

Lions and Tigers Threaten the Validity of Medicare Rules

Frank P. Fedor

Partner

Murphy Austin Adams Schoenfeld

ffedor@murphyaustin.com



A recent decision by the United States Court of Appeals for the District of Columbia adds much needed definition to the interpretative rule exception to the notice and comment requirement of the Administrative Procedure Act (APA).

In *Catholic Health Initiatives v. Sebelius*, 617 F.3d 490 (D.C. Cir. 2010) the provider challenged a section of the Provider Reimbursement Manual (PRM), a guide to Medicare reimbursement policies that is not published under notice and comment procedures. The PRM prohibited reimbursement for insurance premiums paid to a “captive” offshore malpractice insurer if the insurer invested more than 10 percent of its total assets in securities traded in a United States stock exchange, or it invested more than 10 percent of the insurer’s total investment in a specific equity issue of U.S. securities. The Secretary defended her rule (whose ostensible purpose was to preserve the financial viability of the insurer) as an “interpretation” of her reasonable cost statute and regulations. Therefore, according to the Secretary, the PRM provisions in question were not subject to the APA’s notice and comment requirements.

The Court invalidated the PRM’s investment rules by concluding they were not interpretative rules. The PRM rules could not fairly be considered an interpretation of the reasonable cost statute or regulations because the connection between the reasonable cost of the provider and detailed investment rules for an insurer was too attenuated to represent an interpretation of the generalized terms focused on a provider’s costs used in the statute and regulations. “The short of the matter is that there is no way an interpretation of ‘reasonable costs’ can produce the sort of detailed – and rigid – investment code set forth in [the PRM].”

The Court also based its holding on the rule being stated “in numerical terms,” e.g. a 10 percent limit on investments. Creating a rule with a number is typically a legislative function in that it requires the selection of a precise number from several reasonable options based on numbers. Here, the leading case is *Hoctor v. USDA*, 82 F.3d 165 (7th Cir. 1996). Patrick Hoctor dealt in exotic animals on his farm outside Terre Haute. Among his animals were “Big Cats” such as lions, tigers, cougars and snow leopards. His animals were kept in cages or pens. In addition, at the suggestion of his regulator, the U.S. Department of Agriculture, he built a perimeter fence around his entire compound to a height of six feet. The next year the Department issued a memorandum stating that all dangerous animals such as those owned by Hoctor had to be surrounded by a perimeter fence at least eight feet high. That new rule was not promulgated under notice and comment rule making. Patrick Hoctor challenged it on that basis.

The Seventh Circuit held the rule to be legislative and void because it was not promulgated by notice and comment rulemaking.

“There is no way to reason to an eight-foot perimeter-fence rule as opposed to a seven-and-a-half foot fence or a nine-foot fence or a 10 foot fence. None of these candidates for a rule is uniquely appropriate to, and in that sense derivable from, the duty of secure containment. This point becomes even clearer if we note that the eight-foot rule actually has another component—the fence must be a least three feet from any animal’s pen. Why three feet? Why not four? Or two?” (*Hoctor*, at 170)

Both *Hoctor* and *Catholic Health Initiatives* acknowledge that “in scientific and other technical areas, where quantitative criteria are common, a rule that translates a general norm into a number may be justifiable as interpretation.”

The PRM has numerous provisions that contain numbers. *Catholic Health Initiatives* should not be viewed as a license to invalidate each of these rules. Nevertheless, provisions of the PRM or other interpretations that are numerically stated and have an attenuated connection to a general term (such as “reasonable” or “fair and equitable”) in the statute or regulation they claim to “interpret” are good candidates for a new consideration of their validity under the principles considered in *Catholic Health Initiatives*.



CMS January ICD-10 Provider Call ... continued from page 3

- Implementation plan development and impact assessment
- Determining vendor readiness
- Coding gap analysis - what needs to be done for your coding staff?
- Assessing quality of medical record documentation
- Developing an ICD-10 budget
- Consequences of poor preparation

The above list truly outlines many aspects of implementation that our ICD-10 Committee should be addressing this year.

The presentation slides and the written script is available on the CMS website. Remember that CMS continues to host a variety of national provider education teleconferences to help the provider community prepare for the U.S. healthcare industry’s change from the ICD-9 to ICD-10 medical coding system. All teleconferences are free of charge, however you must register to participate.

Watch for more ICD-10 information and educational opportunities being offered by Northern California HFMA in the coming months. ✦

Visit the CMS website dedicated to ICD-10 at:
<https://www.cms.gov/ICD10/>

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is not paneled, and if it was paneled it would have a contract or some document or agreement that would reference that particular situation. However, in doing a review with many provider clients, it seems no one can find a contract that would apply to these circumstances. Upon investigation, we have been able to find letters to some individual hospitals, its medical director, or a pediatric or a NICU unit that defines the authorization. For example, a letter may state the following: “This is to inform you of the Children’s Medical Services Program decision to grant approval to the neonatal intensive care unit at ‘hospital A’ as a Community NICU which is effective as of the date of this letter. The decision is based on your documentation as submitted to CCS.” Other conditions in the letter covers submission of data relative to morbidity and mortality, on-call schedules of the neonatal clinician, and other information that is generally a continuing responsibility of the facility. Generally speaking, this is the only documentation that we have been able to find. It has been confirmed by CCS that some of the documentation relative to the implementation of the program is old, and they in fact may not have hard copy documentation of a contractual nature either. In conclusion, a provider needs to work under the regulation and set up a functional process and procedure so as to obtain authorization to effect appropriate reimbursement. ✦