DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION AND ORDERS OF THE MEDICARE APPEALS COUNCIL REMANDING CASES TO ADMINISTRATIVE LAW JUDGE
Docket Number: M-13-2508

In the case of	**Claim for**
Comprehensive Decubitus Therapy, Inc. d/b/a Advanced Tissue (Appellant)	Supplementary Medical Insurance Benefits (Part B)
(Beneficiary)	(HIC Number)
DME MAC Jurisdictions A, B, C & D (Contractor)	1-1322122613 and 16 others (see attached) (ALJ Appeal Number)

The Medicare Appeals Council (Council) has decided, on its own motion, to review seventeen individual Administrative Law Judge (ALJ) decisions, each dated April 25, 2013, because CMS has articulated error of law material to the outcome of the claims. *See* 42 C.F.R. § 405.1110(c). The decisions addressed overpayments assessed against the appellant-supplier in connection with its claims for Medicare Part B payment for surgical dressings provided to seventeen beneficiaries who were under Medicare Part A care[1] on multiple dates of service between May 10, 2012, and July 25, 2012.[2] The ALJ upheld the overpayments assessed against the appellant, but found that the appellant was entitled to a waiver of the recoupment of the overpayments under section 1870(b) of the Social Security Act (Act).

[1] As CMS's memorandum points out, a majority of the beneficiaries were in Part A home health plans of care; one beneficiary was in a skilled nursing facility (SNF) stay.
[2] The dates of service, the ALJ appeal numbers, and the redacted HIC numbers of the seventeen beneficiaries are in the attached beneficiary list. The Council refers to the beneficiaries by their initials to protect their privacy.

By memorandum dated June 20, 2013, Q2 Administrators, on behalf of the Centers for Medicare & Medicaid Services (CMS), requested the Council's review of the ALJ decisions. CMS's memorandum requesting own motion review is entered into the record as Exhibit (Exh.) MAC-1.

By letter received on July 22, 2013, the appellant requested an extension of time of 14 days from the date of the Council's determination on the request for extension to file a response to CMS's memorandum. Exh. MAC-2. On August 2, 2013, the Council denied the request. Exh. MAC-3. The request was untimely filed, after the expiration of 20 calendar days from the date of the referral. *See* 42 C.F.R. § 405.1110(b)(2). The appellant merely referred to a "delay in receipt" of the referral, without further explanation, or supporting information or documentation, concerning the "delay in receipt." Exh. MAC-2. The appellant also referred to "other logistics issues," but did not offer an explanation, or supporting information or documentation, as to why it needed additional time. *Id.*

SUMMARY OF COUNCIL'S ACTION

The Council agrees with CMS that the ALJ decisions for A.C., E.V., B.S., and A.T. were based on error of law. As discussed below, the ALJ misapplied section 1870(b) of the Act in finding that the appellant was entitled to a waiver of the recoupment of the overpayments in these cases. Therefore, the Council reverses the ALJ decisions for A.C., E.V., B.S., and A.T. on the issue of waiver of recoupment of the overpayments. (See Part I below.)

The Council remands to the ALJ the appellant's claims for G.W., J.O., J.W., L.S., M.F., S.W. and B.S.-2. For these cases, the ALJ issued on-the-record decisions without holding a hearing on the waiver issue, as requested by the appellant. The Council vacates the ALJ decisions for these beneficiaries and remands the cases to an ALJ for further proceedings, including the opportunity for a hearing and the issuance of new decisions. *See* 42 C.F.R. § 405.1110(d). (See Part II below.)

