

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-1694

In the case of

Claim for

Shawn Lee, D.C.

(Appellant)

Supplementary Medical
Insurance Benefits (Part B)

(Beneficiaries)

(HIC Numbers)

Palmetto GBA

(Contractor)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision, partially favorable to the appellant, dated June 28, 2010. The ALJ's decision concerned a non-sample-based overpayment assessed against the appellant for chiropractic services provided to multiple beneficiaries¹ between May 9, 2007 and September 24, 2008. The ALJ determined that all claims associated with 80 beneficiaries had been properly reimbursed; that all claims for 93 beneficiaries had been overpaid and claims associated with 5 beneficiaries had been overpaid in part. The ALJ found the appellant liable for the resulting non-covered costs and determined that the appellant was not entitled to waiver of the recoupment of the overpayment. The appellant has asked the Medicare Appeals Council to review this action. The appellant's request for review has been entered into the record as Exhibit (Exh.) MAC-1.

¹ The ALJ's record identifies, by exhibit numbers 1-177 (including files "114" and "114A"), 178 "beneficiary-specific" claim files. From the Council's review, it is obvious that a number of these individual files involve different dates of service, or date of service ranges, for the same beneficiary. However, to ensure consistency, the Council retains the ultimate "beneficiary-count" employed by the ALJ. Additionally, as explained below, the Council has determined that the ALJ inadvertently identified as Beneficiary 152, a series of claims for two distinct beneficiaries. Accordingly, the Council has identified on those two beneficiaries as "Beneficiary 152A."

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 has considered the record and the appellant's exceptions. The Council adopts the ALJ's global analysis, setting out the elements of coverage and theoretical analysis of the elements of the appellant's documentation which, in the abstract, would satisfy Medicare coverage criteria. However, the Council finds that the ALJ's application of that analysis to the individual beneficiary claims was arbitrary and capricious. Specifically, applying what was essentially the identical form documentation, filled out in the same manner, to distinct beneficiaries, the ALJ arrived at unexplainably different coverage results.

Based upon the appellant's arguments and the ALJ's inconsistent beneficiary-specific analysis, the Council has reexamined the claims for each beneficiary applying, consistently, the elements of the ALJ's global analysis. The resulting coverage revisions, discussed below, are reflected in the Beneficiary List attached to this decision.

BACKGROUND

On January 16, 2009, the Medicare contractor notified the appellant of an overpayment (\$24,661.94 plus interest) associated with the various chiropractic services which the appellant had provided to various beneficiaries between May 9, 2007 and September 24, 2008. The appellant requested a redetermination. The Medicare contractor upheld the overpayment finding, generally, that the appellant had not documented the medical necessity of the reviewed services. The contractor also found the appellant liable for the non-covered costs. Exh. 178 at 65-128.

The appellant requested reconsideration by a Qualified Independent Contractor (QIC). The QIC issued a wholly unfavorable reconsideration. The QIC found that, to the degree the appellant had documented its claims, that documentation did not meet the Medicare coverage criteria for chiropractic services set out in the Medicare Benefit Policy Manual (MBPM) (IOM Pub. 100-02), chapter 15, section 240.1.2 and the applicable Local Coverage Determination (LCD) L16334

Chiropractic Service (Manual Spinal Manipulation).² The QIC found the appellant "responsible" for the overpayment. Exh. 179 at 1-26.

The appellant requested a hearing before an ALJ. The ALJ conducted a hearing, by telephone, on March 2, 2010. The appellant and his consultant testified. In their opening statements, both the appellant and his consultant noted that, at earlier stages of the review process, the appellant's medical records appeared to have been reviewed by a medical doctor and a licensed practical nurse. Both the appellant and his witness questioned the ability of individuals not skilled in chiropractic medicine to understand the information in the appellant's files. Further, the appellant expressed disbelief that all claims for every beneficiary could have been inadequately documented. The appellant's consultant opined, generally, that supporting documentation had been lost during the appeals process and that the appellant could not be held responsible for the contractors' negligence in handling the documentation.³ Beneficiary-specific testimony followed. Throughout this aspect of the hearing both the appellant and his witness testified, generally, that when the appellant established a plan of treatment on a given date, the services identified in that plan were those performed, and billed to Medicare on that and any future dates of service. See ALJ Hearing CD (at, approximately, minute 32 forward).

