

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-12-872

In the case of

Indiana University Health
Methodist Hospital

(Appellant)

Claim for

Hospital Insurance Benefits
(Part A)

(Beneficiary)

(HIC Number)

National Government Services

(Contractor)

(ALJ Appeal Number)

On November 16, 2011, the Administrative Law Judge (ALJ) issued a decision concerning coverage for inpatient hospital services provided by the appellant to the beneficiary from September 7, 2009, to September 8, 2009. The ALJ determined that the record did not support a finding that an inpatient level of care was medically reasonable and necessary under section 1862(a)(1) of the Social Security Act (Act). The ALJ further determined that the appellant was liable for the non-covered costs and was deemed at fault for the overpayment, and not eligible for waiver of recovery pursuant to section 1870(b) of the Act. The appellant has asked the Medicare Appeals Council (Council) to review this action. The Council enters the appellant's request for review into the record as Exhibit (Exh.) MAC-1.

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 Council concurs with the ALJ's overall conclusions, but modifies the ALJ's decision to provide supplemental analysis.

BACKGROUND

The appellant billed the Medicare contractor, National Government Services, Inc. (NGS), for inpatient hospital services provided to the beneficiary from September 7, 2009, to September 8, 2009. Initially, NGS allowed payment for the services. On December 7, 2010, CGI Federal, a Recovery Audit Contractor (RAC) notified the provider that an overpayment had occurred. Exh. 2. The appellant appealed and NGS denied payment at redetermination. See Exh. 4. At redetermination, NGS found that the documentation within the record supported that the beneficiary could have been safely treated as an outpatient and found the appellant remained responsible for the payment of the non-covered services. See *id.* On appeal, the Qualified Independent Contractor (QIC) upheld the contractor denial finding that the beneficiary was admitted in stable condition and remained so throughout his hospital stay. See Exh. 6. The QIC therefore determined that there was insufficient documentation in the record to support the admission as inpatient. See *id.* On further appeal, the ALJ upheld the QIC determination and found that the beneficiary's condition was not critical and did not require inpatient services. See ALJ Decision (Dec.) The ALJ also found the appellant liable for the non-covered services pursuant to section 1879 of the Act and not without fault for the overpayment under section 1870 of the Act. *Id.*

DISCUSSION

Medicare Coverage for Acute Inpatient Hospital Services

In its request for review, the appellant contends that the ALJ performed a retrospective analysis that was not confined to the information available to the treating physician at the time of admission. Exh. MAC-1. The appellant argues that the beneficiary's diagnoses of acute renal failure, dehydration, and viral gastroenteritis increased the medical predictability of further decline in his functional status. *Id.* The appellant further contends that in light of his elderly age, a timely evaluation and immediate treatment was imperative to prevent progression to irreversible renal failure and death. *Id.*

There are no binding statutes, regulations, or NCDs which establish criteria for coverage and payment of inpatient hospital admissions. However, the criteria for inpatient

admission is set forth in the Medicare Benefit Policy Manual (MBPM), CMS Internet Only Manual (IOM) 100-02, which explains:

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, *i.e.*, they should order admission of patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (*i.e.*, their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or non-covered solely on the basis of the length of time the patient actually spends in the hospital.

MBPM, Ch. 1 at § 10.

Additionally, the Medicare Program Integrity Manual (MPIM) (CMS IOM Pub. 100-08), chapter 6, section 6.5.2(A) provides guidance

pertaining to the review of claims for inpatient hospital admissions:

The reviewer shall consider, in his/her review of the medical record, any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary. . . . Inpatient care rather than outpatient care is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting.

