

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION AND ORDER OF REMAND OF
MEDICARE APPEALS COUNCIL
Docket Number: M-12-34

In the case of

Art Ankle & Foot Care
Specialist

(Appellant)

(Beneficiary)

First Coast Service Options

(Contractor)

Claim for

Supplementary Medical
Insurance Benefits (Part B)

(HIC Number)

(ALJ Appeal Number)

The Medicare Appeals Council (Council) has decided, on its own motion, to review the Administrative Law Judge (ALJ)'s "partially favorable" hearing decision dated August 15, 2011, because there are errors of law material to the outcome of the claims. The decision concerned coverage for various podiatric-related services furnished to 65 beneficiaries in 2008 and 2009, billed under 19 CPT codes.¹ See Attachment A. The ALJ allowed coverage for most claims, and dismissed the hearing requests for eight claims.

In deciding whether to accept own motion review, the Council limits its review of the ALJ's decision "to those exceptions raised by CMS." 42 C.F.R. § 405.1110(c)(2).

The Centers for Medicare & Medicaid Services (CMS), through the Q2 Administrators acting on its behalf, referred the ALJ's decision for the Council's own motion review by memorandum dated October 13, 2011. On October 25, 2011, the appellant asked for a copy of the record, pursuant to 42 C.F.R. § 405.1118, and an extension of time to file exceptions to the referral. 42 C.F.R. § 405.1110(d). On January 12, 2012, the Medicare Operations

¹ The ALJ identified this matter as an overpayment case. See Dec. at 7. A review of the beneficiary records does not reflect that any of the claims stemmed from overpayment determinations.

Division staff sent the appellant a copy of the record and informed the appellant that any exceptions will be due on February 17, 2012. On February 7, 2012, the appellant requested replacement of the defective hearing CD and additional time to file exceptions. The appellant was sent a replacement CD and additional time, until March 1, 2012, to file any exceptions. Exceptions were filed on March 1, 2012. We enter the following into the record:

Exhibit (Exh.) MAC-1:	CMS memorandum, dated October 13, 2011;
Exh. MAC-2;	Appellant's letter dated October 25, 2011;
Exh. MAC-3:	Medicare Operations Division letter dated January 12, 2012;
Exh. MAC-4:	Appellant's letter dated February 7, 2012;
Exh. MAC-5:	Medicare Operations Division letter dated February 15, 2012; and
Exh. MAC-6:	Appellant's exceptions dated March 1, 2012.

The Council adopts in part, and vacates and remands in part the ALJ's decision. We do not disturb the ALJ's dismissals with regard to Beneficiaries MS and JP (Attachment B).² We adopt the ALJ determinations pertaining to the beneficiaries listed on Attachment C, in the absence of CMS contentions on these determinations. Lastly, we vacate the ALJ's hearing decision as to the beneficiaries identified on Attachment D, and remand this case to an ALJ for further action. 42 C.F.R. § 405.1110(d).

BACKGROUND

The appellant provided podiatric services to 65 beneficiaries in 2008 and 2009, billed under the following HCPCS/CPT³ codes:

² CMS does not contest the ALJ's dismissals with regard to Beneficiaries SH and DY. Therefore, we do not address these dismissals.

³ CMS has developed the Healthcare Common Procedure Coding System (HCPCS) to establish uniform national definitions of services, codes to represent services, and payment modifiers to the codes. See 42 C.F.R. § 414.2. In order to receive Medicare reimbursement, suppliers utilize the HCPCS in filing claims for services. The Current Procedure Terminology (CPT) is an American Medical Association (AMA) publication of billing codes for medical services. The HCPCS incorporates the CPT coding system and includes additional coding references.

