

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of

Starosta Medical PC
(Appellant)

(Beneficiaries)

Empire Medical Services
(Contractor)

Claim for

Supplementary Medical
Insurance Benefits (Part B)

(HIC Number)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision, dated October 31, 2007, partially favorable to the appellant. The case before the ALJ involved a Medicare overpayment determination rendered against the appellant for a variety of medical services provided to thirty-five beneficiaries between November 12, 2001, and June 17, 2003. The ALJ found Medicare coverage available for a subset of claims for those beneficiaries. The ALJ also found the appellant liable for the cost of the non-covered services. The appellant has asked the Medicare Appeals Council to review the ALJ's action as it pertains to claims for twenty-seven beneficiaries. The Council grants the request for review because there is an error of law. See 20 C.F.R. §§ 404.967 and 404.970, *incorporated by reference* in 42 C.F.R. § 405.856.

The Council has carefully considered the record before the ALJ as well as the appellant's December 28, 2007, request for review; the appellant's January 3, 2008, revised request for review and the appellant's brief, dated May 11, 2009. These documents are entered into the record as Exhibit (Exh.) MAC-1, Exhibit MAC-2 and Exhibit MAC-3, respectively.

As explained more fully below, the Council affirms the ALJ decision in part and reverses it in part.

BACKGROUND

The appellant provided a variety of medical services to beneficiaries between 2001 and 2003. These services were billed to and initially covered by Medicare. In 2005, the Medicare Eastern Benefit Integrity Support Center (EA-BISC) audited the appellant's Medicare billing for the period January 2002 through June 30, 2003, reviewing 1548 claims for services provided to thirty-five beneficiaries. The EA-BISC found coverage appropriate in 355 claims, reduced coverage in 78 claims and denied coverage in 1,115 claims. The EA-BISC identified an overpayment of approximately \$195,675. Essentially the EA-BISC found that the appellant had failed to document its claims or that the documentation provided did not meet the criteria established by the applicable Local Medical Review Policy (LMRP). See Exh. 15.¹

The appellant sought review through the Medicare claims appeals process and ultimately received a partially favorable decision from a Medicare Part B Hearing Officer. See Exh. 8. The appellant then requested a hearing before an ALJ. Before the ALJ, the appellant did not dispute the methodology by which the audit sample was created, and the presentation of her case focused on the availability of Medicare coverage for the services at issue. Following a two-day hearing in which both counsel for the appellant and the appellant participated, the ALJ issued the partially favorable decision currently before the Council. In the decision, the ALJ first set out the case background as well as the generally applicable statutory, regulatory and program guidance. Dec. at 1-9. The ALJ then produced what were essentially thirty-five, beneficiary-specific decisions. *Id.* at 10-115.

Before the Council, the appellant requested "limited review" of the ALJ decision. The appellant indicated that the claims at issue fell into three categories of Medicare coverage - evaluation and management (E & M) services; bone density studies and physical medicine and rehabilitation, *i.e.*, physical therapy (PT). See Exhs. MAC-1 and MAC-2.

¹ The six pages of this exhibit were placed in the record in the improper order so that their subsequent hand-pagination is non-sequential. The chronological first page of this document is page "862" and the chronological last/signature page, is "861."

Generally, the appellant argued:

The ALJ's three determinations that bone mass measurement services were not covered by Medicare were based on errors of fact and contrary to regulations and policy.

The ALJ's determinations sustaining the down-coding of certain E & M services were based on errors of fact and contrary to regulations and policy.

The ALJ's determinations that certain [physical therapy] PT services were not covered by Medicare were based on errors of fact and contrary to regulations and policy.

For any noncovered [physical therapy] services, the appellant qualifies for a waiver of liability.

The administrative process has not afforded the appellant due process of law.

See Exh. MAC-3 at 2, 6, 20 and 38.

LEGAL AUTHORITIES

Medicare covers "medical and other health services" under Part B, which is defined in the Social Security Act (the Act) to include physician services. Act § 1861(s); see also 42 C.F.R. § 410.10(a). Physician services "are the professional services performed by a physician or physicians for a patient including diagnosis, therapy, surgery, consultation and care plan oversight." Medicare Benefit Policy Manual (MBPM) (Pub. 100-02), chap. 15, § 30.A.

