

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

ORDER OF MEDICARE APPEALS COUNCIL
REMANDING CASE TO ADMINISTRATIVE LAW JUDGE

In the case of

Mid South Psychiatric
Associates

(Appellant)

(Beneficiary)

AdvanceMed PSC/CIGNA
Government Services

(Contractor)

Claim for

Supplementary Medical
Insurance Benefits (Part B)

(HIC Number)

(ALJ Appeal Number)

INTRODUCTION

The Administrative Law Judge (ALJ) issued an Order of Dismissal dated May 27, 2009, which concerned an extrapolated overpayment derived via statistical sampling for psychotherapy services provided to the sampled beneficiaries. The ALJ determined that the appellant's individual requests for ALJ hearing failed to satisfy amount in controversy requirements and dismissed all requests for hearing. The appellant has asked the Medicare Appeals Council to review this action.

The Council may deny review of an ALJ's dismissal or vacate the dismissal and remand the case to the ALJ for further proceedings. 42 C.F.R. § 405.1108(b). The Council will dismiss a request for review when the party requesting review does not have a right to a review by the Council. The Council may also dismiss the request for a hearing for any reason that the ALJ could have dismissed the request for hearing. 42 C.F.R. § 405.1108(c).

The Council hereby vacates the order of dismissal and remands this case to an ALJ for further proceedings.

BACKGROUND

The record indicates that Medicare Program Safety Contractor (PSC) AdvanceMed conducted a post-payment review of provider services and, on March 31, 2008, advised the appellant that it had received an extrapolated overpayment in the amount of \$482,607. An AdvanceMed memorandum, dated March 12, 2008, indicates that the PSC had conducted a statistical sample with sample size of 90, determined a "provider paid error rate in sample" of 84.59%, determined an average overpayment for the sample of \$86.10, and extrapolated a total overpayment in the amount of \$482,607 (lower bound).

On July 23, 2008, Medicare contractor CIGNA Government Services issued a redetermination decision. CIGNA stated that the PSC audit for previously paid services in 2005 and 2006 had resulted in the denial of 230 services to 69 beneficiaries. Actual overpayment for the sampled services was \$18,843.53, while the extrapolated overpayment was \$482,607.00. CIGNA found the "services at issue are [not] covered by Medicare" and upheld the assessed overpayment. CIGNA also found the appellant was liable for non-covered costs under section 1879 of the Social Security Act (Act) and not without fault in creating the overpayment under section 1870 of the Act.

The Qualified Independent Contractor (QIC) issued a "partially favorable" reconsideration decision, dated January 12, 2009. An attached spreadsheet set forth whether QIC decisions on sampled claims were unfavorable; favorable; partially favorable; dismissed; rejected; a duplicate; or not disputed. The QIC remanded the case to the contractor for a recalculation of the extrapolated overpayment, in light of the favorable and partially favorable findings.

The ALJ conducted a hearing on May 22, 2009, and issued an Order of Dismissal dated May 27, 2009. Order at 1. The ALJ found that the appellant "conceded at the hearing that said claims had been individually appealed by letters dated February 25 and received March 2, 2009," but that all claims (except one) failed to meet the \$120 amount in controversy (AIC) required for an ALJ hearing. Order at 1, *citing* 42 C.F.R. §§ 405.1002(a)(2), § 405.1006(b)(1), 422.600(a).¹ The ALJ then found that the appellant failed to request aggregation of individual claims pursuant to 42 C.F.R. § 405.1006(e) in order to meet AIC

¹ The Council notes that the ALJ erred in citing 42 C.F.R. 422.600, which applies to Medicare Advantage (MA) plans not at issue in this appeal.

requirements. *Id.* The ALJ concluded that "the \$120 requisite jurisdictional amount for each claim has not been met," excepting one claim that the ALJ also dismissed for lack of a QIC reconsideration decision. *Id.* at 1-2. The ALJ then dismissed all of the appellant's individual requests for ALJ hearing and stated that the QIC reconsideration decision, dated January 12, 2009, remained in effect. *Id.* at 2.

DISCUSSION

The Centers for Medicare & Medicaid Services (CMS) has issued authority governing contractor postpayment medical review. Medicare Program Integrity Manual (MPIM), CMS Pub. 100-08, Ch. 3.² The postpayment review process involves nine major steps by the contractor to determine whether an overpayment has occurred and, if so, overpayment recovery. *See id.* § 3.6. CMS defines postpayment medical review to include estimated overpayments derived from statistical sampling. *Id.* § 3.6.1.B.

In postpayment review, the contractor requests documentation for claims in the sample, re-adjudicates the individual claim by making a coverage and limitation on liability/coding determination, and documents the basis for any overpayment. MPIM, Ch. 3, § 3.6.3. "The results of the re-adjudication within the sampling units are used to determine *the total overpayment amount* for each provider or supplier under review." *Id.* § 3.6.4 (emphasis supplied).

A provider may appeal both individual coverage determinations for sampled claims as well as the validity of the statistical sampling methodology. MPIM, Ch. 3, §§ 3.7, 3.10.1.1. "If the decision issued on appeal contains *either* a finding that the sampling methodology was not valid, *and/or* reverses the revised initial claim determination, [the contractor] shall take appropriate action *to adjust the extrapolation of overpayment.*" *Id.* § 3.10.9 (emphasis supplied). "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." *Id.* § 3.10.9.2.

In light of the above authority, we find that the ALJ erred in dismissing the appellant's requests for hearing. It is clear that the appellant sought review of unfavorable individual claims determinations by the QIC as the basis for revising the

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

extrapolated overpayment. The central issue on appeal is the extrapolated overpayment amount, which was approximately \$500,000 prior to the QIC's remand for recalculation. The individual sample claims were included in that one overpayment.

The fact that the contractor re-opened individual claims to arrive at an extrapolated overpayment does not require that the appellant request aggregation of those claims in order to have them re-adjudicated on appeal for a revised overpayment. Similarly, the fact that the appellant filed individual requests for ALJ hearing, rather than discussing the basis for re-adjudicating sampled claims in one submission, does not require that the appellant seek aggregation of those claims in order to exercise appeal rights. The Council therefore vacates the ALJ dismissal and remands this case for further proceedings.

REMAND ORDER

The ALJ shall offer the appellant the opportunity for a hearing and shall receive evidence and testimony on all disputed issues, including the validity of the statistical sample. The ALJ shall determine whether the sampling methodology is valid and whether sampled claims meet coverage criteria. The ALJ shall also make findings on limitation on liability under section 1879 of the Act and waiver of overpayment under section 1870, as needed. The ALJ shall remand the case to the contractor to recalculate the extrapolated overpayment, if necessary. The ALJ shall issue a decision containing findings of fact and conclusions of law, shall mark as exhibits the evidence used in reaching his decision, and shall create an exhibit list. The ALJ make take any additional action not inconsistent with this order.

MEDICARE APPEALS COUNCIL

/s/ M. Susan Wiley
Administrative Appeals Judge

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: December 23, 2009