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**
Critical Care of North Jacksonville (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
First Coast Service Options, Inc. (Contractor)	**** (ALJ Appeal Number)

The Medicare Appeals Council has decided, on its own motion, to review the Administrative Law Judge's (ALJ's) decisions dated October 11, 2007, because there is an error of law material to the outcome of the claims. The Council hereby vacates the subject hearing decisions and remands this case to an ALJ for further proceedings, including new decisions. *See* 42 C.F.R. § 405.1110(d).

The Council has considered the record that was before the ALJ, as well as the memorandum, with any attachments, from the Centers for Medicare & Medicaid Services (CMS) dated December 7, 2007, and exceptions to the referral filed by counsel for the appellant, dated January 3, 2008.[1] The CMS memorandum and appellant exceptions are hereby entered into the record in this case as Exhibits MAC-1 and MAC-2, respectively.

BACKGROUND

Notice of SVRS Review

This case involves the review of physician evaluation and management (E&M) services provided to 89 beneficiaries from April 1, 2004, through March 31, 2005, as reflected on the attachment hereto. The

[1] The ALJ submitted a memorandum dated December 18, 2007, to the Council in response to the CMS referral memorandum. The regulations make no provision for an ALJ response to an agency referral. The Council therefore has not considered the ALJ response. The ALJ memorandum is marked as Exhibit MAC-3 for identification.

carrier, First Coast Service Options, Inc., sent a "Notice of Statistically Valid Random Sample (SVRS) Review," dated September 27, 2005, (Notice) to the physician. The Notice stated:

> This is to inform you that Medicare has selected a statistically valid random sample (SVRS) of your claims for the purpose of conducting a medical review. This review is being conducted in conjunction with the **Medical Review Progressive Corrective Action (PCA)** program outlined in CMS Transmittal AB-00-72 and is a follow up on a probe review performed in Fiscal year 2004.

The Notice requested that the physician submit medical records within 30 days (on or before October 27, 2005) to substantiate the medical necessity of the services billed. Carrier "Provider Education/Phone Contact Forms" indicate that the provider sought and was given an extension of time for submitting medical records until November 11, 2005, but further requests for extension were denied.

SVRS Medical Review and Education

The contractor Program Safeguards Division (PSD) then issued a letter captioned "Statistically Valid Random Sample (SVRS) Medical Review and Education," dated December 21, 2005. The PSD recounted that it had conducted a medical review on a statistically valid random sample with a total of 366 claims over a one year period, encompassing 135 beneficiaries and 1,785 services. According to the PSD, the medical review "resulted from a probe review performed for services billed during April 1, 2004, through September 30, 2004," to determine whether services billed were covered, documented, correctly coded, and medically reasonable and necessary.

The physician services reviewed were billed under Current Procedural Terminology (CPT) codes 99233 (subsequent hospital care) and 99291 (critical care, evaluation and management). The PSD indicated that it conducted its review, in part, using documentation guidelines developed by the American Medical Association (AMA) and CMS in 1995 and 1997. In "Findings," the PSD denied coverage for most services billed under code 99233 because "the provider failed to submit the documentation," and downcoded 13 claims to code 99232 based on the documentation submitted. The PSD denied coverage for all except two services billed under code 99291 based on a failure to submit documentation and downcoded the two remaining services to code 99233. The PSD found the appellant liable for the overpayment and indicated that it would extrapolate an overpayment based on the findings of the SVRS review.

On February 22, 2006, the carrier issued a letter stating that based on the statistical sample, the provider had been overpaid $260,074.76. The carrier issued a redetermination letter dated July 10, 2006, and the Qualified Independent Contractor (QIC) issued reconsideration decisions affirming the denials, based on an absence of documentation.

ALJ Hearing and Decisions

The ALJ conducted a telephone hearing on August 30, 2007, at which the physician testified on the medical documentation submitted for one beneficiary. Counsel for the appellant also appeared. The ALJ subsequently issued 89 individual decisions captioned "wholly favorable" (30); "partially favorable" (10); and "unfavorable" (49). As relevant to this referral, in wholly and partially favorable decisions, the ALJ made a finding of fact that claims for dates of service on or before August 26, 2004 were improperly reopened by the contractor. The ALJ stated, "[t]here is no overpayment . . . as good cause either did not exist or was not argued for reopening the instant claim(s) after twelve months elapsed."[2] Dec. at 2.

Subsequently in the text, partially favorable decisions stated:

> No overpayment exists as these claims were not timely reopened for review by the Carrier and good cause for opening them after twelve months was not proven by the Carrier.