- **11000:** Debridement of extensive eczematous or infected skin; up to 10% of body surface.
- **11040:** Debridement; skin, full thickness.
- **11721:** Debridement of nail(s) by any method(s), six or more.
- **29540:** Strapping; ankle and/or foot.
- **64450:** Injection, anesthetic agent; Other peripheral nerve or branch.
- **73600:** Radiologic examination, ankle; Two views.
- **73630:** Radiologic examination, foot; Complete, minimum of three views.
- **76942:** Ultrasonic guidance for needle placement (EG., biopsy, aspiration, injection, localization device), Imaging supervision and interpretation.
- **93922:** Noninvasive physiologic studies of upper or lower extremity, arteries, single level, bilateral (EG., ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement).
- **93965:** Noninvasive physiologic studies of extremity veins, complete bilateral study (EG., Doppler waveform analysis with responses to compression and other maneuvers, phleborhedraphy, impedance plethysmography).
- **95903:** Nerve conduction, amplitude and latency/velocity study, each nerve; Motor, with F-wave study.
- **97001:** Physical therapy evaluation.
- **97002:** Physical therapy re-evaluation.
- **97022:** Application of a modality to one or more areas; Whirlpool.
- **97032:** Application of a modality to one or more areas; Electrical stimulation (manual), each 15 minutes.
- **97035:** Application of a modality to one or more areas; Ultrasound, each 15 minutes.
- **97140:** Manual therapy techniques (EG., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes.
- **99203:** Office or other outpatient visit for evaluation and management of a new patient, which requires these 3 key components: a detailed history; a detailed examination; a medical decision making of low complexity.
- **99213:** Office or other outpatient visit for the evaluation and management of an established patient, which requires at

least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity.

Claim Files, Exh. 1. First Coast Service Options (FCSO or contractor) denied coverage for the services as not medically necessary.⁴ See, e.g., AB Claim File, Exh. 1, at 17-21.

On reconsideration, the Qualified Independent Contractor (QIC) issued individual decisions which:

- dismissed the reconsideration requests for certain services for lack of a redetermination decision;
- found coverage for certain identified services; and/or
- upheld the contractor's denial of coverage for certain identified services.

See Claim Files, Exh. 1.

On further appeal, the ALJ conducted a telephonic hearing on July 13, 2011. Dec. at 2. In the "partially favorable" hearing decision, the ALJ denied coverage for seven claims with regard to Beneficiaries LP (97022 and 97032 - 9/15/09), JP (97032 and 29540 - 6/26/09), and VS (97022, 97032, and 76942 - 11/18/08); and found coverage for the remaining claims at issue. Dec., Attachment at 1-10. The ALJ also issued dismissals for eight claims pertaining to the following:

- Beneficiary MS - 76942 RT and LT;
- Beneficiary SH - 29540 RT 79 59 x 2 and 76942 LT;
- Beneficiary JP - 29540 RT and LT;
- Beneficiary DY - 29540 LT.

See ALJ Master File Folder, Orders to Dismiss.

CMS asserts that the ALJ erred in finding coverage for the services at issue without indicating whether the services were covered under any of the applicable Local Coverage Determinations (LCDs); failing to consider the National Correct

⁴ After the initial determination and prior to the issuance of the redetermination, FCSO made adjustments for coverage and payment with regard to certain claims. See, e.g., SH Claim File, Exh. 1, at 20.

Coding Initiative (NCCI)⁵ policy or related program guidance; or, in the alternative, explaining the basis for not following the applicable policy or guidance. CMS argues:

1. The ALJ afforded the treating physician (A.T., D.P.M.)'s hearing testimony greater deference than other evidence, in violation of CMS Ruling 93-1.
2. The ALJ drew an adverse inference from the QIC's decision not to participate in the ALJ hearing, in violation of 42 C.F.R. section 405.1010(f).
3. The ALJ did not base the decision on the record evidence as required by 42 C.F.R. sections 405.1000(d) and 405.1046(a). With regard to Beneficiaries MS and JP for dates of service June 9, 2009 and May 19, 2009, respectively, the ALJ did not determine whether reconsiderations had been issued. Further, the ALJ did not examine the full record to determine whether there was medical documentation included for Beneficiaries VS and JKA to support the claims.
4. The ALJ erroneously found coverage for the diagnostic services provided to Beneficiary MMA on August 13, 2009. The services were furnished without a physician's order in violation of 42 C.F.R. section 410.32(a).
5. The ALJ found certain CPT codes separately reimbursable when billed together, without citing or referencing the evidence relied upon to determine whether the appellant appropriately employed modifiers to bypass the NCCI edit.
6. The ALJ did not consider all of the applicable LCDs.

