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COMMENT

RETROACTIVE RECOVERY OF MEDICARE COSTS AND COVERAGE OVERPAYMENTS

STEPHEN H. JUDSON*

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I. INTRODUCTION

In May 1973, Blue Cross of Florida, Inc. determined that over the past 7 years, it had paid \$6,380,587.40 in Medicare¹ funds to a Miami Beach hospital for services Blue Cross now found medically unnecessary. It informed the hospital that it would begin withholding current payments to offset the error.²

In 1969, Aetna Life and Casualty, determining that it had overpaid a New York State nursing facility at least \$96,000 over the past 2 years, discontinued all further payments, thereby driving the facility out of business.³

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1. Medicare Act, 42 U.S.C. § 1395 *et seq.* (Supp. III, 1973). The Act's functions are explained in section II *infra*.

2. *Mount Sinai Hosp., Inc. v. Weinberger*, 376 F. Supp. 1099 (S.D. Fla. 1974), *rev'd on other grounds*, 517 F.2d 329 (5th Cir. 1975).

3. *Aquavella v. Richardson*, 437 F.2d 397 (2d Cir. 1971).

A Medicare carrier⁴ in Louisiana changed its method of figuring reimbursable hospital costs⁵ and attempted to impose that method on a hospital retroactively for the preceding 4 years by claiming a resulting overpayment of \$260,416.⁶

A doctor specializing in internal medicine was informed by his carrier that claims paid to him in the past had been reopened and that he presently owed thousands of dollars to Medicare. The reopening had revealed that many of his claims represented unnecessary use of his services.⁷

A New York hospital discovered that it had been underpaid⁸ \$394,392 by a Medicare intermediary for the past 2 years. The intermediary admitted the error but refused to pay. When sued, the intermediary and representatives of the Secretary of Health, Education and Welfare (HEW), functioning now in an unfamiliar role, pleaded that the plaintiff should not prevail because the government would suffer great hardship if its payment determinations were held to be subject to reopening⁹ and unlimited retroactive adjustment.¹⁰

These examples of attempted recovery of alleged overpayments and the attempt to recoup an underpayment illustrate the severe unforeseen difficulties facing doctors and hospitals which depend on payment from the Medicare program. Although these attempted retroactive recoveries comprise only part of the health care industry's difficulties with Medicare, they are extremely significant in dollar amount, and they illuminate two other major Medicare controversies: determining reasonable cost¹¹ and determining the existence of medical necessity, a question of coverage.¹²

Retroactive recovery also spotlights the nature of the relationship between the Medicare establishment and the health care industry, a relationship originally largely devoid of the due process requirements of proper notice and impartial administrative agency

4. See text section II and note 19 *infra* for a discussion of carriers.

5. See note 21 *infra* for a discussion of cost formulas.

6. *Columbia Heights Nursing Home & Hosp., Inc. v. Weinberger*, 380 F. Supp. 1066 (M.D. La. 1974).

7. *Szekely v. Weinberger*, 517 F.2d 345 (5th Cir. 1975).

8. See note 21 *infra* for an explanation of underpayments.

9. See note 22 *infra* for an explanation of reopenings.

10. *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663 (2d Cir. 1973).

11. See note 21 *infra*.

12. See note 25 *infra*.

adjudication. In each instance mentioned above, HEW¹³ and its carriers asserted that the hospitals and nursing facilities had no right to judicial review of the carriers' unilateral recovery actions or, in the case of the New York Hospital, to review of the carrier's refusal to retroactively adjust an underpayment. In these cases and others, HEW and its carriers asserted that the hospitals did not even have a right to a formal agency hearing.

Court decisions, in part a product of the vigorous opposition of individual doctors and hospitals, have modified that relationship to a significant degree. They have forced and encouraged both legislative and administrative implementation of due process protections, at least with respect to most cost overpayment disputes. To a certain extent, these protections extend even into coverage determinations, but there is much that must yet be done to ensure doctors and hospitals the same due process protections in coverage disputes they now enjoy when faced with a potential cost overpayment action.

Because an administrative agency not only administers government programs, but also adjudicates disputes between itself as administrator and the persons affected by its programs, due process problems are inherent in the agency's structure. As the result of an agency's apparently unavoidable dual role as judge and interested party in the disputes before it, these due process problems generally will not be remedied by agency personnel left to their own devices. For this reason legislative safeguards and disinterested judicial review of agency action are vital.

An analysis focusing on the problem of attempted large scale recoupments may facilitate the presentation in this article of arguments available to hospitals and doctors for countering arbitrary and unfair acts of Medicare administrators,¹⁴ particularly when coverage questions are involved.

II. THE PURPOSE AND OPERATION OF THE MEDICARE PROGRAM

A brief general description of the Medicare program's purpose and operation is a necessary introduction to a discussion of overpay-

13. See discussion in section II *infra* of the role of HEW in administering the Medicare program.

14. Of course, HEW has a valid interest (which is beyond the scope of this comment) in stopping waste in the health care industry. But HEW's action to control waste must meet the requirements of due process, or it risks destroying both the sound as well as the wasteful portions of the health care industry.

ment conflicts. Basically, the purpose of the Health Insurance for the Aged Act (Medicare Act) is to provide payment of inpatient and outpatient medical expenses incurred as a result of illness or injury by persons over 65 years of age eligible for Social Security retirement benefits.¹⁵ The Act provides payment under part A for inpatient confinement in hospitals and "skilled nursing facilities" and allows benefits under part B for the services of physicians,¹⁶ physical therapists, and other persons.¹⁷ The part A institutions are termed "providers"¹⁸ by the Act. HEW and its subordinate divisions, the Social Security Administration and the Bureau of Health Insurance, are responsible for administering the Medicare program.

Both providers and physicians can elect to submit their requests for Medicare payments to carriers¹⁹ (private insurance companies such as Aetna Life and Casualty or prepayment plans like Blue Cross - Blue Shield) rather than to present claims directly to HEW. Transactions with carriers are the rule, rather than the exception, because carriers' offices are in closer geographical proximity to providers and physicians and because carriers usually are able to make payments more quickly than would HEW.

Part A payment methods differ from those prescribed in part B. Part A reimbursement is made directly to the provider for its reasonable costs of providing services to Medicare patients termed "eligible individuals" under the Act.²⁰ A provider's reasonable

15. S. Rep. No. 404, 89th Cong., 1st Sess. *printed in* U.S. CODE CONG. & ADM. NEWS at 1943 (1965).

16. Medicare Act § 1861(r), 42 U.S.C. § 1395x(r) (Supp. III, 1973) defines *physician* as a licensed M.D. or D.O., or, under certain circumstances, a dentist, podiatrist, optometrist or chiropractor.

17. Persons other than physicians who directly supply services to eligible individuals under part B include physical therapists, X-ray technicians, suppliers of durable medical equipment and prosthetic devices, ambulance operators, and operators of independent laboratories meeting certain conditions. *See* Medicare Act § 1861(s), 42 U.S.C. § 1395x(s) (Supp. III, 1973).

