DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

**ORDER OF MEDICARE APPEALS COUNCIL
REMANDING CASE TO ADMINISTRATIVE LAW JUDGE**

In the case of	**Claim for**
Memorial Hospital of Long Beach (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiary)	**** (HIC Number)
PRG Schultz (RAC) (Contractor)	**** (ALJ Appeal Number)

The Medicare Appeals Council has decided, on its own motion, to review the Administrative Law Judge's (ALJ's) decision dated March 20, 2008, because there is an error of law material to the outcome of the claim. The Council hereby vacates the hearing decision and remands this case to an ALJ for further proceedings, including a new decision. *See* 42 C.F.R. § 405.1110(d).

The Council has considered the record that was before the ALJ, as well as the timely filed memorandum, with any attachments, from the Centers for Medicare & Medicaid Services (CMS) dated May 9, 2008, and exceptions to the referral filed by counsel for the appellant, dated May 29, 2008. The CMS memorandum and appellant exceptions are hereby entered into the record in this case as Exhibits (Exhs.) MAC-1 and MAC-2, respectively.

BACKGROUND

This appeal involves inpatient rehabilitation facility services provided to fifteen beneficiaries listed on the attachment hereto, from August 5, 2002, through November 9, 2004. Dec. at 4. The claims were initially paid by the fiscal intermediary. *Id.* Recovery audit contractor PRG Schultz (RAC or contractor) subsequently sent letters to the appellant, advising that the

documentation submitted in complex postpayment review did not support the services claimed, that the appellant had as a result received an overpayment for those services, and that the appellant was responsible for repayment. *Id.; see* Exh. 2, at 1-2.[1] The intermediary subsequently issued unfavorable redetermination decisions, and the Qualified Independent Contractor (QIC) upheld these denials in reconsideration decisions. Dec. at 5.[2]

The ALJ issued one decision dated March 20, 2008, for all fifteen beneficiaries. As to the issue of reopening of the claims at issue, the ALJ stated that "the burden to go forth on the issue of good cause for reopening would reside with the RAC." Dec. at 5. He discussed the testimony of the RAC representative concerning its data analysis, errors on the face of the claims , and "new and material evidence" supporting the good cause determination. *Id.* at 5-6. The ALJ made a finding of fact that the initial decisions by the contractor in this case and the contract auditor's "reopening" of those initial decisions occurred on the dates listed in the appellant's pre-hearing brief. *Id.* at 6, *citing* Exh. 12, at 28.

The ALJ then stated that the RAC had not supplied evidence sufficient to establish "good cause" for reopening claims beyond one year from the initial determination. Dec. at 11, *citing* 42 C.F.R. §§ 405.980 and 405.986. He then found as follows:
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> Inasmuch as the latest date of payment in this matter was December 16, 2004, initial notice of the overpayment was required to have been made at least by December 15, 2005. Notice at any time in 2006 is well beyond the one year limit and is barred. In this case, the earliest date of notice of overpayment was July 20, 2006. Therefore, all of the reopenings in this matter are untimely and are barred.

Id. at 11-12.

The ALJ rejected the RAC's statement of good cause in the record as sufficient to demonstrate that "new and material evidence" existed to support reopening claims beyond one year. Dec. at

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[1] Citations to the record herein shall be to the claims file for beneficiary F.D., unless otherwise noted.

[2] Attachment A to the ALJ decision does not reflect dates of intermediary redetermination or QIC reconsiderations, as stated in the ALJ decision. Dec. at 1-2.

12-15, *citing* 42 C.F.R. §§ 405.980(b)(2) and 405.986(a)(1). He also rejected the RAC's argument that data review reflected that claims demonstrated "clear evidence of obvious error." *Id.* at 15-16.