The Council also remands to the ALJ the appellant's claims for J.K., R.D., V.W., V.L., M.C. and E.L. For these cases, the ALJ indicated in the ALJ decisions that a hearing was held on April 15, 2013. However, the hearing CD included in the claim files for these beneficiaries includes hearings for only four other beneficiaries, namely A.C., E.V., B.S., and A.T., for which the

Council is issuing a decision. The Council has been unable to obtain the hearing CD(s) for these six beneficiaries and therefore is unable to rule on these appeals. The Council vacates the ALJ decisions for these beneficiaries and remands the cases so that the Office of Medicare Hearings and Appeals (OMHA) can assign the cases to an ALJ for appropriate action. *See* 42 C.F.R. § 405.1110(d). (See Part III below.)

BACKGROUND

The appellant sought, and initially received, Medicare Part B reimbursement for various surgical dressings furnished to seventeen beneficiaries on multiple dates of service between May 10, 2012, and July 25, 2012. Exh. 1 (all claim files). The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) subsequently determined that these payments were made in error, assessed overpayments, and sought recovery of the overpayments. *Id.* Upon redetermination, the DME MACs explained that the costs of these supplies could not be reimbursed while the beneficiaries were in a Medicare covered Part A skilled nursing facility (SNF) stay or in home health episodes of care because these items were included in the bundled payment received by the home health agency (HHA) or the SNF at the HHA or SNF prospective payment system rate. *Id.* On reconsideration, the Qualified Independent Contractor (QIC) affirmed the overpayment assessments for similar reasons. *Id.* The QIC and DME MACs also found the appellant was not without fault for the overpayment amounts and thus that the appellant was ineligible for waiver of recoupment of the overpayments under section 1870(b) of the Act. *Id.*

The appellant filed a request for hearing before an ALJ. After holding a hearing, the ALJ issued seventeen individual, substantively similar decisions. The ALJ concluded that, although the items were not separately payable to the appellant under Part B because the supplies were paid for in accordance with Part A home health consolidated billing provisions, the appellant was entitled to a waiver of recoupment of the overpayments under section 1870(b) of the Act. The ALJ determined that the appellant acted responsibly and made a good faith and reasonable effort to correctly bill Medicare for services provided based on the information available at that time. Decs. at 3. The ALJ stated the following ways in which the appellant acted responsibly: (1) the appellant used proprietary software systems, including Zirmed and Emdeon, which accesses the Common Working File (CWF) to obtain a screen print

of the beneficiaries' Medicare status at the time of the inquiry, (2) the appellant relied on the certificates of medical necessity/orders submitted by the ordering physician that did not indicate the beneficiaries were being seen by a home health agency, and (3) the appellant shipped the items at issue to the beneficiaries in boxes that were marked with large black bold print that read: "Not for Use by Home Health." *Id.* The ALJ also noted that 42 C.F.R. section 424.57(a)(11) states that the supplier must agree not to contact a beneficiary by telephone when supplying a Medicare-covered item in a number of instances. *Id.*[3]

CMS MEMORANDUM

CMS urges the Council to review the ALJ decisions because the decisions were based on error of law material to the outcome of the claims. Specifically, CMS asserts that the ALJ erred in waiving recoupment of the overpayments under sections 1879 and 1870 of the Act. CMS states that section 1879 of the Act applies only when items or services are excluded from coverage as not reasonable and necessary or as constituting custodial care under section 1862(a)(1) or (9) or because a beneficiary fails to meet certain home health or SNF coverage requirements under section 1879(g) of the Act, citing CMS Ruling 95-1 and Medicare Claims Processing Manual (MCPM), Ch. 30, section 20.1.1. CMS asserts that section 1879 does not apply where services are denied because they are subject to consolidated billing and the SNF or home health agency has already been paid. Exh. MAC-1 at 2.

