

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-12-460 [sic M-12-458]

In the case of

Claim for

Cashflow Solutions, Inc.

(Appellant)

Supplementary Medical
Insurance Benefits (Part B)

(Beneficiaries)

(HIC Numbers)

CIGNA Government Services

(Contractor)

(ALJ Appeal Numbers)

The Medicare Appeals Council has decided, on its own motion, to review ten Administrative Law Judge (ALJ) decisions, dated November 16, 2011, because there is an error of law material to the outcome of the claims. The decisions concerned Medicare coverage for pneumatic compression devices (E0675) furnished by the appellant supplier to beneficiaries on dates of service from September 19, 2009 through August 26, 2010.¹ In each decision, the ALJ determined: 1) that the individual beneficiary's use of the pneumatic compression device on certain prior, existing dates of service for which the appellant had received reconsiderations and filed requests for hearing was "reasonable and necessary," and should therefore be covered by Medicare; and 2) that in addition, for each beneficiary, in the absence of medical improvement or other evidence of a change in this beneficiary's medical condition, payment(s) should be made for subsequent periods of up to thirteen months of rental. *E.g.*, A.M. Dec. at 3.

¹ The Council has attached a beneficiary list to this decision that contains the beneficiaries' names, HIC numbers, ALJ appeal numbers, and dates of service. The beneficiaries will receive redacted copies of this list.

By memorandum dated January 10, 2012, Q2 Administrators (the Administrative Qualified Independent Contractor (AdQIC)), on behalf of the Centers for Medicare and Medicaid Services (CMS), asked the Council to review the ALJ's decisions on the Council's own motion. This CMS memorandum is hereby entered into the record as Exhibit (Exh.) MAC-1. The CMS memorandum seeks review of only the second part of the ALJ's decisions, the part determining, prospectively, that "in the absence of medical improvement or other evidence of a change in this beneficiary's medical condition, payment(s) should be made for subsequent periods up to 13 months of rental." *E.g.*, A.M. Dec. at 3. CMS does not seek review of the ALJ's decisions with respect to coverage for dates of service that were properly before the ALJ in this case. See Exh. MAC-1.

The Council has carefully considered the record that was before the ALJ, as well as the CMS memorandum and addendum. The appellant supplier has not filed a response to the CMS memorandum and addendum.

For the reasons set forth below, the Council reverses the ALJ's decisions with respect to *prospective* coverage of the pneumatic compression devices and related appliances. See 42 C.F.R. § 405.1110(d). Because the Council has not been asked to determine whether there were errors of law in the ALJ's findings and conclusions with regard to dates of service properly before the ALJ in each of the ten decisions, the ALJ's findings of coverage for those dates of service will not be disturbed.

BACKGROUND

The appellant furnished each of the beneficiaries with a pneumatic compression device (E0675). The contractor and Qualified Independent Contractor (QIC) both denied Medicare coverage for the devices and appliances. As a result, the appellant sought review of the denials by an ALJ. The claims were consolidated for hearing, and a hearing was held on October 21, 2011. CD Recording of ALJ Hearing, October 21, 2011.

After the hearing, the ALJ issued fully favorable decisions in all ten cases, finding Medicare coverage existed for all of the devices and appliances, and ordering Medicare reimbursement for all identified dates of service at issue. See, *e.g.*, S.R. Dec. at 3. In addition, the ALJ ordered in each of the ten decisions, "In the absence of medical improvement or other evidence of a change in this beneficiary's medical condition,

payment(s) should be made for subsequent periods up to 13 months of rental." See, e.g., *id.* at 3 (emphasis supplied).

Following the issuance of the ten ALJ decisions, CMS referred the cases to the Council for own motion review. CMS contends that the ALJ erred in making *prospective* findings of Medicare coverage in each of the cases, because under the Medicare regulations an ALJ lacks authority to add claims to a pending appeal if those claims have not been adjudicated at the lower appeal levels, that is, in an initial determination, a redetermination, and a reconsideration by a QIC. See 42 C.F.R. § 405.1032(c).

DISCUSSION

An ALJ is bound by statutes, regulations, National Coverage Determinations (NCDs), and CMS rulings. 42 C.F.R. §§ 405.1060(a)(4), 405.1063. According to the Medicare regulations, the issues before the ALJ include all the issues brought out in the initial determination, redetermination, or reconsideration that were not decided entirely in a party's favor. 42 C.F.R. § 405.1032(a). In the instant case, the issue of Medicare coverage for the pneumatic compression devices and related appliances during the specific, identified dates of service was not decided in the appellant supplier's favor, and thus was properly before the ALJ. *Id.* The ALJ addressed the Medicare coverage issue for each of the specific, identified dates of service for each of the ten beneficiaries, and neither the appellant nor CMS disputes those findings and conclusions.

