HCFA Rulings

Department of Health and Human Services

Health Care Financing Administration

Ruling No. 86-1 Date: February 20, 1986

USE OF STATISTICAL SAMPLING TO PROJECT OVERPAYMENTS TO MEDICARE PROVIDERS AND SUPPLIERS

HCFA Rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex statutes or regulations relating to Medicare, Medicaid, Utilization and Quality Control Peer Review, and related matters.

HCFA Rulings are binding on all HCFA components, HCFA contractors, the Provider Reimbursement Review Board, and Administrative Law Judges who hear Medicare appeals. These decisions promote consistency in interpretation of policy and adjudication of disputes.

This ruling, HCFAR-86-1, is the first to be issued in a format separate from the bound HCFA Rulings booklet or a Federal Register notice. HCFA is currently in the process of transferring all HCFA Rulings that have been issued into a looseleaf booklet form. This ruling, which is effective on the date of issuance, will be incorporated into that looseleaf booklet.

SECTION 1815(a), 1842(a), and 1861(v)(1)(A)(ii) (42 U.S.C. 1395g(a), 1395u(a), and 1395x(v)(1)(A)(ii)).--HOSPITAL INSURANCE AND SUPPLEMENTARY MEDICAL INSURANCE--USE OF STATISTICAL SAMPLING TO PROJECT OVERPAYMENTS TO PROVIDERS AND SUPPLIERS

HCFAR-86-1

> HCFA and its Medicare contractors may use statistical sampling to project overpayments to providers and suppliers when claims are voluminous and reflect a pattern of erroneous billing or overutilization and when a case-by-case review is not administratively feasible.

The provider billed and was paid by Medicare for services to beneficiaries from September 1982 through July 1985. As a result of a subsequent audit of the provider's Medicare claims, the intermediary discovered a large number of bills for medically unnecessary services. The intermediary also determined that the provider knew or should have known that the services were not covered and, therefore, was not entitled to have payment made to it for the services.

The intermediary considered conducting a case-by-case review in order to determine the amount the provider has been overpaid for the services. This would have entailed an examination of all of the provider's beneficiary records for the period in question in order to identify those beneficiaries who had received unnecessary services. It also would have been necessary to tabulate the total amount that

---

Medicare had paid the provider for each beneficiary. The intermediary decided that this method of determining the amount of the overpayment was not administratively feasible, given the volume of records involved and the cost of retrieving and reviewing all the beneficiary records for the period in question. The cost of identifying and calculating each individual overpayment itself would constitute a substantial portion of the amount the intermediary might reasonably be expected to recover. Further, the allocation of sufficient staff to reexamine all individual claims for the period in question would interfere with current claims processing activities to an unacceptable degree.

The intermediary notified the provider that, because of the volume of records and the costs of retrieving and reviewing all records for the period as discussed above, it intended to project the overpayment by reviewing a statistically valid sample of beneficiary records and that if it were determined that the provider had been overpaid for the sample cases, it would project the results (again using statistically valid methods) to the entire population of cases from which the sample had been drawn. This would result in a statistically accurate estimate of the total amount the provider had been overpaid for services to these beneficiaries.

The provider objected to the intermediary's use of sampling to project the overpayment on the following grounds:

---

1. There is no legal authority in the Medicare statute or regulations for HCFA or its intermediaries to determine overpayments by projecting the findings of a sample of specific claims onto a universe of unspecified beneficiaries and claims.
2. Section 1879 of the Social Security Act, 42 U.S.C. 1395pp, contemplates that medical necessity and custodial care coverage determinations will be made only by means of a case-by-case review.
3. When sampling is used, providers are not able to bill individual beneficiaries not in the sample group for the services determined to be noncovered.
4. Use of a sampling procedure violates the rights of providers to appeal adverse determinations.
5. The use of sampling and extrapolation to determine overpayments deprives the provider of due process.

(The succeeding presentation of our decision and supporting facts is applicable also to the use of sampling to project overpayments to suppliers (including physicians)

whose claims are processed by Medicare carriers when 100 percent readjudication would be excessively costly or impractical.)