With regard to section 1870 of the Act, the ALJ erred by waiving recoupment of the overpayments on the basis that the appellant relied on the CWF via commercial eligibility verification systems to ascertain the beneficiaries' status on the dates of service at issue. *Id.* at 2, 14. CMS maintains that a supplier's reliance on CWF and commercial eligibility verification systems does not constitute reasonable care in billing as they do not provide a reasonable basis for assuming that the Part B payment was correct. *Id.* at 2-3, 14-18. CMS makes six main points -

> First, CMS has never instructed suppliers to rely on information in the CWF on the date of service as a

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[3] The ALJ's reference to section 424.57(a)(11) appears to have been error. The Council presumes the ALJ intended to cite section 424.57(c)(11), which addresses certain restrictions on DME supplier contacts with beneficiaries.

basis for determining when the beneficiary was in a Medicare Part A stay. Instead, CMS cautions against relying solely on the CWF since CWF information is based on claims Medicare has received and thus will not provide adequate information if the supplier bills before the HHA or SNF does.

Second, CMS has always considered a supplier's bill for services subject to consolidated billing to constitute improper billing and does not consider CWF timeliness limitations a basis for waiving recoupment of an overpayment.

Third, CMS has not endorsed the third-party eligibility services or the precision, accuracy, thoroughness, reliability and timeliness of the information in the reports. Accordingly, these commercial reports cannot serve as a basis for waiving recoupment of an overpayment owed to Medicare.

Fourth, the supplier shares responsibility for ensuring services subject to consolidated billing are billed correctly; thus, a supplier's failure to ascertain a beneficiary's coverage status does not provide a basis for waiving overpayment liability. *See* MCPM, Chapter 6, § 10.4.2 ("while the SNF itself should take reasonable steps to prevent [problems resulting from duplicate billing] from arising, the supplier in this scenario is also responsible for being aware of and complying with the consolidated billing requirements"); *see also* MCPM, Chapter 10, §20.1.2 ("suppliers of [HH] services must be aware that separate Medicare payment will not be made to them [and therefore must] determine whether or not a home health episode of care exists" before furnishing services to a beneficiary).

Fifth, the supplier's remedy if a duplicate payment is recouped is to obtain payment from the SNF or the HHA.

Sixth, with regard to SNF services, CMS places responsibility and oversight for *all* services furnished to SNF residents with the SNF, instructing "the SNF or the rendering provider or supplier under an arrangement with the SNF" to bill Part B for the covered ancillary services such as surgical dressings.

> MCPM, Chapter 7, § 10.1. Thus, the appellant would never demonstrate reasonable care in billing Part B services that it independently furnished to a SNF resident.

See Exh. MAC-1 at 2-3, 13-19 (emphasis in original).

DISCUSSION

I. The Council Reverses the ALJ Decisions for Beneficiaries A.C., E.V., B.S., and A.T. on the Waiver Issue

The Council limits review of these four ALJ decisions to the issues raised by CMS. The Council finds merit in CMS's contentions and reverses the ALJ decisions on the issue of waiver of recoupment of the overpayments.

Section 1879 of the Act

The Council finds that the ALJ erred in applying section 1879 of the Act in these cases. Section 1879 is applied when items or services are not covered because they are found to be not medically reasonable or necessary under section 1862(a)(1) (or in a few other limited circumstances as outlined in CMS's memorandum). *See* Exh. MAC-1 at 2, 13-14; *see also* CMS Ruling 95-1. In these cases, payment for the surgical dressings was denied with respect to all four beneficiaries because the items were not separately reimbursable when a beneficiary is receiving a Part A episode of care, not because the items were found to be not medically reasonable and necessary. *See* Decs. at 5-6. In other words, the items were not denied under section 1862(a)(1), or any other limited circumstance for which section 1879 would apply. Thus, section 1879 is not applicable to these cases.

Section 1870 of the Act

Section 1870(b) of the Act is applicable to these cases and it provides that:

> (b) where -
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> (1) more than the correct amount is paid under this title to a provider of services or other person for items or services furnished an individual and the Secretary determines (A) that, within such period as he may

> specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or (B) that such provider of services or other person was without fault with respect to the payment of such excess over the correct amount . . .
>
> proper adjustments shall be made, under regulations prescribed . . . by the Secretary . . . .