The ALJ then found, in the alternative, that "even if 'good cause' . . . existed," the Medicare Financial Management Manual (MFMM) (Pub. 100-06) limited recovery of the overpayment case to three years after the original payment (in this case, not later than December 31, 2005), absent evidence of provider fault. Dec. at 16-17, *citing* MFMM Ch. 3, §§ 80, 80.1.[3] He stated that since "the notices of overpayment were issued in 2006, . . . the attempt to recover overpayment in this case is barred by CMS's own written policy." *Id.* at 16-17.

DISCUSSION

In deciding whether to accept own motion review, the Council limits its review of the ALJ decision "to those exceptions raised by CMS." 42 C.F.R. § 405.1110(c)(1),(2). CMS argues generally that the ALJ erred in finding that the contractor failed to comply with reopening requirements set forth in 42 C.F.R. §§ 405.980 and 405.986 and in finding that the three year limit barred overpayment recovery. Exh. MAC-1, at 6.

More specifically, CMS argues that a contractor's decision to reopen is non-reviewable in the administrative appeals process. *Id.* CMS further asserts that the statute governing RACs expressly contemplates that "own motion" reopenings by RACs are afforded significant discretion. *Id.* at 7, *citing* Section 1893(h) of the Act. CMS argues that even if the decision to review were subject to review, the data review activities conducted by the RAC meet "good cause" standards for new and material evidence established by CMS policy. *Id.*, *citing* Medicare Program Integrity Manual (MPIM)(Pub. 100-08) Ch. 3, § 3.7; Medicare Claims Processing Manual (MCPM)(Pub. 100-04) Ch. 34, § 10.11.1. CMS also argues that the ALJ erred in relying upon statutory and administrative authority regarding waiver of overpayment recovery, because he made a determination concerning provider fault without making a determination that an overpayment had, in fact, been made. *Id.* at 9.

In response, the appellant argues that the Council should decline CMS's referral on multiple grounds. Exh. MAC-2, at 2-3. Generally, the appellant argues that Social Security case law

[3] Manuals issued by CMS may be found at http://www.cms.hhs.gov/manuals.

establishes that good cause for reopening is reviewable in administrative and judicial processes. *Id.* at 2. The appellant states that discretionary acts of a contractor to reopen are not reviewable, but timelines for reopening are. *Id.* at 2-3. The appellant argues that commentary in CMS's final rule on changes to the Medicare claims appeals process does not reflect an intent to preclude appeals of reopening and revisions of initial determinations. *Id.* at 3. The appellant also argues that adjudicatory bodies may review agency compliance with its own rules, and that a provider's Constitutional due process rights are violated when review of reopening timeliness is denied. *Id.* The appellant finally argues that the referral is inconsistent with a prior Council decision. *Id.*

Reopening Beyond One Year

Congress established the Medicare Integrity Program, under which "the Secretary shall promote the integrity of the Medicare program by entering into contracts in accordance with this section with eligible entities to carry out the activities" listed. Section 1893(a) of the Act. Congress subsequently added a limited demonstration project that authorized recovery audit contractors (RACs) to identify and recoup Medicare overpayments. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)(P.L. 108-173) § 303. Congress expanded the RAC program nationally through the Tax Relief and Health Care Act of 2006. Public Law No. 109-432, 120 Stat. 2922 (Division B, section 302); *see* section 1893(h) of the Act. The Medicare Integrity Program defines a "Medicare contractor" for overpayment recovery to include a RAC under contract with CMS through section 1893. Section 1893(f)(2)(C) of the Act, *cross-referencing* section 1889(g)(2).

A CMS contractor may reopen and revise an initial determination or redetermination on its own motion within 1 year from the date of the initial determination or redetermination for any reason. 42 C.F.R. § 405.980(b)(1). The contractor may reopen and revise an initial determination or redetermination within 4 years for good cause. 42 C.F.R. §§ 405.980(b)(2), 405.986. A contractor may reopen and revise an initial determination at any time if evidence supports that the determination was procured by fraud or similar fault. 42 C.F.R. §§ 405.980(b)(3), 405.902.

