DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

**DECISION OF MEDICARE APPEALS COUNCIL**
**Docket Number: M-12-1062**

| **In the case of** | **Claim for** |
|---|---|
| Comprehab Wellness Group (Appellant) | Supplementary Medical Insurance Benefits (Part B) |
| **** (Beneficiary) | **** (HIC Number) |
| First Coast Service Options, Inc. (Contractor) | **** (ALJ Appeal Number) |

The Medicare Appeals Council has decided, on its own motion, to review the Administrative Law Judge's (ALJ's) decision dated February 6, 2012, because there is an error of law material to the outcome of the claim. *See* 42 C.F.R. § 405.1110. The ALJ's decision concerned a claim for comprehensive outpatient rehabilitation facility (CORF) services the appellant furnished to the beneficiary from February 3, 2010 through February 26, 2010. The ALJ issued a fully favorable, on-the-record decision in which he determined that Medicare would cover and pay for the CORF services furnished to the beneficiary.

By a memorandum dated March 28, 2012, the Centers for Medicare & Medicaid Services (CMS) requested that the Council review the ALJ's decision on its own motion. The CMS memorandum is hereby entered into the record in this case as Exhibit (Exh.) MAC-1. The Council has received no response to the CMS memorandum from the appellant.

The Council has carefully considered the record that was before the ALJ, as well as the CMS memorandum of March 28, 2012. For the reasons explained below, the Council hereby vacates the

ALJ's decision and remands this case to an ALJ for further proceedings, including a new decision. *See* 42 C.F.R. § 405.1110(d). This remand is necessary, in part, because there is no indication that the appellant waived its right to a hearing before an ALJ. *See* Exh. 1, at 1-3.

## BACKGROUND

The appellant furnished CORF services (specifically, occupational therapy) to the beneficiary from February 3, 2010 through February 26, 2010. The Medicare contractor initially denied Medicare coverage and reimbursement for the services and the appellant requested redetermination. The contractor affirmed the denial of coverage on redetermination, finding that the medical record did not support the need for ongoing therapy services, and that the services constituted a maintenance/conditioning program. Exh. 1, at 21-25. The appellant sought review by a Qualified Independent Contractor (QIC). The QIC denied coverage, finding that the services were not properly documented. The QIC cited the Medicare Benefit Policy Manual (MBPM), (Pub. 100-02) at chapter 12, section 30.E, among other sections, as authority for its conclusion that the CORF services were not covered because the beneficiary's plan of care had not been established by a physician or signed by a physician prior to the beginning of treatment. Exh. 1, at 4-8.

The appellant requested hearings before an ALJ. Exh. 1, at 1-3. The ALJ issued a "fully favorable" decision. *See* ALJ Dec. The ALJ found that the appellant's documentation was adequate to support Medicare coverage and payment for CORF services. Specifically, the ALJ determined that the QIC's interpretation of MBPM, chapter 12, section 30.E was "too strict" and that "the physician established and signed the relevant outpatient treatment plans and … any deficiencies in the establishment of the plan of treatment were clearly remedied prior to the dates of service" based on the physician's involvement in ordering the therapy evaluation, specifying the diagnosis, and reviewing and certifying plans of treatment. ALJ Dec. at 6.

CMS referred the case to the Council for possible review on its own motion. *See* Exh. MAC-1. In the referral memorandum, CMS asserts that the ALJ erred by failing to apply correctly the regulations governing CORF plans of treatment. Exh. MAC-1, at 2. CMS argues that the applicable regulations require that a CORF plan of treatment (POT) be established and signed by a

physician before CORF treatment is begun. *Id.* CMS argues that the POT covering January 22, 2010 through February 26, 2010 did not contain the appropriate timely signatures. Rather, the treating therapist did not date his or her signature, and the treating physician did not sign the POT until April 12, 2010, six weeks after the services at issue were furnished.

## APPLICABLE LEGAL AUTHORITY

The regulations, at 42 C.F.R. § 410.105, set forth the following requirements, among others, for coverage of CORF services:

> (a) *Referral and medical history.* The services must be furnished to an individual who is referred by a physician who certifies that the individual needs skilled rehabilitation services, and makes the following information available to the CORF before or at the time treatment is begun:
> (1) The individual's significant medical history.
> (2) Current medical findings.
> (3) Diagnosis(es) and contraindications to any treatment modality.
> (4) Rehabilitation goals, if determined.
>
> * * *
>
> (c) *Plan of treatment.* (1) The service must be furnished under a written plan of treatment that—
> (i) **Is established and signed by a physician before treatment is begun**; and
> (ii) Prescribes the type, amount, frequency, and duration of the services to be furnished, and indicates the diagnosis and anticipated rehabilitation goals.

