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**
Providence St. Joseph Medical Center	Hospital Insurance Benefits (Part A)
(Appellant)	
****	****
(Beneficiary)	(HIC Number)
United Government Services, LLC	****
(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 5, 2008, for eighteen beneficiaries because there is an error of law material to the outcome of the claims in issue. [1] The case before the ALJ arose as the result of overpayment notices issued by a recovery audit contractor (RAC) in a series of claims, filed by the appellant, for Medicare coverage of inpatient rehabilitation services provided to the listed beneficiaries. The ALJ concluded that recovery of the alleged overpayments was barred by 42 C.F.R. §§ 405.980 and 405.986. Further, the ALJ determined that, in ten of the cases at issue, recovery was also barred by chapter 3, sections 80 and 80.1 of the Medicare Financial Management Manual (MFMM) (Pub. 100-06).

[1] The ALJ issued one favorable decision in claims for nineteen beneficiaries, and placed a copy of the decision in each beneficiary's file. *See* Decision at 14 and 17; *see also* Decision, Attachment B. However, the CMS referral memorandum and accompanying beneficiary notices identified only eighteen claims for which review was requested. *See* Exh. MAC-1. The Council concludes that CMS did not refer to the Council the decision with respect to beneficiary E.F (ALJ Appeal No. 1-225679139), and limits its review to the eighteen claims identified by CMS.

The Council has considered the record before the ALJ, as well as the referral memorandum from the Centers for Medicare & Medicaid Services (CMS) dated April 28, 2008, and the appellant's exceptions (dated May 22, 2008) to the CMS referral memorandum. The CMS memorandum and the appellant's exceptions are entered into the record in this case as Exhibits MAC-1 and MAC-2, respectively.

As explained more fully below, the Council vacates the hearing decision and remands these cases to an ALJ for further proceedings, including a new decision. *See* 42 C.F.R. § 405.1110(d).

LEGAL AUTHORITY

The regulations applicable to the claims at issue, codified at 42 C.F.R. §§ 405.900-405.1140, implemented statutory changes enacted by section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106-554) (BIPA) and related provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173) (MMA). 70 Fed. Reg. 11420 (March 8, 2005). Pursuant to section 1869 of the Social Security Act (Act), CMS may reopen or revise any initial determination or reconsidered determination on a Medicare claim pursuant to guidelines established by regulation.

The regulation at 42 C.F.R. § 405.980(b) establishes the time frame for reopening initial determinations and redeterminations initiated by a contractor. In pertinent part, the regulation provides:

> A contractor may reopen and revise its initial determination or redetermination on its own motion - -
>
> (1) Within 1 year from the date of the initial determination or redetermination for any reason.
>
> (2) Within 4 years from the date of the initial determination or redetermination for good cause as defined in § 405.986. . . .

The regulation addressing good cause for reopening is found at 42 C.F.R. § 405.986 and, as applicable here, provides:

> (a) Good cause may be established when –
>
> (1) There is new and material evidence that –

(i) Was not available or known at the time of the determination or decision; and

(ii) May result in a different conclusion; or

(2) The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision. . . .

The regulation at 42 C.F.R. § 405.926 establishes actions that are not initial determinations and not appealable. Included among those actions is a "contractor's . . . decision to reopen or not reopen an initial determination." 42 C.F.R. § 405.926(l). Additionally, the program regulations pertaining to reopenings also provide that a "contractor's QIC's, ALJ's or MAC's decision on whether to reopen is final and not subject to appeal." 42 C.F.R. § 405.980(a)(5).

Section 1870(b) of the Act provides for waiver of recovery of an overpayment to a provider of services or supplier whenever that provider or supplier is without fault in incurring the overpayment. Chapter 3 of the MFMM provides guidance on the treatment of Medicare overpayments. MFMM, chapter three at sections 80 and 80.1 address, respectively, individual overpayments discovered subsequent to the third year after payment was approved and the methodology for determining the third year after the year payment was approved. Sections 90 and 90.1 of that chapter address provider liability for overpayments and examples of situations in which a provider is liable.

BACKGROUND

The appellant submitted claims to Medicare for coverage of inpatient rehabilitation services provided to the eighteen beneficiaries at issue between August 10, 2002, and March 7, 2003. The carrier, United Government Services, initially paid the claims on various dates between September 20, 2002, and April 10, 2003. Decision, Attachment B.