The Supreme Court has long recognized that the Federal Government possesses an inherent right to recover monies illegally or erroneously paid out. United States v. Carr, 132 U.S. 644, 650 (1890); Wisconsin Cent. R.R. v. United States, 164 U.S. 190, 212 (1896). This right exists independent of statute. See United States v. Wurts, 303 U.S. 414, 416 (1938); Grand Trunk W. Ry. v. United States, 252 U.S. 112, 121 (1920). The Government may enforce its right of recoupment by reasonable means, and it may exercise that right without resorting to litigation by offsetting the amount against sums otherwise due. United States v. Munsey Trust Co., 332 U.S. 234, 239-240 (1947). Offsets against current or subsequent obligations may be used to prevent a recipient of Federal funds from retaining monies that are later found to have been unauthorized by the terms and conditions under which they were received. Wisconsin Cent. R.R. v. United States, supra, 164 U.S. at 211-212.

The Government's common law right of recoupment, and its corollary power of recovery by offset, are based on strong considerations of public policy. All funds at the disposal of the Government belong to the public. As custodian of these funds, a Federal agency has the fundamental obligation to ensure that Federal funds are spent only for those purposes permitted by law. Accordingly, if the public's money has been expended in a manner not authorized by statute, the agency's obligation requires it to take

---

administrative actions necessary to prevent an unjust enrichment by the recipient at the expense of the Federal treasury. See United States v. Wurts, supra, 303 U.S. at 415-416; Grand Trunk W. Ry. v. United States, supra, 252 U.S. at 120-121.

The common law right to recover Federal funds has been specifically recognized as being fully applicable to the Medicare program. Mt. Sinai Hospital v. Weinberger, 517 F.2d 329 (5th Cir. 1975); Wilson Clinic and Hospital, Inc. v. Blue Cross, 494 F.2d 50 (4th Cir. 1974). Moreover, the courts have also recognized that extrapolation based on a sample is a valid audit technique in cases arising under the Social Security Act. Illinois Physicians Union v. Miller, 675 F.2d 151 (7th Cir. 1982); State of Georgia v. Califano, 446 F. Supp. 404 (N.D. Ga. 1977); New Jersey Welfare Rights Organization v. Cahill, 349 F. Supp. 501 (D.N.J. 1972); Rosado v. Wyman, 322 F. Supp. 1173 (E.D. N.Y. 1970), aff'd 402 U.S. 991 (1971). In view of the enormous logistical problems in determining massive overpayments in social welfare programs, sampling is the only feasible method available. State of Georgia v. Califano, supra; Illinois Physicians Union v. Miller, supra.

Congress has affirmed the Government's right to recover Medicare Trust Funds by reasonable means from those who have no right to retain them. Section 1815(a) of the Social Security Act, 42 U.S.C. 1395g(a), authorizes "necessary

adjustments on account of previously made overpayments or underpayments" under Medicare Part A. Similarly, as to Part B of Medicare, section 1842(a), 42 U.S.C. 1395u(a), provides that carriers make determinations as to the amount of payments to be made to providers of services and other persons, and authorizes such audits of the records as may be necessary to assure that proper payments are made. In addition, section 1861(v)(1)(A)(ii) of the Act, 42 U.S.C. 1395x(v)(1)(A)(ii), provides for the "making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." These statutory requirements, in effect, would be abrogated if sampling were not available to determine Medicare overpayments. The imposition of such a result would be inconsistent with the settled principle that, when Congress creates a statutory right, the existence of appropriate remedies to enforce that right will be presumed in the absence of a clear indication of a contrary congressional intent. Texas & N.O.R.R. v. Brotherhood of Railway & Steamship Clerks, 281 U.S. 548, 569-570 (1939); Sullivan v. Little Hunting Park, Inc., 396 U.S. 229, 239 (1969).

