persuaded.

Section 1870(b) of the Act does not define the meaning of the term "without fault." However, a provider is without fault if it exercised reasonable care in billing and accepting Medicare payment. MFMM, Ch. 3, § 90. 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 also provides that, generally, a provider's allegation that it was not at fault with respect to payment for noncovered 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. *Id.*

In this case, the PSC performed a post-payment audit, identified payment irregularities, and determined that a sustained or high level of payment error existed. More specifically, in response to a Freedom of Information Act (FOIA) request, the PSC prepared a memo containing the following information:

The particulars of the circumstances that led to the selection of this provider group for audit cannot be disclosed in order to (1) protect the beneficiaries who have submitted complaints and provided information during telephone interviews and (2) guard against disclosure of [the PSC's] criteria for flagging suspect providers since such disclosure would render [its] analytical techniques ineffective in the future.

After receiving beneficiary complaint(s), AdvanceMed asked the Affiliated Contractor (AC) for any actions they had taken regarding the provider group. Once AdvanceMed learned that the AC had reviewed 30 claims of one of the group's members and found an error rate of 40.11%, AdvanceMed ran proprietary aberrancy reports that indicated a pattern of over-utilization of services for all providers in the group. Therefore, AdvanceMed decided to request supporting records from the provider group based on a randomly selected sample of claims. The review of those claims resulted in a paid dollar error rate of 70.3%. The overpayments of those sample claims were extrapolated to the frame of claims paid to the provider group.

Exh. 19(A)(1). Having considered the bases on which the overpayment was found in this case, section 1870(b) of the Act, and the guidance set forth in the MFMM, the Council concurs with the ALJ that the appellant was not without fault in creating the overpayment. See Dec. at 40-42. Accordingly, the Council adopts the ALJ's ultimate conclusion that, because the appellant was not "without fault" in creating the overpayment at issue, no waiver of recovery of the overpayment is warranted.

CONCLUSION

As set forth above, the Council hereby modifies the ALJ's decision only to vacate the decision as it applies to three claims arising from two beneficiaries: CPT code 99232 for beneficiary J.B. on November 17, 2004, and beneficiary M.R. on December 4, and December 5, 2004. We otherwise conclude that the appellant's exceptions present no basis for changing the

ALJ's decision and adopt its remaining portions.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

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

Date: November 10, 2010