Section 1870(b) therefore provides for a waiver of recovery for an overpayment in certain circumstances where a provider or supplier is "without fault." The Medicare Financial Management Manual (MFMM) instructs that a provider or supplier is without fault when the provider or supplier exercised reasonable care in billing for, and accepting the payment; i.e. --

- It made full disclosure of all material facts; and
- On the basis of the information available to it, including but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or, if it had reason to question the payment; it promptly brought the question to the [contractor's] attention.

MFMM, Ch. 3, § 90.

Further, the Medicare Claims Processing Manual (MCPM) provides instructions for suppliers subject to HHA consolidated billing and states that to determine if a beneficiary is under a home health episode of care, the supplier may (1) ask the beneficiary, (2) contact the Medicare contractor, and (3) "as a last resort," the supplier may "request home health eligibility information available on the Common Working File." MCPM, Ch. 10, § 20.1.2. The MCPM further provides that "prior to furnishing services to a Medicare beneficiary, the supplier should routinely ascertain whether the beneficiary is currently receiving any comprehensive Medicare benefits (such as SNF or home health benefits) for which Medicare makes a bundled payment that could potentially include the supplier's services." MCPM, Ch. 6, § 10.4.2.

Additionally, even if a supplier had checked the CWF through CMS and its contractors, the manual strongly cautions suppliers that information on the CWF is supplementary to other sources of information, and "is only as complete and timely as billing by providers allows it to be." MCPM, Ch. 10, § 20.1.2. There will always be a lag time between the date a beneficiary is first admitted to a SNF or home health care and the date the CWF is updated to reflect billing for such care. As a result, the manual reminds suppliers that a beneficiary remains the first and best source of information. *Id.*

Supplier Verification of Beneficiaries' Part A Status

The Council finds that the appellant did not exercise reasonable care with regard to verification of the beneficiaries' Medicare Part A status prior to furnishing the supplies at issue. The record in these cases does not indicate that the appellant made the necessary inquiries of the beneficiaries, or contacted the Medicare contractor directly to ascertain whether the beneficiaries were receiving Part A episodes of care during the relevant dates of service. *See, generally,* Beneficiary Claim Files.

The manual directs that the beneficiary is the "first avenue," *i.e.*, primary source, of information. MCPM, Ch. 10, § 20.1.2. This is because beneficiaries and their representatives should have the most complete information as to whether they are receiving home health care. The Council audited the ALJ hearing recording, and during the hearing, the appellant's representative explicitly stated that the appellant did not contact beneficiaries A.C. and B.S. ALJ Hearing CD. The appellant's representative indicated that a voicemail was left for A.T. who responded with a "voice shot" on the appellant's pre-recorded answering system that directs the caller to answer pre-recorded questions such as whether he or she still wants the shipment and whether anything has changed since the last order, by directing the caller to push buttons 1, 2 or 3 in accordance with a particular answer option. *Id.* However, it is not certain whether there was a pre-recorded question regarding whether the beneficiary was receiving home health services. *Id.* In the case of E.V., the appellant thought that this beneficiary was under another insurance plan and so the appellant did not run eligibility screening for Medicare. Instead, the appellant contacted the other insurance plan which indicated the items would be covered but then denied the claim because the

beneficiary was now on Medicare. *Id.* The appellant then billed Medicare after using third-party eligibility services. *Id.*

A CWF provided by CMS and its contractors is a Part A and Part B benefit validation system that uses localized databases maintained by designated Medicare contractors called hosts, and it contains the beneficiary's entitlement, utilization, history, Medicare Secondary Payer, and Health Maintenance Organization data. *See* MCPM, Ch. 27, § 10 (discussing the CWF System). The record in these cases does indicate that the appellant checked the beneficiaries' eligibility using one of the proprietary software programs available, in this instance Emdeon Business Services or ZirMed. *See* Beneficiary Claim Files; ALJ Hearing CD. However, the record fails to demonstrate that the appellant checked the CWF directly to verify that the beneficiary was not receiving covered Part A episodes of care. Nor does the record indicate that the appellant attempted to acquire the CWF information directly from the contractor.