Section 1833(e) of the Act prohibits payment "to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due." The regulations also make clear that it is the responsibility of the appellant to furnish sufficient information to enable the contractor to determine whether payment is due and the amount of the payment. 42 C.F.R. § 424.5(a)(6). Thus, an appellant has the burden to provide sufficient documentation, evidence and testimony that indicates the services provided are covered by Medicare.

Section 1862(a)(1)(A) of the Act directs that, notwithstanding any other coverage provision, "no payment may be made under part A or part B for any expenses incurred for items or services "which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Section 1848 of the Act established a new payment system for all physician services beginning in 1992. Pursuant to section 1848(a)(1), payment for physician services is based on the lesser of the actual charge for the service or the amount determined under a fee schedule. Section 1848(b)(1) of the Act requires that for each year beginning with 1992 the Secretary of Health and Human Services shall establish by regulations fee schedules that designate payment amounts for all physician services. Subsection (c)(4) provides that the Secretary may establish ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement the fee schedule. Subsection (c)(5) provides that the Secretary shall establish a uniform procedure coding system for the coding of all physician services.

Implementing regulations for the fee schedule were codified at 42 C.F.R. part 414, subpart A. Section 414.40 establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes. The Medicare coding system, HCPCS, is based on the American Medical Association's Physicians' Current Procedural Terminology (CPT).²

ANALYSIS

1. Bone Density Scans

At issue are denials of Medicare coverage for bone density scans provided to three female beneficiaries (A.G., Z.K. and Y.V.) in June 2003. In each case, the ALJ determined that the beneficiary's case file did not support the associated claim for coverage of a bone density scan, specifically that there was no substantial evidence that the beneficiaries were estrogen deficient as alleged by the appellant. Dec. at 30, 38 and 105.

The appellant cites 42 C.F.R. § 410.31(d)(1) which provides, in pertinent part, that bone mass measurement is a Medicare-covered

² The ALJ provided a brief synopsis of the various CPT codes and LMRPs involved in this case. Dec. at 4-9. Below, the Council will address only the specific CPT codes or LMRPs necessary to its analysis.

benefit for a woman determined, by her physician (or qualified non-physician practitioner), to be estrogen deficient. The appellant notes that her findings were based upon the beneficiaries' long-standing post-menopausal status and argued that the ALJ erred in ignoring these findings absent any contradictory evidence in the record. Exh. MAC-3 at 2. The appellant also cites a CMS response to comment published in the Federal Register as evidence of the discretion afforded physicians in applying 42 C.F.R. § 410.31(d)(1). The CMS response addressed, in part, a concern that because there was not an existing diagnosis code "to describe the condition of estrogen-deficient" practitioners could be forced to use several other codes to describe conditions likely to result from estrogen deficiency. Consequently, there could be variations in Medicare coverage from carrier to carrier. CMS, referencing comments from 1998, responded that:

We allowed the treating physician or other treating practitioner the discretion and flexibility to determine whether a female beneficiary is estrogen deficient and at clinical risk for osteoporosis. Creating a code specifically for reimbursement when the condition is described by other codes is not required.

Exh. MAC-3 at 2-3 (citing 71 Fed. Reg. 69695 (Dec. 1, 2006)).

The appellant contends that the "ALJ's decision does not conform to the regulatory standard and . . . [the] policy interpretation expressed by CMS." Moreover, the appellant asserts that her testimony and the accompanying medical records supported the claims for coverage. See Exh. MAC-3 at 3-6.

As the appellant notes, in each claim at issue, the ALJ's analysis was essentially identical, denying coverage because the appellant failed to demonstrate that the particular beneficiary was estrogen-deficient. The ALJ found that the beneficiaries did not meet the criteria for bone density scans, but did not identify the criteria being applied.