When the proposed appeals regulations at 42 CFR Part 405, Subpart I were published in 2002, CMS stated that "[s]ince a reopening of an initial determination is an administrative

action to correct erroneous payment, there is no requirement for a burden of proof." Medicare Program: Changes to the Medicare Claims Appeal Procedures; Proposed Rule, 67 Fed. Reg. 69311, 69327 (Nov. 15, 2002). In the final rule, CMS further considered, and expressly declined to establish, an evidentiary burden of proof for reopening or to create enforcement mechanisms for the good cause standard beyond CMS's evaluation and monitoring of contractor performance. Interim Final Rule with Comment Period, 70 Fed. Reg. 11420, 11453 (Mar. 8, 2005).

When conducting a postpayment medical review of claims, contractors must adhere to reopening rules. Medicare Program Integrity Manual (MPIM)(Pub. 100-08) Ch. 3, § 3.6.B. However, neither the ALJ nor Council have jurisdiction to review that aspect of the contractor's action. A contractor's decision on whether to reopen is final and not subject to appeal. 42 C.F.R. § 405.926(l), 405.980(a)(5). This restriction extends to whether or not the contractor met the good cause standards for reopening set forth in 42 C.F.R. § 405.980(b)(2). CMS has expressly, and recently, stated that the enforcement mechanism for good cause standards lies within CMS's evaluation and monitoring of contractor performance, not the administrative appeals process. 70 Fed. Reg. at 11453.

The Council notes that the date of reopening is the date that a contractor "takes some action (which can be documented) questioning the correctness of the determination within 4 years . . . after the date the initial determination was approved." MFMM Ch. 3, § 170.2.B. In this case, the contractor sent the appellant letters requesting documentation concerning the instant claims. *See, e.g.,* Exh. 2, at 7. The letter states that the RAC has selected the appellant's claims for review due to "recent review and discovery of potential overpayment" and that the appellant must provide supporting documentation or an overpayment may be assessed. *Id.* The Council finds that the ALJ erred in determining that the date of reopening was the date of the overpayment letter. The request for documents by the RAC clearly questioned the correctness of the initial determinations and thus constitutes the reopening.

The Council rejects the appellant's arguments that case law concerning Social Security benefits controls this case. Social Security benefits are determined under different statutory and regulatory structure and are different in nature and purpose than Medicare claims appeals. As noted above, Congress and CMS have recently established requirements for revisions to the

Medicare claims appeal process, including reopenings. The Council follows those requirements and thus finds the appellant's reliance on Social Security case law unavailing.

The Council also finds unpersuasive the appellant's reading of the Federal Register commentary concerning the revised appeals process. Exh. MAC-2, at 19-20. As noted above, CMS expressly and recently declined to establish an evidentiary or "burden of proof" standard for good cause determinations for reopening. CMS also expressly declined to take enforcement of contractor good cause determinations outside of the CMS review process of Medicare contractors.

The Council also finds that the appellant's arguments concerning review of timeliness of reopening, and the Medicare case law that it cites in support, is insufficient to affirm the ALJ in this case. Exh. MAC-2, at 6-19. The appellant's arguments concerning timeliness necessarily implicate the good cause determination that the Council finds that it has no jurisdiction to review. The Council thus finds this argument unavailing.

The Council also finds the appellant's arguments concerning procedural due process violations of the Constitution inapposite. Exh. MAC-2, at 22-23. As the appellant notes, a provider retains all appeal rights in the administrative appeals process for revised determinations issued subsequent to a reopening. *Id.* at 18, *citing* MCPM, Ch. 34, § 10. The appellant's reliance upon the "Accardi doctrine" is also unavailing (*Id.* at 20-22), in that CMS has reserved to itself the determination of consequences for a contractor's noncompliance with agency rules concerning good cause. Thus, consequences of noncompliance with agency rules remain in CMS's purview in this instance, not administrative adjudication.

