

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-12-1066

In the case of

Delaware Hospice, Inc.
(Appellant)

(Beneficiary)

Cahaba GBA

(Contractor)

Claim for

Hospital Insurance Benefits
(Part A)

(HIC Number)

(ALJ Appeal Number)

The Medicare Appeals Council has decided, on its own motion, to review the Administrative Law Judge's (ALJ's) decision dated February 2, 2012, because there is an error of law material to the outcome of the claim. See 42 C.F.R. § 405.1110. In that decision, the ALJ determined that hospice services, provided by appellant, Delaware Hospital, Inc., to the beneficiary from June 1, 2010, through June 30, 2010, were not covered by Medicare because the beneficiary was not terminally ill. However, the ALJ further determined that the appellant was entitled to Medicare payment pursuant to the limitation on liability provision of section 1879 of the Social Security Act (Act).

By memorandum dated March 29, 2012, the Centers for Medicare & Medicaid Services (CMS) referred the matter to the Council to consider reviewing the ALJ's decision on its own motion. The Council admits the CMS memorandum into the administrative record as Exhibit (Exh.) MAC-1. The appellant has not filed exceptions to the CMS memorandum.

As explained below, the Council adopts the portion of the ALJ's decision concerning Medicare coverage, as CMS did not contest the ALJ's coverage findings.¹ However, the Council reverses the ALJ's decision as it pertains to Medicare payment for the

¹ The ALJ found that the hospice services were not medically reasonable and necessary.

services. We find that the appellant, Delaware Hospice, Inc., is liable for the costs of the non-covered services.

BACKGROUND

This matter involves hospice services provided by Delaware Hospice, Inc., to the beneficiary from June 1, 2010, through June 30, 2010. The appellant submitted a claim seeking payment for these services, which was initially denied by the Medicare Administrative Contractor, (Cahaba GBA), because the medical record lacked the requisite physician certifications. Exh. 3 at 76. Upon redetermination, the contractor denied Medicare coverage, finding the documentation did not support the beneficiary had a life expectancy of six months or less at the time the services were furnished. *Id.* at 77.

Thereafter, the appellant requested reconsideration by the Qualified Independent Contractor (QIC). The QIC denied Medicare coverage, finding that the medical documentation did not establish that the beneficiary had a terminal illness with a life expectancy of six months or less: "the record did not support a 10% weight loss in the prior six months or inability to maintain caloric intake, signs of increasing dysphagia or aspiration, uncontrolled pain, severe recurrent infections, multiple decubitus ulcers, abnormal laboratories, or decline in functional scoring or unstable co-morbid or secondary conditions." Exh. 4 at 90. The QIC also determined that the provider was liable under section 1879 of the Social Security Act (Act) for the non-covered services. *Id.* at 91. In response to the unfavorable contractor decisions, the appellant requested ALJ review. Exh. 5 at 108.

Following a telephonic hearing, the ALJ issued a decision finding the hospice services were not medically reasonable and necessary because the beneficiary was not terminally ill and thus, did not qualify for hospice services. Citing the applicable Local Coverage Determination (LCD), (L13653)², the ALJ found that the documentation in the beneficiary's medical record did not support a decline during the dates of service. Dec. at 5. In reaching this conclusion, the ALJ noted two persuasive facts: the improvement in PPS from 40% to 50% to 60% and the suggestion by the physician that the beneficiary be removed from hospice and restart treatment. *Id.* After finding the hospice

² See LCD L13653, titled "Hospice Determining Terminal Status, Rev. 7, issued by Cahaba Government Benefit Administrators, LLC., available at www.cms.gov/medicare-coverage-database.

services were not medically reasonable and necessary, the ALJ determined that the limitation on liability provision of section 1879 of the Act applied to this case. Applying this provision to the facts at issue, the ALJ found that both the beneficiary and appellant did not and could not have reasonably been expected to know the hospice services were not covered by Medicare. *Id.* at 6. Thus, the ALJ ultimately waived liability for the beneficiary and the appellant. *Id.* The CMS request for own motion review by the Council on the issue of appellant's liability for the non-covered services followed.