Having reviewed the case files for these beneficiaries, the Council reverses the ALJ's denial of coverage for the bone density scans for each of the three beneficiaries. The records show that each beneficiary was post-menopausal and identified as estrogen deficient by the appellant. The beneficiaries had other co-morbidities, such as osteoarthritis or osteoporosis,

which raised valid concerns about their respective bone densities. The Council notes that the CMS policy interpretation, cited above, vests a great deal of latitude in a treating physician's determination as to a patient's estrogen-deficiency. In the cases at hand the appellant's determinations did not overstep the latitude provided by CMS. Accordingly, the Council finds that the bone density scans at issue may be covered by Medicare.

Attachment A to this decision identifies the beneficiaries and claims at issue.

2. Downcoding of Evaluation and Management Services

The Codes

The following CPT codes are involved in consideration of the claims at issue:

CPT Code 99215 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of three key components -

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually the presenting problems are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

CPT Code 99214 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of three key components -

- a detailed history;
- a detailed examination; and
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually the presenting problems are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

CPT Code 99213 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of three key components -

- an expanded problem focused history;
- an expanded problem focused examination; and
- medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually the presenting problems are of moderate to high severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

CPT Code 99223 - Inpatient hospital care, per day for the evaluation and management of a patient, which requires these three components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's floor or unit.

CPT Code 99233 - Subsequent hospital care, per day for the evaluation and management of a patient, which requires at least two of these three key components:

- a detailed interval history;
- a detailed examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's floor or unit.

CPT Code 99205 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components -

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually the presenting problems are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

CPT Code 99204 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components -

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually the presenting problems are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

The Claims

Beneficiary A.F. - At issue is a November 12, 2001, office visit billed under CPT Code 99214, but down-coded to Code 99213. The beneficiary presented to the appellant with multiple medical issues "including surgical, diabetes mellitus, arthritis and cellulitis." The appellant conducted what it described as a "detailed examination,"³ ordered lab work and a consultation for the osteoarthritis. The ALJ determined that the record contained insufficient documentation justifying a Medicare claim billed at Code 99214. Dec. at 26. The appellant asserts that she provided a detailed history and examination and engaged in moderate decision making. Exh. MAC-3 at 8.

The beneficiary presented with a variety of medical conditions the treatment of which were necessarily interrelated. For example, consideration of surgery cannot be made independent of the care and treatment of diabetes. **The Council finds that Medicare reimbursement is available for this claim as billed under CPT Code 99214.**

Beneficiary S.K. - At issue is a June 29, 2002,⁴ office visit billed under CPT Code 99214, but down-coded to Code 99213. The beneficiary presented to the appellant for examination related to dizziness, heartburn, drowsiness and blurred vision. The beneficiary conceded to the appellant that he had stopped taking some of his medications. The appellant performed a "detailed examination," reviewed the beneficiary's medications and restarted some. Dec. at 41. The appellant asserts that the "number of diagnoses and/or management options is multiple and

³ As used here and elsewhere in this analysis, the appellant describes the term "detailed examination" as one of "head, ears, eyes, nose, throat, lungs, heart, abdomen and extremities."

⁴ The ALJ Decision contains what appears to be a typographical error relative to the date of service for this beneficiary. The ALJ decision identifies three dates of service, March 18, 2002, April 24, 2002 and June 29, 2002. Dec. at 39. The ALJ found that the appellant properly billed for the March 18 and April 24 dates. *Id.* at 39-40. The ALJ's analysis then moves to consideration of the third date where the ALJ notes that the "record does not substantiate that the beneficiary met the criteria for payment of the office visit on April 24, 2002, at the level of 99214." The ALJ's summary of her findings provides that the appellant's 99214 coding for the March 18 and April 24, 2002 office visits are supported by the record, but the down-coding of a June 29, 2002 visit to 99213 is appropriate. Dec. at 40-41. The appellant repeats this misstatement of the date at issue in her brief. See Exh. MAC-3 at 8. The Council concludes that the date of service in issue is June 29, 2002.

the risk of complications and/or morbidity or mortality is moderate." Exh. MAC-3 at 8. The record for this beneficiary does not support Medicare coverage for the service as claimed by the appellant. **Therefore, the claim was properly down-coded for reimbursement under CPT Code 99213.**

Beneficiary N.L. - At issue are claims for an initial hospital visit, occurring September 5, 2002, billed at CPT Code 99223, and subsequent hospital visits, occurring September 6, 8 and 10, 2002, billed under CPT Code 99233. Each billing was down-coded to provide a lower level of reimbursement (Code 99223 to 99221 and Code 99233 to 99232).