Furthermore, we find no merit in the appellant's arguments at the ALJ hearing as to why it did not contact the beneficiaries directly. We do not find that the appellant was prohibited from contacting the beneficiaries for whom this was their first order with the appellant or for whom the appellant had not been in contact with in the last six months, as the appellant argues and the ALJ appears to agree. *See* Decs. at 3, *citing* 42 C.F.R. § 424.57(a)(11); *see also* note 3 *supra*. We have addressed this issue in many prior decisions involving the appellant, explaining that Medicare guidelines are not inconsistent with the prohibitions against unsolicited telephone contacts by suppliers and that ultimately the appellant is not prohibited from making the necessary inquiry with the beneficiary to ascertain whether he or she is in a Part A episode of care.[4]

[4] For example, in a decision (on own motion review) similar to the instant case, docketed under M-13-1796 and issued July 16, 2013, the Council reversed the ALJ's allowance of waiver of recovery of overpayments assessed against the appellant. Therein we considered, and rejected, the appellant's contention that section 1834(a)(17)(A) of the Act and its implementing regulations at 42 C.F.R. § 424.57(c) prohibit suppliers from directly contacting beneficiaries for the purposes of verifying Part A status. The appellant merely reasserted the same argument here, and also argued that the Office of the Inspector General (OIG) has issued a fraud alert, concerning telemarketing practices of durable medical equipment (DME) suppliers, which also prohibits such contact. The specific language that the appellant highlighted in the OIG fraud alert states a physician's preliminary written or verbal order prescribing DME for beneficiaries is not a substitute for a beneficiary's written consent to DME supplier contact with the beneficiary. That fraud alert discusses in detail the requirements of section

In addition, we are not persuaded by the appellant's argument at the ALJ hearing that CMNs should be accepted as proof that the beneficiaries were not under home health care on the dates at issue, which the ALJ indicated is an example of how the appellant acted responsibly in billing for these items. The CMNs contain a check-box to identify whether the beneficiary is "being seen by Home Health," but it is not clear who checked the box to indicate "No," when it was checked, or the time period it is purported to reflect. *See, e.g.*, A.C. Exh. 1 at 84.

Ultimately, then, the Council concludes that the appellant has not demonstrated, under Medicare guidelines, that it exercised reasonable care in billing for, and accepting, payment for the overpaid claims. We also agree with CMS's remaining assertions with regard to the supplier's obligation to ensure duplicate billing does not occur and the supplier's remedy for duplicate payments. As such, we do not find that the appellant was without fault in incurring the overpayments at issue and reverse the ALJ's decision to waive the recovery of the overpayments under section 1870(b) in these cases.

Thus, the Council concludes that the appellant's reliance on the third-party eligibility verification services' reports does not demonstrate that it had exercised reasonable care to verify that the four beneficiaries were not receiving Part A episodes of care prior to furnishing the supplies.

Consolidated Billing Guidelines

Section 1862 of the Act specifies items or services excluded from Medicare coverage. All four of the beneficiaries were in home health episodes of care on the dates of service at issue. As relevant here, subsection (a)(21) prohibits payment for items or services which are furnished to an individual who is under a plan of care of a home health agency (HHA) unless the claim for payment for such services is submitted by the HHA.

Moreover, any items or services furnished are subject to consolidated billing under a prospective payment system (PPS) for Part A services. Thus, in general, a Part B supplier furnishing items to a beneficiary receiving Part A services at an HHA is not entitled to separate payment, unless some exception applies. Surgical dressings are, by definition,

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1834(a)(17)(A) of the Act, which the Council previously addressed. *See* A.C. Exh. 3.

included in home health benefits. Medical supplies, including surgical dressings (which are not durable medical equipment), are generally not exempted from consolidated billing and thus are not separately reimbursable. *See* Act §§ 1861(h) and 1861(m)(5); MCPM, ch. 10, § 90 (describing services beyond the scope of a home health Part A benefit when the beneficiary is not under a home health plan of care).