*Id.* (emphasis added).

The MBPM, chapter 12, section 30.E, provides:

> The CORF services must be furnished under a written rehabilitation plan of treatment established and signed by a physician who has recently evaluated the patient. It is expected that the physician will establish the rehabilitation plan of treatment in consultation with the physical therapist, occupational

> therapist or speech-language pathologist who will provide the actual therapy. The physician wholly establishes the respiratory therapy plan of treatment. The physician may be either a CORF physician or the patient's referring physician if the physician provides a detailed rehabilitation plan of treatment that meets the following requirements.
>
> **The rehabilitation plan of treatment must be established and signed by a physician prior to the commencement of treatment in the CORF setting** and contain the diagnosis, the type, amount, frequency, and duration of skilled rehabilitation services to be performed, and the anticipated skilled rehabilitation goals.

*Id.* (emphasis added).

**DISCUSSION**

The Council finds that remand is necessary because, on the present record, the ALJ erred in applying the regulations governing Medicare coverage of CORF services. Remand is also required to afford the appellant the opportunity for a hearing.

As noted above, CORF services must be provided pursuant to a written POT "established and signed by a physician before treatment is begun." 42 C.F.R. § 410.105(c)(1)(i); *see also* MBPM, Ch. 12, § 30.E. As pertinent here, the regulation establishes three requirements for the POT: 1) it must be *established* by a physician; 2) it must be *signed* by a physician; and 3) both establishment and signature must occur *before treatment begins*. ALJs and the Council are bound by all Medicare regulations. 42 C.F.R. § 405.1063. Further, as the ALJ acknowledged, ALJs and the Council must give "substantial deference" to CMS guidance. *Id.* *See* Dec. at 3-4. Thus, the ALJ may only find that CORF services are covered if all three criteria specified in 42 C.F.R. § 410.105(c)(1)(i) are present.

The primary issue raised by CMS in the referral memorandum relates to the third criterion: whether the beneficiary's treating physician established and signed the POT before CORF treatment began. CMS argues that, because the physician's signature was dated approximately six weeks after the CORF services at issue ended, it is not possible to conclude that the

POT was signed before the appellant began furnishing CORF treatment to the beneficiary. Exh. MAC-1, at 8.

The Council has reviewed the record in this case and has verified that the treating physician, in fact, signed the beneficiary's POT several weeks after the CORF services were rendered. Therefore, the Council agrees that the POT was not signed by the physician before the appellant began furnishing CORF treatment to the beneficiary. Providers and suppliers have the burden to prove that they are entitled to Medicare payment. *See, e.g.,* Social Security Act (Act), section 1833(e); 42 C.F.R. § 424.5(a)(6). A provider or supplier must establish that the facts support its entitlement to Medicare payment. The supplier in this case has not met that burden based on the binding regulations and interpretive manual sections pertinent to CORF services.

Based on these findings, we find that the ALJ erred in ordering Medicare reimbursement for the CORF services at issue because the services were furnished before the beneficiary's POT was signed by a physician.

## INSTRUCTIONS ON REMAND

As noted above, the ALJ issued a fully favorable decision on the record. In doing so, the ALJ complied with the regulation at 42 C.F.R. § 405.1038(a). However, the Council finds that the ALJ erred in his application of the provisions 42 C.F.R. § 410.105(c)(1)(i). Further, we find no indication in the record before us that the appellant waived its right to appear before the ALJ. *See, e.g.,* T.C. Exh. 1, at 1-3. Accordingly, remand is necessary to provide the appellant an opportunity for a hearing.

On remand, the ALJ shall—

1. Offer the opportunity for a hearing, providing notice to the parties (the appellant and the beneficiary), in accordance with 42 C.F.R. § 405.1022.

2. Issue a decision applying all elements of 42 C.F.R. § 410.105(c)(1)(i).

3. If the ALJ determines that any or all of the CORF services are not covered by Medicare, the ALJ will then address the

liability of the appellant and the beneficiaries under section 1879 of the Act.

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

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

/s/Constance B. Tobias, Chair
Departmental Appeals Board

Date: May 17, 2012