18. Medicare Act § 1861(u), 42 U.S.C. § 1395x(u) (Supp. III, 1973) defines *provider of services* as a hospital, skilled nursing facility, or home health agency.

19. Medicare Act §§ 1816, 1842, 42 U.S.C. §§ 1395h, 1395u (Supp. III, 1973). Section 1395u(f) defines *carrier* as

a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier

20. Medicare Act §§ 1811, 1836, 42 U.S.C. §§ 1395c, 1395o (Supp. III, 1973), defines *eligible individuals* as those 65 years of age and older receiving Social Security retirement

costs²¹ are estimated at the beginning of its fiscal year and are usually paid in 12 or 24 equally spaced allotments over the year. At the end of a year, a cost report is submitted by the provider to the carrier and a "determination" is made by the carrier of the reasonable costs incurred for that year. Once the determination is made, the cost payments are increased or decreased in order to reconcile the past year's payments with the actual costs incurred.²²

A part B physician is reimbursed directly only if he obtains an assignment of benefits from the individual patient,²³ otherwise, the

benefits, or those under 65 receiving Social Security total disability benefits.

21. The Medicare Act § 1861(v), 42 U.S.C. § 1395x(v) (Supp. III, 1973) defines *reasonable cost* as:

[T]he cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies and services

20 C.F.R. §§ 405.401 -488 (1974) establish the criteria for determining reasonable cost and provide in pertinent part:

All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne by the [Medicare] program is related to the care furnished [Medicare] beneficiaries so that no part of their cost would need to be borne by other patients.

Id. at § 405.402(a).

As formulated herein, the principles give recognition to such factors as depreciation, interest, bad debts, educational costs, compensation of owners, and an allowance for a reasonable return on equity capital of proprietary facilities.

Id. at § 405.402(c). It can be seen that many factors are included in a single yearly cost determination. The provider must use a Medicare-approved cost accounting method, is reimbursed only for certain approved items and must purchase supplies and services at competitive market rates. Costs can be underpaid or overpaid by the misapplication by the carrier of any of the above-mentioned factors to the provider's specific situation.

22. The Medicare Act § 1861(v), 42 U.S.C. § 1395x(v)(1)(A)(ii) (Supp. III, 1973) provides that regulations shall:

provide 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 (emphasis added).

Note the distinction between (1) adjustment payments from year to year to reconcile estimated advance payments with actual costs incurred *and* (2) reopening closed determinations and reports from several years past and finding that the determinations themselves were made incorrectly. It is the latter situation which is the subject of cost overpayment controversies. Whether section 1395x(v)(1)(A)(ii) provides authority for reopenings has been the subject of heated judicial debate.

23. By signing the appropriate section of a Medicare part B claim form, the patient may *assign* to his physician his right to receive benefits. A physician accepting such an assignment

patient receives the benefit. Part B payments are made for reasonable fees rather than for the costs the doctors actually incur.²⁴

Both part A providers and part B doctors are subject to a provision of the Act which directs that services which are not medically "necessary" for the diagnosis or treatment of disease or injury are not "covered" services for which payment can be made.²⁵

III. RETROACTIVE RECOVERY OF COST OVERPAYMENTS

Of the two main problem areas in Medicare law—cost determinations and coverage determinations—the cost area has become the more settled. Recent legislation in that area has provided greatly improved due process protection and has clarified obscurities in the old law, simplifying a court's task of statutory construction.

The cost area still merits attention, however. The first important judicial confrontations between the Medicare bureaucracy, and the health industry, involving significant sums of money in dispute, were concentrated in the cost area. Cases concerning coverage disputes assume an understanding of the due process and statutory construction aspects of these early cost cases, and refer to the cost cases as authorities on these points.

Then too, the recent quiescence in the cost area is only relative; statutory and administrative problems still remain unresolved. Furthermore, the lessons learned in studying the cost area can serve as guidelines in solving the significant problems which exist in the coverage arena.

A. *Judicial Developments*

Recent court decisions have generally allowed reopenings of

binds himself not to collect from the patient any portion of his fee disallowed by Medicare. 42 U.S.C. § 1395u(b)(3)(B)(ii) (Supp. III, 1973). For this reason, physicians accept assignments only from uncreditworthy patients.

24. A doctor may, for example, set a fee of \$4.00 for an office diagnostic procedure which actually costs him \$3.28 to perform. If this \$4.00 is within the bounds of what other doctors in the area charge for the same procedure, it will be deemed a reasonable fee.

25. 42 U.S.C. § 1395y(a)(1) (Supp. III, 1973). There is a distinction between (1) reasonable costs and (2) expenses or services not covered because they are not medically necessary. Initial cost determinations assume that the patient needs the services provided (e.g., 2 weeks in the hospital, 15 electrocardiograms and a heart catheterization). The inquiry is then directed to whether these services have been provided as economically as possible. Initial coverage (medical necessity) determinations question whether the patient actually needed the services provided, or whether some or all of the tests and treatments he received were unnecessary.

cost reports, holding that the Medicare Act does not bar judicial review of reopenings and attempted recoveries and that HEW must accord due process to providers.

1. STATUTORY AUTHORITY TO REOPEN COST DETERMINATIONS

The sections of the Act to which the courts have looked for HEW's authority to reopen past cost report determinations are obscurely worded,²⁶ giving rise to differing judicial interpretations. A Louisiana district court in *Columbia Heights Nursing Home & Hospital, Inc. v. Weinberger*,²⁷ found that 42 U.S.C. § 1395x(v)(1)(A)(ii) (Supp. III, 1973)²⁸ provides no "clear" statutory authority for reopening past yearly cost determinations, presumably because the section does not so state specifically. Since old reports could not be reopened, the overpayment alleged by the Secretary could not be recouped from the provider.²⁹

In *Wilson Clinic & Hospital, Inc. v. Blue Cross*,³⁰ however, the Court of Appeals for the Fourth Circuit did find that the Medicare Act contains at least implied statutory authority for reopening previous years' cost determinations³¹ and that the HEW regulation,³² which expressly permits reopenings of old cost determinations is properly grounded in the Act.

The plaintiff hospital in *Kingsbrook Jewish Medical Center v. Richardson*,³³ like the hospital in *Columbia*, was provided by its carrier with a cost accounting method³⁴ which the carrier later decided produced incorrect results. Yet, unlike the situation in

26. The section of the Act most germane to the issue of reopenings is section 1861(v), 42 U.S.C. § 1395x(v)(1)(A)(ii) (Supp. III, 1973), set out in note 22 *supra*.

27. 380 F. Supp. 1066 (M.D. La. 1974).

28. See note 22 *supra*.

29. See additional discussion of the *Columbia* case, section III, A, 2 *infra*.

30. 494 F.2d 50 (4th Cir. 1974).

31. The court stated:

Reopenings are contemplated generally by the Act. To begin with, it impliedly, if not expressly, envisages the canvassing of all payments to a provider. See: [42 U.S.C.] § 1395g; § 1395f(b); § 1395h(a)(2)(B). Obviously, this tutelage embraces the power and duty to reopen settlements.