The billing for an initial visit (CPT Code 99223) involved a visit prior to surgery for a broken hip. The beneficiary otherwise presented with a history of atrial fibrillation and vascular disease. The appellant performed a "detailed examination" and discussed lab results. The ALJ determined that the appellant's services did not satisfy the criteria for billing an initial visit at Code 99223. Dec. at 45. Similarly, the ALJ found that the services provided to the beneficiary on the three post-operative visits failed to meet the level of complexity needed to satisfy the criteria for Medicare reimbursement under CPT Code 99233. *Id.* at 45-46.

The appellant maintains that the services for the four dates at issue should be reimbursed as billed. The appellant asserts that the beneficiary presented, initially, with a significant risk of complications and/or morbidity. Additionally, post-operative visits involved extensive management options and continued risk of complications and/or morbidity. Exh. MAC-3 at 9-11.

The evidence of record does not support the appellant's claims for higher levels of coverage. Neither the treatment provided, nor the course of evaluation demonstrates comprehensive or detailed histories and examination or high-complexity medical decision making. **Therefore, the claims at issue for this beneficiary were properly down-coded for reimbursement under CPT Codes 99221 and 99232.**

Beneficiary V.M. - At issue is a June 17, 2003, office visit billed under CPT Code 99214, but down-coded to Code 99213. The beneficiary presented to the appellant with lower back and abdominal pain. The appellant performed an assessment noting abdominal pain, possible back ache, arteriosclerosis, heart

disease and chest pain. The appellant ordered an abdominal sonogram, colonoscopy and laboratory work. The appellant argued that, due to the beneficiary's multiple diagnoses, her actions required decision making of moderate complexity. Dec. at 62-63.

The appellant asserts that "the elements of 'history' and 'examination' were satisfied for this date of service at the level required for code 99214" and that "moderate" decision making was involved. Exh. MAC-3 at 11-12. Following an examination of the beneficiary's claim folder, the Council agrees. The appellant's actions in her treatment of the beneficiary on June 17, 2003, support Medicare reimbursement as originally billed. **The Council finds that Medicare reimbursement is available for this claim as billed under CPT Code 99214.**

Beneficiary N.M. - At issue is a June 4, 2002, office visit billed under CPT Code 99214, but down-coded to Code 99213. The beneficiary presented to the appellant with chest and neck pain, as well as a history of cardiovascular problems and stroke. The appellant prescribed physical therapy. The ALJ determined that the appellant's services were not sufficiently complex to merit payment under Code 99214. Dec. at 69. The appellant asserts that reimbursement for the services as billed was merited based upon the risk of complication and/or morbidity involved with an individual of this age and physical condition. Exh. MAC-3 at 12. Based upon the beneficiary's medical history, the claim for the June 4, 2002, services provided to the beneficiary is eligible for Medicare reimbursement as originally billed. **The Council finds that Medicare reimbursement is available for this claim as billed under CPT Code 99214.**

Beneficiary Y.N. - At issue is a June 4, 2002, office visit billed under CPT Code 99214, but down-coded to Code 99213. The beneficiary presented with chief complaints of chest tightness, dyspnea on exertion and an increased need to urinate at night. The appellant determined that the beneficiary's asthma was not well-controlled and that he had high blood pressure. The ALJ determined that the services provided did not qualify for Medicare reimbursement under CPT Code 99214. Dec. at 70. The appellant asserts that she was faced with multiple diagnoses and employed moderate decision making in treating this beneficiary. Exh. MAC-3 at 12-13.