Exh. MAC-1, at 2-4.

The appellant responds:

1. The ALJ "merely observed" that A.T., D.P.M.'s testimony would be given great deference, "but not greater than the administrative record."
2. The ALJ did not draw an adverse inference from the QIC's non-participation in the hearing.

⁵ The acronyms CCI and NCCI are interchangeable. The Medicare Claims Processing Manual (MCPM) uses "CCI". The CMS website and NCCPM use "NCCI."

3. The ALJ's decision was based on the record, which is supported by the ALJ's denials of seven claims.
4. The ALJ did not err in finding coverage for diagnostic services provided to MMA because there is no requirement that a physician maintain a copy of the order for services.
5. Because modifiers were appropriately applied for separate reimbursement for certain CPT codes when billed with other specified codes, the ALJ was not required to cite or reference evidence relied upon in rendering his decision.
6. The ALJ referenced only some of the applicable LCDs.

Exh. MAC-2.

DISCUSSION

Additional ALJ action is required, as explained below. 42 C.F.R. § 405.1126.

ALJ DECISIONS MUST BE BASED ON RECORD EVIDENCE

A. Qualified Independent Contractor (QIC) Dismissals

A QIC may dismiss a request for reconsideration. 42 C.F.R. § 405.972. Among the bases for dismissal is the absence of a redetermination on the initial determination for which reconsideration is sought. 42 C.F.R. § 405.972(b)(6). A QIC's dismissal "is final and binding, unless ... modified or reversed by an ALJ under § 405.1004" 42 C.F.R. § 405.972(e).

The regulation at 42 C.F.R. § 405.1004 provides, in part:

(b) If the ALJ determines that the QIC's dismissal was in error, he or she vacates the dismissal and remands the case to the QIC for a reconsideration.

(c) An ALJ's decision regarding a QIC's dismissal of a reconsideration request is final and not subject to further review.

The QIC dismissed the request for reconsideration with regard to the claims for MS, billed under codes 76942 RT and LT (ultrasonic guidance for needle replacement/June 9, 2009); and JP, billed under codes 29540 RT 7959 and LT 79 (strapping/May

19, 2009). MS Claim File, Exh. E/1 at 3-5; JP Claim File, Exh. 1, at 4-5. The QIC issued a dismissal in each instance because the contractor had not issued a redetermination. In each dismissal, the ALJ noted that the contractor had not issued a redetermination with regard to the referenced claims. See ALJ Master File, at Bates No. 10, 12.

The ALJ agreed with the QIC's dismissal of the request for reconsideration based on the lack of a redetermination for the specific claims at issue. CMS contests the ALJ's affirmation of the QIC's dismissal. CMS asserts that redeterminations were in fact issued by the contractor for each beneficiary on the referenced dates of service. Exh. MAC-1, at 2, 14-15.

Review of the redetermination pertaining to MS reflects that the contractor adjusted the payment allowance for codes 76942 RT and LT. See MS Claim File, Exh. E/1, at 17. As for JP, for the date of service May 19, 2009, the contractor did not decide 29540 RT and LT. See JP Claim File, Exh. 1, at 54-58.

The ALJ reviewed the QIC's dismissals and affirmed them. The ALJ's actions are final and not subject to further review. 42 C.F.R. § 405.1004(c).

B. Record Documentation in Support of Coverage

The regulation at 42 C.F.R. § 405.1046(a) provides that an ALJ will issue a written decision based on evidence offered at the hearing or otherwise admitted into the record. See Social Security Act (Act), section 1869(d)(4).

CMS contends that the ALJ did not examine the full record to determine whether there was medical documentation included for VS and JKA to support coverage. CMS argues that, with regard to VS, the record in fact contains medical documentation for the beneficiary for the dates and services at issue. Exh. MAC-1, at 15. Additionally, as to JKA, CMS asserts that the ALJ's favorable determination is in error in that the medical documentation purported to pertain to this beneficiary in fact relates to another beneficiary. *Id.*

A review of the record discloses that the records for VS were incorporated into the file for KS. Additionally, a review of the record pertaining to JKA divulges that the medical records within this beneficiary's file pertain to another beneficiary. See JKA Claim File. Therefore, on remand, the ALJ will review

the beneficiary files and make a determination based on the record evidence as it pertains to each beneficiary.

