

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

Elmwood Health Center

(Appellant)

Hospital Insurance Benefits
(Part A)

(Beneficiary)

(HIC Number)

Pinnacle Business Solutions

(Contractor)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated March 17, 2009, which concerned the appellant's claim for Medicare coverage of skilled nursing facility (SNF) services provided to the beneficiary between March 1, 2008, and March 31, 2008.¹ The ALJ determined that the documentation in the record did not support the appellant's claim for coverage. The ALJ also determined that the appellant was liable for the cost of the non-covered services. The appellant has asked the Medicare Appeals 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 appellant's request for review, and attachments, has been entered into the record as Exhibit (Exh.) MAC-1.

¹ The initial and redetermination decisions identified the dates of service as March 1-31, 2008. In the hearing before the ALJ, one of the appellant's representatives clarified that the dates of the speech therapy services provided during the period at issue were March 11, 2008, through March 24, 2008. Dec. at 8-9; see also Exh. 1 at 11. However, there is no evidence in the record that the appellant seeks to restrict further proceedings to the speech therapy alone.

APPLICABLE LEGAL AUTHORITY

Medicare Part A covers post-hospital skilled nursing facility (SNF) care upon certain conditions. *See, generally,* Section 1861(h) of the Social Security Act (Act); 42 C.F.R. §§ 409.5 and 409.20. Medicare does not cover claims for SNF services "where such expenses are for custodial care." Section 1862(a)(9) of the Act. Medicare also excludes from coverage items and services that are not "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Section 1862(a)(1)(A) of the Act.

Section 1814 of the Act addresses "Conditions and Limitations on *Payment for Services*" (emphasis added). It provides, in relevant part, that payment may be made to providers for covered care only if, in the case of post-hospital extended care services, a physician certifies (and recertifies) that such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care. Section 1814(a)(2)(B) of the Act.

These statutory provisions are restated in Medicare regulations at 42 C.F.R. part 424 - Conditions for Medicare Payment. In pertinent part, those regulations provide that Medicare will pay for post-hospital SNF care when a physician certifies that a beneficiary needs daily skilled nursing or rehabilitation services that, as a practical matter, can only be provided on an inpatient basis in a SNF and the "care was needed for a condition for which the individual received inpatient care in a participating hospital" or the individual was correctly assigned to one of the Resource Utilization Groups (RUGs) designated, pursuant to 42 C.F.R. § 409.30, as representing the required level of care. *See* 42 C.F.R. §§ 424.20(a)(1)(i) and (ii); *see also* Medicare General Information, Eligibility and Entitlement Manual (GIEEM)(Pub. 100-01), Ch. 4, § 40; Medicare Benefit Policy Manual (MBPM)(Pub. 100-02), Ch. 8, § 40.²

The physician certification must be obtained at admission "or as soon thereafter as is reasonable and practicable," with recertifications required within 14 days of admission and every 30 days thereafter. *See* 42 C.F.R. §§ 424.20(b)(1); 424.20(d)(1) and 424.20(d)(2).

² Manuals issued by the Centers for Medicare & Medicaid Services (CMS) can be found at <http://www.cms.hhs.gov/manuals>.

The regulation at 42 C.F.R. § 424.11(b) provides that: "No specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. . . ." Additionally, in relevant part, the MBPM provides: "There is no requirement for a specific procedure or form as long as the approach adopted by the facility permits verification that the certification and recertification requirement is met." MBPM, Ch. 8, § 40. "*Certification or recertification statements may be entered on or included in forms, notes, or other records that a physician . . . normally signs in caring for a patient, or on a separate form.*" *Id.* (Emphasis added.) When a SNF's failure to obtain the required certification is not the result of the medical necessity (or lack of necessity) of the services,³ but is instead the result of the physician's refusal to certify for other reasons, "the SNF cannot charge the beneficiary for covered items or services." *Id.* "The routine admission order established by a physician is not a certification of the necessity for post-hospital extended care services There must be a separate signed statement indicating that the patient will require on a daily basis SNF covered care." *Id.*

Section 1879(a) of the Act provides for the limitation on liability for items or services denied Medicare coverage as not "reasonable and necessary" or as "custodial care" under sections 1862(a)(1)(A), (a)(9) of the Act, absent "knowledge" by a beneficiary or provider that the items or services would not be covered. Section 1879(a); 42 C.F.R. § 411.400(a). A beneficiary has "knowledge" of noncoverage when he or she has been given written notice of noncoverage by the provider, practitioner, or supplier. 42 C.F.R. § 411.404(a). A provider may have knowledge, in relevant part, based on its written notice of noncoverage to the beneficiary or its own experience, actual notice, or constructive notice. 42 C.F.R. § 411.406. CMS has provided further guidance on financial liability protections in its Medicare Claims Processing Manual (Pub. 100-04) at Chapter 30.

