DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

ORDER OF MEDICARE APPEALS COUNCIL
REMANDING CASE TO ADMINISTRATIVE LAW JUDGE
Docket Number: M-2010-274

In the case of	**Claim for**
Desert Valley Hospital (Appellant)	Medicare Advantage (MA) Benefits (Part C)
**** (Enrollee)	**** (HIC Number)
Kaiser Foundation Health Plan, Inc. (MA Organization (MAO))	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated September 16, 2009, concerning inpatient hospital services the appellant Desert Valley Hospital (DVH) furnished the enrollee between March 9, 2007, and March 12, 2007. The ALJ found that the enrollee was stable for transfer at the time of inpatient hospital admission to DVH on March 9, 2009, and that the appellant did not secure prior authorization from the MAO prior to furnishing post-stabilization inpatient care to the enrollee. Consequently, the ALJ concluded that the MAO was not responsible for post-stabilization services. The appellant provider has filed a request asking the Medicare Appeals Council to review this decision.

The regulation codified at 42 C.F.R. § 422.608 states that "[t]he regulations under part 405 of this chapter regarding MAC 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 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 actions 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). We hereby vacate the ALJ's decision and remand for further proceedings.

LEGAL STANDARDS

Scope of Benefits

A managed care organization offering a MA plan must provide enrollees with "basic benefits," which are all items and services covered by Medicare Part A and Part B available to beneficiaries residing in the plan's service area. 42 C.F.R. § 422.101(a). A MA plan must comply with national coverage determinations (NCDs), local coverage determinations (LCDs), and general coverage guidelines included in original Medicare manuals and instructions. 42 C.F.R. § 422.101(b). By regulation, NCDs are also binding on ALJs and the Medicare Appeals Council. 42 C.F.R. § 405.1060.

Emergency Services

The MA organization is financially responsible for emergency services provided to evaluate or stabilize an emergency medical condition. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or

- Serious dysfunction of any bodily organ or part.

42 C.F.R. § 42 C.F.R. § 422.113(b)(1)(i).

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.

Id. at 422.113(b)(1)(ii).

Stabilization of an Emergency Medical Condition

The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the MA organization.

Post-stabilization care services means covered services that are:

- Related to an emergency medical condition;
- Provided after an enrollee is stabilized; and
- Provided either to maintain the stabilized condition, or under certain circumstances (see below), to improve or resolve the enrollee's condition.

Id. at 422.113(c)(1).

MA Organization Financial Responsibility

The MA organization is financially responsible for post-stabilization care services obtained within, or outside, the MA organization that:

- Are pre-approved by a plan provider or other MA organization representative;
- Are not pre-approved by a plan provider or other MA Organization representative, but are administered to maintain the enrollee's stabilized condition within one hour of a request to the MA organization for pre-approval of further post-stabilization care;

> • Are not pre-approved by a plan provider or other MA organization representative, but administered to maintain,improve, or resolve the enrollee's stabilized condition if:
>
> > • The MA organization does not respond to a request for pre-approval within one hour;
> > • The MA organization cannot be contacted; or
> > • The MA organization representative and the treating physician cannot reach an agreement concerning the enrollee's care, and a plan physician is not available for consultation. In this situation, the MA organization must give the treating physician the opportunity to consult with a plan physician. The treating physician may continue with care of the patient until a plan physician is reached or one of the criteria below is met.

Id. at 422.113(c)(2).

The MA organization's financial responsibility for post-stabilization care services it has not pre-approved ends when:

> • A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;
> • A plan physician assumes responsibility for the enrollee's care through transfer;
> • An MA organization representative and the treating physician reach an agreement concerning the enrollee's care; or
> • The enrollee is discharged.

Id. at § 422.113(c)(3).[1]

The Medicare Managed Care Manual, Pub. 100-16, chapter 4, section 20, repeats the regulatory criteria, with little sub-regulatory discussion or clarification. However, section 20.4, does add that an enrollee may appeal the determination to be transferred from one inpatient setting to another or to be discharged.

[1] A relevant excerpt from the MAO's Evidence of Coverage is appended to this order.

