DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-09-1306

In the case of	**Claim for**
Care Improvement Plus (Appellant)	Medicare Advantage (MA) (Part C)
**** (Enrollee)	**** (HIC Number)
Care Improvement Plus (MA Organization (MAO))	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated July 21, 2009. The ALJ determined that Southern Maryland Hospital Center (SMHC) appropriately admitted the enrollee on March 6, 2008, and billed the services it furnished to the enrollee from March 6, 2008, to March 7, 2008, as inpatient hospital services. Care Improvement Plus, the MAO, has asked the Medicare Appeals Council to review the ALJ's decision.

The regulation codified at 42 C.F.R. § 422.608 states that "[t]he regulations under part 405 of this chapter regarding MAC [Medicare Appeals Council] review apply to matters addressed by this subpart to the extent that they are appropriate." The regulations "under part 405" include the appeal procedures found at 42 C.F.R. part 405, subpart I. With respect to Medicare "fee-for-service" appeals, the subpart I procedures pertain primarily to claims subject to the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), 70 Fed. Reg. 11420, 11421-11426 (March 8, 2005). The Council has determined, until there is amendment of 42 C.F.R. part 422 or clarification by the Centers for Medicare & Medicaid Services (CMS), that it is "appropriate" to apply, with

certain exceptions, the legal provisions and principles codified in 42 C.F.R. part 405, subpart I to this case.

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 MAO's timely request for Council review (Form DAB-101 and attached argument headed "Basis for Disagreement with Administrative Law Judge Decision"), filed by counsel, is admitted into the record as Exh. MAC-1.[1] The Council notes that the SMHC has not filed a response to the MAO's request for review. The enrollee has been sent a copy of the MAO's request for review.

The Council concludes that there is no basis for changing the ALJ's decision. For the reasons and bases set forth below, the Council adopts the ALJ's decision.

DISCUSSION

The enrollee, a 79-year-old woman with a medical history including hypertension, heart murmur, angina, and coronary artery disease, fell at home on March 6, 2008. She was seen that day at the SMHC emergency room for fractures of the left wrist and the sternum. She was admitted to the SMHC inpatient telemetry unit for a cardiology consult and a cardiologist's clearance for surgery on her left wrist (open reduction, internal fixation), scheduled for March 10, 2008.

The matter before the Council is inpatient admission of the enrollee from March 6 to 7, 2008, at the SMHC. The plan's position is that the enrollee could have been appropriately treated at a lower level of care and should not have been admitted as an inpatient. The plan requests the Council's review of the ALJ's decision favorable to the hospital.

[1] Counsel for the MAO requested an opportunity to file a brief in support of the request, which the Council granted. The Council has not received a brief from the MAO.

Reversing the decision of Maximus Federal Services, the ALJ determined that the inpatient admission and services provided on March 6 to 7, 2008, are covered and the associated expenses are the responsibility of the plan. Dec. at 7. The ALJ considered, in particular, the four factors in the Medicare Benefit Policy Manual (MBPM), CMS Pub. 100-02, Ch. 1, section 10, for making a decision to admit a patient:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

MBPM, Ch. 1, section 10.

As to the first factor, the ALJ considered the evidence, including the hearing testimony of Dr. J.G., who opined that the enrollee had a severe left wrist fracture requiring open reduction, internal fixation. She was given two doses of intravenous Dilaudid in the emergency room. The ALJ noted evidence that the sternum fracture, although non-displaced, was very painful with movement and was causing pulmonary complications, for which the enrollee received 2 liters of oxygen. He also noted that the enrollee reported significant pain (10 out of 10) during the inpatient admission, and was given medication, including Vicodin and Percocet. Dec. at 1, 5, 6-7.

