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Client Alert

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ALJ Denies Recovery of Alleged Overpayment Based on Untimely Action by CMS Contractors

In a complex case involving delays, oversights, and improper proceedings by CMS contractors, U.S. Administrative Law (ALJ) Judge Barry H. Jenkins recently ruled that CMS was not entitled to recovery of an alleged Medicare overpayment for rehabilitation services furnished at a Texas skilled nursing facility. This important precedent shows that CMS must act in a timely manner if it believes an overpayment has been made. If not, then the provider may have an avenue of defense against claims of overpayment.

Facts of the case. In 2005, the Office of Inspector General (OIG) notified the provider of the results of an audit of certain selected rehabilitation claims and services for the years 2002 and 2003. Using statistical analysis, the OIG extrapolated an alleged overpayment of approximately $1.6 million. Two years later, in October 2007, CMS issued notices of overpayment based on an updated audit report. In early 2008, the Medicare contractor issued individual redetermination decisions denying each claim appealed. The provider's subsequent request for reconsideration was dismissed by the Qualified Independent Contractor (QIC) because the contractor's redetermination did not address the statistical sampling and extrapolation issues. After intervention by CMS and after the contractor issued a second redetermination decision, the QIC vacated the dismissals and issued an unfavorable decision, upholding the previous redetermination decisions and affirming the statistical extrapolation, despite admitting that the documents to support the calculation could not be located. CMS was required to intervene again, and the QIC then issued an amended reconsideration decision supporting the statistical extrapolation, even though it found that the extrapolated demand amount was inaccurate.

The ALJ rules that CMS's claim of overpayment was time-barred. The provider appealed the overpayment demands and statistical extrapolation to the ALJ after receiving unfavorable decisions from the contractor at the redetermination level and from the QIC at the reconsideration level.

In his decision, Judge Jenkins noted that the "case has suffered a tortured procedural history," and that the "lower level decisions were disjointed at best." Against this convoluted procedural backdrop, the ALJ found that the actions of the CMS contactors were untimely, which barred recovery of the alleged overpayment. In addressing the time limits for reopening of a contractor's initial payment determination, the ALJ resolved a tension in the rules regarding review of a contractor's reopening decision. Under 42 CFR §405.980(b), a contractor may, on its own motion, reopen and revise its initial determination for good cause within four years from the date of the initial determination, or

at any time if the contractor determines that payment was procured by fraud. The ALJ noted that this rule is "in direct conflict" with section 405.980(a)(5) of the same regulation. 42 CFR §405.980(a)(5) provides that "the contractor's decision on whether to reopen is final and not subject to further review." Nevertheless, the ALJ found jurisdiction to review all procedural aspects of the reopening because 42 CFR §405.980(a)(5) only bars review of the "decision of whether to reopen." Here, it was uncontroverted that the contractor's decision to reopen the claims was not prompted by any finding of fraud.

Upon review of the time frame for the reopening decision, the ALJ reaffirmed prior decisions of the Medicare Appeals Council that the date of the reopening is the date that the contractor formally demands reimbursement of the alleged overpayment, not the date of any audit action by the OIG. The claims in this case were reopened by the contractor in October 2007, which is more than four years after claims with dates of service in 2002. Therefore, the ALJ determined that such claims were improperly reopened and that recovery of any alleged overpayment was barred.

For other claims, the ALJ found that recovery was barred by Section 1870(b) of the Social Security Act. Under Section 1870(b), a provider of services is "deemed to be without fault" if notice to the provider of the overpayment is three or more years after the initial payment was made for the services rendered. Since more than three years had elapsed between the date that the provider was paid for the rehabilitation services and the date that CMS sought to recoup the alleged overpayment, the ALJ found that liability was waived on the basis that the provider was deemed to be without fault under Section 1870(b).

Importance of this decision. This decision points out that Medicare providers should carefully review the time frames in which CMS contractor decisions are made to reopen claims and to seek recovery of alleged overpayments, particularly where a statistical extrapolation is involved. As noted by ALJ Jenkins, "Congress could not have intended to hold providers 'on the hook' indefinitely after payment has been made for services rendered." Where administrative processing and decision-making by CMS contractors is delayed beyond statutory deadlines, providers may argue that any recovery of alleged overpayments is barred.