³ "If a physician refuses to certify because, in his/her opinion, the patient does not require skilled care on a continuing basis for a condition for which he/she was receiving inpatient hospital services, the services are not covered and the facility can bill the patient directly. The reason for the physician's refusal to make the certification must be documented in the facility records." GIEEM, Ch. 4, § 40.

BACKGROUND

On February 1, 2008, following a qualifying hospital stay, the beneficiary was admitted to the appellant's skilled nursing facility (SNF). There, the beneficiary received physical, occupational and speech therapy. At issue here are the SNF services provided between March 1, 2008, and March 31, 2008, with particular focus on the speech therapy services, which were intended to address swallowing difficulties and related issues.

A copy of the bill is not in the record. The Medicare contractor apparently initially found that the appellant's "documentation did not support the medical necessity for the services" and directed that the appellant's SNF claim be down-coded from Resource Utilization Codes (RUG) that presumptively represented skilled SNF care to those that did not.⁴ Exh. 1 at 1, 16, 20, and 22. Specifically, the contractor down-coded RMA-02 to IB1-02 for March 1, 2008, through March 8, 2008, and allowed CB2-38 as billed from March 9, 2008, through March 31, 2008. IB1-02 is a presumptively unskilled RUG category; CB2-38 is a presumptively skilled RUG category. 70 Fed. Reg. 45026, 45045 (Aug. 4, 2005). Upon redetermination, the contractor upheld its initial down-coding and resulting partial denial, finding that the appellant "did not submit any additional medical records except the request for redetermination with a summary of the therapy services which does not support criteria coverage for the . . . speech therapy." Exh. 1 at 3. The contractor concluded that the "documentation submitted did not support the medical necessity for the skilled nursing and therapy services [from March 1, 2008, through March 8, 2008]. Without the required documentation to establish . . . medical necessity . . . Medicare payment cannot be allowed." The contractor found the appellant liable for the non-covered services. See Exh. 1 at 3 and 11; Dec. at 8-9.

The appellant requested review by a Qualified Independent Contractor (QIC). The QIC denied coverage finding that --

review of the submitted documentation revealed that the required certification was not submitted with a description of the skilled services that were to be provided to the beneficiary. Medicare . . . requires that the physician

⁴ The period at issue encompassed more than one ARD billing period and, thus, each billing period was given a different RUG code.

utilize this certification/re-certification as the document that indicates not only the need for the skilled services, but also a description of the skilled services ordered for the patient.

Exh. 3 at 8. The QIC found the appellant liable for the non-covered services. *Id.* It is unclear whether the QIC intended to deny all services, including those previously allowed by the contractor.

The appellant requested a hearing before an ALJ. On March 10, 2009, the ALJ conducted a hearing, by telephone, at which two representatives of the appellant testified. At several points during the hearing the appellant's representatives and the ALJ discussed whether certain documentation, received by the ALJ with the appellant's request for hearing, constituted duplicate documentation filed at earlier stages of review or new evidence, not previously in the record before the QIC. One of the appellant's representatives recounted that, on more than one occasion, the Medicare contractor had forwarded other claims to the QIC for reconsideration without including all of the documentation the appellant had previously submitted.⁵ In her decision, the ALJ determined that the appellant had not demonstrated good cause for the late submission of this documentation and excluded it as evidence in this case. See ALJ Hearing CD (March 10, 2009); Dec. at 2; see also Rejected Documents Folder, ALJ Appeal No. 1-376146271.

The ALJ also specifically refused to admit into evidence or consider a document identified as "the second page" of the recertification form. The ALJ noted that while the "second page" provided supporting information, as asserted by the appellant, it was created in "December 2008,"⁶ well after the dates of service in issue. Dec. at 9.

⁵ The appellant's representatives also stated that they were engaged in discussions with the Medicare contractor regarding past episodes of "lost" claim documentation. However, in this case, the appellant's representatives could not specifically identify the material it had originally provided to the intermediary. The appellant's representatives also argued that since the intermediary had not based its decision on the absence of documentation, it stood to reason that the "new" evidence at issue had been submitted earlier in the appeals process, and was not a new submission.