Since HCFA's contractors process vast numbers of Medicare claims (for example, in fiscal year 1985, intermediaries received over 59.5 million Medicare claims and carriers

received over 270.8 million Medicare claims), an interpretation that title XVIII of the Act mandates that a 100 percent review of cases be conducted before HCFA or its contractors can determine that providers or suppliers have been overpaid would make it virtually impossible for HCFA to implement these statutory provisions in many cases. A case-by-case review could require a significant diversion of staff from the ongoing claims process, and the cost of determining the amount of an overpayment would be prohibitively high unless a sampling method were used. To fulfill the congressional intent, HCFA must adopt realistic and practical auditing procedures. The alternative is to conclude that the intent of Congress was that, if case-by-case overpayment determinations are not administratively feasible, the Medicare Trust Funds must forego restitution of funds improperly obtained by providers and suppliers. We do not believe that was Congress' intent.

We also do not believe that the statutory provisions limiting provider or beneficiary liability preclude the use of sampling. In instances where Medicare coverage is denied because items or services furnished are not "medically necessary" or constitute "custodial" care, section 1879 of the Act, 42 U.S.C. 1395pp (42 CFR 405.330), authorizes a limitation of the beneficiary's liability when the beneficiary did not know, and could not reasonably be expected to have known, that the items or services were not

"medically necessary" or that they constituted "custodial" care. The Medicare program will make payments to the provider when both the beneficiary and the provider were without the requisite knowledge. When the beneficiary did not have such knowledge, but the provider did, liability for the denied services rests with the provider and the beneficiary's liability is waived. The beneficiary will be indemnified by the Medicare program if he or she has already paid the provider. See 42 U.S.C. 1395pp. Liability will rest with the beneficiary only when he or she knew or could have been expected to know that the items or services furnished were not "medically necessary" or were "custodial" in nature.

The use of sampling to determine overpayments for medically unnecessary services or custodial care does not deprive a provider of its right to bill those beneficiaries who knew or should have known that they were receiving these services. Under the governing regulation, 42 CFR 405.334, a beneficiary is presumed not to have had such knowledge unless he or she was notified in writing by the provider, the intermediary, or the Peer Review Organization (PRO). For example, when a beneficiary who is receiving a course of treatment has received a previous denial notice stating that similar items or services were not covered, the previous denial notice would constitute evidence that the beneficiary

did or should have had knowledge of noncoverage. See 42 CFR 405.334 for examples of acceptable written notice to a beneficiary. The operation of this provision effectively serves to resolve most limitation of liability questions in the beneficiary's favor. However, a provider that wishes to bill individual beneficiaries not included in the sample can identify those individuals who were previously informed that they were receiving noncovered services by inquiring of the intermediary or PRO as to whether it sent a notice to the individual. (The provider presumably did not give notice to the beneficiary that the services were not covered because, if it had, it is unlikely that it would have billed Medicare for the services.)

Even if we assume that a provider is effectively precluded from billing a beneficiary in certain cases, this assumption would not bar the Government from its fundamental obligation to ensure that Federal funds are spent only for those purposes permitted by law. As between the provider and the Government, strong considerations of public policy favor recovery. On the other hand, the provider had the responsibility to know and should have known that the services furnished were not medically necessary. Moreover, as the United States Court of Appeals for the Fifth Circuit recognized in Mt. Sinai Hospital of Greater Miami v. Weinberger, 517 F.2d 329 (5th Cir. 1976), the provider assumes substantial responsibility for overpayments.

> ... [the hospital] is not a neutral, innocent party in this three-way transaction between HEW, Medicare beneficiary and Medicare provider. The decision to provide a service is made by the individual attending physician, who is far better informed on both the medical issue and the scope of Medicare coverage than is the patient-beneficiary. The physician is either an employee of the hospital or a doctor with staff privileges. Whatever else the granting of staff privileges may connote, it is clear to us that it involves a delegation by the hospital of authority to make decisions on utilization of its facilities. 534 F.2d at 338.

In reimbursing providers, HCFA has to balance the need to process billings rapidly in order that a provider's liquidity needs do not suffer and the need to verify that the claims submitted are for services covered by the Act. Mixed into this balance is the volume of claims which must be reviewed. Considering the volume of claims (as cited earlier to be over 330.3 million for fiscal year 1985), it is virtually impossible to examine each bill submitted by a provider or supplier in sufficient detail to assure before payment in every case that only medically necessary services have been provided. Therefore, as a practical matter, HCFA and its contractors must depend on the provider to submit claims for services that are covered by the Act. In most cases, this reliance is justified. However, if HCFA or its contractors later have reason to make an indepth and careful review of claims for services which had been previously paid and discover that medically unnecessary services have been provided, a provider cannot cry "foul" when these payments (to which they were never legally entitled) are recovered.