On June 13, 2006, and July 6, 2006, the Recovery Audit Contractor (RAC) issued overpayment notices in these claims. The appellant sought redetermination, and then reconsideration of the

reopened and revised determination on each claim. Coverage for the claims was denied at both levels of review, typically because the beneficiaries' records did not demonstrate that the services were reasonable and necessary.[2]

Following timely requests for hearings, on February 6, 2008, the ALJ conducted a single telephonic hearing to address the appellant's claims. The appellant and the RAC appeared at the hearing and provided testimony. The ALJ characterized the issue to be decided as "whether or not the notice of overpayment from the contract auditor [RAC] to the appellant was filed." Dec. at 5. The ALJ concluded that "the notice was not timely, and that [the] lack of timeliness . . . [was] dispositive of the issues. . . ." *Id.*

The ALJ found that since there was no new and material evidence, not available or known at the time of the initial decision, which may have resulted in a different conclusion, the RAC had not demonstrated good cause for the reopenings. Thus, CMS was limited in its recovery of overpayments to the one year limit established by 42 C.F.R. § 405.980(b)(1). Dec. at 12. The ALJ then noted that 10 of the claims involved notices of overpayment issued more than three fiscal years after the initial payment. The ALJ then determined:

> No evidence was adduced at the hearing showing a "pattern of billing errors" or other similar fault by the provider in this case. Therefore, even if "good cause" for reopening the initial decision existed the provisions of . . . [MFMM] Chapter 3, §§ 80 and 80.1 would limit recovery to the third year following the year in which the original bill was paid (i.e. not later than December 31, 2005). Inasmuch as, the notices of overpayment were all issued in 2006, I find that the attempt to recover overpayment in the 10 cases paid in 2002 is barred by CMS's own written policy.

Dec. at 16.

Before the Council, CMS argued that the ALJ erred in determining that consideration of the alleged overpayments at issue was barred by 42 C.F.R. §§ 405.980 and 405.986. Following a discussion of the pertinent legislative authority and program guidance, CMS asserted that the contractor's decision to reopen these claims was not reviewable in the administrative appeals process. Rather, under the applicable regulations and guidance on reopenings, CMS

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[2] *See, e.g.*, Claim file for beneficiary R.V at Exhibits 4 and 5.

contended that it was merely required to provide the appellant with the rationale for the reopenings as it had done in these cases. Exh. MAC-1 at 5-8 and 10. CMS also argued that while the ALJ could, in theory, review the question of waiver of recovery of overpayments, the ALJ erred in waiving recovery for the claims "absent a determination as to whether an overpayment in fact existed." *Id.* at 8-10.

In response to the CMS memorandum, the appellant argued that, based upon applicable case law, the ALJ had the jurisdiction to determine whether there existed "good cause" to reopen initial Medicare determination of coverage more than one year after the provider (*i.e.* the appellant) was paid on the claims. Exh. MAC-2 at 6-15. The appellant contended that Medicare regulations provided the ALJ with jurisdiction to review the timeliness of a reopening in the context of a revised redetermination resulting from reopening and did not bar ALJ review of the timeliness of reopenings and revisions of initial determinations. *Id.* at 15-19. The appellant also asserted that the CMS position on reopening was not supported by commentary found in the Federal Register. Rather, the Supreme Court's *Accardi Doctrine*[3] (rules promulgated by a federal agency, which regulate the rights and interests of others, are controlling upon the agency) mandated administrative and judicial review of the CMS action. Exh. MAC-2 at 19-22. Further, the appellant maintained that failure to review the reopening determination violated procedural due process and was contrary to a prior determination of this Council (*Palomar Medical Center,* ALJ Appeal No. 1-153282378, *et al.* (Jan. 11, 2008)). Exh. MAC-2 at 22-24. Finally, the appellant argued that an ALJ is not required to make a determination on the substantive merits of a claim prior to finding a provider is without fault and waiving the recovery of an overpayment. Here, the appellant asserted, the ALJ correctly determined that there was no pattern of billing errors and thus, the appellant was without fault in 10 of the 19 claims at issue.[4] *Id.* at 24-27.

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[3] United States *ex rel.* Accardi v. Shaughnessy, 374 U.S. 260 (1954).