The MCPM reiterates these separate reimbursement guidelines and provides that:

> **10.3 - Payments Under Part B for Services Furnished by Suppliers of Services to Patients of a Provider**
>
> Section 1861(w)(1) of the Act permits a hospital, critical access hospital, skilled nursing facility, home health agency, or hospice to obtain under arrangement, services for which an individual is entitled to under Medicare. Doing so discharges the liability of such individual or any other person to pay for the services. This is required in specified situations where the provider is paid under a PPS system.
>
> Examples of this include:
>
> - **While a patient is under a home health plan of care, the HHA must provide all covered and medically reasonable home health services and certain supplies (subject to consolidated billing) either directly or under arrangement.**
>
> - Where a patient is a SNF inpatient, the SNF must furnish all services within the scope of the SNF benefit.
>
> - Where a patient is a hospital inpatient, the hospital must furnish certain inpatient services.
>
> - Certain services are considered included in the Rural Health Clinic or Federally Funded Health Clinic visit.
>
> **In such cases, the supplier must look to the provider for payment and the provider will bill the FI** [fiscal intermediary]. . . .

MCPM, ch. 1, § 10.3 (emphasis added).

The ALJ found that the items at issue were subject to consolidated billing. Decs. at 3. Moreover, the ALJ concluded, and the record sufficiently demonstrates, that the four beneficiaries were in home health episodes of care on the dates of service at issue. *Id.* As such, the items at issue were payable to the HHA under the consolidated billing PPS for the Part A home health services and thus separate Part B payment would not be made to the appellant. The record indicates that the appellant did not dispute that the beneficiaries were in a Part A HHA plan of care. In sum, it is clear that the surgical dressings at issue are not eligible for separate Part B reimbursement.

Moreover, for the above reasons, the Council concludes that for beneficiaries A.C., B.S., A.T., and E.V., the appellant is not entitled to a waiver of recoupment of the overpayments for these items under section 1870(b) of the Act. The Council reverses the ALJ decisions for these four beneficiaries on this issue.

II. The Council Remands the Appellant's Claims for G.W., J.O., J.W., L.S., M.F., S.W. and B.S.-2 for an Opportunity for a Hearing and Issuance of New Decisions

The Council vacates seven of the ALJ decisions (issued under ALJ appeal numbers 1-1322246178, 1-1322246447, 1-1322246520, 1-1322295602, 1-1322303253, 1-1322303454, and 1-1322122751) and remands these cases to an ALJ for further proceedings, including an opportunity for a hearing and the issuance of new decisions. *See* 42 C.F.R. § 405.1110(d). The Council finds that remand is necessary because the appellant asked for an ALJ hearing in its requests for an ALJ hearing on the issue of liability for the overpayments assessed against it on these claims, and was not given an opportunity for a hearing on that matter. *See, e.g.*, G.W. Exh. 1 at 6, 13-15. On remand, the ALJ shall consider the authorities that are relevant to a determination of whether the appellant exercised reasonable care in billing, as summarized herein and discussed in detail in the CMS referral memorandum.

III. The Council Remands the Appellant's Claims for J.K., R.D., V.W., V.L., M.C. and E.L. for Appropriate Action, Because the Record is Incomplete

The Council vacates six ALJ decisions (issued under ALJ appeal numbers 1-1322246304, 1-1322303310, 1-1322346307, 1-1322353392, 1-1322353518, and 1-1322240073) and remands those cases for further ALJ action. The Council has received the claim files for these six beneficiaries. The record materials for these cases include a notice of hearing that identifies the six beneficiary cases in question and states that a hearing was scheduled to be held on April 15, 2013. Each of the six ALJ decisions states that a telephone hearing was held on April 15, 2013. Each of the six claim files includes a compact disc. We have audited the six recordings, and every one is a recording of the hearing held in connection with the appeal for the four beneficiary cases in which the Council has issued a decision on the merits of the waiver question, and not the six beneficiary claims at issue. *See* Part I above.