DIAGNOSTIC TESTING

CMS argues that the ALJ erred in allowing coverage for diagnostic services (95903) provided to MMA on August 13, 2009, without a physician's order, in violation of 42 C.F.R. § 410.32(a). Exh. MAC-1, at 3, 15-16. Section 410.32 sets out the conditions for coverage of Part B diagnostic tests:

All ... diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary (see § 411.15(k)(1) of this chapter).

42 C.F.R. § 410.32(a) (emphasis added).

The appellant argues that the record does reflect an order for the nerve conduction studies. Exh. MAC-2 at 4-5. FCSO has issued LCD L29164, for services billed under code 95903, as we discuss below. The ALJ shall readjudicate this claim on remand, taking into consideration the applicable authorities.

APPLICABLE LCDS

An ALJ and the Council are bound by the Act, regulations, NCDs, and CMS Rulings. 42 C.F.R. §§ 405.1060(a)(4), 405.1063. Neither an ALJ nor the Council is bound by LCDs or CMS program guidance, such as program memoranda and manual instructions, "but will give substantial deference to these policies if they are applicable to a particular case." 42 C.F.R. § 405.1062(a). The ALJ and the Council must explain their reasoning for not following an applicable LCD or program guidance in a particular case. 42 C.F.R. § 405.1062(b).

CMS contends that the ALJ's decision, which referenced LCDs L29289, L29164, L29314, and L29199 in the "Policy and Guidance" section, did not acknowledge other applicable LCDs. CMS further asserts that, at any rate, the ALJ did not "discuss, apply, address, or articulate any specific coverage criteria applicable

to any of the claims at issue." Exh. MAC-1, at 4. FCSO has published the following LCDs applicable to this case:⁶

- LCD L29258: *Peripheral Nerve Blocks* (64450);
- LCD L29237: *Noninvasive Physiological Studies of Upper or Lower Extremity Arteries* (93922);
- LCD L29234: *Non-Invasive Evaluation of Extremity Veins* (93965);
- LCD L29314: *Strapping* (29540, 29550, 29580);
- LCD L29128: *Debridement Services* (11000, 11040);
- LCD L29289: *Therapy and Rehabilitation Services* (97001, 97002, 97022, 97032, 97035);
- LCD L29199: *Injection of Trigger Points* (20552);
- LCD L29061: *Arthrocentesis* (20600, 20605);
- LCD L29232: *Nail Debridement* (11720, 11721);
- LCD L29318: *Surgical Treatment of Nails* (11730, 11732);
- LCD L29164: *Electromyography and Nerve Conduction Studies* (95900, 95903, 95904, 95934).

As CMS indicates, in the "Policy and Guidance" section of the decision, the ALJ acknowledged only several of the applicable LCDs. Absent from the decision is discussion or analysis of the applicability of the LCDs cited to the beneficiary-specific facts in each case. The ALJ's analysis of the case with regard to the 65 beneficiaries at issue consisted of the following:

With regard to the claims determined favorably by the undersigned, the testimony, billing statements and medical records provided by the appellant demonstrate that the disputed services were reasonable and necessary for the treatment of the beneficiaries'

⁶ LCDs are available in the Medicare Coverage Database at <http://www.cms.gov/Medicare/Coverage/DeterminationProcess>. The following list of LCDs includes parenthetical references to the billed codes at issue.

medical condition. The record reflects the dosage, method of administration and when applicable, location, were documented in the beneficiaries['] medical records provided by; the appellant. Physician orders, diagnosis forms identifying the HCPCS and CPT codes and/or the beneficiary's progress notes for the dates of serve at issue, were initialed or signed by the treating physician or nurse practitioner, which demonstrates the services were provided under the guidance of appropriate medical personnel as required by Medicare. After reviewing all the evidence on file, the ALJ finds that the record demonstrates Medicare coverage criteria was established for the services identified as payable to the appellant.

As set forth in Attachment A, the ALJ determines that seven (7) services provided to three (3) beneficiaries were not medically reasonable and necessary. The appellant did not submit medical documentation for these beneficiaries for the relevant dates of service. Without this documentation, the undersigned is unable to determine if the services were medically reasonable and necessary.