CMS issued a Ruling in 1993, which established that, "no presumptive weight should be assigned to the treating physician's medical opinion in determining the medical necessity of inpatient hospital or SNF [skilled nursing facility] services under section 1862(a)(1) of the Act. A physician's opinion will be evaluated in the context of the evidence in the complete administrative record." HCFA (now CMS) Ruling 93-1 (eff. May 18, 1993). There is no presumption that a treating physician's judgment, or decision, to admit a beneficiary as an inpatient establishes Medicare coverage for the inpatient hospital stay. CMS Ruling 93-1 contains broad guidance on physician certification requirements, the weight to be given to the certifying physician's opinion, and the criteria for evaluating the medical documentation for purposes of determining the reasonableness and necessity of an inpatient hospital admission. The ruling indicates that a physician's certification of the hospital admission does not guarantee coverage under Medicare Part A, and it requires that the Medical evidence support the admission decision to ensure coverage.

Having considered the appellant's contentions and reviewed the administrative record, the Council concurs with the ALJ's assessment that the record does not support that the beneficiary's inpatient hospital stay was medically reasonable and necessary under section 1862(a)(1)(A) of the Act.

With respect to the appellant's contention that the ALJ's analysis was based on a "retrospective" view of the record, the Council notes that even with solely reviewing the information available to the admitting physician, the record does not support that an acute inpatient level of care was necessary. In this case, the beneficiary presented to the Emergency Room (ER), late in the evening, on September 6, 2009. Exh. 9 at 7. The beneficiary's creatinine level was 2.42, which was an increase

from his baseline score of 1.6. Exh. 10 at 12. His blood urea nitrogen (BUN) level was 71, which was also above the normal baseline. *Id.* In the Resident's Admitting Notes, Dr. S.A. indicated that the beneficiary was an 88 year old male with a four day history of watery diarrhea with episodes as frequent as every hour. Exh. 9 at 4. Dr. S.A. indicated that the beneficiary was not experiencing nausea, vomiting, abdominal pain, bloody stools, fevers or chills. *Id.* at 4. The Admitting Notes indicated that the physicians' clinical impression was that the beneficiary suffered from diarrhea and acute renal failure.¹ *Id.* at 3. The patient "assessment and plan" stated that the diarrhea was likely viral gastroenteritis and noted that "per wife [diarrhea] improved today so likely self limited". *Id.* The acute renal failure was noted to likely be prerenal and therefore hydration with IV fluids and stool studies were ordered. *Id.*

The record indicates that at presentment, the beneficiary's condition was not so critical that an acute level of inpatient care was necessary. In this case the beneficiary could have received necessary medical monitoring and treatment on an outpatient, observation care basis. As such the Council concurs with the ALJ that the inpatient services provided to the beneficiary did not meet the coverage criteria set forth in MBPM, Ch. 1, § 10 and section 1879 of the Act.

Medicare Part B Coverage and Payment for Outpatient Services

The appellant also takes issue with the ALJ's finding that the beneficiary could have been treated at an "observational level", contending that there is no "intermediate status", i.e., a patient is either an outpatient or an inpatient, and therefore asserts the ALJ committed an error of law in making such a conclusion. Exh. MAC-1.

The Council agrees with the appellant's contention that "observation" is not a level. Nevertheless, as stated above, we do however find that the beneficiary could have been monitored as an outpatient and received observational care. The MBPM provides:

Observation care is a well-defined set of *specific, clinically appropriate services*, which include ongoing

¹ The record indicates that multiple physicians assessed the beneficiary prior and post inpatient admission, including Dr. S.A. (the admitting physician) and Dr. S.S. (the attending physician). See Exh. 10.

short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

Ch.6 § 20.6 (emphasis added).

During the observation stay, patients should be actively assessed and, if necessary, treated, in order to determine if they should be admitted for further care or may be safely discharged. 66 Fed. Reg. 59856, 59880 (Nov. 30, 2001). Under Medicare's prospective payment systems, however, this type of short stay qualifies as an outpatient observation stay, even if the beneficiary occupies a hospital bed and receives a hospital level of care.

