DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-13-04

In the case of	**Claim for**
Brittany Farms Health Center	Hospital Insurance Benefits (Part A)
(Appellant)	
****	****
(Beneficiary)	(HIC Number)
National Government Services	****
(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 August 2, 2012, because there are errors of law material to the outcome of the claim. In that decision, the ALJ found that skilled nursing facility (SNF) services the provider furnished to the beneficiary from October 22, 2010, through October 27, 2010 were not medically reasonable and necessary under section 1862(a)(1) of the Social Security Act, and did not meet the conditions and limitations of payment pursuant to section 1814(a)(2)(B) of the Act. The ALJ found that the provider furnished valid advance notice to the beneficiary of non-coverage, and that the provider was not liable under section 1879.

By memorandum dated September 27, 2012, and received October 1, 2012, the Centers for Medicare & Medicaid Services (CMS) asked the Council to take own motion review of the ALJ's decision. The Council admits CMS's referral memorandum into the record as Exhibit (Exh.) MAC-1. The Council has not received a response to the CMS referral memorandum from either the provider or the beneficiary. *See* 42 C.F.R. § 405.1110(b)(2).

The Council has carefully considered the record that was before the ALJ, as well as the CMS memorandum. For the reasons

explained below, the Council is issuing a decision favorable to the beneficiary.[1] *See* 42 C.F.R. § 405.1110(d). However, the beneficiary may instead request that the Council remand for a hearing within 30 days from the date of notice of this decision. *Cf.*, 42 C.F.R. § 404.1038(a)(an ALJ may issue a favorable decision on the record offering the opportunity for a hearing).

BACKGROUND

This matter involves SNF services the appellant provider furnished to the beneficiary from October 22, 2010, through October 27, 2010. Exh. MAC-1, at 1. The contractor, National Government Services (NGS), denied Medicare coverage initially and on redetermination. Exh. 16, at 1. In the redetermination, the contractor stated that the claim would remain denied because the services provided were non-skilled. *Id.* at 2. The contractor further determined that the provider was liable for the cost of the non-covered services. *Id.* at 2-3.

On reconsideration, the Qualified Independent Contractor (QIC) similarly concluded that the services were not covered by Medicare. Exh. 17, at 1-3. The QIC also concluded that the record did not contain certification for SNF services and, absent such documentation, "Medicare cannot make payment on the claim." *Id.* at 2b.[2] The QIC acknowledged the presence of an Advance Beneficiary Notice (ABN) in the record. *Id.* However, the QIC determined the ABN to be invalid. The QIC stated:

> In order to be valid a [SNFABN] must have one, but not both, option box checked by the beneficiary [or] authorized representative . . .
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> . . . [the ABN] submitted did not have either option box checked. Therefore, the notice was invalid. Additionally, in this case the denial was due to the provider's failure to submit complete documentation, including a certification for SNF services. The beneficiary could not have been expected to know that the provider would fail to submit complete

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[1] CMS does not specifically contest the ALJ's determination of non-coverage of the SNF services. Therefore, the issue of non-coverage is not before the Council.

[2] Any record citation referencing a "b" designation denotes the back side of a two-sided document in which the back side has not been assigned a separate page designation at the lower level of appeal.

> documentation. Thus, even if the [ABN] submitted was valid, the beneficiary would not be liable for these noncovered charges.

Id. at 2b. Therefore, the QIC found the appellant liable. *Id.* at 2b-3.

The appellant requested a hearing before an ALJ. The record does not document that the ALJ notified the beneficiary of the hearing. *See* Exh. 19. The ALJ held a hearing on June 12, 2012. Hearing CD. The appellant's representative appeared and provided testimony. *Id.* On August 2, 2012, the ALJ issued his hearing decision in which he found that:

> The undersigned reviewed the testimony of the Appellant's representative, . . . that willful inattention to instructions directed to the beneficiary in a telephonic notice as to filling out an ABN constituted constructive notice and a proper factual predicate for waiver of liability pursuant to Social Security Act Section 1879 . . .
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> . . . the Appellant did not meet the conditions and limitations of payment pursuant to § 1814(a)(2)(B) of the [Act], at the skilled level of care for post-hospital services rendered and as billed to the Appellant for dates of service of October 22 to October 27, 2011. The services are properly excluded from coverage pursuant to § 1862(a) of the [Act], as they are not medically reasonable and necessary.