⁶ Specifically, December 22, 2008. See Rejected Documents Folder, ALJ Appeal No. 1-376146271 at 171 (FAX pagination).

Following consideration of the evidence, the ALJ found that the appellant had failed to provide any --

- documentation regarding the Beneficiary's prior hospitalization, including the discharge summary;
- documentation regarding the Beneficiary's decline in status, or even an order for the speech therapy services;
- evidence of the services that were actually provided.

See Dec. at 9. Consequently, the ALJ denied the appellant's claim for coverage, determining that she could not "make a determination as to whether the services were so inherently complex that they could only be provided by or under the supervision of a skilled therapist." Dec. at 9. The ALJ also found the appellant liable for the cost of the non-covered services at issue. *Id.* at 9-10. Again, it is unclear whether the ALJ intended to deny all services, including those previously allowed by the contractor.

In its request for review, the appellant notes that the contractor initially denied the therapy services as not medically necessary and downcoded the claim. The appellant asserts that the ALJ erred by excluding from the record what the appellant characterized as "evidence of certification." The appellant again asserts that it had not been notified that the certification form was inadequate prior to the QIC reconsideration decision. The Council assumes that the appellant's reference is to a page entitled Certification and Recertification Forms, submitted with its Request for Review. There are four forms on the page, each signed by a physician and sequentially dated February 2, 9 and 27, 2008, and April 12, 2008. This page is followed by the December 22, 2008 "second page" rejected by the ALJ. The appellant contends that these forms were submitted to Maximus Federal Services and, if read in conjunction with the other evidence in the file, support its argument for coverage. The appellant also argues that it should not be penalized for obtaining a certification timely and then penalized when a subsequent level of appeal considers the certification to be incomplete. Exh. MAC-1 at 1-3. Finally, the appellant contends that the therapy services were skilled, and reasonable and necessary. *Id.*

ANALYSIS

As explained below, physician certification for SNF services is a condition for payment under section 1814 of the Act and 42 C.F.R. part 424, rather than a requirement for coverage under sections 1812 and 1862(a) of the Act and 42 C.F.R. part 409, subpart D. In analyzing a prepayment case such as the one at hand, the adjudicator must first decide if the services are covered. Except in cases involving an overpayment, whether all of the conditions for payment are met is seldom an issue before an ALJ or the Council. See 42 C.F.R. §§ 405.1032 and 405.10446(c). Accordingly, it is an error of law for an ALJ to consider the absence of a certification as precluding a finding of coverage.

Section 1814 of the Act addresses "Conditions and Limitations on Payment for Services" (emphasis added). It provides, in relevant part, that payment may be made to providers for covered care only if, in the case of post-hospital extended care services, a physician certifies (and recertifies) that such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care. Act § 1814(a)(2)(B). The statute's provisions are restated in Medicare regulations at 42 C.F.R. part 424 - Conditions for Medicare Payment. (Emphasis added.) The regulation at 42 C.F.R. § 424.20 describes the content and timing requirements for valid certification.

The Council finds that the ALJ erred in requiring a physician certification as a condition of Medicare coverage in this case. Physician certification is a condition of payment under section 1814 of the Act and 42 C.F.R. part 424, and not an element of coverage. As framed in the initial and review determinations, the issue before the ALJ in this case was not whether a physician certified in writing that this beneficiary needed daily skilled care or was assigned to the correct RUG (42 C.F.R. § 424.20(a)), but whether the therapy services met the coverage criteria for skilled care under the RUG categories billed.⁷ In other words, if the services are otherwise not covered - because they do not meet the coverage requirements in 42 C.F.R. §§

⁷ Even if certification had been at issue, the ALJ erred by looking only at a discrete certification statement, rather than reviewing the medical record as a whole to determine if the requisite elements of certification were present. See 42 C.F.R. §§ 424.11(b) and (c); Medicare Benefit Policy Manual (MBPM), chapter 8, section 40. Appropriate orders for daily skilled care found in progress notes or other parts of the medical record may serve as certification.

409.30 - 409.34, the adjudicator does not reach the issue of whether a physician completed a certification of the need for covered skilled nursing and/or rehabilitation care nor deny "coverage" on that basis.

