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**
St. Francis Hospital (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiary)	**** (HIC Number)
Quality Insights of Delaware (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated July 14, 2009, which concerned the beneficiary's inpatient hospital admission and subsequent stay from September 24, 2008, through September 26, 2008. The ALJ determined that the provider was liable for the inpatient hospital services. The appellant, St. Francis Hospital, has asked the Medicare Appeals Council (Council) to review this action.

The Council reviews the ALJ's decision *de novo.* 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's action to the exceptions raised by the party in the request for review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c). The Council enters the appellant's request for review, dated September 10, 2009, as Exhibit (Exh.) MAC-1.

The Council hereby vacates the hearing decision and remands this case to an ALJ for further proceedings, including the issuance of a new decision. *See* 42 C.F.R. §§ 405.1108(a), 405.1128(a).

BACKGROUND AND PROCEDURAL HISTORY

During the relevant time period, the beneficiary was a 40-year old female, who was admitted to St. Francis Hospital following a

diagnosis of acute exacerbation of asthma and abdominal pain. Exh. 2, at 41.

Quality Insights of Delaware (Quality Insights), the Quality Improvement Organization (QIO) for Delaware, issued a notice to the appellant that it had reviewed the beneficiary's acute inpatient stay and, after a review of the medical documentation, determined that the beneficiary did not require an acute inpatient level of care. Exh. 2, at 29-30. The appellant appealed the unfavorable determination and Quality Insights issued its reconsideration on March 23, 2009. Exh. 2, at 24. Quality Insights denied the appellant's request for reconsideration "due to no additional information provided." *Id*.

The appellant then requested a hearing before an ALJ, which was held on July 1, 2009. Dec. at 1. The ALJ issued a decision on July 14, 2009, addressing only whether the appellant was liable for the inpatient hospital services, which the QIO had determined were not covered. The ALJ found that the appellant should have known that the services provided would not be covered by Medicare; thus, the appellant was liable for the non-covered admission. *Id*. at 9-10. Thereafter, the appellant requested review of the ALJ's decision. *See* Exh. MAC-1.

DISCUSSION

The ALJ found that the appellant, as a provider of services, was limited in the scope of its appeal of the QIO decision to the ALJ. *See* Dec. at 9. Citing 42 C.F.R. § 478.40 and CMS Ruling 95-1, the ALJ found that the appellant could not appeal the QIO's finding that the inpatient admission was not medically reasonable and necessary; rather, the ALJ found, the appellant was limited on appeal to the issue of limitation on liability under section 1879 of the Social Security Act (Act). *Id.* Thus, while the provider had appealed the denial of the claim, including the issues of both coverage and liability, the ALJ declined to address coverage on jurisdictional grounds. *Id.* The ALJ found that the appellant was liable for the cost of the non-covered services, consistent with the QIO decision. *Id.* at 10.

The Council notes that the authorities cited by the ALJ are interpretations of section 1155 of the Act, which historically provided that any *beneficiary* dissatisfied with a determination of a QIO could appeal to an ALJ if the amount in controversy

following the QIO reconsideration was $200 or more. Section 1155 did not extend such right to appeal to the ALJ level to a provider or supplier of Medicare items or services, but was instead silent on such matter. CMS, through the authorities cited by the ALJ, clarified that only beneficiaries, but not providers or other practitioners, could appeal an unfavorable QIO coverage (as opposed to liability) decision to an ALJ.

However, with the passage of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Congress significantly changed the appeals process to create a uniform process for Medicare Part A and Part B appeals, which was phased in beginning in 2005. BIPA, Pub.L. 106-554, § 521, 114 Stat. 2763A (2000). Pursuant to these statutory changes to section 1869 of the Act, the Secretary of Health and Human Services promulgated new appeals regulations at 42 C.F.R. Part 405, Subpart I (section 405.900 *et seq.*). In the preamble to such regulations, CMS stated that, "we believe that the interests of the appeals process would be best served by ensuring that providers are afforded an equal opportunity to be heard with regard to all Medicare initial determinations . . . we are specifying that Medicare providers may file administrative appeals of initial determinations to the same extent as beneficiaries." 70 Fed. Reg. 11420, 11427 (March 8, 2005).

In an August 17, 2009 letter to the Council, submitted in a similar case from the HHS Chief Counsel, Region V, the Office of General Counsel (OGC), who spoke for both HHS and CMS, stated that it was HHS's position that section 1155 of the Act and its corresponding regulations "should not be read in isolation" given the subsequent BIPA legislation and implementing regulations. The OGC Chief Counsel cited the Supreme Court, stating that "[o]ver time, . . . subsequent [A]cts can shape or focus [the statute's] meanings. The 'classic judicial task of reconciling many laws enacted over time, and getting them to "make sense" in combination, necessarily assumes that the implications of a statute may be altered by the implications of a later statute.'" FDA v. Brown & Williamson Tobacco, 529 U.S. 120, 143 (2000), (citing United States v. Fausto, 484 U.S. 439, 453 (1988)). OGC further asserted:

> Arguably, enactment of section 521 of BIPA could constitute an implied repeal of section 1155 of the Act insofar as it appears to be in irreconcilable conflict with the earlier provision, covers the whole

> subject of the earlier provision, and seems clearly intended as a substitute. (citation omitted)
>
> Applying the more-recent section 1869 regulations in this case would give effect to the broad legislative changes enacted by Section 521 of BIPA, changes that were meant to provide a uniform appeals process for Medicare Part A and Part B claims and to expand provider appeal rights. Applying section 1155 and its related regulations creates a separate and more limited appeals process for providers, a result that appears to directly contradict BIPA and the revised 1869 regulations.

Because HHS has taken such a position with regard to its appeals regulations and policy statements, the Council finds that section 1155 and its implementing regulation and policy guidelines were not binding on the ALJ in light of the recent BIPA law and new appeals regulations at 42 C.F.R. Part 405, Subpart I. The new law and regulations collectively provide that either a provider/practitioner or a beneficiary may appeal both the findings on coverage and liability to an ALJ following an inpatient hospital admission denial by a QIO, if at least $120 remains in controversy. *See, generally,* 42 C.F.R. §§ 405.906, 405.924(b)(11), 405.1002, and 405.1006(b)(1). Thus, the Council finds that the ALJ was not restricted to addressing only the limitation on liability in the provider's appeal of this unfavorable QIO decision.

INSTRUCTIONS ON REMAND

- The ALJ shall offer the parties an opportunity to present testimony and participate in a supplemental hearing and shall provide notice of the date and time of the hearing to all parties. 42 C.F.R. § 405.1020(c)(1).

- The ALJ shall decide whether the inpatient hospital services at issue were medically reasonable and necessary for the beneficiary, as required by section 1862(a)(1)(A) of the Act, citing the reasons for the decision and providing evidentiary support from the record that was used to make the decision. 42 C.F.R. § 405.1046.

- The ALJ shall consider liability under 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/ Gilde Morrisson
Administrative Appeals Judge

Date: December 29, 2009