

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

ACTION AND ORDER OF MEDICARE APPEALS COUNCIL

In the case of

Claim for

O'Connor Hospital
(Appellant)

Hospital Insurance Benefits
(Part A)

(Beneficiary)

(HIC Number)

National Government Services
(Contractor)

(ALJ Appeal Number)

The Medicare Appeals Council (Council) received the above-captioned case on referral from the Centers for Medicare and Medicaid Services (CMS). The timely-filed memorandum from CMS dated November 12, 2009, is entered into the record as Exhibit (Exh.) MAC-1. As explained more fully below, we have decided not to review the Administrative Law Judge's (ALJ's) decision dated September 16, 2009.

This case arises from the appellant's claim for Medicare coverage of inpatient hospitalization services furnished to the beneficiary on November 1, and 2, 2004. Medicare initially paid this claim. Subsequently, the Recovery Audit Contractor (RAC) reopened this claim and requested medical records for review. On December 7, 2007, the RAC advised the appellant that the services provided were not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act (Act), and thus, the appellant had received an overpayment. D.O. Claim File, Exh. 3. The overpayment was upheld at the redetermination and reconsideration levels of appeal. *Id.* at Exhs. 5, 8.

On further appeal, the ALJ issued one decision addressing the appellant's claims arising from services furnished to four separate beneficiaries. The ALJ's September 16, 2009, decision was "fully favorable" and granted Medicare coverage for the inpatient services furnished to three of the beneficiaries.

As to the fourth beneficiary, which is the sole claim at issue here, the ALJ's decision was "partially favorable." The ALJ denied Medicare coverage for the inpatient hospitalization services as billed because they were not reasonable and necessary for the beneficiary's condition, but found that "the observation and underlying care are warranted." *Id.* at 15. The ALJ also found the appellant liable for any difference between the covered and non-covered services pursuant to section 1879 of the Act, and the appellant was not entitled to waiver of recovery of any overpayment remaining pursuant to section 1870 of the Act. *Id.* at 16. In addition, the ALJ determined that she did not have authority to review the RAC's reopening of the claim. *Id.* at 17.

In its referral memorandum to the Council, CMS asserts that the ALJ erred as a matter of law by ordering Medicare payment for "the observation and underlying care" provided to the beneficiary because those services are not separately billable under Part A. Exh. MAC-1 at 1.

The Council does not agree that the case contains an error of law.¹ The position advanced by CMS in its memorandum is inconsistent with the guidance set forth in the CMS Manuals.

CMS has expressly stated that Part B payment may be made if Part A payment is denied. In relevant part, the Medicare Benefits Policy Manual (MBPM) states:

Payment may be made under Part B for physician services and for the nonphysician medical and other health services listed below when furnished by a participating hospital (either directly or under arrangements) to an inpatient of the hospital, but only if payment for these services cannot be made under Part A.

In PPS hospitals, this means that Part B payment could be made for these services if:

- No Part A prospective payment is made at all for the hospital stay because of patient exhaustion of benefit days before admission;

¹ This order is consistent with the Council's earlier decision *In the Case of UMDNJ*, issued on March 14, 2005, and available on the Departmental Appeals Board public website at <http://www.hhs.gov/dab/macdecision/umdnj.htm> (last visited Jan. 28, 2010).

- **The admission was disapproved as not reasonable and necessary (and waiver of liability payment was not made);**
- The day or days of the otherwise covered stay during which the services were provided were not reasonable and necessary (and no payment was made under waiver of liability);
- The patient was not otherwise eligible for or entitled to coverage under Part A (See the Medicare Benefit Policy Manual, Chapter 1, § 150, for services received as a result of noncovered services); or
- No Part A day outlier payment is made (for discharges before October 1997) for one or more outlier days due to patient exhaustion of benefit days after admission but before the case's arrival at outlier status, or because outlier days are otherwise not covered and waiver of liability payment is not made.

MBPM, CMS Pub. 100-02, Ch. 6 at § 10 (emphasis added). This manual section clearly indicates that payment may be made for covered hospital services under Part B, if a Part A claim is denied for any one of several reasons.

Similar language permitting payment up to the limits of coverage appears in chapter 1 of the MBPM:

If a patient receives items or services in excess of, or more expensive than, those for which payment can be made, payment is made only for the covered items or services or for only the appropriate prospective payment amount. **This provision applies not only to inpatient services, but also to all hospital services under Parts A and B of the program.** If the items or services were requested by the patient, the hospital may charge him the difference between the amount customarily charged for the services requested and the amount customarily charged for covered services.