Moreover, the Secretary is instructed to issue regulations for the making of "suitable retroactive corrective adjustments" whenever the indemnity of the provider appears "inadequate or excessive." [42 U.S.C.] § 1395x(v)(1)(A)(ii).

Id. at 52.

32. 20 C.F.R. § 405.499(g)(1974), then in effect, has been superseded by 20 C.F.R. § 405.1885 (1975).

33. 486 F.2d 663 (2d Cir. 1973).

34. See note 21 *supra*.

Columbia, this method underpaid Kingsbrook, the provider. When the hospital demanded reimbursement, HEW, now owing funds instead of being owed, took the position that the new, more accurate, cost accounting method could be applied only prospectively. The Court of Appeals for the Second Circuit held that section 1395x(v)(1)³⁵ was express statutory authority for reopening and readjusting past yearly cost reports,³⁶ including those instances in which HEW would be required to reimburse the provider for previous underpayments. The court ordered the Secretary to reimburse Kingsbrook and, if necessary, to promulgate regulations under which reimbursement could be accomplished.

Section 1395hh of the Act,³⁷ a general authorization enabling the Secretary to promulgate necessary regulations, which could include those governing reopening, further shows that section 1395x(v)(1) is as clear and express an authority for reopening cost reports as the Second Circuit stated. In any event, absent a specific statutory prohibition, the government retains its common law right

35. 42 U.S.C. § 1395x(v)(1) (1970), *as amended*, 42 U.S.C. § 1395x(v)(1)(A)(ii) (Supp. III, 1973).

36. The wording of section 1395x(v)(1) which the *Kingsbrook* court holds is "plain" authority for reopenings is set out in note 22 *supra*. It is the same wording construed by the courts in *Columbia* and *Wilson Clinic*. The *Kingsbrook* court reasoned as follows:

[T]he Medicare Act incorporates a twofold adjustment process: (1) to rectify errors produced by the interim payment procedure; (2) to correct flaws in the aggregate reimbursement to which a provider is entitled due to an erroneous method of determining reimbursable cost. . . .

This distinction between methods of payment and methods of determining costs is highlighted by the drafters' use of different sections of the Act, section 1395g and section 1395x(v)(1) respectively, to describe each. Section 1395g authorizes periodic reimbursement "prior to audit or settlement by the General Accounting Office . . . with necessary adjustments on account of previously made overpayments or underpayments. . . ." This statutory language delineating an interim payment procedure, necessarily based on cost estimates, must be contrasted with the reference in section 1395x(v)(1) to "methods of determining costs" to be established for calculation of the annual and, if accurate, final measure of reimbursable costs incurred by the provider. With this descriptive duality in mind, we believe that the corrective adjustments contemplated under section 1395g, required to remedy provider errors revealed after audit, are of a kind different from the corrective adjustments mandated by section 1395x(v)(1), designed to rectify mistakes made by HEW in formulating a particular method of determining cost. (Footnotes omitted).

486 F.2d at 669-70.

37. 42 U.S.C. § 1395hh (Supp. III, 1973). "The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter."

to recover moneys mistakenly paid.³⁸ No court has ever held that the Medicare Act abrogates the government's common law right to recover *cost* overpayments.³⁹

In summary, the prevailing view is that cost reports can be reopened upon request under either section 1395x(v)(1)(A)(ii) or the common law rule.

2. MEDICARE'S DUE PROCESS DEFICIENCIES

Since the courts generally agree that cost reports may be reopened, and these reopenings may involve tens or hundreds of thousands of dollars, standards are needed to prevent HEW and its carriers from abusing the reopening process.⁴⁰ In seeking to recoup their money, HEW and its carriers in the past have demonstrated gross disregard for the constitutionally protected due process rights⁴¹ of the providers. Before May 1972 there were no regulations providing for even informal hearings on reopenings. The plaintiff in *Coral Gables Convalescent Home, Inc. v. Richardson*,⁴² had 50 percent of its current payments suspended by Aetna Life and Casualty to enable the insurance company to recoup alleged overpayments found when old yearly cost reports were reopened. Although the Aetna personnel who made the redeterminations held informal face-to-face conferences with the nursing home, no administrative hearing was provided either before or after the suspension of payments. The district court in *Coral Gables* held that, on these facts, due process demanded at least a post-suspension hearing. The court ordered the Secretary to hold the hearing and, if necessary, to promulgate regu-

38. *Wilson Clinic & Hosp., Inc. v. Blue Cross*, 494 F.2d 50, 52 (4th Cir. 1974), citing *Wisconsin Central R.R. v. United States*, 164 U.S. 190, 212 (1896). The policy behind this right is that the money in dispute belongs to the people and can always be recovered by the government for them.

39. *Mount Sinai Hosp., Inc. v. Weinberger*, 517 F.2d 329 (5th Cir. 1975), holds that the Act does not prohibit recoveries of *coverage* overpayments. See text, section IV, A, 1 *infra*.

40. Since May 1972, HEW regulations have barred cost report reopenings made more than 3 years after the date of original determination. 20 C.F.R. § 405.499(g) (1974), as amended, 20 C.F.R. § 405.1885 (1975).

41. The importance of due process is self-evident. It inhibits arbitrary action and totalitarianism. Its vital elements include notice of the action being taken and of the reasons for it, as well as the opportunity to be heard, to defend against the action, to answer charges and to present and refute evidence before an impartial adjudicator, who creates an accurate record of the adjudication which is used if an appeal from the hearing decision is desired to be taken. See generally K. DAVIS, ADMINISTRATIVE LAW TEXT, chs. 7 & 8 (3d ed. 1972).

42. 340 F. Supp. 646 (S.D. Fla. 1972).

lations to put impartial hearing procedures into effect.⁴³

Although regulations outlining hearing procedures were promptly adopted,⁴⁴ due process deficiencies still existed. The regulations provided that neither the carrier nor HEW could be made parties to the hearing so that final orders in favor of the provider were not binding on HEW or the carrier.⁴⁵ In addition, these regulations did not provide for judicial review of hearing decisions.

On at least three occasions, it appears that even the minimal due process requirements of the regulations were not met by the carriers involved, although the courts did not reach the merits of these contentions: cross examination of witnesses was not permitted;⁴⁶ a hearing officer was accused of being a biased participant in a reopening determination;⁴⁷ and a carrier clearly disregarded the command of regulation 405.999g(e)⁴⁸ that no cost reports were to be regained more than 3 years after the reports had been approved.⁴⁹ Furthermore, another violation of procedural due process occurred when one of HEW's carriers approved a cost accounting system, instructed a provider to use it, and later, summarily suspended present payments to recoup the overpayments the system had allegedly been producing.⁵⁰ In response to this abuse, the court in *Columbia Heights Nursing Home & Hospital, Inc. v. Weinberger*,⁵¹ announced the sound rule that where a provider has relied to its detriment on the express representations of a carrier, the carrier and HEW will be estopped from recovery unless the carrier can show clear, unambiguous statutory authorization of its right to recover.⁵²

43. The court indicated that the procedure must give the provider detailed written notice of the redeterminations made as a result of the reopening as well as notice of a right to a hearing. At the hearing, the plaintiff was to be permitted to introduce evidence and to cross-examine the intermediary personnel who had reopened his old cost reports. The decision-maker at the hearing was to be impartial and unassociated with the reopening decision; moreover, he was required to state the reasons for his decision and to indicate the evidence on which he relied. *Id.* at 651.