The Council notes that the courts have recognized the above distinctions between coverage and payment. The United States Court of Appeals for the Second Circuit has ruled in a Medicare Part A SNF case that a physician's certification of the need for medical services is not required to determine coverage of skilled nursing facility services. *Friedman v Secretary of Dept. of Health and Human Services*, 89 Fed. 2d 42 (1987). Rather, the Court found, as the Secretary contended, that coverage and payment are two separate inquiries: first the Secretary determines whether the services involved are covered by Medicare, and, second, if coverage is established, whether the other requirements for payment to the provider have been met. *Id.* at 45.

Keeping the above principles in mind, the Council finds that in this case the ALJ unduly focused on the issue of certification without first analyzing whether the coverage requirements for the SNF services at issue had been met. Although the ALJ listed a number of other defects in the record, her primary focus was the certification issue.

In addition, the Medicare program does not restrict the definition of a "certification" to the completion of a particular form or use of specific language. The physician certification must be obtained at admission "or as soon thereafter as is reasonable and practicable," with recertifications required within 14 days of admission and every 30 days thereafter. 42 C.F.R. § 424.20(d). Recertifications must indicate, in relevant part, "[t]he reasons for the continued need" for SNF care, the estimated time that the beneficiary will need to remain in the SNF, and "[p]lans for home care, if any." 42 C.F.R. § 424.20(c).

However, [t]here is no requirement for a specific procedure or form as long as the approach adopted by the facility permits verification that the certification and recertification requirement is met." MBPM, Ch. 8, § 40. "*Certification or recertification statements may be entered on or included in forms, notes, or other records that a physician. . . normally signs in caring for a patient, or on a separate form.*" *Id.* (emphasis supplied). When a SNF's failure to obtain the

required certification is not the result of the medical necessity (or lack of necessity) of the services,⁸ but is instead the result of the physician's refusal to certify for other reasons, "the SNF cannot charge the beneficiary for covered items or services." Id.

The Council finds that the ALJ erred in not determining whether the skilled nursing facility services furnished to the beneficiary from March 1, 2008, through March 31, 2008, met the Medicare coverage requirements set forth in 42 C.F.R. §§ 409.30 - 409.35. In reaching this conclusion, the Council recognizes that the hearing decision ends with a recitation of other factors the ALJ considered in denying coverage of the SNF services. However, the Council finds that the hearing decision does not deal in any depth with these additional issues or explain why they support denial of coverage. For example, the ALJ states that the appellant failed to provide any documentation regarding the beneficiary's prior hospitalization, including the discharge summary. Dec. at 9. However, the ALJ has not explained why the hospital records were necessary to resolve coverage in this case. No issue was raised below concerning whether the services that beneficiary received during the period at issue were related to her qualifying inpatient hospital stay, and, if not, whether this factor would have affected coverage of the services provided during the dates in question. The ALJ also stated that although the evidence includes weekly therapy notes, the appellant has not provided any evidence that the services were provided. However, because the decision does not describe and comment upon the therapy notes, we cannot determine what level of detail the ALJ considers necessary to establish that the services were provided and medically necessary.

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

⁸ "If a physician refuses to certify because, in his/her opinion, the patient does not require skilled care on a continuing basis for a condition for which he/she was receiving inpatient hospital services, the services are not covered and the facility can bill the patient directly. The reason for the physician's refusal to make the certification must be documented in the facility records." GIEEM, Ch. 4, § 40.

INSTRUCTIONS ON REMAND

On remand,

- The ALJ shall offer the parties an opportunity for a supplemental hearing, the focus of which shall be coverage of the SNF services provided during the period at issue. The ALJ shall clarify the precise scope of the issues for the hearing, including whether the ALJ is revisiting any periods and skilled RUG categories the contractor previously found covered. In addition, the ALJ shall offer to the appellant an opportunity to demonstrate that the excluded documentation had, in fact, been submitted to the Medicare contractor as the appellant contended during the hearing.
- Upon completion of the proceedings, the ALJ shall issue a new decision consistent with this order. Specifically, the ALJ shall consider and make findings concerning whether the skilled nursing and rehabilitation services provided during the period at issue met Medicare coverage requirements.
- The ALJ shall make a decision regarding whether the SNF services at issue are covered by Medicare, as specified in 42 C.F.R. §§ 409.30 - 409.35.
- To the extent that services are not covered as either custodial or not reasonable and necessary, as required by sections 1862(a)(1) and (a)(9) of the Act, the ALJ shall determine any limitation on liability for the non-covered services pursuant to the authority cited herein.

The ALJ may take further action not inconsistent with this order.

MEDICARE APPEALS COUNCIL

/s/ M. Susan Wiley
Administrative Appeals Judge

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: October 30, 2009