In the decision, the ALJ set out the Medicare coverage criteria for chiropractic services as contained in the applicable legal authorities. Dec. at 4-14. The ALJ indicated that, pursuant to chapter 15, section 240.1.2 of the MBPM, an initial visit must recount the patient's medical history with a detailed description of the present illness, an evaluation of the musculoskeletal/nervous system through physical examination, a diagnosis, treatment plan and date of initial treatment. Documentation of subsequent treatment requires a history, physical examination and documentation of treatment on the date

² LCD L16334 was issued by the appellant's then Medicare contractor, National Heritage Insurance Corporation (NHIC). In September 2008, Palmetto GBA, replaced NHIC as the appellant's Medicare contractor. Palmetto's LCD for Chiropractic Service (L28249) is essentially the same as the NHIC LCD in effect during the periods of service at issue.

³ In response to this concern, the ALJ permitted the appellant an opportunity to submit additional documentation, subsequently entered into the record as Exhibit 183. See ALJ Hearing CD and Dec. at 2.

of service. Dec. at 6-7. The ALJ also noted particularly, and correctly, that the then applicable LCD, L16334, was patterned after the Medicare guidance for chiropractic services contained at chapter 15, section 240.1.2 of the MBPM. *Id.* at 12. The ALJ then provided a global analysis of the evidence and the appellant's testimony.

The ALJ rejected the appellant's contention that the findings of non-coverage were related to the fact that "non chiropractic professionals" had reviewed the cases. The ALJ noted that "several of the examination reports and plans of care were virtually identical to one another. This was obvious to a layperson, and did not require professional training of any type." Dec. at 12. The ALJ found that the appellant's SOAP (Subjective, Objective Assessment and Plan) notes served as adequate plans of care. *Id.* However, the ALJ identified as a "major problem" the fact:

that the examinations and plans of care were intended to serve as treatment notes for the first session of the plan of care. However, nothing in the language of the plans of care or treatment could in any way be construed as indicating that the treatment per the plan of the SOAP began on these occasions. No reasonable person, whether MD, chiropractor, RN or layperson, reading this document, could be expected to have concluded that the treatment planned in the SOAP notes was actually performed or evaluated based on the plan of care alone. The Plan portion of the SOAP notes tells only what will be done. There must also be some document substantiating performance of this plan.

Dec. at 14.

More specifically, the ALJ found that, to varying degrees,

There was no documentation of treatment given on the day of a visit.

There was no documentation for initial and subsequent visits, nor documentation to support performance of services as billed. There were no office notes, progress notes, test results or physician orders indicating the medical necessity of performing the services on the dates in question.

The visit notes did not indicate the mechanism of trauma for treatment of some of the beneficiaries.

There was no indication of short or long term goal time frame.

There was no review of chief complaints.

There was no documentation of changes since the last visit or evaluation of a treatment's effectiveness in follow-up visits

There was no indication of symptoms or physical findings justifying the performance of services in accordance with Medicare guidelines.

Dec. at 14-16.

The ALJ then assessed the appellant's documentation for each of the beneficiaries. As noted above, the ALJ determined that claims for 80 "beneficiaries" were properly reimbursed by Medicare, claims for 93 "beneficiaries" had been overpaid, and claims for 5 "beneficiaries" were properly paid in some part and overpaid in others. Dec. at 16-37. Pursuant to sections 1879 and 1870 of the Social Security Act (Act), the ALJ then found the appellant liable for the resulting non-covered costs and found that the appellant was not eligible for waiver of recoupment. *Id.* at 37.

By letter dated July 1, 2010, the appellant asked the ALJ to reopen the decision. There, the appellant asserted that it had provided all "medical records for each beneficiary . . . before the ALJ hearing." Exh. 184 at 1. With its request to reopen, the appellant provided an additional 129 pages of documentation consisting of pages excerpted from the ALJ's decision and medical records for various beneficiaries. *See generally* Exh. 184 at 2-130.

On July 13, 2010, the ALJ issued a ruling denying the appellant's request to reopen. Citing 42 C.F.R. §§ 405.1018 and 405.1028, and based upon the appellant's failure to show good cause for submitting this new documentation "for the first time

after a decision on the merits, the ALJ excluded the appellant's new documentation from evidence.⁴ See ALJ's Ruling.

In his request for review by the Council, the appellant focuses on the ALJ's denial of coverage for certain claims based on what the appellant characterizes as an absence of documentation. The appellant indicates that in the hearing the ALJ "notified us of some missing medical documents due to . . . [the QIC] not forwarding all medical documents." The appellant notes that it provided documentation in response to this situation and yet the ALJ still denied coverage based on the absence of documentation for beneficiaries. Exh. MAC-1.