44. 20 C.F.R. §§ 405.490-99 (1974), *as amended*, 20 C.F.R. §§ 405.1801-.1889 (1975).

45. *St. Jude Manor Nursing Home, Inc. v. Richardson*, 3 CCH MEDICARE AND MEDICAID GUIDE ¶ 27,226 at 9,103 (M.D. Fla. Oct. 2, 1972).

46. *Goldstein v. United States*, 201 Ct. Cl. 888 (1973).

47. *Id.*; *Temple Univ. v. Associated Hosp. Serv.*, 361 F. Supp. 263 (E.D. Pa. 1973).

48. 20 C.F.R. § 405.499g(e) (1974), *as amended*, 20 C.F.R. § 405.1885 (1975).

49. *Wilson Clinic & Hosp., Inc. v. Blue Cross*, 494 F.2d 50, 56 n.3 (4th Cir. 1974) (Boreman, J., dissenting). (These facts noted by Judge Boreman are not mentioned in the majority opinion.)

50. *Columbia Heights Nursing Home & Hosp., Inc. v. Weinberger*, 280 F. Supp. 1066 (M.D. La. 1974).

51. *Id.*

52. If categorized as a reliance estoppel exception to the general rule allowing reopenings,

3. JURISDICTION OF THE COURTS TO REVIEW COST DISPUTES

Given the large sums of money involved and the due process errors and omissions of HEW and its intermediaries detailed above, it is imperative that providers have the access to the courts which the Secretary has continually sought to deny them.⁵³ Fortunately, it is now settled that court review may be obtained even in situations where the Medicare Act does not expressly provide for it,⁵⁴ as long as the claim falls within the scope of federal question jurisdiction⁵⁵ or is reviewable under the Administrative Procedure Act.⁵⁶ Section 205(h) of the Social Security Act⁵⁷ is not a bar to review in those situations.⁵⁸ Apparently Congress did not originally contemplate that HEW and the providers would become involved in cost disputes of the dollar dimensions discussed here.⁵⁹

Only in those situations usually involving *individuals*, where

Columbia can be harmonized with the majority of cases holding that there is authority to reopen cost reports. See text, section I, A, 1 *supra*.

53. See cases cited note 58 *infra*.

54. *Id.*

55. "The district courts shall have original jurisdiction of all civil actions wherein the matter in controversy exceeds the sum or value of \$10,000 . . . and arises under the Constitution, laws, or treaties of the United States." 28 U.S.C. § 1331(a) (1970).

56. "A person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action . . . is entitled to judicial review thereof." 5 U.S.C. § 702 (1970). "[F]inal agency action for which there is no other adequate remedy in a court [is] subject to judicial review." 5 U.S.C. § 704 (1970). "This chapter applies . . . except to the extent that—(1) statutes preclude judicial review; or (2) agency action is committed to agency discretion by law." 5 U.S.C. § 701 (1970). Though no law prevents doctors or hospitals from suing the Secretary of HEW in state court, federal court would seem to be the preferred forum because of the federal judiciary's familiarity with the Administrative Procedure Act and the potential practical difficulties of enforcing a state court's order against an agency of the federal government.

57. Social Security Act § 205 (h), 42 U.S.C. § 405(h) (1970) provides:

The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency, except as herein provided.

See text accompanying note 60 *infra*. This section is incorporated into the Medicare Act by 42 U.S.C. § 1395 ii (Supp. III, 1973).

58. *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663 (2d Cir. 1973); *Aquavella v. Richardson*, 437 F.2d 397 (2d Cir. 1971); *Mount Sinai Hosp., Inc. v. Weinberger*, 376 F. Supp. 1099 (S.D. Fla. 1974), *rev'd on other grounds*, 517 F.2d 329 (5th Cir. 1975); *Temple Univ. v. Associated Hosp. Serv.*, 361 F. Supp. 263 (E.D. Pa. 1973).

59. This is evidenced by the fact that Congress amended the Act to provide for express court review of cost disputes. 42 U.S.C. § 1395oo (Supp. III, 1973). See text section III, B, 1 & 2 *infra*. The statutory silence remains as to court review of coverage disputes between providers and intermediaries. See text section IV *infra*.

the Act establishes explicit review procedures, does section 205(h) bar the use of alternative means of review.⁶⁰ The circuits are in general agreement that suits against the Secretary, not specifically provided for under the Act, are not barred by the doctrine of sovereign immunity.⁶¹

B. *Statutory Amendments*

The courts have protected providers during the reopening process by permitting judicial review of HEW's actions and by enforcing providers' constitutional rights to due process. Congress has also created a procedure which will help to insure HEW's responsible conduct during cost determination reopenings.

In October 1972, Congress, adding section 1878⁶² to the Medicare Act, established a Provider Reimbursement Review Board (PRRB) which, for the first time, provides a non-carrier-based, and therefore relatively neutral, forum for hearings on cost determination disputes where the amount in controversy exceeds \$10,000. Furthermore, in an additional 1974 amendment to section 1878, Congress expressly provided for judicial review of any final decision of the PRRB.⁶³ In January 1975, the PRRB began hearing cases arising from cost periods ending on or after June 30, 1973.

C. *Revised Hearing Regulations: HEW's Positive Response to Judicial and Congressional Guidance*

In October 1974, HEW adopted new regulations⁶⁴ covering cost determinations and reopenings, as well as hearings by the PRRB. These regulations represent a generally positive response by HEW to judicial criticism of its past conduct and to the statutory guidance of Congress. Section 405.1885 of the regulations provides that

60. *Aquavella v. Richardson*, 437 F.2d 397, 402 (2d Cir. 1971).

61. *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663 (2d Cir. 1973); *Mount Sinai Hosp., Inc. v. Weinberger*, 376 F. Supp. 1099 (S.D. Fla. 1974), *rev'd on other grounds*, 517 F.2d 329 (5th Cir. 1975).