DISCUSSION

Background

The enrollee presented to the DVH emergency department (ED) for emergency care on March 9, 2007. The enrollee was then admitted to DVH as an inpatient that same day. DVH contacted the MAO on March 12, 2007, to arrange for transfer to a plan facility. The MAO paid for ED care, and the inpatient hospital care that occurred after DVH first notified it on March 12, 2009, of the enrollee's admission. At issue in this case is whether the MAO must pay for care provided after the enrollee was admitted to DVH as an inpatient, but before DVH notified the MAO of the enrollee's admission.[2] This period has been referred to as post-stabilization care in the proceedings below.

The Council has considered the record and appellant's exceptions. Generally, the appellant asserts that the treating physician's opinion on whether the enrollee is stable is binding on the MAO as provided in 42 C.F.R. § 422.113. The appellant further asserts that the ALJ erred in phrasing the issue as whether the MAO was required to cover post-stabilization care, as this improperly assumes that DVH conceded that the enrollee was stable for transfer at the time of inpatient admission to DVH. The DVH asserts that it has established that at the time the enrollee was admitted as an inpatient, the treating physician did not feel that he was sufficiently stable to be transferred or discharged. It further asserts that all care provided after the inpatient admission was further stabilizing care, and not post-stabilization care.

On January 29, 2010, the Council received Kaiser's response to the request for review. Kaiser urges the Council to affirm the ALJ's decision. Specifically, relying on EMTALA [Emergency Medical Treatment and Active Labor Act] definitions of stability and caselaw, it asserts that the enrollee was stable prior to admission as an inpatient, but that DVH failed to contact it timely. Kaiser contends that it is not bound by the treating physician's opinion. Further, Kaiser contends that that opinion

[2] Read literally, the ALJ's decision could be interpreted as finding that Kaiser has no responsibility to pay for any care after admission on March 9, 2009, even though Kaiser has paid for the ED care and the care after DVH notified it on March 12, 2009. Neither party has urged this interpretation on the Council. The ALJ should clarify this issue on remand, if it is material to his decision.

does not make an MAO financially responsible if the treating physician decides that the enrollee is not stabilized, because the MAO, as well as the ALJ, may determine if the treating physician's opinion is reasonable and necessary and supported by the medical record.

The ALJ found that he had the authority to decide whether "a beneficiary was stabilized for transfer at a point in time while at the non-plan hospital even if the treating physician decided that the beneficiary was not so stable." The ALJ found that the enrollee was stable for transfer when admitted to DVH as an inpatient, and that the MAO was not responsible for any subsequent post-stabilization care.

Analysis

We begin our analysis with the Secretary's rulemaking, which interpreted the statute consistent with an express legislative grant of authority. As explained in the final rule for the Medicare + Choice (M+C, now Medicare Advantage) program published in the Federal Register on June 29, 2000, section 1852(d)(2) of the Act gives the Secretary express authority to establish requirements needed to promote the 'efficient and timely coordination of appropriate maintenance and post-stabilization care' (hereafter together referred to as 'post-stabilization care'). Section 1852(d)(1)(C)(iii) of the Act establishes an M+C organization's responsibility to provide reimbursement for these services. Section 1852(d)(1)(E) of the Act states that the M+C organization must provide coverage for emergency services without regard to prior authorization or the emergency care provider's contractual relationship with the organization. 65 Fed. Reg. 40170, 40201.

The rulemaking further recognized that the statute protects the enrollee and the emergency provider from the responsibility of seeking prior authorization from the MAO *until* the enrollee is stable for discharge or transfer. *Id.* at 40200. "Implicit in this requirement is the fact that the [MAO] may not require the provider to call for approval of services prior to the point of stabilization." Id. at 40201. Accordingly, the implementing regulations at 42 C.F.R. § 422.113(b) prohibit an MAO from giving instructions to enrollees to seek prior authorization for emergency or urgently needed services. In addition, the MAO may not give instructions to providers to seek prior authorization from the MAO before an enrollee has been stabilized.

In providing emergency services, the emergency service provider has the authority to establish a plan of care. *Id.* at 40204. The MAO is financially responsible for post-stabilization services until the MAO and the treating physician execute a plan for safe transfer of responsibility, with the needs and condition of the patient as the primary concern. *Id.* at 40203. Ultimately, if, as here, agreement cannot be reached between the emergency provider and the MAO, a dispute over whether the conditions for MAO coverage for post-stabilization care services have been met may be resolved in an appeal by the provider (if the provider agrees not to charge the enrollee.) *Id.*