ANALYSIS

Appellant's Arguments

The appellant's argument does little more than generally reference an unidentified spectrum of claims where the appellant believes the ALJ has denied coverage based on the "lack of documentation." Having examined the ALJ's decision in the context of the evidence of record, the Council concludes that the appellant's position is based upon a misinterpretation of the ALJ's rationale. The ALJ's reasoning is not necessarily that there is no physical "paper" documentation in a particular beneficiary's record, but that the substantive content of that documentation does not satisfy the Medicare guidance for coverage of the chiropractic services in issue.

Generally, the ALJ's analysis was based upon the Medicare coverage criteria for chiropractic services found at chapter 15, section 240.1.2 of the MBPM and replicated in LCD L16334. See Dec. at 4-13. The Council incorporates by reference here, the ALJ's recitation of the applicable Medicare coverage criteria. In the decision's global analysis, the ALJ identified the elements of coverage which must exist in a record to secure coverage, evidence of treatment performed pursuant to a plan of care. The ALJ found that the appellant's beneficiary-specific SOAP Notes included a valid plan of care for each beneficiary as part of the initial evaluation. The ALJ also determined, correctly, that a claim for coverage must also be supported by authenticated evidence of treatment performed on a given date of service. The ALJ found that the SOAP Notes/Plans of Care did not include/contain documentation of chiropractic manipulation

⁴ As indicated above, to ensure completeness of the record, the ALJ identified the appellant's complete request for reopening as Exhibit 184.

on the same date as the initial evaluation. However, the ALJ found that appellant's beneficiary-specific "Daily Notes," notes, signed by the appellant and memorializing the treatment performed by the appellant on a given date of service supported claims for coverage. See Dec. at 13-16.

The Council agrees with the ALJ that the appellant's claims for coverage had to have evidence of a documented service performed pursuant to a plan of care. For its part, the appellant has not identified specific error in the ALJ's analysis, but has presented, as it did before the ALJ and at earlier stages of review, general argument that he has adequately demonstrated the medical necessity of the services at issue. The Council disagrees. Pursuant to section 1833(e) of the Act, an appellant bears the responsibility for documenting the medical necessity of a claim for coverage. See also 42 C.F.R. § 424.5(a)(6). The appellant has not demonstrated that the SOAP Notes/Plans of Care alone constituted proper documentation of chiropractic manipulation.

Revisions to the ALJ's Beneficiary-Specific Findings

Although the theory underlying the ALJ's global analysis (services must be provided pursuant to a plan of care and adequately documented) was correct, the ALJ did not apply that analysis to the beneficiary-specific claims in a consistent manner. For example, the claim files for Beneficiary 45 and Beneficiary 56 consist **only** of their respective SOAP Notes/Plans of Care. However, the ALJ covered the claim for Beneficiary 56 while denying the claim for Beneficiary 45. Such contradictory findings appear throughout the ALJ's analysis. Compare Beneficiary 40 and Beneficiary 41. Similar inconsistencies appear in the ALJ's analysis of claims involving claims supported by SOAP notes/Plans of Care **and** Daily Notes Compare e.g. Beneficiary 167 and Beneficiary 169.

Accordingly, the Council has found it necessary to reexamine, in the context of the ALJ's global analysis, each beneficiary's claim file as well as the additional, beneficiary-specific documentation in Exhibit 183 in order to ensure that the ALJ's analysis is applied consistently. However, the Council's beneficiary-specific review uncovered additional anomalies in certain claims. These anomalies are addressed generally below and, as indicated, are reflected in the coverage determinations in the attached Beneficiary List.

As a result the Council has revised, extensively, the ALJ's original beneficiary-specific coverage findings. Those specific revisions are captured, in their entirety, in the attached Beneficiary List.

A. SOAP Note/Plan of Care Alone Does Not Document Treatment

Generally, in the Council's Beneficiary List, the designation "Not Covered" means that the claim for service for that date, usually the initial date of service, is supported **only** by a SOAP Note/Plan of Care dated on or before the date of service.⁵ In most cases the appellant has not documented that a covered service was performed on the initial visit. The designation "**COVERED**" means that the claim for a particular date of service is supported by both a concurrent or prior-dated SOAP Note/Plan of Care and a signed Daily Note.