MBPM, Ch. 1 at § 10 (emphasis added).

For the purposes of this decision, an intermediary processes both Part A and Part B claims from providers.² Section 1816 of the Act and the implementing regulations recognize that not all claims are "clean claims" that will be paid promptly as billed. The regulation in effect at the time of service provides that:

The intermediary takes appropriate action to reject or adjust the claim if -

- (i) The intermediary or the QIO determines that the services furnished or proposed to be furnished were not reasonable, not medically necessary, or not furnished in the most appropriate setting; or
- (ii) The intermediary determines that the claim does not properly reflect the kind and amount of services furnished.

42 C.F.R. § 421.100(a)(2).

Further, the Medicare Financial Management Manual (MFMM) recognizes that additional action may be necessary by both the intermediary and provider to properly adjust, or offset, the amount due under Part B against a Part A overpayment. Specifically, it states:

A. Benefits Payable Under Part B - [Fiscal Intermediary, or] FI

Where the FI determines that a Part A overpayment has been made to a provider on behalf of a beneficiary, it shall ascertain whether the beneficiary is entitled to any Part B payment for the services in question. (See Medicare Benefit Policy, Chapter 6.) If it appears that Part B benefits are payable, it shall arrange for billings under Part B. It shall use any Part B benefit as an offset against the Part A overpayment.

MFMM, CMS Pub. 100-06, Ch. 3 at § 170.1.

² The functions performed by intermediaries during the period at issue have been transitioned to Medicare Administrative Contractors (MACs). See 42 C.F.R. §§ 421.100, 421.104.

This manual section demonstrates that CMS contemplated scenarios, like the instant one, in which a contractor would offset at least a portion of an overpayment recovery as the result of other benefits due to the provider.

The Medicare Claims Processing Manual (MCPM) also recognizes that although providers may sometimes bill for services that are not covered as billed, they are nonetheless entitled to correct payment. See MCPM, CMS Pub. 100-04, Ch. 29 at § 170.1 ("Claims Where There is Evidence That Items or Services Were Not Furnished or Were Not Furnished as Billed"). It instructs contractors to deny or downcode the payment, as appropriate. *Id.*

Finally, the MCPM states:

If a provider fails to include a particular item or service on its initial bill, an adjustment bill(s) to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing a claim. **However, to the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing.**

MCPM, Ch. 3 at § 50. Further, the MCPB makes clear that the claim need not take any particular form to be valid.

For those billing carriers and DMERCS, a claim does not have to be on a form but may be any writing submitted by or on behalf of a claimant, which indicates a desire to claim payment from the Medicare program in connection with medical services of a specified nature furnished to an identified enrollee. It is not necessary that this submission be recorded on a CMS claim form, that the services be itemized or that the information submitted be complete (e.g., a note from the enrollee's spouse, or a bill for ancillary services in a nonparticipating hospital, could count as a claim for payment).

The writing must contain sufficient identifying information about the enrollee to permit the obtaining of any missing information through routine methods, e.g., file check, microfilm reference, mail or telephone contact based on an address or telephone number in file. Where the writing is not submitted on a claims form, there must be enough information about the nature of the medical or other health service to enable the contractor with claims processing jurisdiction to determine that the service was apparently furnished by a physician or supplier.

MCPM, Ch. 1 at § 50.1.7 ("Definition of a Claim for Payment").

In this case, the provider submitted a timely claim for services which was paid under Part A. When the RAC reopened the determination on the initial claim at issue here, it had the same plenary authority to process and adjust the claim as it did when that claim was first presented and paid. The RAC's revised initial determination states that the beneficiary met the criteria for outpatient observation status. Exh. 3. The QIC also found that outpatient observation status would have been an appropriate course of treatment. Exh. 8. The ALJ agreed that outpatient observation status was reasonable and necessary.

A printout of the line item bill is in the record. Exh. 6. The intermediary needed only supplementary information in order to process a Part B claim for the very same services identified on the original Part A claim. Consistent with the CMS manual provisions discussed above, the contractor shall work with the provider to take whatever actions are necessary to arrange for billing under Part B, and thus, offset any Part A overpayment. The contractor shall issue a new initial determination upon effectuation. 42 C.F.R. § 405.1046(c).

Accordingly, the Council will not take own motion review of this case. The ALJ's September 16, 2009, decision is binding. We refer the case to Q² Administrators for effectuation of the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: February 1, 2010