Dec. at 8. Further, on Attachment A to the decision ("Claims and Line Items Report"), in the category labeled "ALJ's Decision," the ALJ noted only "fully favorable," "unfavorable," or "dismissed" to identify the action taken. Neither the decision nor Attachment A reflects that the ALJ considered whether the individual claims are covered under an LCD. Neither provides any indication that substantial deference was afforded to the applicable LCDs, nor a rationale for not following the LCDs. See 42 C.F.R. § 405.1062.

NCCI EDITS

CMS contends that the ALJ erred in finding that certain identified codes are separately reimbursable when billed together without citing or referencing the evidence relied upon to determine appropriate modifiers were used.

CMS has developed the Healthcare Common Procedure Coding System (HCPCS) to establish "uniform national definitions of services, codes to represent services, and payment modifiers to the codes." 42 C.F.R. §§ 414.2 and 414.40(a). The HCPCS is divided into two principal subsystems, referred to as level I and level

II of the HCPCS. Level I of the HCPCS is comprised of CPT-4, a numeric coding system maintained and copyrighted by the American Medical Association (AMA). The CPT-4 is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. These health care professionals use the CPT-4 to identify services and procedures for which they bill public or private health insurance programs. Decisions regarding the addition, deletion, or revision of CPT codes are made by the AMA. The CPT codes are republished and updated annually by the AMA. Level I of the HCPCS, the CPT-4 codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians.⁷

CMS developed the NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. CMS developed its coding policies based on coding conventions defined in the AMA's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (NCCPM).⁸ The NCCPM includes an introduction and narrative chapters that address general coding policy instructions, as well as instructions specific to certain codes or groups of codes.

CMS has provided additional guidance in the Medicare Claims Processing Manual (MCPM) which, in part, states:

The Correct Coding Initiative was developed to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims.

* * *

All services integral to accomplishing a procedure are considered bundled into that procedure and, therefore, are considered a component part of the comprehensive code.

⁷ See <http://www.cms.gov/MedHCPCSGenInfo/>.

⁸ See <http://www.cms.gov/NationalCorrectCodInitEd>.

* * *

CPT codes which are mutually exclusive of one another based either on the CPT definition or the medical impossibility/improbability that the procedures could be performed at the same session can be identified as code pairs. These codes are not necessarily linked to one another with one code narrative describing a more comprehensive procedure compared to the component code, but can be identified as code pairs which should not be billed together.

* * *

Generally, [add-on codes] are identified with the statement "list separately in addition to code for primary procedure" in parentheses, and other times the supplemental code is used only with certain primary codes, which are parenthetically identified. The reason for these CPT codes is to enable physicians and others to separately identify a service that is performed in certain situations as an additional service. Incidental services that are necessary to accomplish the primary procedure . . . are not separately billed.

* * *

The narrative for many CPT codes includes a parenthetical statement that the procedure represents a "separate procedure."

MCPM, Pub. 100-04, Ch. 12, § 30.

As part of the NCCI, CMS publishes tables of "edits" that identify pairs of codes that should not be reported together.⁹ CMS explains that:

The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported. The NCCI contains two tables of edits. The Column One/Column Two Correct Coding Edits table and the Mutually Exclusive Edits table include code pairs that should not be reported together for a

⁹ See <http://www.cms.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage>.

number of reasons explained in the Coding Policy Manual.

See <http://www.cms.gov/NationalCorrectCodInitEd/>.

Column One, in the Correct Coding Edits Tables, identifies procedures which may include multiple services that, when performed together, should only be billed under that code. Column Two identifies procedures that can be billed separately when performed individually, but when performed with a comprehensive procedure cannot be separately paid unless the edit permits the use of a modifier associated with the NCCI. If a provider reports both codes of an edit pair, the Column One code is eligible for reimbursement and the Column Two code is denied. National Correct Coding Initiative Policy Manual (NCCIPM), Physician Version 14.3, Chapter 1, § A - Introduction; § O - Misuse of Column Two Code with Column One Code.

