DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
Comprehensive Decubitus Therapy, Inc., d/b/a Advanced Tissue (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
CIGNA (DME MAC) (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated September 23, 2008, which concerned surgical dressings, specifically, collagen dressing, non-impregnated gauze, impregnated gauze, and tape (billed using codes A6021, A6402, A6266, A4450), furnished by Comprehensive Decubitus Therapy, Inc. to the beneficiary on July 31, 2007. The ALJ determined that the items were not covered by Medicare and that the supplier was not entitled to a waiver of liability. The appellant supplier has asked the Medicare Appeals Council to review this action.

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).

As set forth below, the Council finds that although the supplies are not covered by Medicare the appellant is entitled to a waiver of liability under section 1870(b) of the Social Security Act (Act). Therefore, the Council modifies the ALJ's decision.

BACKGROUND AND PROCEDURAL HISTORY

On July 30, 2007, the beneficiary's podiatrist signed a Certificate of Medical Necessity (CMN), ordering the surgical dressings at issue for the treatment of two decubitus ulcers located on the beneficiary's right foot. Exh. 13 at 31. The CMN stated that the beneficiary was not currently receiving home health care. On July 31, 2007, the appellant checked the beneficiary's Medicare eligibility through the ZirMed website.[1] The inquiry indicated that as of July 31, 2007, the beneficiary had Medicare Parts A and B coverage and was not enrolled in a home health episode of care. Exh. 8 at 24. On July 31, 2007, the appellant shipped the supplies to the beneficiary, who received the items on August 2, 2007. Exh. 19 at 32.

The appellant submitted a claim to the Medicare contractor for the surgical supplies furnished on July 31, 2007. The contractor initially paid the claim on August 20, 2007; however, the contractor subsequently issued an overpayment notice for the items on November 9, 2007. The overpayment notice stated that the beneficiary was under a home health episode of care on the date of service of July 31, 2007; thus, under consolidated billing, the supplies were included in the home health agency's payment and were not separately billable to Medicare. Exhs. 1-2.

On January 21, 2008, the appellant submitted a bill to the home health provider for reimbursement of the supplies. Exh. 3 at 5. On February 5, 2008, the home heath agency (HHA) responded that it was not responsible for the cost of the items because (1) it did not order them, and (2) the HHA certification period was from June 29, 2007, through August 1, 2007,[2] and since the supplies shipped on July 31, 2007, one day before discharge, the

---

[1] From our website research, ZirMed apparently provides a resource to health care providers in which a provider can determine a patient's insurance coverage status prior to furnishing items and supplies. *See* www.ZirMed.com. The appellant alleges that ZirMed is a Medicare contractor and provides access to Medicare's Common Working File (CWF). The Council is has been unable to verify the relationship between CMS/Medicare and ZirMed.

[2] On August 28, 2007, the supplier received an order for additional supplies for the beneficiary and again conducted an eligibility check through ZirMed. The response indicated that the beneficiary was receiving home health services from June 29, 2007, through August 27, 2007. At that time, the bill for the items at issue was already submitted. It is not clear whether there was another home health agency that provided services from August 2, 2007, through August 27, 2007; nonetheless, the supplier did not have access to this information at the time it submitted the bill for the items at issue.

supplies must have arrived at the beneficiary's home after the HHA enrollment period had ended.[3] Exh. 10 at 28.

The supplier recognized a discrepancy in the reported dates of home health care services provided to the beneficiary, contacted the Medicare contractor for clarification, and submitted a request for redetermination on February 13, 2008. The Medicare contractor upheld the overpayment on redetermination, finding that the beneficiary was enrolled in a home health episode of care during the date of service in question and that the supplier was responsible for the overpaid costs. Exh. 4 at 7-9.

The appellant requested a Qualified Independent Contractor (QIC) reconsideration. The QIC likewise found that the beneficiary was under a home health period of care on the date of service at issue and that the "primary home health agency is responsible for providing these services either directly or under arrangement." Exh. 6 at 17. The QIC further concluded that "another entity is responsible for payment for the surgical dressings." *Id*.

On June 24, 2008, the appellant requested an ALJ hearing, and on September 4, 2008, the ALJ held a telephone hearing on the matter. Exh. 7, Dec. at 1. The ALJ issued an unfavorable decision on September 23, 2008, determining that the surgical dressings were not covered by Medicare and that the "waiver of liability provisions in Section 1870 and Section 1879 of the Act do not apply to this case." Dec. at 6.

The appellant subsequently requested review of the ALJ's decision contending that it is entitled to a waiver of liability under both sections 1870 and 1879, or in the alternative, entitled to payment because the items at issue were received by the beneficiary on August 2, 2007, one day after he was discharged by the home health agency.

[3] In follow-up discussions with the HHA in an attempt to resolve the HHA enrollment period date discrepancy, the HHA again stated that the final HHA date of service was August 1, 2007, and that this claim was billed to Medicare on October 15, 2007, and paid on October 29, 2007. Exh. 9 at 26. Because the HHA did not submit its bill until after the supplier billed for the items at issue, the information was not yet available through the Common Working File (CWF).

DISCUSSION

Medicare Coverage

The surgical dressings at issue do not qualify for separate Medicare payment to the supplier. Section 1862 of the Act specifies exclusions from Medicare coverage and payment. Specifically, section 1862(a)(21) prohibits separate Medicare payment for items "for home health services (including medical supplies . . .), furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the [home health] agency."

