DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
Elmhurst Care Center (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiary)	**** (HIC Number)
National Government Services, Inc. (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated June 3, 2009, which concerned the Resource Utilization Group (RUG) III reimbursement level for services the appellant skilled nursing facility (SNF) furnished to the beneficiary from February 1, 2008, through February 14, 2008. The ALJ determined that the RUG-III level of "RHC," applied by the contractor, is correct. The ALJ further found that the appellant is liable for the noncovered 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 will be made a part of the record as Exhibit (Exh.) MAC-1.

As explained below, the Council modifies the ALJ's decision, concurring that the beneficiary's SNF stay was correctly coded at the RUG-III level of RHC, but for different reasons than the ALJ stated.

Background and Procedural History

The appellant provided SNF services to the beneficiary from January 18, 2008, through February 14, 2008, after a sixteen-day hospitalization for fever and weakness caused by urosepsis. Dec. at 2; Exh. 9 at 189. Using the Prospective Payment System (PPS), the SNF billed Medicare for the February 1 to February 14, 2008 portion of the beneficiary's SNF care at the RUG-III level of "RML." Exh. 11 at 196, 197.[1] The contractor denied reimbursement at the RML level, because it found no evidence of extensive nursing services (specifically intravenous (IV) medications) in the file. *Id.* Instead, on redetermination the contractor approved payment at the RHC level. Exh. 11 at 198-201.

On reconsideration, the Qualified Independent Contractor (QIC) also found that the documentation did not support that extensive nursing services (IV medications) were received during the look back period (of January 15, 2008 through January 28, 2008). Exh. 14 at 232-35. As the QIC explained, the medical record did not include acute hospital medication administration records or physician orders to support that the beneficiary received IV medication during the 14-day look back period. *Id.* at 233. The QIC also stated that the RHC level of coding was correct, and the appellant was liable for noncovered costs. *Id.* at 232-33.

The appellant requested and received an ALJ hearing. The ALJ decided that the beneficiary's SNF stay was correctly coded at the RUG-III level of RHC, for three related reasons. First, the ALJ quoted from an online posting by a healthcare consulting company stating that including pre-SNF admission services (received in the hospital), when they have occurred in a 14-day look back period, could result in overpayments to SNFs. Dec. at 8. Second, the ALJ stated that allowing the SNF to set an assessment reference date of the eleventh day of the beneficiary's SNF stay, and to then use a 14-day look back period to include hospital services, is not consistent with the purpose and intent of the MDS (Minimum Data Set) system and Medicare's Prospective Payment System (PPS). *Id.* at 9. Third, the ALJ required that the assessment reference date be set as

[1] The Prospective Payment System, and specifically the Medicare Assessment Schedule, including assessment reference dates, look back periods, and applicable Medicare payment days, is explained in the Interim Final Rule, 63 Fed. Reg. 26,252, 26,267 (May 12, 1998), and the Final Rule, 64 Fed. Reg. 41,644 (July 30, 1999). *See also* CMS, Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0 (December 2002, Revised December 2008) at 2-1, 2-4, and 2-5.

January 31, 2008 (the fourteenth day the beneficiary was in the SNF), rather than January 28, 2008 (the eleventh day) which the SNF had selected --- in order to prevent the SNF from using hospital services as part of the basis for setting a RUG-III level. *Id.*

Appellant's Contentions

The appellant contends that it validly set the beneficiary's assessment reference date (ARD) on the eleventh day of her SNF stay, and that therefore the pertinent look back period is January 15, 2008, through January 28, 2008. Exh. MAC-1. The appellant also contends that the beneficiary received IV medication in the hospital on January 17, 2008, because a transfer form in the file says her medicines were changed to include Augmentin (orally) on that date, and because the ALJ acknowledged that the beneficiary last received IV antibiotics on January 17, 2008. *Id.; see also* Dec. at 9.

The Council has evaluated the record and both of these contentions. The Council concludes that legally the Prospective Payment System allows the appellant to perform the 14-Day Medicare MDS Assessment on the eleventh day of the beneficiary's SNF stay, designate the eleventh day as an ARD, and establish a look back period of fourteen days from that date, thereby including three days of hospital services in the look back period. However, the Council also finds that the record in this case does not contain sufficient documentation to establish whether or not the beneficiary received IV medication during those last three days of her hospitalization. The reasons for these determinations are explained below.

1. The Prospective Payment System requires a 14-Day Medicare MDS Assessment by the fourteenth day, and allows the SNF to select an assessment date (ARD) from the eleventh to the fourteenth day.

The Medicare Prospective Payment System (PPS) for skilled nursing facilities was established by the Balanced Budget Act of 1997, and first implemented in an Interim Final Rule, and then a Final Rule. 63 Fed. Reg. 26,252 (May 12, 1998); 64 Fed. Reg. 41,644 (July 30, 1999). The PPS provides for the day of the beneficiary's SNF admission to be counted as Day 1, and requires that the "14-Day Medicare MDS (Minimum Data Set) Assessment" be

performed between the eleventh and the fourteenth day. 64 Fed. Reg. 41,668. On this basis, the SNF can designate an assessment reference date (ARD) from the eleventh to the fourteenth day, depending on when it performs the 14-Day Medicare MDS Assessment. *Id.* In this case, the SNF performed the assessment on the eleventh day, making that day the assessment reference date. *See* Exh. 7 at 150.