The Council also disagrees that a provider maintains a Constitutionally protected property interest in monies wrongly paid from Medicare funds. Exh. MAC-2, at 22-23. Congress has enacted legislation, and CMS has promulgated implementing regulations, which clearly provide a means by which Medicare funds wrongly paid may be recovered as overpayments and establishing appeal rights for that process. The Council thus sees no basis for recognizing a Constitutionally protected property interest in overpayments, in light of Congressional authority for postpayment claim review and overpayment recovery to the contrary.

The Council also finds no basis for affirming the ALJ's decision based upon the appellant's reference to the Council's decision *In the Case of Palomar Medical Center.* Exh. MAC-2, at 23-24. Council decisions are not precedential, and the record in *Palomar* is not currently before us. The portion of the decision cited by the appellant focuses on a procedural issue, not the jurisdictional issue currently before us. We thus find that *Palomar* provides no basis for affirming the ALJ in this case.

ALJ Coverage Analysis

The appellant also argues that the ALJ appropriately concluded that the appellant was without fault on 12 of the 15 cases at issue. Exh. MAC-2, at 24-25, *citing* MFMM Ch. 3, § 80. The Council finds that the ALJ erred in making such a determination.

Medicare is a defined benefit program, with certain specific exclusions. *See, e.g.,* Section 1862(a) of the Act. Coverage criteria for inpatient rehabilitation facility services are set forth in CMS Ruling 85-2 and Medicare Benefit Policy Manual (MBPM)(Pub. 100-02) Chapter 1, § 110.

An item or service may meet Medicare coverage criteria, yet still be excluded from coverage as not reasonable and necessary or as constituting custodial care in a particular case. Sections 1862(a)(1)(A) and 1862(a)(9) of the Act. In that case, section 1879 of the Act may limit the liability of a beneficiary or provider for noncovered items or services based upon whether or not they had prior knowledge of noncoverage. Section 1879(a) of the Act; 42 C.F.R. §§ 411.400(a), 411.404, 411.406. Section 1870 of the Act governs recovery of overpayments, based upon provider or beneficiary fault. Absent evidence to the contrary, a provider is deemed without fault for an overpayment discovered after the third calendar year following the year of payment. Section 1870(c) of the Act; MFMM Ch. 3 § 70.3.A.

"An overpayment does not exist if a determination is made that the limitation of liability provision [under section 1879] applies." MFMM Ch. 3 § 70.1.B. "Once the contractor has concluded that an overpayment exists (that is, a finding that payment cannot be made under the waiver of liability provisions) it makes a § 1870(b) determination" on provider or beneficiary fault in creating the overpayment." *Id.* § 70.3. The contractor would then determine whether waiver of recovery was appropriate under section 1870(c). *Id.* "If § 1879 of the Act is applicable, then § 1879 determination is made first since [a

section 1870] overpayment does not exist if payment can be made under § 1879 because there was lack of knowledge by both the beneficiary and the provider." *Id.*

The Council finds that the ALJ erred in relying upon the three-year restriction in the MFMM and section 1870(c) as an alternate grounds for denying recovery of the overpayment. As the statutes and administrative authority make clear, section 1870 is not reached until there has first been a coverage determination, followed by a reasonable and necessary analysis under section 1862(a)(1) and, if necessary, a limitation on liability analysis under section 1879. At that point, a section 1870 analysis is appropriate.

Conclusion

The Council finds that the ALJ erred in deciding that the claims for these beneficiaries had not been properly reopened. The Council has further determined that it is necessary to remand this case to afford the appellant an opportunity for a hearing on the coverage issues raised in those claims.

REMAND ORDER

The ALJ shall afford the appellant the opportunity for a hearing concerning the issues that have not been resolved in this case, including coverage of the individual claims and, as necessary, determinations on liability and fault for any overpayment. The ALJ shall provide notice of the hearing date and time to the parties, the contractor, and QIC. 42 C.F.R. § 405.1020(c)(1). The ALJ may take further action not inconsistent with this order.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

/s/ Mary C. Peltzer
Appeals Officer

Date: July 23, 2008