However, the ALJ also ruled in each of the ten cases that payment should be made for subsequent periods of up to thirteen months of rental, in the absence of medical improvement or other evidence of a change in the beneficiary's medical condition. See, e.g., A.M. Dec. at 3. In each case, the ALJ had no initial determination, no redetermination, and no QIC reconsideration for a subsequent period or periods of rental, up to thirteen months or otherwise. There was no evidence that any claims for subsequent periods of rental had been adjudicated at the lower appeal levels, and therefore the ALJ's rulings on "subsequent periods of up to 13 months of rental" were in direct contravention of 42 C.F.R. § 405.1032(c).

Section 405.1032(c) provides:

(c) *Adding claims to a pending appeal.*

An ALJ cannot add any claim, including one that is related to an issue that is appropriately before an ALJ, to a pending appeal unless it has been adjudicated at the lower appeals levels and all parties are notified of the new issue(s) before the start of the hearing.

Therefore, the ALJ's rulings for coverage or payment for subsequent periods of up to thirteen months of rental of pneumatic compression devices and appliances in each of these ten cases must be invalidated.

There are a number of practical and policy reasons for this Medicare regulation. First, without development at the lower appeal levels, there are insufficient facts in the record to support an ALJ's adjudication of an issue. In the instant cases, there was no medical evidence to demonstrate whether or not the individual beneficiaries would continue to need and qualify for the use and coverage of a pneumatic compression device in subsequent months. In all likelihood, many of them would experience a change in their medical conditions, and a pneumatic compression device might no longer be required. Moreover, the ALJ's grant of coverage for "subsequent periods of up to 13 months," "in the absence of medical improvement or other evidence of a change in the beneficiary's medical condition," bypasses the statutory, NCD, and Local Coverage Determination (LCD) requirements that place the responsibility on the provider to furnish medical evidence in support of its claim for Medicare coverage for the devices and appliances.

Second, if parties were allowed to bypass the lower appeal levels and bring claims directly to an ALJ, there would be far more requests for ALJ adjudication than could reasonably be handled. There are numerous cases in which an initial determination, a redetermination, and/or a QIC reconsideration will result in a grant of coverage, a denial with a rationale that results in no further appeal, or a partial grant or denial. These cases may never require ALJ consideration.

Moreover, to the extent that the ALJ's decision on either existing or prospective dates of service, or both, in one or more of these ten cases is based on the representation that a prior ALJ had issued a favorable decision on an earlier date or dates of service for the same beneficiary, that decision is not

well founded. Prior ALJ decisions are not binding or precedential. See, e.g., 70 Fed. Reg. 11420, 11449 (Mar. 8, 2005) (Medicare administrative appeal decisions have no precedential value). An ALJ is not bound by any prior decision reached by another ALJ. The Council is likewise not bound to follow any prior ALJ decision, whether or not favorable, because it is not possible to know what evidence was before the prior adjudicators in the other appeals. Each appeal must stand on its own merits, including the evidence of medical reasonableness and necessity for its dates of service.

Finally, it is not feasible for an adjudicator to always know what other claims are or will be pending before another adjudicator. Adjudicating additional claims not currently before an ALJ could result in multiple, inconsistent decisions on identical dates of service for the same beneficiary. For example, if future rental months for the same ten beneficiaries in this case are/were concurrently pending before another ALJ, that ALJ could be issuing a (possibly inconsistent) decision on a claim purportedly covered by this ALJ's decision on prospective months. This would make the concept of finality unfathomable and implementation impossible.

For these reasons, the prohibition on adding claims at the ALJ level that have not been adjudicated at lower appeals levels is clear and unequivocal. See 42 C.F.R. § 405.1032(c).² Therefore, the Council reverses and vacates that part of each of the ten ALJ decisions that reads, "In the absence of medical improvement or other evidence of a change in this beneficiary's medical condition, payment(s) should be made for subsequent periods up to 13 months of rental." The Council does not alter the other parts of these ten ALJ decisions, as they are not before the Council.

DECISION

It is the decision of the Medicare Appeals Council that Medicare does not cover or pay for the pneumatic compression devices and

² The provisions in the statute and regulations for "capped rental periods" for certain types of medical devices (e.g., 42 C.F.R. §§ 414.229, 414.230) do not alter the requirements for current, date-specific proof of medical reasonableness and necessity contained in the relevant NCD and LCDs for pneumatic compression devices and appliances. Nor do these provisions for "capped rental periods" abrogate the requirement that ALJs adjudicate only those issues and claims that have been adjudicated at the lower appeals levels. 42 C.F.R. § 405.1032(c).

appliances in these ten cases for any period of time other than the specific dates of service at issue in each decision, identified in the list of beneficiaries attached to this decision. Therefore, the Council invalidates and vacates that part of each ALJ decision purporting to cover additional dates of service not before the ALJ.

The Council does not alter or disturb the ALJ's determination in each of these ten cases that Medicare will cover the existing dates of service specifically stated in each decision that were properly before the ALJ.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/ Stanley I. Osborne, Jr.
Administrative Appeals Judge

Date: April 6, 2012