DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

ORDER OF MEDICARE APPEALS COUNCIL
REMANDING CASE TO ADMINISTRATIVE LAW JUDGE

In the case of	**Claim for**
International Rehab Sciences, Inc. (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiaries)	Multiple (HIC Numbers)
DMERC Regions B & C (Contractors)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a dismissal order dated November 13, 2008. The claims at issue concerned coverage for neuromuscular electronic stimulators (NMESs) furnished to two beneficiaries on April 22, 2007 ([redacted]) and September 25, 2007 ([redacted]). The ALJ dismissed the request for hearing with regard to these two beneficiaries on the grounds that their cases could not be properly aggregated and they did not each independently meet the minimum required amount in controversy. The appellant has asked the Medicare Appeals Council (Council) to review this action.

The Council may deny review of an ALJ's dismissal or vacate the dismissal and remand the case to the ALJ for further proceedings. 42 C.F.R. § 405.1108(b). The Council will dismiss a request for review when the party requesting review does not have a right to review by the Council. The Council may also dismiss the request for a hearing for any reason that the ALJ could have dismissed the request for hearing. 42 C.F.R § 405.1108(c).

The Council hereby vacates the order of dismissal and remands this case to an ALJ for further proceedings.

BACKGROUND

This case originally involved claims for five beneficiaries which were appealed to an ALJ following five individual reconsideration decisions. Each of the claims involved NMES equipment furnished for one or more rental months to one beneficiary. In its request for a hearing before the ALJ, the appellant listed the five beneficiaries and claims on an attachment, and stated the following in the body of the request for hearing:

> All of the claims on the attached chart involve the same device and supplies and have common issues of denial and will involve common evidence. Appellant requests that all of the claims be aggregated pursuant to 42 C.F.R. § 405.1006. All of these claims were the subject of reconsiderations by the QIC, and were all timely appealed to an ALJ. It would be in the interest of judicial and Appellant efficiency to aggregate these claims.

Exh. 1, at 1.

The ALJ held a consolidated hearing on the claims for all five beneficiaries. The ALJ issued three individual unfavorable decisions with respect to three of the five beneficiaries.[1] However, with regard to the claims of the two beneficiaries at issue here, the ALJ dismissed the request for hearing. In each of these two cases, only one month of rental had been billed for the NMES equipment for $99 each; thus, less than the required minimum of $120 was at issue for each beneficiary.[2]

The ALJ further determined that the two cases at issue could not be properly aggregated for purposes of meeting the amount in controversy requirement. The ALJ acknowledged that the appellant had, in fact, specifically requested aggregation within the meaning of the appeals regulations. However, the ALJ found that the claims could not be aggregated based on his reading of the statutory provision allowing aggregation. He reached this conclusion for two reasons: (1) while the cases

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[1] With regard to the three beneficiaries for whom the ALJ issued unfavorable decisions ([redacted]), the Council has issued a separate decision addressing their claims.

[2] We do not address the ALJ's extensive discussion of how he calculated the amounts in controversy given our resolution here that the claims should have been aggregated.

involved “same or similar equipment,” such equipment was provided to multiple beneficiaries, thus not meeting the statutory first prong for aggregation, and (2) while the cases involved common issues of law, they did not also involve common issues of fact, and thus did not meet the statutory second prong for aggregation. The ALJ dismissed these two cases for failure to meet the required minimum amount in controversy. This appeal followed.

MEDICARE PROVISIONS

Section 1869(b)(1)(E) of the Social Security Act (Act) provides that cases may be aggregated to meet the minimum amount in controversy, under the following circumstances:

> In determining the amount in controversy, the Secretary [of Health and Human Services], under regulations, shall allow two or more appeals to be aggregated if the appeals involve –
>
> (I) the delivery of similar or related services *to the same individual* by one or more providers of services or suppliers, or
>
> (II) common issues of law *and* fact arising from services furnished to two or more individuals by one or more providers of services or suppliers.

(Italics added.)