62. Medicare Act, § 1878, 42 U.S.C. § 139500 (Supp. III, 1973).

63. Pub. L. No. 93-484, § 3 (Oct. 26, 1974), *cited in* 1974 U.S. CODE CONG. & AD. NEWS 1674-75.

64. 20 C.F.R. §§ 405.1801-.1889 (1975), superseding §§ 405.490-.499 (1974) which were criticized by the court in *St. Jude Manor Nursing Home, Inc. v. Richardson*, 3 CCH MEDICARE AND MEDICAID GUIDE ¶ 27,226 (M.D. Fla. Oct. 2, 1972). See note 45 *supra* and accompanying text. For a discussion of these regulations and a thorough treatment of the cost area see Homer & Platten, *Medicare Provider Reimbursement Disputes: An Analysis of the Administrative Hearing Procedures*, 63 GEO. L.J. 107 (1974).

no cost report may be reopened after 3 years from the date of original determination.⁶⁵ Review by the PRRB and the courts is explicitly provided for disputes over *reopenings* of cost determinations.⁶⁶ Further, the carrier has been made a party to all PRRB hearings, so that an adjudication in favor of a provider will be binding on the carrier.⁶⁷

The new regulations will pose some difficulties, however. Since they were written before section 139500 of the Medicare Act was amended in 1974, the regulations conflict with 139500's expanding judicial review provisions. Regulations⁶⁸ limiting judicial review to situations where the Secretary has modified a PRRB decision adversely to the provider, are now without statutory authority, since any adverse decision of the PRRB or the Secretary may now be reviewed as provided by amended section 139500.

Another difficulty arises with section 405.1885(c) which states: "Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision."⁶⁹ This regulation could be used in an attempt to prevent a provider from obtaining *court* review of a carrier's or the PRRB's refusal to reopen a cost determination unfavorable to the provider. The best answer to such an argument is that there is no statutory basis for such a regulation and it is therefore void.⁷⁰

In the cost area, then, hospitals and doctors have fought for and won judicial and congressional protection of their due process rights vis-a-vis HEW, especially their right to court review of its actions. The field has now become reasonably stable and fair for the health care industry. Although recoveries of cost overpayments continue, HEW has been forced to respect the rights of providers during the recovery process.

IV. RETROACTIVE RECOVERY OF COVERAGE OVERPAYMENTS

While *cost* determinations pertain to the efficient *delivery* of

65. 20 C.F.R. § 405.1885(e) (1975). This 3-year limit applies to any reopening action undertaken after May 27, 1972.

66. 20 C.F.R. § 405.1889 (1975).

67. 20 C.F.R. § 405.1843 (1975).

68. 20 C.F.R. §§ 405.1871-.1875, .1877 (1975).

69. 20 C.F.R. § 405.1885(c) (1975).

70. *Id.* The court in *Kingsbrook* held that the Secretary must reopen a cost determination for the provider because the Medicare Act required that it do so. There is nothing in the new amendments (section 139500) that changes this, or that precludes direct court review of whether a regulation is without statutory authority.

medical services, *coverage* (medical necessity) determinations address a patient's initial *need* for the service. The providers face, in the coverage area, critical statutory construction and procedural issues, similar to those discussed above pertaining to cost: whether the Medicare Act allows reopenings of past coverage determinations; whether it permits judicial review of HEW's coverage decisions; and what specific due process safeguards providers and doctors may claim as a matter of right. Additionally, coverage determinations intrude upon the practice of medicine to a far greater extent than do cost determinations. This intrusion creates an additional vital issue as to what constitutes the allowable extent of federal control of the practice of medicine.

Although coverage issues are similar to cost issues, the mechanics are somewhat different. First, doctors who receive payment under part B of the Medicare Act, as well as providers who receive payment under part A, are subject to coverage determinations,⁷¹ whereas cost decisions apply only to institutions. Secondly, direct cost determinations are regularly made only once a year, while direct coverage determinations review the circumstances of each individual patient's treatment.⁷²

These mechanical differences, as well as the difference between the subject matter of coverage determinations (medical necessity) and that of cost determinations (efficient delivery), have resulted in variations in the development of statutory and case law in each area. Additionally, the continuing conflict over increasing federal control over the practice of medicine has kept coverage law unsettled.

A. *Judicial Developments*

Coverage case law has focused on statutory construction as the courts have struggled to decide two issues: (1) Does the Medicare

71. 42 U.S.C. § 1395y(a) (Supp. III, 1973).

72. In contrast to this direct review, large numbers of coverage determinations for a particular provider can be reopened indirectly by a statistical sampling method. If a statistically valid sample of patient confinements shows an average overpayment, this average can be generalized to each and every confinement in the group from which the sample was taken. For instance, a carrier, considering 400 cases of confinement for diagnosis "X", reviews the medical records of 15 of the cases in detail. The reviewer determines that each of the 15 patients in the sample received an average of two unnecessary electrocardiograms. Each of the 400 cases is then considered overpaid by the cost of two electrocardiograms. Statistical sampling was used in the *Mount Sinai* case, discussed in the text following note 73 *infra*.

Act bar or allow retroactive coverage reopenings? (2) Does the fact that doctors are paid under part B of the Act operate to deny them access to judicial review of HEW's actions? Due process issues are also raised in the coverage cases, but the courts in deciding these cases refer to the due process holdings of the cost cases.

1. COVERAGE REOPENINGS ARE NOT BARRED BY STATUTE

The major case on the issue of whether reopenings of coverage determinations are allowed is *Mount Sinai Hospital, Inc. v. Weinberger*.⁷³ The Fifth Circuit Court of Appeals, reversing the district court, held that the Medicare Act, rather than abrogating the government's common law right to recoup payments mistakenly made for unnecessary services, specifically recognizes that right in certain of its provisions.⁷⁴

This author believes that the circuit court's holding properly determines that the Medicare statute contains no bar to recovery. The district court had found such a bar within section 1395y(a), which provides that "no payment may be made . . . for any expenses incurred for items or services . . . which are not reasonable and necessary . . ." ⁷⁵ This interpretation, however, was too heavy a strain to put on these words, which are routinely found in the "exclusions" section of private group health insurance policies.

Though the district court's result was not logically supportable, it was an attempt to remedy the inherent unfairness caused by recoupment of large sums of money after long periods of time, impairing the hospital's ability to continue to provide its full range of services. The circuit court realized the harsh effect of its reversal,⁷⁶ but offered no hope for mitigation. Future courts, confronted with recoupments, however, should realize that although a fair result cannot be attained through statutory construction as the district court had attempted in *Mount Sinai*, such equitable doctrines as estoppel, unclean hands, and laches may be employed to mitigate any inequities that would result from attempted coverage overpayment recoveries.

73. 376 F. Supp. 1099 (S.D. Fla. 1974), *rev'd on other grounds*, 571 F.2d 329 (5th Cir. 1975). *Szekely v. Florida Medical Ass'n*, 517 F.2d 345 (1975), a companion case which reaches the same result as the *Mount Sinai* case, also employs the same reasoning. *Mount Sinai* applies to providers and *Szekely* to doctors.

74. *Mount Sinai Hosp., Inc. v. Weinberger*, 517 F.2d 329, 345 (5th Cir. 1975).

75. 42 U.S.C. § 1395y(a) (1970).

76. *Mount Sinai Hosp. Inc. v. Weinberger*, 517 F. 2d 329, 338 n.30 (5th Cir. 1975).

2. DOCTORS' ACCESS TO JUDICIAL REVIEW OF COVERAGE REOPENINGS

Does the judicial review provision of the Medicare Act,⁷⁷ discriminate against doctors, denying them the same access to the courts as that given to hospitals? The provision (section 1395ff) deals only with an individual patient's right of review, but the courts have considered that section germane to the issue of a doctor's right to judicial review of coverage reopenings.