The Council finds that the appellant's treatment of this beneficiary involved detailed examination and medical decision

making of moderate complexity. **The Council finds that Medicare reimbursement is available for this claim as billed under CPT Code 99214.**

Beneficiary E.P. - At issue is a February 13, 2002, office visit billed under CPT Code 99214, but down-coded to Code 99213.⁵ The beneficiary was 87 years old with a mass in her colon and a cardiac history. The beneficiary presented at the appellant's office on February 13, 2002, for an evaluation of laboratory work related to the cecal mass. The ALJ determined that the record did not support the appellant's claim for coverage of services billed under CPT Code 99214. Dec. at 77. The appellant asserts that the beneficiary's pre-existing medical condition, which also included anemia, and consideration of the multiple management and treatment options related to the mass in her colon justified billing for services under CPT Code 99214. Exh. MAC-3 at 13-14. Having reviewed the beneficiary's claim folder the Council agrees with the beneficiary that E & M services requiring a detailed history and decision making of moderate complexity were involved in her February 13, 2002, office visit with the beneficiary. **The Council finds that Medicare reimbursement is available for this claim as billed under CPT Code 99214.**

Beneficiary A.S. - At issue are two office visits. The first visit, occurring March 27, 2002, was down-coded from CPT Code 99205 to Code 99204. An August 29, 2002, visit was billed under CPT Code 99214, but was down-coded to Code 99213.

On March 27, 2002, the beneficiary presented to the appellant, in an initial visit, with complaints of a cough, of ten-day duration, with yellow sputum, a low-grade temperature, burning in the left flank of "a few weeks" duration, dyspnea on exertion and severe pain in the right calf and lower back when walking. The appellant altered the beneficiary's medications and ordered laboratory testing which included a renal and abdominal sonogram and an echocardiogram. The ALJ determined that this initial office visit had been properly downcoded. Dec. at 89. The appellant asserts that, given the multitude of conditions involved with this beneficiary, she provided comprehensive medical examination and history as well and engaged in decision

⁵ The ALJ also upheld the down-coding of a May 15, 2002 office visit from 99214 to 99213 and a January 13, 2003 office visit from 99215 to 99214. Dec. at 77. However, the appellant offered no argument in its brief regarding those two dates. See Exh. MAC-3 at 13-14. The Council affirms the ALJ's findings as to those dates without further comment.

making of high complexity. Exh. MAC-3 at 14. Based on the beneficiary's record and the applicable coding criteria, the appellant properly billed this initial office visit. **The Council finds that Medicare reimbursement is available for this claim as billed under CPT Code 99205.**

The appellant billed Medicare for the beneficiary's August 29, 2002, office visit under CPT Code 99214, but the visit was down-coded to CPT Code 99213. The beneficiary presented to the appellant with left flank pain, electrolyte imbalance and increases in sodium and potassium. The appellant evaluated laboratory tests and carotid Doppler results and found that the beneficiary had a urinary tract infection. The ALJ determined that the appellant's services did not support a claim billed at CPT Code 99214. Dec. at 89. The appellant asserts that, given the multitude of conditions involved with this beneficiary, she provided a detailed medical examination and history and engaged in decision making of moderate complexity. Exh. MAC-3 at 15. **Having reviewed the beneficiary's record and the applicable coding criteria, the Council finds that this claim was properly down-coded for reimbursement under CPT Code 99213.**

Beneficiary K.S. - At issue are two office visits (August 8, 2002 and May 29, 2003) each originally billed under CPT Code 99214, but down-coded to Code 99213. On August 8, 2002, the beneficiary presented to the appellant with pain in her right hand. The appellant ordered a plan of treatment which included a prescription for Lecosol, an x-ray of the beneficiary's right hand and physical therapy. The appellant also ordered that lab work was to be repeated in six weeks. The ALJ determined that, in spite of the appellant's claims that the beneficiary's osteoarthritis and heart disease complicated the appellant's assessment, this visit did not satisfy the criteria for Medicare reimbursement under CPT Code 99214. Dec. at 92. The appellant asserts that the number of diagnoses and/or management options satisfied the coverage criteria under CPT Code 99214. Exh. MAC-3 at 15-16. The Council finds no support in the record or the coding guidelines for the Medicare coverage of the claim as billed. **Therefore, the claim was properly down-coded for reimbursement under CPT Code 99213.**

The beneficiary presented to the appellant on May 29, 2003 with itchiness and puffiness in her eyes. The appellant reviewed the arterial doppler and arterial PPG of the beneficiary's lower extremities and prescribed three medications. The ALJ determined that this visit did not satisfy the criteria for

Medicare reimbursement under CPT Code 99214. Dec. at 92-93. The appellant asserts that the number of diagnoses and/or management options satisfied the coverage criteria under CPT Code 99214. Exh. MAC-3 at 16-17. The Council finds no support in the record or the coding guidelines supporting Medicare coverage for the claim as billed. **Therefore, the claim was properly down-coded for reimbursement under CPT Code 99213.**

Beneficiary G.Z. - At issue are office visits on July 17, 2002, and February 5, 2003, originally billed under CPT Code 99214, but down-coded to Code 99213.