[4] At the outset of its response to the CMS memorandum, the appellant asserted that "as evidenced in the case file, there were 11 of 19 cases . . . initially paid in 2002 and . . . therefore subject to the without fault provision." Exh. MAC-2 at 1, n.1.

DISCUSSION

The ALJ did not have the authority to review the CMS decision to reopen these claims.

The question presented by this case is not whether the contractor reopened these claims after four years without regard to the regulatory limits. Rather, the appellant simply disagrees that the contractor had good cause, or sufficiently articulated good cause, to reopen. Based upon the weight of the authority addressed below, 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).

As noted above, the appellant cited extensive case law which, it asserted, supported the ALJ's authority to review the CMS decision to reopen the claims at issue. *See e.g.,* Exh. MAC-2 at 12-14. In large part, the cases relied upon by the appellant were drawn from decisions of the Provider Reimbursement Review Board (PRRB) and the Social Security Administration (SSA). Generally, those cases concerning other regulatory schemes are not pertinent to the issue before the Council. It is well-established that, under the pre-BIPA statutory scheme, there was no statutory authority for reopenings. *See* Califano v. Sanders, 430 U.S. 99 (1977). BIPA amended the Act to include, for the first time, specific reopening provisions under regulatory guidelines established by the Secretary. *See* section 1869(b)(1)(G) of the Act. The grant of authority confers legislative effect on the Secretary's regulations.

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. 11420, 11453 (Mar. 8, 2005).

In the proposed rule, CMS stated that the goal of the Medicare payment system should be to pay the correct amount. 67 Fed. Reg. 69327. However, CMS emphasized that it was clarifying the conditions for using the reopening process as reopenings had often been misconstrued as a level of the appeals process. *Id.* In the final rule, CMS reiterated that reopenings "continue to be discretionary actions on the part of contractors . . . not subject to appeal." 70 Fed. Reg. 11420, 11451 and 11453. Further, in the case of unfavorable decisions, due process concerns are addressed by the fact that affected parties have the right to appeal. *Id.* at 11453.

The appellant cited SSA regulations, and case law thereon, as analogous support for its position that CMS is required to prove good cause as part of the reopening and revision of a final decision. *See, e.g.,* 20 C.F.R. §§ 404.988 and 404.989 (2004). As noted above, these regulations are not applicable to this case. In addition, the current program regulation, at 42 C.F.R. § 405.980, provides a stratified structure for reopening. Pursuant to 42 C.F.R. § 405.980(a)(1)(i) a CMS contractor may reopen an *initial determination or redetermination*. An ALJ's or the Council's authority to reopen is limited to *revision of the hearing decision (an ALJ*) or *the hearing and review decision (the Council)*. 42 C.F.R. §§ 405.980(a)(1)(ii) and (iii). Notably, neither the ALJ nor the Council have any authority to reopen or revise an initial determination or redetermination.

The appellant challenged CMS's position that the regulations at 42 C.F.R. §§ 405.926(l) and 405.980(a)(5) precluded ALJ review of the timeliness of the contractor's determination to reopen or revise initial determinations. The appellant asserted that "[a]ll that is precluded is review of a contractor's decision to reopen an initial determination, not whether the underlying prerequisites are satisfied." Exh. MAC-2 at 17. The appellant continued, contending that "[t]he most reasonable reading of the regulations would be that the discretionary decision of a contractor as to whether or not a 'final determination' should be reopened is not reviewable. That is, a contractor has the discretion to decide whether an initial determination should be reopened, and that discretionary decision may not be challenged." *Id.*

The appellant then cited chapter 34, section 10 of the Medicare Claims Processing Manual (MCPM) (Pub. 100-04) which it asserts "supports the conclusion that it is only the discretionary choice of the contractor that is not appealable." *Id.* at 18. Specifically, "Reopenings are a discretionary action on the part of

the contractor. A contractor's decision to reopen a claim is not an initial determination and is therefore not appealable . . . if the reopening results in a revised adverse determination, then new appeal rights would be offered on that revised determination." *Id.* The appellant concluded that "it is the discretionary choice of the contractor, whether or not to reopen an initial determination that is not appealable. In contrast, the result of the reopening, revised determination, clearly may be appealed." Exh. MAC-2 at 18.