Individual patients have an express statutory right to court review of any part A benefit determination in which the amount in controversy after the administrative hearing is \$1,000 or more.⁷⁸ Individual patients have no right to court review of a part B benefit determination regardless of dollar amount, although they are allowed an administrative hearing.⁷⁹ There is clear, convincing evidence of legislative intent to preclude a "person" from taking a dispute over part B benefits to court. The policy is to "avoid overloading the courts with minor matters,"⁸⁰ because the average part B total benefit is often well under \$1,000.

Because of HEW's attempts to apply this clearly patient-directed discrimination under part B to doctors, a doctor faces an additional burden (above and beyond that encountered by part A providers) in gaining access to the court whenever HEW attempts to recoup tens of thousands of dollars of alleged coverage overpayments from him. Congress in 1965 (and probably in 1972) did not contemplate that coverage disputes of this magnitude would occur between HEW and part B practitioners.⁸¹ Clearly, however, sums of this magnitude are not "minor matters." The intent of Congress,

77. 42 U.S.C. § 1395ff (Supp. III, 1973) provides in part:

(b)(1) Any individual dissatisfied with any determination . . . as to—
 . . . (C) the amount of benefits under part A of this subchapter . . . shall be
 entitled to a hearing thereon by the Secretary
 . . . and to judicial review of the Secretary's final decision after such hearing

Section 1395ff is silent as to a determination under part B.

78. *Id.*

79. 20 C.F.R. §§ 405.801 *et seq.* (1974).

80. *Bohlen v. Weinberger*, 483 F.2d 918, 924-25 (3d Cir. 1973) (Aldisert, J., dissenting), quoting 118 CONG. REC. 33991-92 (1972) (remarks of Senator Bennett which indicated the legislative history of 42 U.S.C. § 1395ff (Supp. III, 1973)).

81. [T]he legislative history . . . does suggest that Congress did not provide review "of a determination concerning the amount of benefits under part B [because such] claims will probably be for substantially smaller amounts than under part A." 1965 U.S. CODE CONG. & AD. NEWS 1995.

483 F.2d at 921 n.12.

cited above, applies to individual claimants and probably to doctors or suppliers appealing one claim at a time. It should not apply to a doctor who has just been tapped for a refund of an alleged overpayment of \$150,000.

The cases, though not in agreement, tend to support the proposition that section 1395ff does not deny doctors access to court when large sums of money are involved. *Szekely v. Florida Medical Association*⁸² states simply that the court acquires jurisdiction under 28 U.S.C. § 1331(a)⁸³ and 5 U.S.C. § 702⁸⁴ and that 42 U.S.C. § 405(h) is no bar to a suit by a doctor when HEW is attempting to recover coverage overpayments from him. Additionally, under *Szekely* sovereign immunity is no bar to a suit against the Secretary of HEW under the *Larsen-Dugan* officer suit exception to the sovereign immunity bar.⁸⁵

*Canterbury Medical Associates, Inc. v. Richardson*⁸⁶ takes a more modest approach. Although the court decided that review was available on grounds no longer applicable due to the 1972 amendments, the court also stated a promising alternative theory: Even if practitioners were first forced to participate in agency hearings,⁸⁷ section 1395ff of the Act does not on its face provide the clear and convincing evidence of intent to preclude judicial review required by *Abbott Laboratories v. Gardner*.⁸⁸

82. [1973-1974 Transfer Binder] CCH MEDICARE AND MEDICAID GUIDE ¶ 27,105 (S.D. Fla. July 11, 1974) *rev'd on other grounds*, 517 F.2d 345 (1975) *citing* Kingsbrook Jewish Medical Center v. Richardson, 486 F.2d 663 (2d Cir. 1973).

83. See note 55 *supra*.

84. See note 56 *supra*.

85. [1973-1974 Transfer Binder] CCH MEDICARE AND MEDICAID GUIDE ¶ 27,105 at 10,591. The district court noted:

Since the thrust of the plaintiff's challenge concerns the legal authority of the Secretary to reopen previously paid claims, the case at bar comes within the *Larsen-Dugan* "officer suit" exception to the doctrine of sovereign immunity. *Dugan v. Rank*, 372 U.S. 609 (1963); *Larson v. Domestic and Foreign Commerce Corp.*, 337 U.S. 682 (1949). The Fifth Circuit Court of Appeals has stated that an "officer suit" is maintainable if the averments in the complaint are affirmative and explicit. *Carter v. Seaman*, 411 F.2d 767, 770-71 (5th Cir. 1969). The relief sought, cessation of the suspension order, does not offend *Larson's* admonition regarding relief requiring affirmative government action since the government routinely distributes medicare funds due to individual enrollee-beneficiaries absent an assignment being made.

86. [1973-1974 Transfer Binder] CCH MEDICARE AND MEDICAID GUIDE ¶ 26,704 (D. Mass. Mar. 27, 1973).

87. As provided in 20 C.F.R. §§ 405.801 *et seq.* (1974).

88. 387 U.S. 136, 140-41 (1967). In *Canterbury*, the Court noted:

Even *Russi v. Weinberger*,⁸⁹ which forced a doctor back to a part B administrative hearing for a determination on the merits of the suspension of payments, implies that judicial review will not be denied, provided administrative remedies must have been exhausted. The implication arises from the court's statement that the plaintiff's claim, which did not raise allegations of due process violations, was not sufficient to by-pass agency review. All of these cases, including *Russi*, permit judicial review of due process questions arising in part B determinations without any requirement that administrative remedies be exhausted first.

B. *Statutory Amendments: Artfulness and Dissonance*

The courts have served providers' and doctors' legitimate financial and due process interests in the medical necessity area, attempting to bar recoveries of coverage overpayments and assuring access to judicial review of HEW's actions. Congress, on the other hand, while apparently moving, perhaps with some success, to protect these same interests, exacts as its price, the ever increasing control of the practice of medicine.

1. PSRO'S: OUTSIDE THE REALM OF AGENCY EXPERTISE?

The cause of Congress' dissonant approach to medical necessity problems is clear: HEW must exercise control over medical necessity, yet HEW is forbidden to control it. On the one hand, determinations of what constitutes medically necessary care are inextricably bound up with decisions concerning the manner in which doctors practice medicine; the government pays the doctor, so the government has the ability to set conditions on its payment. On the other hand, the first sentence of the Medicare Act reads:

Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided⁹⁰

Thus, in light of the strong presumption of reviewability that has developed in the law, it is certainly less than clear that a grant of review under particular foreseeable circumstances is tantamount to a denial of review as to other less favorable circumstances.

[1973-1974 Transfer Binder] CCH MEDICARE AND MEDICAID GUIDE ¶ 26,704 at 9,356 n.4.

89. 373 F. Supp. 1349 (E.D. Va. 1974).

90. 42 U.S.C. § 1395 (Supp. III, 1973).