As evidence on the second, third, and fourth factors, the ALJ noted, in particular, the enrollee’s history of cardiac conditions, reports of severe chest pain, and comorbidities, including high blood pressure. He also noted that while an echocardiogram is not a diagnostic study that, by itself,

requires inpatient admission, a doctor determined that the enrollee required a cardiology consult and clearance, in an inpatient setting, in light of the enrollee's history of cardiac conditions. Dec. at 7.

The ALJ further determined, based on the medical documentation and hearing testimony, that the attending physician appropriately determined that inpatient care for more than 24 hours would be needed, referring to the MBPM provisions in Ch. 1, section 10, which provide that while a "decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors," a physician "should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more." He noted that the inpatient stay in this instance was about 40 hours, and that the enrollee was released when she was found stable. She was not kept on an inpatient status until after the surgery. Dec. at 7.

The Council has considered the plan's request for review. The plan does not raise any specific contentions on the ALJ's assessment of the medical documentation or hearing testimony to support his decision. The plan's contention is that the aforementioned MBPM provisions address only a physician's decision to admit a patient and not whether the services provided on an inpatient basis were medically necessary. The plan quotes a portion of the Quality Improvement Organization Manual (QIOM), CMS Pub. 100-10, Ch. 4, section 4110 provisions as applicable authority on this point[2] and seems to be asserting that the ALJ should have, but did not, address the issue of medical necessity of inpatient admission in this instance.

First, the Council disagrees with the plan's position that the ALJ did not address the issue of medical necessity of the enrollee's inpatient admission. He stated that "the treatment

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[2] As quoted by the plan:

> Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient at any time during the stay. The patient must demonstrate signs and symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

Exh. MAC-1 at 4, quoting QIOM, Ch. 4, section 4110.

the Beneficiary received at [SMHC] was medically necessary and appropriate only in [an] inpatient setting." Dec. at 7. And, he identified "whether the inpatient admission was appropriate and medically necessary . . ." as an issue for resolution. Dec. at 2.

Further, while it is true that the ALJ did not specifically discuss the QIOM section 4110, that omission, alone, would not be a basis for overturning the ALJ's decision. The question for the Council, in light of the plan's argument for reversal, is whether the coverage criteria for the inpatient services in question were nonetheless met under the facts of this case.

The plan argues, specifically, that at the time of admission[3] no abnormality in vital signs was documented; that a CT scan conducted prior to admission resulted in no finding of intrathoracic injury; that the enrollee did not have an acute medical condition requiring inpatient care; and that the pre-admission EKG did not result in findings requiring inpatient care. Exh. MAC-1 at 5.

The Council concludes that the coverage criteria were met in this instance. A provision of QIOM, Ch. 4, section 4110, not quoted by the plan, but which is relevant to this analysis, provides that a "physician reviewer must consider, in his/her view of the medical record, *any pre-existing medical problems or extenuating circumstances* that make admission of the patient medically necessary." In this instance, the attending physician was particularly concerned about the enrollee's cardiac

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[3] MBPM, Ch. 1, section 10 describes how inpatient admissions are to be reviewed (emphasis supplied):

> Under original Medicare, the Quality Improvement Organization (QIO) for each hospital is responsible for deciding, during review of inpatient admissions on a case-by-case basis, whether the admission was medically necessary. Medicare law authorizes the QIO to make these judgments, and the judgments are binding for purposes of Medicare coverage. In making these judgments, however, QIOs consider *only the medical evidence which was available to the physician at the time an admission decision had to be made. They do not take into account other information (e.g., test results) which became available only after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary.*

conditions. The possibility of heart failure and the development of arrhythmia and further pulmonary complications were the main reasons for the physician's determination that the enrollee should be cared for in an inpatient setting. The Council concludes that the preponderance of the evidence of record indicates that, at admission and during the brief inpatient hospital stay, the enrollee required acute inpatient hospital care. The record supports a finding that the beneficiary's medical status and foreseeable adverse consequences, as determined by a physician, were such that acute inpatient care was medically necessary in this instance.

The Council adopts the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

Date: March 15, 2010