On July 17, 2002, the beneficiary presented to the appellant with complaints of mild weakness and headache. The appellant prescribed a number of laboratory tests. The ALJ found that the appellant's services did not satisfy the coding criteria for CPT Code 99214 and sustained the down-coding to Code 99213. Dec. at 109. The appellant asserts that the number of diagnoses and/or management options satisfied the coverage criteria under CPT Code 99214. Exh. MAC-3 at 17-18. The Council finds no support in the record or the coding guidelines for Medicare coverage of the claim as billed. **Therefore, the claim was properly down-coded for reimbursement under CPT Code 99213.**

On February 5, 2003, the beneficiary presented to the appellant for consultation in connection with abnormalities in the beneficiary's laboratory tests including decreases in hemoglobin and hematocrit. The laboratory test results indicated that the beneficiary's anemia was worsening; his diabetes and hypertension remained uncontrolled and he had chronic renal insufficiency. The ALJ determined that the services provided to the beneficiary in this visit did not satisfy the coverage criteria for a claim billed under Code 99214. Dec. at 109. The appellant asserts that the number of diagnoses and/or management options satisfied the coverage criteria under CPT Code 99214. Exh. MAC-3 at 18-19. The services provided by the appellant on February 5, 2003, support Medicare coverage for the claim as originally billed. **The Council finds that Medicare reimbursement is available for this claim as billed under CPT Code 99214.**

Beneficiary A.Z. - At issue is an April 9, 2003, office visit originally billed under CPT Code 99214, but down-coded to CPT Code 99213. The beneficiary presented to the appellant with pain in his occipital area, stiffness in his neck, increased fatigue and decreased mobility and endurance. The appellant

prescribed laboratory work and physical therapy. The ALJ determined that the appellant's E & M services did not satisfy the coverage criteria under CPT Code 99214. Dec. at 113. The appellant asserts that the number of diagnoses and/or management options satisfied the coverage criteria under CPT Code 99214. Exh. MAC-3 at 19. The Council finds that the services provided by the appellant on April 9, 2003, as documented, do not support Medicare coverage for the claim as billed. **Therefore, the claim was properly down-coded for reimbursement under CPT Code 99213.**

Attachment B-1 to this decision identifies the appellant's claims for Medicare coverage of E & M services which are reimbursable under the CPT Codes originally billed by the appellant.

Attachment B-2 to this decision identifies the appellant's claims for coverage of E & M services which were properly down-coded for Medicare reimbursement.

3. Physical Therapy Services

At issue are claims for Medicare coverage of physical therapy (PT) services provided to thirteen beneficiaries.⁶ The appellant indicates that, in each claim, the ALJ determined that the appellant satisfied the requirements for Medicare reimbursement for PT services, but for the lack of "anticipated goals" in the beneficiaries' respective plans of treatment. The appellant notes that the regulation at 42 C.F.R. § 410.61 sets out the required content for a therapy plan. Specifically, the regulation provides:

Content of the plan. The plan prescribes the type, amount, frequency and duration of the physical therapy, occupational therapy, or speech-language pathology services to be furnished to the individual, and indicates the diagnosis and anticipated goals.

42 C.F.R. § 410.61(c).⁷

The appellant argues that, in his consideration of the beneficiaries' claims at issue, the ALJ mischaracterized the

⁶ Four of these beneficiaries also had claims involved in the down-coding of E & M services.

⁷ Erroneously cited by the appellant as 42 C.F.R. § 410.61(e). See Exh. MAC-3 at 20.

regulation interpreting it, at various times, to require that the anticipated goals be "stated," "listed" and "specifically listed." Exh. MAC-3 at 20.