The pre-PSRO system of determining medical necessity, which is still in operation, is a largely imperfect program. Staying barely within the spirit of the above cited statutory prohibition against interference, carriers hire doctors and nurses as full-time employees. These captive practitioners make medical necessity determinations on whatever claims are brought to their attention by non-medical employees. Because many medical necessity issues can be missed under this system when the claim is originally paid, the spectre of reopening and review of large numbers of a doctor's or hospital's past claims looms whenever, by chance, that doctor or hospital has been brought to the carrier's special attention.

Against this background, Congress passed legislation in 1972 enabling the establishment of a nationwide network of local Professional Standards Review Organizations,⁹¹ manned entirely by licensed practicing local physicians, which will make coverage determinations for each patient before and during each confinement.

Although the PSRO's superficially seem to increase doctors' self-determination of the parameters of the practice of medicine, they, in fact, tighten federal control by centralizing nationally the norms under which local doctor groups must make their pre-confinement coverage determinations.⁹² Pre-confinement review, however, would have a positive effect assuming no bureaucratic snarls are created. It would largely eliminate the need for reopenings and recoveries of coverage payments because the initial decisions on coverage will have been made carefully by qualified personnel and moneys will no longer be paid erroneously to the extent they now are.

As a failsafe device to allow recovery of the potentially much smaller amounts of money it may pay in error, a PSRO will have the limited power to recover up to \$5,000 from a doctor or hospital. In the alternative, it may suspend a doctor or a hospital from parti-

91. 42 U.S.C. § 1395 (Supp. III, 1973.) establishes Professional Standards Review Organizations (PSROs).

92. Where the actual norms of care . . . in [an] . . . area are significantly different from professionally developed regional norms of care . . . the [local PSRO] . . . concerned shall be so informed, and . . . the [local PSRO] . . . may apply such norms in such [local] area as are approved by the National Professional Standards Review Council.

42 U.S.C. § 1350c-5(a) (Supp. III, 1973).

Each [local PSRO] . . . shall utilize the [regional] norms developed under this section as a principal point of evaluation and review

42 U.S.C. § 1320c-5(c) (Supp. III, 1973).

cipation in the Medicare program if, after warning, unnecessary treatment of patients continues.⁹³ Since suspension from the program is as severe a penalty as paying back large sums of money previously received, PSRO's merely replace the possibilities of extensive coverage reopenings with another equally unpleasant possibility. The net gain to the doctor or hospital is that the PSRO sanctions are accompanied by the explicit due process safeguards of warning, notice and an absolute statutory right to hearing and judicial review of any suspension or limited recovery actions.⁹⁴

Until a local PSRO is fully functional, however, its penalties and its limited authority to reopen coverage, by the terms of section 1320c-2, are not operative.⁹⁵ The process of establishing PSRO's is a slow one. Although they were authorized in 1972, it will be 1977 or 1978 before a majority of them are operating provisionally and 1980, at the earliest, before most of them will be in permanent operation with the full responsibilities and powers envisioned by section 1320c. This timetable could be lengthened further by disputes within local medical communities and between organized medicine and HEW.⁹⁶ Many segments of the medical profession are resisting the implementation of PSRO's because they realize that PSRO's will represent a *de facto* tightening of federal control over medical practice.⁹⁷

Because PSRO's and their sanctions are not yet a reality, it is necessary to look at another section of the 1972 amendments which has the *present* capacity to affect reopenings and recoveries of coverage overpayments.

2. SECTION 1395PP: CONTROLLING MEDICAL NECESSITY WHILE SEEMING NOT TO

Congress, in 1972, knew that the PSRO's would not be opera-

93. 42 U.S.C. § 1320c-9(b) (Supp. III, 1973).

94. *Id.*

95. 42 U.S.C. § 1320c-2 (Supp. III, 1973).

96. The Supreme Court recently upheld, over the challenge of the Association of American Physicians and Surgeons, the PSRO system to review the treatment of Medicare patients. *Association of Am. Physicians & Surgeons v. Mathews*, 96 S. Ct. 388, *aff'g mem.* 395 F. Supp. 125 (N.D. Ill. 1975).

97. The PSRO amendment, 42 U.S.C. § 1320c (Supp. III, 1973) is a portion of subchapter XI of the Social Security Act. The Medicare Act is subchapter XVIII of the Social Security Act. Therefore, the PSRO amendment is technically not subject to the Act's prohibition against federal interference with the practice of medicine. See note 90 *supra* and accompanying text.

tional for some time and that medical necessity disputes needed some current statutory direction. Yet it remains to be seen whether, at that point, Congress contemplated the massive retroactive coverage reopenings and denials which took place subsequent to 1972. Section 1395pp,⁹⁸ promulgated to fill the time gap, has the capacity to ease the burden on doctors and hospitals which results from massive reopenings of medical necessity determinations. It also operates to bring the practice of medicine more directly under the control of HEW⁹⁹ and may restrict court review of HEW's medical necessity determinations and attempted recoupments of coverage overpayments.

The stated purpose of the section is to reduce the adverse effect on practioners and providers of agency determinations which disallow reimbursements for services which were not covered under the Act because they were not necessary. Section 1395pp is elliptically entitled: "Payment for . . . services notwithstanding . . . [their] disallowance." The import of this section is that providers will be paid anyway if they "did not know and could not reasonably have been expected to know"¹⁰⁰ at the time services and items were provided that these measures would be disallowed as not reasonable or necessary. Regulations effective as of February 5, 1975,¹⁰¹ list the criteria for determining whether there was knowledge at the time services were rendered that they would be disallowed. The criteria include a presumption of no knowledge,¹⁰² which may be rebutted by evidence that a provider or practitioner had been informed that the same or similar services were not covered. The presumption may also be rebutted as to providers by evidence showing that the provider does not regularly comply with the following administrative criteria:¹⁰³

- 1) Proper utilization review as set out in section 405.1035;
- 2) Timely billing;

98. 42 U.S.C. § 1395pp (Supp. III, 1973).

99. Note, in contrast, that by virtue of the PSRO amendment, federal control is exercised over medicine, not through the existing HEW bureaucracy, but through a National Professional Standards Review Council, a body of eleven doctors not otherwise in the employ of the United States. 42 U.S.C. § 1320c-12 (Supp. III, 1973). It is somewhat more legitimate for this body of doctors to be the instrument of centralized medical control than it is for HEW to exercise that control directly through its lay bureaucrats.

100. 42 U.S.C. § 1395pp(a) (1)-(2) (Supp. III, 1973).

101. 20 C.F.R. §§ 405.195, 405.330-.332 (1975).

102. 20 C.F.R. § 405.332(b) (1975).

103. 20 C.F.R. §§ 405.195, .332(b)(3) (1975).

- 3) Prompt notice to attending physicians of utilization decisions; and
- 4) A past coverage denial history of less than five per cent of total yearly services provided.¹⁰⁴

However, even if the above administrative criteria have been met, and even if the provider or doctor has not been informed, he will still be deemed to have knowledge if it is "clear and obvious" that the provider should have known that the disputed services were not covered.¹⁰⁵

The actual effect of section 1395pp's "limitation on liability mechanism" is to put a non-medical label (that of "prior knowledge") on medical necessity issues. By handling medical necessity determinations in such a manner that only non-medical questions are asked, the HEW-carrier bureaucracy has effectively increased its control of these medical necessity determinations and of the entire medical necessity area.