The Medicare Claims Processing Manual (MCPM), Pub. 100-04, Ch. 10, § 20.1.1, explains HHA consolidated billing:

> Medicare payment for services subject to home health consolidated billing is made to the primary HHA, so separate Medicare payment for these services will never be made. The primary HHA is responsible for providing these services, either directly or under arrangement. This responsibility applies to all services that the physician has ordered on the beneficiary's home health plan of care.

MCPM, Pub. 100-04, Ch. 10, § 20.1.1.

The appellant in this case independently billed for collagen dressing, non-impregnated gauze, impregnated gauze, and tape, provided on July 31, 2007. The record indicates that the beneficiary was receiving home health care from June 29, 2007, through at least August 1, 2007. The billed July 31, 2007, date of service falls clearly within that home health care period, is subject to consolidated billing, and therefore does not qualify for separate payment in accordance with section 1862(a)(21) of the Act.

Limitation of Liability

The Council further finds that the limitation of liability provisions in section 1879 does not apply the present case, however, section 1870(b) is applicable and the appellant meets the requirements for waiver of liability.

Section 1879

The limitation on liability provisions of section 1879 apply only to denials where the items or services are determined to be not medically reasonable and necessary (section 1862(a)(1) of the Act); or are for custodial care (section 1862(a)(9)); or in the case of home health services, because the beneficiary was not homebound or did not need skilled nursing care on an intermittent basis (section 1879(g)(1)), or where hospice care is provided to an individual who is later determined not to be terminally ill (section 1879(g)(2)). In this case, denial of payment was made under the home health consolidated billing exclusion of section 1862(a)(21) of the Act, and therefore section 1879 limitation on liability is not applicable.

Section 1870

Section 1870 of the Social Security Act (Act) provides, *inter alia*, that --

> (b) where –
>
> > (1) more than the correct amount is paid under this title to a provider of services . . . and the Secretary determines (A) that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services . . . , or (B) that such provider of services . . . was without fault with respect to the payment of such excess over the correct amount . . .
> >
> > proper adjustments shall be made, under regulations prescribed . . . by the Secretary . . . .

Section 1870(b) of the Act applies to overpayments made by providers and suppliers, such as the appellant, and therefore is applicable here. Section 1870(b) provides waiver of liability for an overpayment in certain circumstances where a provider or supplier is "without fault." The Medicare Financial Management Manual (MFMM) (CMS Pub. 100-06), instructs that a provider or supplier is "without fault" when the provider or supplier:

> exercised reasonable care in billing for, and accepting the payment; *i.e.*;

- It made full disclosure of all material facts; and

- On the basis of the information available to it, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or, if it had reason to question the payment; it promptly brought the question to the [fiscal intermediary's (FI's)] attention.

MFMM, Ch. 3 § 90.[4]

The Medicare Claims Processing Manual (MCPM), Pub. 100-04, Ch. 10 § 20.1.2, provides instructions for suppliers subject to HHA consolidated billing. It states that in order to determine if a home health episode of care exists a supplier may, (1) "ask the beneficiary," (2) contact the Medicare contractor, such as the fiscal intermediary, carrier, Medicare Administrative Contractor (MAC), or durable medical equipment(DME) MAC, or (3) "as a last resort," may "request home health eligibility information available on the [CWF]." The manual notes that the "carrier's, MAC's or DME MAC's information is based only on claims Medicare has received from home health agencies at the day of the contact." *Id*.

Based on the facts of this case, the Council finds that the appellant exercised reasonable care in billing for the items at issue. Moreover, the Council finds that based on the information available to it, the appellant had a reasonable basis for assuming that the payment was correct. The order for the surgical supplies at issue, certified by the beneficiary's doctor, indicates that the beneficiary was not receiving home health services as of July 30, 2007. The record includes a progress note also written on July 30, 2007, stating, "[the beneficiary's] wife can now do [the treatments utilizing the surgical supplies] at home, so [the beneficiary] discontinued home health." Exh. 12 at 30. On July 31, 2007, the appellant contacted ZirMed to verify Medicare eligibility and received further indication that the beneficiary was not currently

[4] The appellant argues that it is against "equity and good conscious" to prohibit payment for the supplies at issue. The "against equity and good conscience" language is derived from section 1870(c) of the Act. The ALJ erred in his application of 1870(c), concluding that the supplier did not meet the requirements based on the date of retraction. Instead, section 1870(c) applies to overpayments made to beneficiaries and does not apply to this supplier's appeal.

obtaining home health services. Based on these assurances, the supplier's determination that the beneficiary was not receiving home health services when it supplied and billed for the items at issue was reasonable. Therefore, the Council finds that the appellant was without fault in this overpayment, and recovery of the overpayment is waived. Section 1870(b) of the Act.

DECISION

It is the decision of the Medicare Appeals Council that the surgical dressings at issue are not separately payable to the appellant due to home health consolidated billing provisions. However, the appellant is without fault with respect to this overpayment based on its efforts to verify the beneficiary's coverage status in advance of providing the items; therefore, recovery of the overpayment is waived under section 1870(b) of the Act.

MEDICARE APPEALS COUNCIL

/s/Gilde Morrisson
Administrative Appeals Judge

/s/Constance B. Tobias, Chair
Departmental Appeals Board

Date: March 13, 2009