DISCUSSION

The Council limits its review of the ALJ's action to those exceptions raised by CMS. 42 C.F.R. § 405.1110(c). Thus, the scope of our review is limited to the issue of appellant's liability for the non-covered services. CMS does not dispute the ALJ's finding that the hospice services were not medically reasonable and necessary or the ALJ's finding that the beneficiary did not know and could not have reasonably been expected to know the hospice services were not covered by Medicare. Exh. MAC-1 at 2.

In this case, the Council finds that the ALJ erred as a matter of law in waiving appellant's liability for the non-covered hospice services provided to the beneficiary from June 1, 2010, through June 30, 2010. While we agree with the ALJ that a section 1879 limitation of liability analysis is applicable and warranted in this case, we nevertheless disagree with the ALJ that such an analysis results in a waiver of liability for the appellant. Thus, the Council reverses-in-part the ALJ's decision as to the appellant's liability. We leave undisturbed the ALJ's coverage determination as well as the ALJ's determination regarding the beneficiary's liability.

Limitation of Liability under Section 1879

As a general matter, the determination as to waiver of financial liability of a beneficiary or a provider for items or services for which Medicare coverage is denied is through the operation of applicable law and regulations, and consideration of any relevant program guidance. The ALJ and the Council are bound³ to

³ An ALJ is bound by statutes, regulations, National Coverage Determinations (NCDs), and CMS rulings. See 42 C.F.R. § 405.1063.

apply such authorities (including CMS Ruling No. 95-1)⁴ and guidance if applicable to a given case. In the instant case, we have stated, above, that a discussion of section 1879 is applicable to the facts of this case. After the ALJ determined that the services were denied as not reasonable and necessary, it became incumbent upon the ALJ to determine who bore the burden of payment for the non-covered services.

CMS Ruling 95-1 makes clear that Medicare payment under the limitation on liability provision is dependent upon two primary factors. First, the claims for the services or items furnished must have been denied for one of the following reasons. The services or items were:

- not reasonable and necessary under section 1862(a)(1) of the Act;
- for custodial care and, therefore, not covered under section 1862(a)(9) of the Act;
- denied because the beneficiary was unintentionally, inadvertently, or erroneously placed into a noncertified bed (one that does not meet the requirements of section 1861(e) or (j) of the Act), as referenced by section 1879(e) of the Act; or
- non-covered home health services furnished to a beneficiary who was not "homebound" or who did not require "intermittent skilled nursing care" (as required by sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act), as referenced by section 1879(g) of the Act.

CMS Ruling 95-1.

The first factor of the analysis has been satisfied by the ALJ's finding the services denied as not reasonable and necessary pursuant to 1862(a)(1) of the Act. The second factor in

⁴ The "limitation on liability provision" of Section 1879 of the Social Security Act (the Act) provides financial relief to beneficiaries, providers, practitioners, and other suppliers by permitting Medicare payment to be made, or requiring refunds to be made, for certain services and items for which Medicare payment would otherwise be denied. CMS explained its position concerning the requirements for determining whether Medicare payment will be made under this provision found in section 1879 of the Act with Ruling No. 95-1.

determining if Medicare payment is made under the limitation on liability provision is whether the beneficiary and/or the provider, practitioner, or other supplier knew or could reasonably have been expected to know that the items or services (for which Medicare payment was denied on one of the bases listed above) were excluded from coverage. Having determined that there was no evidence in the record that the beneficiary knew or should have been expected to know that the services would not be covered, the ALJ turned its attention to the appellant's potential liability and determined:

"After carefully reviewing the evidence presented at the hearing, I find that it is very difficult to prognosticate a patient's status from month to month, so I am waiving the provider's liability[i]n this case because the appellant could not have reasonably been expected to know the services would not be covered."

Dec. at 6.