The appeals regulations set out the conditions under which the Secretary has determined that aggregation is appropriate:

> Either an individual appellant or multiple appellants may aggregate two or more claims to meet the amount in controversy for an ALJ hearing if –
>
> (i) The claims were previously reconsidered by a QIC;
>
> (ii) The request for ALJ hearing lists all of the claims to be aggregated and is filed within 60 days after receipt of all of the reconsiderations being appealed; and
>
> (iii) The ALJ determines that the claims that a single appellant seeks to aggregate involve the delivery of similar or related services, or the claims that multiple appellants seek to aggregate involve common issues of law and fact….

42 C.F.R. § 405.1006(e)(1).[3]

DISCUSSION

In discussing his reasons for rejecting aggregation of the five claims, the ALJ first concluded that the claims met the regulatory requirements for aggregation in that the "claims involve a single appellant and the delivery of the similar or related services." ALJ Decision at 9. He nevertheless rejected aggregation because, in his view, the statutory language requires that the claims involve a single "individual," receiving the delivery of similar or related services, i.e., a single beneficiary. He explained that he viewed the regulation as "in error" because it "clearly contradicts the plain meaning of the statute." Id. He then opined that the statutory language is preferable to the regulatory approach. He also concluded that the claims did not share common issues of fact.

We conclude that the ALJ is wrong for two reasons. First, the regulation is not in irreconcilable conflict with the statute and ought to be applied. Second, contrary to the ALJ's opinion, the claims at issue also meet the statutory requirement of involving "common issues of law and fact."

The Council notes that ALJs (as well as the Council) are bound by both statutes and regulations. 70 Fed. Reg. at 11457; 67 Fed. Reg. 69312, 69331 (Nov. 15, 2002); *accord* Abiona v. Thompson, 237 F.Supp.2d 258, 265 (E.D.N.Y. 2002). Any inconsistencies in the language between the statute and regulations must be reconciled if at all possible, since neither an ALJ nor the Council has the authority to ignore or invalidate a statute or regulation. The Council has determined that the statutory and regulatory provisions at issue here may be read together with consistency.

The statute mandates that the Secretary *shall allow* two or more appeals to be aggregated if the appeals involve the delivery of similar or related services to the same individual by one or more providers of services or suppliers. The statute does not, however, restrict the circumstances under which the Secretary

[3] The aggregation regulation was promulgated pursuant to the Medicare, Medicaid, and SCHIP Benefits Act of 2000 (BIPA) (Pub. L. 106-554), and became effective for all decisions issued by a Qualified Independent Contractor (QIC). 70 Fed. Reg. 11420, 11425 (March 8, 2005).

may grant aggregation to only the circumstances in which it requires that aggregation be available.

The regulation provides for aggregation opportunities stated more broadly than those specifically required by the statute. The Secretary's election to expand aggregation beyond the statutory minimum requirements does not create any irreconcilable conflict. The ALJ thus should have complied with the regulation and granted aggregation on the grounds that the claims involved a single appellant in each case delivering similar or related services.

The ALJ noted in his analysis that some discussion in the preamble to the Interim Final Rule "echoes the language of the statute, rather than that of the regulation." ALJ Decision at 9. The language to which he referred is as follows:

> [In this regulation,] the aggregation provisions were revised: Two or more appeals are allowed to be aggregated when the appeals either involve the delivery of similar or related services to the same individual by one or more providers and suppliers, or there are common issues of law and fact arising from services furnished to two or more individuals by one or more providers or suppliers.
>
> In the proposed rule, we proposed to limit aggregation of claims under BIPA to those that meet the statutory requirements for aggregation, that is, those that involve the delivery of similar or related services to the same individual, or common issues of law and fact arising from services furnished to two or more individuals. *Individual appellants will no longer be allowed to aggregate all timely filed claims, regardless of issue*.

70 Fed. Reg. 11,420, 11,459 (March 8, 2005) *(italics added)*. The expressed purpose of the regulatory change was to move away from a system in which individual appellants were permitted to aggregate all of their claims with no effort made to determine whether the services were in any way related. The preamble, thus, earlier notes that, under prior regulations, the Secretary interpreted the same statutory language (then in former section 1869(b)(2) of the Act) in a final regulation published March 16, 1994 which –

> established two methods of aggregation: one for individual *appellants* and one for multiple *appellants*. Individual appellants appealing either Part A or Part B claims were allowed to aggregate two or more claims within a specified period, regardless of issue, to meet the jurisdictional minimums for a carrier hearing and ALJ hearing. Multiple appellants, however, were allowed to aggregate their claims only under the statutory requirements; that is, if the claims involved the delivery of similar or related services to the same individual or common issues of law and fact arising from services furnished to two or more individuals.