Modifiers attached to the end of a HCPCS/CPT code provide physicians with a mechanism to indicate that, although still described by the code definition, a service or procedure has been modified by some circumstance. Each NCCI edit has a modifier indicator. A modifier indicator of "0" denotes that NCCI-associated modifiers cannot be used to bypass the edit. A modifier indicator of "1" denotes that NCCI-associated modifiers can, under appropriate circumstances, be used to bypass the edit. NCCIPM, Physician Version 14.3, Chapter 1, § A - Introduction; § O - Misuse of Column Two Code with Column One.

With regard to modifiers generally, the NCCIPM explains:

It is very important that NCCI-associated modifiers only be used when appropriate. In general these circumstances relate to separate patient encounters, separate anatomic sites or separate specimens. (See subsequent discussion of modifiers in this section.) Most edits involving paired organs or structures (e.g., eyes, ears, extremities, lungs, kidneys) have modifier indicators of "1" because the two codes of the code pair edit may be reported if performed on the contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI edit

indicates that the two codes generally cannot be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic locations. However, if the two corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers generally should not be utilized.

NCCIPM, Physician Version 14.3, Chapter 1, § E.1.

CMS acknowledges that, in each instance, the modifier indicator for the column one codes when billed with the column two codes is "1," which indicates the use of modifiers in certain cases which result in bypass of the NCCI edits. See Exh. MAC-1, at 17-18. Specifically, the coding pairs at issue are:

- 97002/97032/97035 (column one codes) when billed with 64450 (column two code);
- 11720/11721 (column one codes) when billed with 97022 (column two code); and
- 95903 (column one code) when billed with 95900 (column two code).¹⁰

Exh. MAC-1, at 16-18. The codes at issue were billed using modifiers "GP," "LT," "RT," "79," "59," and/or "51." See Claim Files for RC, Exh. 1, at 29; SH, Exh. B/1, at 39; CLK, Exh. 1, at 24; MMA, Exhs. D/1, at 24, E/1, at 21; AN, Exh. 1, at 24; MS, Exh. 1, at 23; VS, Exh. 1, at 26; EW, Exh. 1, at 26.

CMS contends that the ALJ did not analyze the applicable program guidance in conjunction with the services billed in making his determination that separate reimbursement was allowable. The Council agrees with CMS's argument. Absent from the record is any analysis or discussion which reflects the ALJ's consideration of NCCI policy or program guidance.

In order to determine whether separate reimbursement is allowable, there must first be a finding that the services are

¹⁰ The referenced claim pertains to services provided to MMA on August 13, 2009. The services billed under code 95900 were paid on redetermination. See MMA Claim File, Exh. E/1, at 14. CMS does not contest the coverage and payment determination for code 95900; only separate reimbursement for code 95903 when billed with 95900.

covered. Each service at issue is included in the discussion under the "Applicable LCDs" heading. Therefore, on remand, should the ALJ find that the identified services are covered services, a determination on the issue of separate reimbursement of the above-referenced claims will be rendered. To that end, the ALJ shall consider and address the applicability of program guidance, including the MCPM, the NCCI, and the HCPCS/CPT Codebook for 2008 and 2009.

TREATING PHYSICIAN RULE

CMS argues that the ALJ afforded greater deference to the testimony of the treating physician in violation of CMS Ruling 93-1. Exh. MAC-1, at 2-3, 13-14.

As the Supreme Court noted, the treating physician rule was originally developed by the Courts of Appeals as a means to control disability determinations made by Social Security ALJs. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, No. 02-469 slip op. at 5 (2003). The Court observed that the rule had not attracted universal adherence outside the social security disability context, even in other public and private benefit contexts. *Id.* at 6, n.3.¹¹ The Court specifically declined to extend the rule to claims for disability benefits arising under ERISA, noting that the Secretary of Labor had issued no regulations on this matter, despite a grant of authority to promulgate necessary or appropriate regulations. The Court held that the adoption of the treating physician rule was best left to Congress or the superintending administrative agency. *Id.* at 9. Here, too, the Secretary of Health and Human Services has full authority under sections 1871 and 1872 of the Act to adopt rules and regulations regarding the nature and extent of proofs and evidence but has issued no regulation endorsing the treating physician rule.