Dec. at 5. The ALJ found, in effect, that the beneficiary was liable for the non-covered services, and that the provider was not liable.

CMS filed a referral memorandum for the Council's own motion review, dated September 27, 2012, and received by the Council on October 1, 2012. Exh. MAC-1. In the memorandum, CMS argues that the ALJ's decision is erroneous as a matter of law in five respects:

> 1. The ALJ erred by failing to issue a notice of hearing to the beneficiary, in violation of 42 C.F.R. §§ 405.1008 and 405.1022.

> 2. The ALJ erred in failing to provide the beneficiary with notice of the ALJ's decision pursuant to section 405.1046(a) of Title 42 of the C.F.R.
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> 3. The ALJ erred in applying section 1879 of the Act to limit appellant's liability. *See* 42 C.F.R. § 405.1063(a). The ALJ failed to consider section 411.406(e) of Title 42 of the CFR, stating providers participating in Medicare have constructive knowledge of the Act, the C.F.R., and program guidance published by CMS and its contractors.
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> 4. The ALJ erred in finding appellant furnished the beneficiary with sufficient notice of non-coverage. The ALJ failed to consider sections 40.3.1.2 and 70.5 of chapter 30 of the Medicare Claims Processing Manual which require an ABN of Medicare non-coverage to be furnished in advance of the service.
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> 5. The ALJ erred in failing to consider whether section 1879 of the Act was applicable to limit the beneficiary's liability in this case in light of appellant's failure to furnish the beneficiary prior notice of Medicare non-coverage for SNF services furnished from October 22, 2010, until October 27, 2010.

Exh. MAC-1, at 1-2.

DISCUSSION

Proper Notice of Proceedings and Actions at the ALJ Level of Review

The beneficiary was a party to the proceedings at the ALJ level, even if she had not been the party that requested a redetermination, reconsideration, and ALJ hearing. *See* 42 C.F.R. §§ 405.902; 405.906(a),(b). Therefore, in addition to the appellant, the ALJ should have notified the beneficiary of any proceedings at the ALJ level. Further, the regulations at 42 C.F.R. § 405.1046(a) require that, among other things, "the ALJ will issue a written decision that gives the findings of fact, conclusions of law, and the reasons for the decision . . . [t]he ALJ mails a copy of the decision to all the parties at their last known address, to the QIC that issued the

reconsideration determination, and to the contractor that issued the initial determination."

In this case, the record lacks documentation that the beneficiary was afforded the opportunity to fully participate in the proceedings at issue. Specifically, the record lacks any documentation indicating that:

a) The beneficiary acknowledged receipt of the ALJ's Notice of Hearing and her intent to participate in the proceedings, or that the Office of Medicare Hearings and Appeals (OMHA) contacted the appellant for an explanation regarding its failure to acknowledge receipt of the Notice of Hearing. *See* 42 C.F.R. § 405.1020(c)(1).

b) The beneficiary indicated in writing that she did not wish to participate in an ALJ hearing.[3] *See* 42 C.F.R. § 405.1020(d).

c) The beneficiary was provided with Notice of the ALJ's Decision. *See* 42 C.F.R. § 405.1046(a).

In sum, it is not possible to ascertain from the record in this case that, during the ALJ proceedings, the ALJ afforded the beneficiary the due-process based procedural protections required by the Medicare regulations. This was an error of law.

Liability

The provider has not contested non-coverage of the SNF services from October 22, 2010, through October 27, 2010. The request for hearing instead only asserts that the beneficiary is liable, based on telephone and written notice given on October 25, 2010, that the services would be non-covered effective October 28, 2010. Exh. 18 at 19.

Section 1879 of the Act may limit the liability of a beneficiary or a supplier or provider for non-covered items or services based upon whether they had prior knowledge of non-coverage. Section 1879 of the Act; 42 C.F.R. §§ 411.400(a), 411.404, 411.406. A beneficiary is deemed to have knowledge of non-coverage if the supplier or provider furnishes written notice to the beneficiary explaining why it believes that Medicare will not cover the item or service, before the services are

[3] At the outset of the hearing, the ALJ states only that the beneficiary is not taking part in this hearing. Hearing CD at 9:33:40-50.

furnished. 42 C.F.R. §§ 411.400, 411.404(b). A supplier or provider is deemed to have knowledge of non-coverage, in part, when it informs the beneficiary before furnishing the item or service that it is not covered. 42 C.F.R. § 411.406(d)(1). A supplier or provider also has actual or constructive knowledge of non-coverage based upon "[i]ts receipt of CMS notices, including manual issuances, bulletins, or other written guides or directives from [Medicare contractors]" and "[i]ts knowledge of what are considered acceptable standards of practice by the local medical community." 42 C.F.R. §§ 411.406(e)(1),(3).