2. Because the Prospective Payment System allows the appellant to designate the patient's eleventh day in the SNF (January 28) as the assessment reference date, this establishes a look back period of January 15 to January 28, 2008, which includes three days in the hospital.

The ALJ was correct that under the Prospective Payment System, because the current version of the Minimum Data Set Assessment Tracking Form (MDS 2.0) asks for information on some of the patient's medical needs within the last two weeks, the result may be payment for patient needs that no longer existed once the patient entered the skilled nursing facility. Dec. at 8-9. However, CMS specifically noted this issue in 2005, and explained that it was not going to alter the Prospective Payment System to address it. In the preamble to the Final Rule for the FY 2006 Prospective Payment System, CMS explained:

> In the FY 2006 SNF PPS proposed rule, we invited public comment on possible changes in MDS coding requirements, such as decreasing the length of the "look-back" period (to restrict coding of certain high intensity services to those actually received in the SNF). . ..
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> *Comment:* We . . . received numerous comments on the change in the MDS assessment "look back" period to restrict MDS reporting to services furnished in the SNF rather than during the preceding hospital stay. While some commenters supported the change in terms of SNF reimbursement policy, most commenters believed there were strong care planning reasons for retaining the current policy. Specifically, the commenters were concerned that facility staff would be unable to perform an accurate assessment of the resident, and that the elimination of the data would result in an underestimate of resource needs and negatively affect the development of an individualized care plan. A number of commenters also recommended that the type of changes discussed in the proposed rule needed to be coordinated

> with other CMS initiatives, including the development of MDS 3.0 and the upcoming STM study.
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> *Response:* After reviewing the comments, we agree that the changes discussed above should be addressed as part of a comprehensive examination of both the MDS 3.0 design initiative and the case-mix classification system. Therefore, we will not implement changes at this time, but will continue to study these and other issues during the upcoming STM study and MDS 3.0 design initiative.

Final Rule, 70 Fed. Reg. 45,026, 45,035 (Aug. 4, 2005) (emphasis added).

Therefore, the appellant is correct that when it designated the eleventh day of the beneficiary's SNF stay as an assessment reference date, it established a look back period of two weeks prior to that day, including the last three days of the beneficiary's hospitalization. However, for the reasons explained below, in this case the appellant has not provided sufficient documentation that the beneficiary received intravenous medication in the hospital on those three days to warrant a RUG-III coding of RML.

3. The appellant has not demonstrated that the beneficiary received IV medications during the look back period (from January 15, 2008, through January 28, 2008).

The appellant seeks to rely on the beneficiary's hospital care, specifically her receipt of an IV antibiotic (Rocephin) in the hospital, in order to establish the higher RML RUG-III coding and payment level during her SNF stay. Therefore, it is incumbent upon the appellant to submit records sufficient to document the beneficiary's receipt of IV medication in the hospital, and to demonstrate that this occurred during the look back period. *See* Section 1833(e) of the Act; 42 C.F.R. § 424.5(a)(6).

The appellant has not submitted hospital records. It relies solely on one Interagency Referral/Patient Transfer form that says the beneficiary began taking Augmentin (an oral antibiotic) on January 17, 2008. Exh. 9 at 189 (front). That form also states that the beneficiary's medication was changed to Rocephin "since 1/10/2008." *Id.* (back). A separate form, the New York State Dept. of Health Hospital and Community Patient Review

Instrument, states that the beneficiary started Augmentin on January 16, 2008. Exh. 1 at 8, 11. From this limited (and inconsistent) information, the appellant asks us to infer that the beneficiary continued with the IV administration of Rocephin until the date on which she started taking Augmentin. CD Recording of ALJ Hearing, June 2, 2009. However, the documentation submitted does not state that this occurred, and it does not state when the beneficiary was still taking Rocephin (intravenously) and when she stopped taking it. As a result, there is no clear documentation that she was taking IV antibiotics on January 15, 16, or 17, 2008.

The lack of documentation here is significant. If the appellant considered the beneficiary's hospital medication history a potentially significant factor in her needs for medical care at the SNF, then it should have obtained the relevant records (i.e., either the doctor's orders or the hospital's medication administration records). Without these records, physicians and other staff members at the SNF could not make informed judgments about the beneficiary's needs and medical care. In addition, without submitting these records to Medicare, the appellant cannot document that the beneficiary actually received IV medication at the hospital during the look back period. The QIC's reconsideration is explicit on this point: "The medical record did not include acute hospital medication administration records or physician orders to support that the beneficiary received IV medications during the 14-day look back period." Exh. 14 at 233.

Therefore, the RUG-III coding at the RHC level is correct, and the appellant's request for coding at the RML level must be denied. The appellant is liable for the noncovered costs.

DECISION

The Council modifies the ALJ's decision, concurring that the beneficiary's SNF stay was correctly coded at the RUG-III level of RHC, because the look back period could include three days during the beneficiary's hospital stay, but the appellant failed to submit documentation of the beneficiary's receipt of IV

medication during those three days. The appellant is liable for the noncovered costs.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: October 16, 2009