B. No Plan of Care

Chapter 15, section 240.1.1 of the MBPM and LCD L16334 require that chiropractic service be provided in accordance with a plan of care. The ALJ found that the appellant's SOAP notes constituted a valid plan of care. However, the Council finds that the identified dates of service for the following beneficiaries were not supported by SOAP Notes/Plans of Care predating, or contemporaneous to, the date of service claimed. Thus, these services cannot be covered by Medicare, even though in some cases there may be valid subsequent Daily Notes, as there is no evidence that they were provided pursuant to a plan of care.

Beneficiary 25 - 5/28/07

Beneficiary 105 - 7/25/08; 7/30/08 and 8/5/08 (The Council recognizes that there are Daily Notes for dates of service 7/30/08 and 8/5/08. However, the absence of a Plan of Care precludes coverage.)

Beneficiary 126 - 6/2/08 and 6/4/08

Beneficiary 132 - 4/8/08 and 4/10/08

⁵ The Council notes however, that in spite of the appellant's argument before the ALJ that a SOAP Note standing alone constituted adequate documentation of a service having been performed on that date, its claims for Beneficiaries 114A and 160 are accompanied by SOAP Notes and Daily Notes for the initial date of service.

Beneficiary 133 - 3/27/08 and 4/1/08 (Additionally, there are no Daily Notes for these dates of service.)

These claims are identified on the Beneficiary List as "Not Covered No PoC."

C. No Daily Notes

The ALJ found Medicare coverage for claims where the appellant provided services pursuant to a Plan of Care and corresponding daily treatment notes (Daily Notes). The Council finds that the following claims, although based upon a Plan of Care are not supported by any Daily Notes corresponding to the claimed dates of service:

Beneficiary 5 - 5/21/07

Beneficiary 9 - 5/18/07

Beneficiary 51 - 5/18/07

Beneficiary 82 - 5/10/07

Beneficiary 114A - 7/25/08

Beneficiary 128 - 5/27/08

Beneficiary 159 - 10/25/07

Beneficiary 162 - 11/28/07; 12/13/07; 12/20/07 and 12/26/07

These claims are identified on the Beneficiary List as "Not Covered No Doc."

D. Deficient Daily Notes

While the claim file for the following beneficiary has what would be otherwise sufficient Daily Notes supporting services, the Daily Notes are not signed by a physician and thus cannot be considered evidence that service was provided as claimed:

Beneficiary 114 - 8/5/08; 8/7/08 and 8/11/08

These claims are identified on the Beneficiary List as "Not Covered No Sig."

E. Two Beneficiaries Identified as "Beneficiary 152"

In its review of the record involving the dates of services purportedly claimed for Beneficiary 152 (C.J. ***), the Council discovered that the ALJ had, inadvertently, combined consideration of claims for two beneficiaries with common first and last names, but different middle initials (J. and K.) and HICNs. Consequently (and in order to otherwise maintain continuity with the numbering system employed by the ALJ), in the attached Beneficiary List the Council has created Beneficiary Number 152A for Beneficiary C.K. ***.

The Council found further that the appellant's additional evidence (as was allowed by the ALJ and entered into the record as Exhibit 183) comported with the ALJ's characterization of the claimed dates of service as being for Beneficiary 152, but was clearly associated with, and intended to apply, to the two distinct individuals. See Exh. 183 at 251-258. The Council's finding is borne out by the Beneficiary List accompanying the Medicare contractor's redetermination, which identifies two distinct individuals. See Exh. 178 at 44-46. The Council's review of the QIC's reconsideration shows that the error originated in the QIC's creation of the Beneficiary List for that action. See Exh. 179 at 14-15.

Liability and Waiver of Recoupment of Overpayment

As noted above, the ALJ found that the appellant was liable for the non-covered costs resulting from the overpayment pursuant to section 1879 of the Act and that the appellant was not entitled to waiver of recoupment of the overpayment under section 1870(b) of the Act. The Appellant has not challenged the ALJ's findings on liability of waiver and recoupment and the Council will not disturb them.

DECISION

The Medicare Appeals Council adopts the ALJ's global analysis of the requirements for Medicare coverage of chiropractic services, but concludes that it was inconsistently applied. Consequently, the ALJ's beneficiary-specific findings are reversed and, consistent with the Council's analysis above, replaced by those contained in the Beneficiary List accompanying this decision. The appellant's overpayment should be recalculated to reflect the Council's findings. The appellant remains liable for the

resulting non-covered costs under section 1879 of the Act and is not entitled to waiver of recoupment of the overpayment under section 1870 of the Act.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: August 29, 2011