The appellant draws a contrast between the regulation's language providing a treatment "plan prescribes the amount, frequency and duration of the physical . . . therapy" and the language providing that an anticipated goal merely be indicated. Exh. MAC-3 at 20 (emphasis added). The appellant maintains that this distinction is reinforced by the Medicare Carriers Manual, at section 2218(e)(2), which instructs that a plan "indicates anticipated goals" and "specifies" the type, duration amount and frequency of therapy. The appellant asserts that when, interpreted in its proper context, the regulation merely requires that a plan "indicate" its goal and contends that the plans in issue meet this standard. Exh. MAC-3 at 20-21.

There may be some merit to the appellant's argument that the ALJ appears to have applied an overly restrictive interpretation of 42 C.F.R. § 410.61(c). However, even under the lesser standard advocated by the appellant, there is no basis for reversing the ALJ's denial of coverage for these PT claims.

The Council has reviewed the case file for each beneficiary at issue and finds no, even minimally substantive, reference to "goals" in any documents purporting to be plans of care or progress notes. While the appellant may not need to provide something as exacting, as it believes is suggested by the ALJ, the pertinent records do not even "indicate" goals. As noted in 42 C.F.R. § 410.61(a) Medicare coverage is available for rehabilitation therapy furnished under a written plan of treatment. As noted above, section 410.61(c) establishes a plan's content. The complete absence of goals provides no basis for making a reasoned coverage determination. There is no context by which a reviewer can assess the treatment offered or the progress of a beneficiary, *i.e.*, its effectiveness, in that course of treatment. Nor does the appellant's explanation of the goals for the beneficiaries, offered at the ALJ hearing, satisfy the regulatory coverage requirement. The appellant's testimony is an after-the-fact statement not, for example, to clarify an existing, stated goal, but rather attempting to provide an anticipated goal, where none was documented to exist.

Accordingly, the Council affirms the ALJ's determination that Medicare coverage is not available for PT claims at issue. Those claims are identified in Attachment C to this decision.

4. Limitation on Liability and Waiver of Liability for Recoupment of Down-Coded E & M and Non-Covered PT Services

The appellant asserts that a waiver of liability for non-covered services is appropriate because she could not know or reasonably have been expected to know that additional documentation would be required to "'indicate' anticipated goals of physical therapy services prior to receipt of the ALJ decision." Exh. MAC-3 at 38.

Section 1879 of the Act provides that where neither a provider nor beneficiary knew or could reasonably have been expected to know that services would not be covered based on a finding that the services were not medically reasonable and necessary under section 1862(a)(1) of the Act, payment may nonetheless be made notwithstanding such finding in certain circumstances. The Medicare Program Integrity Manual (MPIM), CMS Pub. 100-16, chapter 3, section 3.4.2.E, and the Medicare Claims Processing Manual (MCPM), CMS Pub. 100-04, chapter 30, section 20.1.3, provide that (1) denials based on a failure of a provider or supplier to furnish adequate documentation to establish that the services qualify for reimbursement, or (2) the downcoding of services by the contractor because the furnished services were billed at a level higher than was reasonable and necessary to meet the needs of the patient, are both denials (or partial denials) under section 1862(a)(1) of the Act. The Council finds that the appellant knew or could reasonably have been expected to know, under the circumstances presented here, that the services did not meet documentation guidelines based on constructive knowledge of those guidelines, as they are published in CMS manuals and are commonly understood in the medical community. Thus, the appellant is liable for the cost of the non-covered services.

Moreover, section 1870 of the Act governs the recovery of overpayments, based upon provider or beneficiary fault. Section 1870(b) allows for a waiver of recovery of an overpayment to a provider or supplier if it is without fault in incurring the overpayment. Section 1870(b) of the Act effectively presumes no fault on a provider's part where an overpayment determination is made "subsequent to the third year following the year in which notice was sent to such individual that such amount had been paid" in the absence of evidence to the contrary. The appellant has not asserted that the overpayment determination here occurred "subsequent to the third year following the year in

which notice was sent to such individual that such amount had been paid."