Sampling does not deprive a provider of its rights to challenge the sample, nor of its rights to procedural due process. Sampling only creates a presumption of validity as to the amount of an overpayment which may be used as the basis for recoupment. The burden then shifts to the provider to take the next step. The provider could attack the statistical validity of the sample, or it could challenge the correctness of the determination in specific cases identified by the sample (including waiver of liability where medical necessity or custodial care is at issue). In either case, the provider is given a full opportunity to demonstrate that the overpayment determination is wrong. If certain individual cases within the sample are determined to be decided erroneously, the amount of overpayment projected to the universe of claims can be modified. If the statistical basis upon which the projection was based is successfully challenged, the overpayment determination can be corrected.

The provisions of the statutes and regulations provide a constitutionally sufficient means by which the provider may challenge an overpayment determination. In cases of denials made through sampling which are based on medical necessity or custodial care, section 1879 of the Act, 42 U.S.C. 1395pp, permits the provider to assert the same appeal rights that an individual has under the statute when the individual does not exercise his rights to appeal. Under Part A, these rights

include an opportunity for reconsideration (42 CFR 405.710-405.716), an oral evidentiary hearing by an administrative law judge (42 CFR 405.720-405.722), Appeals Council Review (42 CFR 405.701(c) and 405.724), and finally judicial review if the amount in controversy is $1,000 or more (42 CFR 405.730; 42 U.S.C. 1395ff(b)(2)). In cases which do not involve medical necessity or custodial care, 42 CFR 405.370, et seq. sets out the applicable procedures through which current payments may be suspended (offset) to recover an overpayment under the Medicare program. Under 42 CFR 405.371, a provider is given notice as to the basis for the overpayment and an opportunity to respond before an intermediary may suspend current Medicare reimbursement. 42 CFR 405.372, in conjunction with 42 CFR 405.370(b), forestalls any suspension pending consideration of any statement by the provider in opposition to the notice of suspension. Finally, if it is determined that a suspension should go into effect, written notice of the determination will be sent to the provider or other supplier. The notice will contain specific findings on the conditions upon which the suspension was based and an explanatory statement for the final decision. Thus, the administrative scheme provides sufficient means for a provider to challenge overpayment determinations that are made on the basis of sampling.

Under Part B, suppliers who accept assignment may request a Medicare carrier to review a payment determination with which the supplier disagrees (42 CFR 405.807). If the supplier is dissatisfied with the carrier's review determination, the supplier may request a hearing before a carrier hearing officer if the amount in controversy is $100 or more (42 CFR 405.820). There are no further appeals available under Part B. In U.S. v. Erika, Inc., 456 U.S. 201 (1982), the Supreme Court ruled unanimously that, under current law, the Part B hearing is rightfully the final step in the Part B appeals process.

In summary, the use of sampling is a reasonable and cost effective method of projecting overpayments under Medicare. It is not unfair to a provider or supplier to hold it accountable for the receipt of Medicare funds to which it is not entitled under the statute. To the contrary, allowing a provider or supplier improperly to retain large sums of program funds would be unfair to the intended beneficiaries of Medicare and to the taxpayers who contribute to the trust funds. As the Supreme Court held in Richardson v. Perales, 402 U.S. 389 (1971), the system must not only be fair, but it must work.

Accordingly, it is held that the use of statistical sampling to project an overpayment is consistent with the Government's common law right to recover overpayments, the Medicare statute, and the Department's regulations, and does

not deny a provider or supplier due process. Neither the statute nor regulations require that a case-by-case review be conducted in order to determine that a provider or supplier has been overpaid and to determine the amount of overpayment.

DATED: 2/20/86

/s/ Henry R. Desmarais
Acting Administrator, Health
Care Financing Administration

U.S. GOVERNMENT PRINTING OFFICE: 1986 - 491 – 264/42028