Because the treating physician in the emergency provider retains responsibility for the plan of care until a transfer of care is accomplished, the regulation at 42 C.F.R. § 422.113(b)(3) establishes a clear rule: "The physician treating the enrollee **must decide when** the enrollee may be considered **stabilized for transfer or discharge**, and **that decision is binding** on the [MAO]." Emphasis added. Consistent with 42 C.F.R. § 422.113(c)(1), the EOC provides: "**When the doctors who are giving you Emergency Care say that your condition is Clinically Stable** and the emergency is over, what happens next is called 'Post-stabilization Care.' Post-stabilization care is the Services you **receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable**." Emphasis added. Despite this unambiguous language, the ALJ found that he had the authority to reach a conclusion contrary to the treating physician's decision on when the enrollee is stabilized for transfer or discharge. This was error. When documented in the contemporaneous medical records, the treating physician's decision with respect to when the enrollee is stabilized for transfer or discharge binds the MAO and adjudicators. By definition, post-stabilization care does not begin until after the treating physician decides when the enrollee is stabilized for transfer or discharge. The MAO is financially responsible for post-stabilization care as provided in 42 C.F.R. § 422.113(c)(2).

However, the extent to which the decisionmaker defers to the treating physician's decision must logically depend in the first place on the physician clearly documenting in the medical record "when the enrollee may be considered stabilized for transfer or discharge." That decision by the treating physician triggers an emergency provider's obligation to notify the MAO. The rulemaking states that it is "clearly in the hospital's best interest to contact the [MAO] as soon as the patient is

stabilized," and that "it is reasonable to expect the emergency provider to contact the [MAO] within an hour of the point at which the member is stabilized." 65 Fed. Reg. 40170, 40201. Thus, we ordinarily expect that the physician's decision would have been documented, if at all, before the time of DVH's first contact with the MAO to arrange for a transfer of care. If that decision was not documented, however, then it is reasonable for the ALJ to examine the record and reach an independent conclusion on when the patient was stabilized in light of all the facts and circumstances.

In this case, the ALJ never reached a conclusion on whether the treating physician documented "when the enrollee [was] considered stabilized for transfer or discharge." Given the language of the regulation, it does not appear that mere notations in the medical record that the enrollee was stable would be a substitute for an explicit decision by the treating physician as to "when the enrollee may be considered stabilized for transfer or discharge." Nor does contact by DVH with the MAO substitute for documentation of the treating physician's decision.

The ALJ concluded that because the enrollee had been transferred from the ED to an inpatient status, the transfer was an indication that the enrollees' medical conditions had stabilized. However, the Secretary's rulemaking only provides limited instances in which an inpatient admission is, by itself, deemed to represent a patient's stabilization. 69 Fed. Reg. 46866, 46885 (Aug. 3, 2004). Only for purposes of cost-sharing imposed by the MAO on the enrollee do post-stabilization services begin upon inpatient admission. 42 C.F.R. § 422.113(c)(2)(iv). Similarly, for purposes of the conditions of participation, EMTALA requirements end on inpatient admission.[3] Further, CMS did not incorporate the EMTALA test of stability in the MA regulations at 42 C.F.R. § 422.113, and any case law concerning EMTALA is not on point. Thus, inpatient admission from an ED is not deemed as evidence of stabilization for purposes of post-stabilization care. 69 Fed. Reg. 46866,

[3] Medicare policy states broadly that "The Conditions of Participation (COP) requirements cannot be used as a basis for denying payment. The COPs define specific quality standards that providers must meet to participate in the Medicare program. A provider's compliance with the COPs is determined by the regional office (RO) based on the State survey agency recommendation." Medicare Program Integrity Manual, Pub. 100-08, ch. 3, § 3.4.2.1, Role of Conditions of Participation Requirements When Making a Payment Decision.

46885. Rather, the *sine qua non* under 42 C.F.R. § 422.113 is whether the enrollee is stable for transfer or discharge.

The Council therefore remands this case to the ALJ for further consideration and a new decision. The ALJ shall clarify whether Kaiser is responsible for services after DVH notified it of the enrollee's admission, if material.

In addition, the ALJ's decision states both that Exhibit 22 was admitted into the record, and that Exhibit 22 was not admitted into the record. Dec. at 2. The precise content of the record is therefore unclear. The ALJ shall also clarify the status of Exhibit 22.

The ALJ may take any other action that is not inconsistent with this remand order. *See* 42 C.F.R. § 405.1126(b).

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/ Leslie Weyn
Appeals Officer

Date: February 16, 2010