Section 1870(b) does not define the meaning of the term "without fault." However, a provider is without fault if it exercised reasonable care in billing and accepting Medicare payment. CMS Manual System, Medicare Financial Management (MFMM), CMS Pub. 100-06, Ch. 3, § 90. A provider is considered not "without fault" if, e.g., it did not submit documentation to substantiate that services billed were covered, or billed, or Medicare paid, for services the provider should have known were not covered. *Id.* at § 90.1. The MFMM explains that the provider should have known about a policy or rule if the policy or rule is in the provider manual or in the regulations. *Id.*

The MFMM also provides that, generally, a provider's allegation that it was not at fault with respect to payment for non-covered services because it was not aware of coverage requirements is not considered a basis for finding it "without fault" if one of several conditions is met. One such condition is if the provider billed, or Medicare paid for, services the provider should have known were not covered. *Id.*

Having considered the basis on which the overpayment was found in this case, as discussed above, section 1870(b) of the Act, and the guidance set forth in the MFMM, the Council finds the appellant was not without fault in creating the overpayment. As noted above, the beneficiary's claim folders did not contain discernable goals for PT. Regardless of the ALJ's interpretation of the regulatory requirement, an appellant is charged with knowledge that it is required to adequately document claims for Medicare coverage. That documentation was not available in the context of these claims. Accordingly, the Council concludes that a waiver of recoupment of the overpayment involving PT services is not warranted because the appellant was not "without fault" in creating the overpayment as required by section 1870 of the Act.

5. Due Process

The appellant asserts that "the Audit Report and the administrative review process did not provide . . . due process of law in that at no time was [the] Appellant provided adequate and appropriate information to present a full defense to the audit adjustment proposed." Exh. MAC-3 at 38. The appellant also assails the general lack of specificity in the audit report

and its failure to comport with the U.S Government audit standards as published by the Comptroller of the United States in *Government Auditing Standards*. *Id.* at 38-40. The Council finds no merit in the appellant's due process arguments. The appellant has had full and complete access to the administrative claims review process and has been ably represented by counsel. Throughout that process, the appellant has been informed, repeatedly, that the basis for the denials of coverage for its claims was the lack of adequate supporting documentation. The ALJ conducted a thorough review of each claim at issue, identifying the reasoning for decision on each claim. Before both the ALJ and the Council, the appellant has presented thorough and well-reasoned argument. While the result of those arguments may not have been entirely favorable to the appellant, there is no evidence that the perceived lack of specificity in the audit report compromised the appellant's ability to present her case.

6. Extrapolation

Due to the Council's partially favorable findings in this case, the contractor is directed to calculate a new extrapolated overpayment amount for this case upon implementation.

FINDINGS

The Medicare Appeals Council has carefully considered the entire record and makes the following findings:

1. The ALJ's denial of coverage for the Medicare coverage of the bone density scans provided to the beneficiaries identified in Attachment A to this decision is reversed.
2. The ALJ's decision to down-code the appellant's claims for Medicare coverage of E & M services provided to the beneficiaries identified in Attachment B-1 to this decision is reversed. The claims identified in Attachment B-1 are reimbursable under the CPT Codes billed by the appellant.
3. The ALJ's decision to down-code the appellant's claims for Medicare coverage of E & M services provided to the beneficiaries identified in Attachment B-2 to this decision is affirmed. The claims

identified in Attachment B-2 are reimbursable as downcoded by the ALJ.

4. The ALJ's denial of Medicare coverage for the PT services provided to the beneficiaries identified in Attachment C of this decision is affirmed.

5. Waiver of liability for the overpayments of the noncovered PT services identified in Attachment C to this decision is not available to the appellant.

6. The appellant remains liable for the cost of all non-covered services, including those differences in reimbursement resulting from the down-coding of claims.

7. The appellant's due process rights were not violated by the audit or the subsequent appeals process.

DECISION

It is the decision of the Medicare Appeals Council that the ALJ's findings and conclusion with regard to the beneficiaries and claims identified in attachments A and B-1 to this decision are reversed. The ALJ's findings and conclusion with regard to the beneficiaries and claims identified in Attachments B-2 and C to this decision are affirmed. The appellant remains liable for all non-covered services, including the differences in reimbursement resulting from down-coding.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: September 23, 2009