It remains to be seen, however, just how HEW will attempt to use the statute; whether the Secretary will apply it only to single claims as they are initially reviewed, or whether attempts will be made to apply it retroactively, (which will raise reopening problems) either to single claims or to massive reopenings of past claims already paid to a single provider or practitioner. The language of the new regulations would seem to indicate a single claims application in that each individual patient is to be a party to any proffered review of a determination made under 1395pp.¹⁰⁶ Apparently also, the action taken on this single claim basis may be either prospective or retroactive. Section 405.704(B) of the January 6, 1975, regulations indicates that an initial determination as to an individual enrollee includes a determination of any prior HEW overpayment. Section 405.331(B) states that under certain circumstances an overpayment to a provider for the benefit of an individual patient can be recouped from the provider.

If HEW applies 1395pp with the desire to benefit providers and

104. Part A Intermediary Letter No. 73-42 (Oct. 1973) gives the 5 percent figure; it is not found in the published regulations. Note that under this 5 percent figure, even Mount Sinai Hospital, which received \$22 million a year in Medicare funds and which has had \$6 million of its claims denied over a 6-year period, (although not yet recovered) meets the criteria to be held not to have knowledge.

105. 20 C.F.R. § 405.332(b)(4) (1975).

106. 20 C.F.R. § 405.704 (1975).

practitioners by more frequently finding "no knowledge," it will reduce the confusion and uncertainty in the coverage area. If 1395pp is applied in a hard line manner even to single claims, however, it will increase the confusion and conflict already present regarding reopenings. Furthermore, the combination of such a hard line approach with the attempted application of 1395pp and its regulations to the mass retroactive coverage denials experienced by the plaintiffs in *Mount Sinai*, *Szekely*, *Russi* and *Canterbury*,¹⁰⁷ would compound the problems.

The new regulations promulgated under 1395pp do not address clearly the problem of reopenings of coverage determinations on a mass scale (i.e., all the claims for one doctor for a four-year period). However, HEW might still attempt to apply 1395pp to retroactive coverage reopenings since no clear statutory language exists to prevent this approach. Regulations providing for the suspension of current payments to recover past overpayments have been in effect since 1972.¹⁰⁸ Current payments could be suspended under these regulations, and the doctor or provider could be tied up for months in 1395pp administrative hearings in which he might be permitted to argue only whether he knew in advance that his claims might be denied as medically unnecessary. At the least, an extra issue to litigate has been added. A provider might not be able to get to court on the medical necessity issue until he has exhausted administrative remedies on the related issue of knowledge. Further, a doctor might not be able to get to court on any issue because 1395pp provides no court review for part B administrative hearings on knowledge.

A provider or doctor would argue against such a limitation on judicial review on the basis that the administrative hearings provide remedies only on the issue of knowledge. Since he is coming to court on a different issue, medical necessity, and the administrative hearings cannot provide the remedy he seeks (they cannot decide questions of medical necessity) he should not be required to submit to them first. The difficulty with this approach is that if the knowledge issue is decided in his favor, he would not need to have the medical issue resolved. In any event the courts should not be denied to part

107. By the same token, a generous application of section 1395pp to retroactive coverage reopenings would preclude HEW's recovery from providers and doctors and so would reduce uncertainty and unfairness in this area.

108. 20 C.F.R. §§ 405.370-.373 (1974).

B physicians after they have submitted to the hearings, since the restrictions imposed by Congress on judicial review of part B decisions were intended only to avoid burdening the courts with claims involving minimal amounts. In addition, 1395pp seeks only to prevent doctors from taking *single* claims to court from the knowledge hearings. If, however, HEW elects to find the provider or physicians without knowledge most of the time, 1395pp could be a positive force for eliminating the inequities previously caused by massive coverage reopenings and suspensions.

In summary, section 1395pp raises at least as many questions as it answers. Whether it will cause doctors and hospitals more or less difficulty will depend on how HEW applies it. It seems certain that, regardless of its other effects, it will increase HEW's control over the doctors' practice of medicine.

Viewing the state of the law in the coverage area, it seems that no trend is as discernible as that of increasing federal supervision and control of the practice of medicine. Recovery of coverage payments may or may not be barred and PSRO's may or may not come to pass. But the most encouraging sign is that, as in the coverage area, doctors and hospitals have carved out a permanent access to the courts and the courts are admirably fulfilling their traditional role, guarding the health industry's due process rights.

V. CONCLUSION

By perseverance and a willingness to fight, hospitals have won recognition of their right to due process protections when faced with administrative attempts to recoup cost overpayments. Continued efforts by hospitals and doctors in the courts could well result in the same due process protections being extended when coverage questions are involved.

Doctors and hospitals should not forget, however, that these protections may also be obtained through legislative action. While it is true that the courts have generally been more receptive to requests for these basic protections, an effort should be made to seek the following statutory protections:

1. Express Statutory Right of Review

A provider or doctor should have an express statutory right to judicial review on *any* matter in which the amount in controversy exceeds \$10,000. It is probable that this has not occurred because Congress is loath to give an express right of judicial review for any

matter unless it also provides for a prior agency review of that matter, which prevents court determinations of factual questions. If this is Congress' rationale, the jurisdiction of existing agency hearing bodies could be expanded to include review of *any* matter arising under the Medicare Act subject to minimum dollar limits. Although this problem has been substantially solved for cost reopening problems, it remains for coverage problems.

2. Statutory Three-Year Limitation on Retroactive Reopenings

This limit already exists for costs. It should be expressly extended to coverage reopenings as they are applied to providers and practitioners.

3. Statutory Dollar Limits on Retroactive Recoveries of Both Cost and Coverage Overpayments

Suspension of current payments to recoup past cost or coverage overpayments should not be permitted regardless of fault¹⁰⁹ (short of fraud) when such suspension could cause a provider or practitioner to cease operating or to cease providing a substantial portion of its services; suspensions not having this effect could be allowed. The best reason for this recommendation is that no medical service entity which enters an agreement with HEW, as provided in section 1395cc(a) for providers and in section 1395a(3)(b)(ii) for practitioners or suppliers, should be required to risk economic annihilation as a condition of association.

As discussed earlier in this article, judicially encouraged congressional deliberations have resulted in legislation which provides an adequate structure of due process protection in the cost area of Medicare law.

The statutory protections suggested above comprise a similar framework of fairness for the coverage area. While seeking legislative enactment of these protections, it is also desirable to take a parallel course of action in the courts so that if Congress does not act, the suggested statutory framework would be approximated as closely as possible by the judiciary through case decisions based on theories of equity.

Doctors, hospitals and their legal representatives should work

109. 42 U.S.C. § 1395gg(c) (Supp. III, 1973).

before both Congress and the courts to advance the proposition that the same structure of fairness that exists in the cost area can and should be quickly implemented for the coverage area. The foregoing suggestions as to the limits of retroactive recovery comprise the basic outline of that structure.