CMS program guidance provides:

> The purpose of the ABN is to inform a Medicare beneficiary before he or she receives specified items or services that otherwise might be paid for that Medicare certainly or probably will not pay for them on that particular occasion. The ABN, also, allows the beneficiary to make an informed consumer decision whether or not to receive the items or services for which he or she may have to pay out of pocket.
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> The provider . . . must issue an ABN each time, and as soon as, it makes the assessment that Medicare payment certainly or probably will not be made. A provider . . . shall notify a beneficiary by means of timely (as defined in § 40.3.3) and effective (as defined in § 40.3.4) delivery of a proper notice document (as defined in § 40.3.1) to a qualified recipient.

Medicare Claims Processing Manual (MCPM), CMS Pub. 100-04, Ch. 30, § 40.3. The MCPM also indicates that, among things, a valid ABN must provide the date on which non-coverage of services commences, as well as contain sufficient reason why the provider why the appellant believes the services will not be covered by Medicare. *Id.* at §§ 40.3, 40.3.8.

Further, other pertinent manual guidance provides:

> The contractor will not consider a telephone notice to a beneficiary, or authorized representative, to be sufficient evidence of proper notice for limiting any potential liability, <u>unless the content of the telephone contact can be verified and is not disputed by the beneficiary</u>. If telephone notice was followed up immediately with a mailed notice . . . and the

> beneficiary signed the written notice accepting responsibility for payment, the contractor will accept the time of the telephone notice as the time of ABN delivery.

MCPM, Ch. 30, § 40.3.4.2 (emphasis added).[4]

In this case, the ABN at issue states "[t]he effective date of your current skilled nursing services will end: 10/27/10."[5] Exh. 14, at 55. In addition, a letter from the appellant dated October 25, 2010, and addressed to the beneficiary's representative, indicates that the SNF services provided to the beneficiary will cease to be covered by Medicare as of October 28, 2010. *Id.* at 52. Neither the ABN nor the October 25, 2010, letter from the appellant address termination of coverage for SNF services provided between October 22 and 27, 2010. Therefore, the Council finds no evidence that the beneficiary was adequately informed of the probability of Medicare non-coverage of SNF services from October 22, 2010, through October 27, 2010, before the services were furnished.

The ALJ further held that the provider was not liable under section 1879 because "it could not have reasonably known or been on notice of Medicare's requirements for payment for rehabilitative services ordered." Dec. at 5. This is an error of law. Under the regulations at 42 C.F.R. § 411.408, the provider is presumed to have constructive notice of Medicare policies published in the Federal Register or included in CMS and contractor notices. The provider is thus liable under section 1879 of the Act.

In addition, the QIC found that the provider did not obtain valid physician certifications. Exh. 17. Section 1814 of the Act is captioned "Requirement of Requests and Certifications." Subsection 1814(a)(2)(B), which the ALJ also cited as a denial basis, contains the requirements for physician certification. The appellant has not filed any exceptions asserting that it had a valid physician certification. As part of its provider agreement, the regulation at 42 C.F.R. § 489.21(b)(1) states that the provider agrees not to charge the beneficiary for otherwise covered services for which it lacks the required

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[4] Manuals issued by the Centers for Medicare and Medicaid Services (CMS) can be found at http://www.cms.gov/manuals.

[5] The ABN is unsigned by either the beneficiary or her representative. The ALJ deprived the beneficiary of the opportunity to either verify or contest notice by not joining her as a party to the hearing.

physician certification. Thus, even if the services were covered, the provider would not be able to bill the beneficiary unless it had a valid physician certification.

DECISION

It is the decision of the Medicare Appeals Council that the services from October 22, 2010, through October 27, 2010, are not medically reasonable and necessary and thus not covered under section 1862(a)(1) of the Act. The beneficiary is not liable under section 1879. The provider is liable under section 1879. The ALJ’s decision is reversed.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/ Leslie A. Sussan, Member
Departmental Appeals Board

Date: December 28, 2012