Here, the ALJ in a conclusory fashion makes a determination that the appellant did not have actual or constructive knowledge that the services at issue would not be covered by Medicare. The ALJ stated that a careful review of the evidence presented at the hearing led to the conclusion that the appellant lacked sufficient knowledge to warrant liability for the non-covered services. Dec. at 6. However, after review of the entire administrative record, to include the hearing recording, the Council finds that the ALJ failed to consider section IV(b) of CMS Ruling 95-1 (Determining Knowledge), and erred as a matter of law. See 42 C.F.R. § 405.1063 (stating an ALJ is bound by laws, regulations, and CMS Rulings).

Determining Appellant's Knowledge

The limitation on liability provision of section 1879 of the Act only applies to waive an appellant's liability if the healthcare provider did not know, and could not reasonably have been expected to know that payment would not be made for such items or services. See CMS Ruling 95-1, §§ I and IV. Section 411.406 of Title 42 of the C.F.R. sets forth the criteria for determining whether a healthcare provider knew that services were excluded from Medicare coverage as custodial care or as not reasonable and necessary. Relevant to this case, subsection (e)(1) of the regulation explicitly states that a healthcare

provider knew or could have been expected to know the services were excluded from coverage on the basis of "written guides or directives" from contractors. 42 C.F.R. § 411.406(e)(1). Additionally, CMS Ruling 95-1 plainly states that if a physician clearly indicates in a patient's medical record that the patient no longer needs the service or level of care the provider is furnishing or if the physician indicates the patient could be discharged, evidence based on medical records exists clearly indicating the provider had knowledge that Medicare payment for services or items would be denied. CMS Ruling 95-1, § IV.

As CMS points out, the ALJ's decision to deny Medicare coverage for the hospice services furnished to the beneficiary in this case, was predicated on two specific factual findings. MAC-1 at 7; Dec. at 5. The ALJ specifically noted that documentation of "the improvement in PPS from 40% to 50% to 60% and the suggestion by the physician that the beneficiary be removed from hospice and restart treatment" contributed to his determination. Subsequent to the finding that the services at issue were not medically reasonable and necessary because the beneficiary's condition was not terminal, the ALJ, found the limitation of liability provision of section 1879 of the Act applicable to waive the appellant's liability because "Appellant did not know and could not have reasonable known the hospice services would not be covered by Medicare." Dec. at 6. We agree with CMS, that this determination is contrary to the ALJ's own factual findings.

As the ALJ noted in his decision, LCD L13653 required that the beneficiary show "progression of disease evidenced by recurrent infections; . . . dependence on more activities of daily living; and increasing emergency room visits. The documentation should paint a picture for the reviewer to clearly see why the patient is appropriate for hospice care." Dec. at 5, citing LCD L13653. Just as the QIC concluded, the ALJ decided that the medical documentation in the record did not support a decline during the period at issue and ultimately did not satisfy the requirements of the LCD. *Id.* In addition to the clinical documentation findings, the ALJ found the beneficiary's physician indicated the beneficiary could be discharged from hospice care and returned to treatment. Dec. at 5. CMS correctly argues that CMS Ruling 95-1 characterizes a physician's statement that the beneficiary no longer needs the level of care or can be discharged as evidence clearly indicating knowledge of noncoverage. Exh. MAC-1 at 7-8. CMS Ruling 95-1 instructs that the provider is accountable for information contained in the

patient's medical records, such as the patient's medical chart, attending physician's notes, or similar records, since these are provider records. CMS Ruling 95-1, § IV. Thus, in waiving the appellant's liability based upon lack of knowledge, the ALJ clearly failed to comply with the language and instructions provided in CMS Ruling 95-1, and committed an error of law material to the outcome of this claim.

DECISION

The hospice services furnished to the beneficiary on the dates of service during the period from June 1, 2010, through June 30, 2010, were not covered by Medicare because the beneficiary was not terminally ill. The provider is not entitled to a waiver of liability under section 1879 of the Act because the appellant knew or should have known that Medicare would not cover the services. Thus, the ALJ's decision is reversed, in part, in accordance with the foregoing discussion.

MEDICARE APPEALS COUNCIL

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

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

Date: June 28, 2012