We agree with the appellant that the result of the reopened and revised determination is appealable. We further agree that the contractor has discretion to find good cause, and thus reopen. The appellant then suggests that the ALJ and MAC may, nonetheless, somehow second guess a contractor's exercise of discretion in finding good cause, and the contractor's articulation of good cause. The appellant's argument that the ALJ has the power to look behind the contractor's decision to reopen presents a distinction without a difference, and is not supported by the cited authorities. The appellant is expressly asking that the ALJ and Council "review a contractor's decision to reopen an initial determination." The regulation at 42 C.F.R. § 405.926(l) forbids this.[5] The appellant's position contradicts the specific language of the regulation and the intent expressed in the preamble to the final rule that reopenings "continue to be discretionary actions on the part of contractors . . . not subject to appeal." 70 Fed. Reg. 11420, 11451 and 11453.

The appellant asserted that the Supreme Court's *Accardi* doctrine, that rules promulgated by a federal agency regulating the rights and interests of others are controlling upon that agency, supports it position. The appellant's due process concerns are directly addressed by the regulations and accompanying preamble. The regulations specifically provide that 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. An

[5] By comparison, the SSA regulation at 20 C.F.R. § 404.903 sets out administrative actions, that were not "initial determinations," but actions which the SSA retained the authority to review. Included in that listing was the *denial of a request to reopen* a determination or decision. 20 C.F.R. § 404.903(l). Emphasis supplied. That regulation did not specifically proscribe review of a determination to reopen, unlike the regulations applicable here.

appellant's due process rights are preserved by the ability to appeal the merits of revised determination. 70 Fed. Reg. 11420, 11453.

The appellant further asserts that a recent decision by this Council, *Palomar Medical Center* (Jan. 11, 2008), supports the position that ALJ's have the jurisdiction to review the timeliness of reopenings and revision of initial determinations. This assertion is not persuasive. The appellant has not supplied a copy of that decision for the record. The Council's actions are not precedential and, generally, are not published. Additionally, the Council conducts *de novo* review of each ALJ decision. *See* 42 C.F.R. § 405.1100(c).

Waiver of recovery

As the ALJ discussed, chapter 3, sections 80 and 80.1 of the MFMM address time-based limitations on the recovery of overpayment. The provisions addressing waiver of recovery of an overpayment from a a provider are found in chapter 3, section 90 of the MFMM. Generally, a "provider is liable for overpayments it received unless it is found to be without fault . . . Normally, it will be clear from the circumstances whether the provider was without fault in causing the overpayment. Where it is not clear, the FI [fiscal intermediary] or carrier shall develop the issue." MFFM, Chp. 3, § 90. The MFFM then sets out numerous examples of situations in which a provider is liable for an overpayment. MFFM, Chp. 3, § 90, ¶¶ A-L.

Regardless of the substantive validity of the ALJ's conclusions on reopening, having determined, that there were no overpayments the issue of waiver for recovery of overpayments was not before the ALJ. The ALJ conceded as much, casting the analysis in the hypothetical. *See* Dec. at 16 (even if "good cause" for reopening . . . existed"). Absent a finding of overpayment, waiver of the overpayment for claims paid in 2002 was not before the ALJ. Further, the ALJ's analysis on this issue is unsound in that it contains no analysis on the substance of the waiver issue. Specifically, the ALJ did not address whether the "provider . . . is . . . without fault." *See* MFMM Chp.3, § 90.

The Council vacates the ALJ’s decision for the eighteen beneficiaries at issue and remands those cases to the ALJ to conduct a new hearing and issue new decisions on whether the claims opened beyond one year of their respective dates of service 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 will determine whether the claims at issue can be covered under Medicare.

- If necessary, after a resolving the question of coverage, the ALJ will consider whether the overpayments involving claims paid in 2002 can be waived in the context of section 1870(b) of the Act and chapter 3, sections 80, 80.1, 90 and 90.1 of the MFMM.

- If necessary, the ALJ will resolve conflict between the appellant’s assertion, in Exhibit MAC-2 at 1, n.1, that Medicare paid 11 claims in 2002 and Attachment B to the ALJ decision which indicates 10 claims were paid in 2002.

The ALJ may take further action not inconsistent with this order.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/ M. Susan Wiley
Administrative Appeals Judge

Date: July 23, 2008