The Court of Appeals for the Second Circuit was influential in the development of the treating physician rule in Social

¹¹ The Supreme Court also noted that treating physicians may have an incentive to favor their patient. *Id.* at 9. Judge Posner has pragmatically observed that "the fact that the claimant is the treating physician's patient also detracts from the weight of that physician's testimony, since, as is well known, many physicians (including those most likely to attract patients who are thinking of seeking ... benefits) will often bend over backwards to assist a patient in obtaining benefits." *Hofslein v. Barnhart*, 2006 WL 469484, No. 05-2640 slip op. at 4 (7th Cir. 2006).

Security disability cases.¹² For Medicare cases, however, the Second Circuit stated that "[t]he Medicare statute unambiguously vests final authority in the Secretary, and no one else, to determine whether a service is reasonable and necessary, and thus whether reimbursement should be made." *State of New York o/b/o Bodnar v. Secretary*, 903 F.2d 122, 125 (1990). The court further found "no contradiction, however, between Congress's vision of the physician and the URC (utilization review committee) as gatekeepers initially determining eligibility and Congress's delegation to the Secretary of ultimate authority to determine whether the services provided a patient are covered by Medicare." *Id.* at 126.

In *State of New York o/b/o Stein v. Secretary of HHS*, 924 F.2d 431 (2d Cir. 1991), the Second Circuit explicitly deferred ruling on the district court's application of the treating physician rule to coverage of an inpatient hospital rehabilitation admission. The court stated:

We are not prepared at this time to pass judgment upon the district court's holding that the case can be disposed of by applying the treating physician rule that is used in social security disability cases. Under this rule, "[t]he treating source's opinion on the subject of medical disability... is (1) binding on the fact-finder unless contradicted by substantial evidence, because the treating source is inherently more familiar with a claimant's medical condition than are other sources." [internal citation omitted] We believe it better practice to have the Secretary first advise us what role if any the attending physician rule played in the instant case and will play in future cases of this nature. After this has been done, a judicial determination can be made as to whether the Secretary's procedures in this regard meet statutory requirements.

Id. at 433-34.

In *State of New York o/b/o Holland v. Sullivan*, 927 F.2d 57 (2d Cir. 1991), the Court reiterated that it would not apply the

¹² The Social Security Administration later issued a detailed regulation describing how medical evidence, including opinion evidence, should be evaluated in the disability claims process. 56 Fed. Reg. 36,960 (Aug. 1, 1991); 20 C.F.R. § 404.1527. The Court of Appeals for the Second Circuit upheld the new regulation in *Schisler v. Sullivan*, 3 F.3d 563 (2d Cir. 1993) as a valid exercise of the Secretary's rulemaking authority.

treating physician rule without first considering the Secretary's input: "[W]e will also follow *Stein* in leaving for the Secretary's initial consideration the issue of whether the treating physician rule, applicable to disability cases, [cite to *Schisler*], applies to Medicare coverage determinations." *Id.* at 60.

In response to these Second Circuit cases, CMS issued Ruling 93-1 (*eff.* May 18, 1993), to explain the position of the agency on the treating physician rule. The Ruling provides that no presumptive weight should be assigned to a treating physician's medical opinion in determining the medical necessity of inpatient hospital or skilled nursing facility services.¹³ Rather, "[a] physician's opinion will be evaluated in the context of the evidence in the complete administrative record." Moreover, the Ruling adds parenthetically that it does not "by omission or implication" endorse the application of the "treating physician rule" to services not addressed in the Ruling, *e.g.*, services other than Medicare Part A services.

We note that the Second Circuit decisions did not address the weight to afford a treating physician's opinion concerning the medical necessity of services that he or she had performed and for which the physician was seeking reimbursement under Part B. Rather, the cases involve situations in which the physician's patient was admitted to, and treated by, a Part A facility. In those circumstances, the physician is providing an opinion about the necessity of the admission and/or continued stay in the facility, which, if the services are covered, will receive the Part A reimbursement.