70 Fed. Reg. at 11,459 (emphasis added). The change in the regulation does indeed move toward the statutory provision by requiring individual appellants to make a showing that similar services were involved. In neither the prior nor the revised post-BIPA regulations, however, are the aggregation opportunities limited to "beneficiaries" as opposed to "appellants" as they are in the statute. In this context, we do not view the reference to the statute in the preamble discussion as intended to override *sub silentio* the explicit regulatory provision allowing aggregation of claims by individual appellants where similar services are delivered.

For these reasons, the Council finds that the aggregation regulation of 42 C.F.R. 405.1006(e)(1) allows for the aggregation of claims involving the same or similar equipment by a single provider or supplier to multiple beneficiaries. In this case, the appellant asserted, and the ALJ found, that the cases at issue involved same or similar equipment.

We also note that the ALJ misunderstood the concept of claims for different individuals sharing common issues of fact. The definition of "[c]ommon issues of law and fact" in the regulations for aggregation purposes is a situation where the claims "are denied, or payment is reduced, for similar reasons and arise from a similar fact pattern material to the reason the claims are denied or payment is reduced." 42 C.F.R. § 405.1006(a)(1).

The ALJ by contrast applied a very different standard to evaluate whether the appellant demonstrated common issues of law

and fact. Specifically, the ALJ found that the appellant failed to establish on the record before him that "sufficient common facts pertain in the present matter such that deciding such common facts would effectively allow a decision to be rendered in each case without reference to all but the most minimal of disparate and unique facts." ALJ Decision at 11. The ALJ cites no authority, and we find none, to support the idea that common issues of fact exist only when an ALJ is able to restrict his review to the "most minimal" reference to individual scenarios. The regulatory standard merely requires that the claims "arise from a similar fact pattern" in regard to the basis for denial.

As noted, the appellant asserted in its request for an ALJ hearing that these claims all "involve the same device and supplies and have common issues of denial and will involve common evidence." Exh. 1, at 1. The ALJ stated that he was reviewing the request in the light more favorable to the appellant and was assuming that common issues of law were present. ALJ Decision at 11. Indeed, there is no question that all of the claims are rooted in the application of a single National Coverage Determination 160.12 which sets out coverage limitations for use of neuromuscular electrical stimulation for disuse atrophy.

The ALJ made no finding that the fact patterns involved were not similar; rather, he felt no common issues of fact were persent merely because he would need to perform an "in-depth review of the individual and unique facts surrounding each beneficiary's medical treatment and history." Id. The ALJ's error is thus to have misread the law as requiring not merely "common issues of law and fact" but as demanding virtually identical facts. In other words, the requirement is not that no individual facts exist but only that there be common facts be at issue. The specific device used was the same in each case. The capabilities of that device and the role of such stimulation in addressing medical conditions were factual issues common across all the claims, as illustrated by the inclusion in the evidence in multiple case files of numerous scientific articles. The fact scenarios all involve beneficiaries who received prescriptions for use of neuromuscular electrical stimulation for disuse atrophy. We do not agree that the existence of common issues of fact is negated merely because resolving medical necessity of specific claims may also require reviewing individual medical records.

For all the reasons explained above, the Council concludes that the claims at issue meet the requirements for aggregation and the appellant made a proper request for aggregation. The Council therefore remands the cases to an ALJ for a decision on the merits of the claims.[4]

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

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

/s/ Leslie A. Sussan
Member,
Departmental Appeals Board

Date: April 8, 2009

[4] The Council notes that the ALJ has already held a hearing on all five of the claims which were part of the case below. The appellant has not argued that the ALJ did not allow it a full and fair opportunity to present its arguments on the merits of each claim. For this reason, the Council does not find it necessary to direct the ALJ to hold another hearing on the claims.