On August 20, 2013, the Council's staff contacted the Office of Medicare Hearings and Appeals (OMHA) in an effort to obtain an audible recording of the April 15, 2013 hearing for these six beneficiaries. OMHA indicated that it was unable to provide a recording of the proceedings.

The six cases in question are similar to the four cases for which the Council has issued a decision on the waiver question. They all involve claims for similar types of supplies, furnished to beneficiaries who were under home health care, and subsequent overpayments assessed against the appellant supplier. They all present the common central question of whether the appellant exercised reasonable care in billing for the items at issue and accordingly may be found without fault for the purposes of any waiver of recovery of the overpayments. Based on our review of the written materials in these six cases and CMS's referral, the Council concludes that the CMS referral has articulated material legal error as it relates to this question. The Council therefore has a basis for exercising own motion review authority in these cases. However, given that the ALJ's decisions indicate that the ALJ has held hearings in these cases the record of these cases appear to be incomplete, the Council will not now reach a decision in these cases.

The Council vacates the ALJ decisions for these six beneficiaries and remands these cases so that OMHA can assign the cases to an ALJ for appropriate action.

DECISION AND ORDERS

For the reasons stated above, the Council:

I. Reverses the ALJ decisions for appellant's claims for beneficiaries A.C., E.V., B.S., and A.T. with respect to the issue of waiver of recoupment of the overpayments. The Council concludes that the appellant is not entitled to a waiver of recoupment of the overpayments under section 1870(b) of the Act.

II. Vacates the ALJ decisions for G.W., J.O., J.W., L.S., M.F., S.W. and B.S.-2 and remands these cases to the ALJ for further proceedings, including a hearing and new decisions. *See* 42 C.F.R. § 405.1110(d). On remand, the ALJ shall, at minimum, take the following actions:

1. Offer the appellant an opportunity for a hearing. The ALJ shall also offer the CMS contractors an opportunity to participate in the hearing. Any waiver or declination of the opportunity to participate in an ALJ hearing will be documented, in writing, in the record.

2. Address the issue of the appellant's liability pursuant to section 1870(b) of the Act, as this is the only issue appealed by the appellant in the request for hearing.

3. Make a complete record of the evidence, including the hearing proceedings, if any. The record will include, marked as exhibits, the documents used in making the decision under review, including, but not limited to, claims, medical records, written statements, certificates, reports, affidavits, and any other evidence the ALJ admits. In the decision, the ALJ must also discuss any evidence excluded under 42 C.F.R. section 405.1028 and include a justification for excluding the evidence. 42 C.F.R. § 405.1042(a).

4. Issue a new decision or decisions in accordance with the authorities discussed above.

III. Vacates the ALJ decisions for J.K., R.D., V.W., V.L., M.C. and E.L. and remands these cases to the ALJ for further action. On remand, the ALJ will:

1. Continue efforts to obtain an audible recording of the hearing proceedings for these beneficiaries. If an audible audio recording is located, the ALJ may return the complete record (audio recording and claim files) directly to the Departmental Appeals Board, MS 6127, Medicare Appeals Council, 330 Independence Avenue, S.W., Cohen Building, Room G-644, Washington, DC 20201. The Council will then consider further appropriate action.

2. If the recording is not obtained, the ALJ shall offer the opportunity for a *de novo* hearing. The recordings of any further oral proceedings shall be retained in the claim files.

3. The ALJ will then take additional appropriate action, including the issuance of a new decision (or decisions).

The ALJ may take further action not inconsistent with these orders.

MEDICARE APPEALS COUNCIL

Date: SEP 17 2013