In *Arruejo v. Thompson*, 2001 WL 1563699 (E.D.N.Y. 2001), the district court declined to apply the treating physician rule to claims for physician services under Medicare Part B. And, in language that is particularly apt in the present case, the *Arruejo* court added:

Even if the rule were found to apply, it would not save plaintiffs' claims. The treating physician rule, as noted above, is based on the premise that a treating physician has intimate familiarity with a patient's specific medical circumstances, and operates on the assumption that evidence about the patient's condition or diagnosis will be proffered. The

¹³ CMS Rulings are binding on ALJs and the Council. 42 C.F.R. §§ 401.108, 405.1063.

regulatory scheme envisions a well-documented and supported basis for the conclusion and opinion of the treating physician. . . . In this way, the codified rule resembles the case law from which it was derived. [Citing *Friedman v. Sec'y of the Dep't of Health and Human Serv.*, 819 F.2d 42, 46 (2d Cir. 1987) and section 1833(e) of the Act, requiring Medicare beneficiaries and their doctors to submit the necessary documentation to justify payment.] For these reasons, even if the treating physician rule were to be extended to Medicare cases, there is simply no basis for its application here. Plaintiffs did not submit medical records or other evidence to the ALJ showing the medical conditions of the patients who were [being treated], nor have they presented such evidence here. Rather, plaintiffs rely on the mere fact the treating physicians . . . requested the [services], without providing any patient-specific evidence of the reasons for those requests. This is simply not a sufficient showing to create a prima facie case of medical necessity under either case law or regulations.

Id. at 14.

The hearing CD discloses the following statements made by the ALJ with regard to the treating physician's (A.T.'s) testimony:

. . . I'm showing no indications in my files that the QIC . . . has elected to appear. That's, uhm, otherwise I would have to be calling them, and bringing them on line and so forth. Uhm, now that's something of importance to especially you Dr. [A.T.] . . . your testimony under oath is that of a treating doctor of podiatric care . . . as the treating physician, you are giving testimony that is of greater deference, that is to say more weight, than if somebody else is appearing and giving counter-testimony under oath

Hearing CD at 9:36:12-9:38:09.

Strictly speaking, Ruling 93-1 does not apply in this Part B case. However, CMS raises a valid point only to the extent it is arguing that an ALJ may not assign presumptive weight to a treating physician's testimony, without considering the full

evidentiary record. A.T.'s opinion or determination is but one form of evidence that should be considered within the context of all other evidence of record relevant to coverage.

ADVERSE INFERENCE FROM CMS NON-PARTICIPATION

The regulations in 42 C.F.R. § 405.1010 set out the parameters within which CMS and/or its contractors may participate in an ALJ hearing. Such participation includes "filing position papers or providing testimony to clarify factual or policy issues . . ." *Id.* at § 405.1010(c). Participation in an ALJ hearing precludes CMS or its contractor being "called as a witness during the hearing." *Id.* at § 405.1010(d). An "ALJ cannot draw any adverse inferences if CMS or its contractor decides not to participate in any proceeding before an ALJ, including the hearing." *Id.* at § 405.1010(f).

CMS contends that the ALJ's hearing statements indicate the ALJ drew an adverse inference against CMS and/or the contractors based on their non-participation in the ALJ proceedings. Exh. MAC-1, at 2. The appellant asserts that the ALJ weighed the testimonial and other evidence on record, and determined that "the disputed services were reasonable and necessary." Exh. MAC-2, at 3. We are unable to agree with CMS that the ALJ's statements, as quoted above, indicate that the ALJ drew a negative inference from the QIC's non-participation.

REMAND INSTRUCTIONS

Consistent with the above discussion, on remand, the ALJ shall:

- Offer an opportunity for a supplemental hearing. Provide notice of the hearing in accordance with the applicable regulations. Any waiver of the right to a supplemental hearing shall be documented in writing.
- issue a new decision which explains the basis for the decision(s) consistent with the applicable regulations and other relevant coverage authorities. Should the ALJ decline to give substantial deference to any applicable authority to which the ALJ is not bound, the ALJ shall provide an explanation for not following the authority.
- if necessary, evaluate the issue of liability pursuant to section 1879 of the Act.

The ALJ may take further action not inconsistent with this order.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

/s/Constance B. Tobias, Chair
Departmental Appeals Board

Date: June 28, 2012