Dec. at 8. Wholly favorable decisions subsequently stated:

> The appellant's Memorandum of Law in Support of Appellant's Motion to Waive or Dismiss and in Support of Assignment of Level of Care to Particular Claims addressed claims that the appellant contends are not proper because the Carrier failed to show good cause for reopening an initial determination after twelve months has elapsed. It further indicated that this provision would eliminate review of any claims with dates of service from March 1, 2004 through August 26, 2004 as the Notice of Statistically Valid Random Sample is dated September 27, 2005. The undersigned has reviewed the file and finds no statement by the Carrier stating that it has good cause for reopening the instant

[2] *See, e.g.,* ALJ decisions for beneficiaries A.H. (wholly favorable) and M.T. (partially favorable).

> claim(s). In light of the lack of evidence as to why these claims were reopened after twelve months this Administrative Law Judge cannot uphold the overpayment determination as the Carrier was not entitled to reopen them without first proving good cause.

Dec. at 8.[3] The ALJ then found that claims improperly reopened by the carrier were covered by Medicare as medically reasonable and necessary. *Id.* at 9.

DISCUSSION

In deciding whether to accept own motion review when CMS did not participate in the ALJ proceedings or participate as a party, the Council "will limit its consideration of the ALJ's action to those exceptions raised by CMS." 42 C.F.R. § 405.1110(c)(2). In its referral memorandum, CMS states: "This referral addresses only the judge's determination that claims with dates of service on or prior to August 24, 2004, 'were not timely reopened for review . . . and good cause for reopening them after twelve months was not proven by the Carrier." Exh. MAC-1, at 1.

The Council finds that the ALJ erred in concluding that the contractor wrongly reopened claims beyond one year without making an evidentiary showing of good cause. *See* 42 C.F.R. § 405.980(b)(2). When the proposed new appeals regulations were published, CMS explained in its discussion on reopening for fraud or similar fault 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 considered and expressly declined to establish an evidentiary burden of proof to reopen or to create enforcement mechanisms for the good cause standard beyond CMS evaluation and monitoring of contractor performance. Medicare Program: Changes to the Medicare Claims Appeal Procedures; Interim Final Rule, 70 Fed. Reg. 11419, 11453 (Mar. 8, 2005).

When conducting a postpayment medical review of claims, contractors must adhere to reopening rules. Medicare Program Integrity Manual (Pub. 100-08)(PIM), Ch. 3, §3.6.B, *citing* Medicare Carrier Manual (MCM) § 12100.[4] "The decision to conduct a sample study of a

[3] The Council was unable to locate this document or two pre-hearing motions referenced by the ALJ (Dec. at 1) as exhibits in the administrative record.
[4] CMS manuals can be located at http://www.cms.hhs.gov/manuals.

physician's or supplier's claims constitutes a reopening of all determinations in the population from which the sample is drawn, but only when such a decision is documented and is clearly intended to question the correctness of all such determinations." MCM § 12100.7. The Council finds that the Notice dated September 27, 2005, satisfies this standard.

Moreover, since the contractor's decision to conduct statistical sampling constituted a reopening of all subject claims, neither the ALJ nor Council have jurisdiction to consider that issue in the appeals process. 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 lack of jurisdiction extends to whether or not the contractor met good cause standards for reopening set forth in 42 C.F.R. § 405.980(b)(2). CMS has expressly 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. 11420, at 11453 (Mar. 8, 2005).

The Council therefore remands this case to the ALJ to issue new decisions on whether the claims reopened beyond one year (i.e., those with dates of service of April 1, 2004 through August 26, 2004) are covered under the Medicare program.

REMAND ORDER

On remand, the ALJ shall give the parties the opportunity for another hearing and shall provide notice of the time and date of the hearing to the parties, the contractor, and the QIC. 42 C.F.R. § 405.1020(c)(1). The ALJ "decision[s] must be based on evidence offered at the hearing or otherwise admitted into the record." 42 C.F.R. § 405.1046(a). The ALJ must make a complete record of the evidence, which "will include marked as exhibits, the documents used in making the decision under review . . . ." 42 C.F.R.

§ 405.1042(a)(1),(2). The ALJ may take further action not inconsistent with this order.

MEDICARE APPEALS COUNCIL

Gilde Morrisson
Administrative Appeals Judge

Thomas E. Herrmann
Administrative Appeals Judge

Date: February 29, 2008