In this case, the beneficiary received diagnostic tests routinely performed as outpatient observation services that do not require inpatient admission. See e.g., Exh. 12. The Council does not question that this medical care, as provided to the beneficiary, was necessary and appropriate. As such, the Council concludes that the services furnished to the beneficiary qualify for Medicare coverage under Part B as outpatient services.

The Centers for Medicare & Medicaid Services (CMS) has expressly stated that Part B payment may be made for hospital services if Part A payment is denied. In relevant part, the MBPM states:

Payment may be made under Part B for physician services and for the nonphysician medical and other health services listed below when furnished by a participating hospital (either directly or under arrangements) to an inpatient of the hospital, but only if payment for these services cannot be made under Part A.

In PPS hospitals, this means that Part B payment could be made for these services if:

- No Part A prospective payment is made at all for the hospital stay because of patient exhaustion of benefit days before admission;
- **The admission was disapproved as not reasonable and necessary (and waiver of liability payment was not made);**
- The day or days of the otherwise covered stay during which the services were provided were not reasonable and necessary (and no payment was made under waiver of liability);
- The patient was not otherwise eligible for or entitled to coverage under Part A (See the Medicare Benefit Policy Manual, Chapter 1, § 150, for services received as a result of noncovered services); or
- No Part A day outlier payment is made (for discharges before October 1997) for one or more outlier days due to patient exhaustion of benefit days after admission but before the case's arrival at outlier status, or because outlier days are otherwise not covered and waiver of liability payment is not made.

MBPM, Ch. 6, § 10 (emphasis added).² This manual section clearly indicates that payment may be made for covered hospital services under Part B, if a Part A claim is denied for any one of several reasons.

Similar language permitting payment up to the limits of coverage appears in chapter 1 of the MBPM:

If a patient receives items or services in excess of, or more expensive than, those for which payment can be made, payment is made only for the covered items or services or for only the appropriate prospective payment amount. **This provision applies not only to inpatient services, but also to all hospital services under Parts A and B of the program.** If the items or services were requested by the

² CMS manuals are available at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>.

patient, the hospital may charge him the difference between the amount customarily charged for the services requested and the amount customarily charged for covered services.

MBPM, Ch. 1 at § 10 (emphasis added).

Further, the Medicare Financial Management Manual (MFMM) recognizes that additional action may be necessary by both the contractor and provider to properly adjust, or offset, the amount due under Part B against a Part A overpayment.³ Specifically, the MFMM states:

A. Benefits Payable Under Part B - FI

Where the FI determines that a Part A overpayment has been made to a provider on behalf of a beneficiary, it shall ascertain whether the beneficiary is entitled to any Part B payment for the services in question. (See Medicare Benefit Policy, Chapter 6.) If it appears that Part B benefits are payable, it shall arrange for billings under Part B. It shall use any Part B benefit as an offset against the Part A overpayment.

MFMM, CMS IOM 100-06, Ch. 3, § 170.1.

This manual section demonstrates that CMS contemplated scenarios, like the instant one, in which a contractor would offset at least a portion of an overpayment recovery as the result of other benefits due to the provider.

The Medicare Claims Processing Manual (MCPM) also recognizes that although providers may sometimes bill for services that are not covered as billed, they are nonetheless entitled to correct payment. See MCPM, CMS IOM 100-04, Ch. 29, § 280.3 ("Claims Where There is Evidence That Items or Services Were Not Furnished or Were Not Furnished as Billed"). It instructs contractors to deny or downcode the payment, as appropriate. *Id.*

Finally, the MCPM states:

³ The regulations and guidance quoted herein continue to refer to the contractor as a "fiscal intermediary" or "FI." However, the functions that were formerly performed by intermediaries have been transitioned to Medicare Administrative Contractors. See 42 C.F.R. § 421.104.

If a provider fails to include a particular item or service on its initial bill, an adjustment bill(s) to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing a claim. **However, to the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing.**

MCPM, Ch. 3 at § 50. The MCPM makes clear that the claim need not take any particular form to be valid:

For those billing carriers and DMERCS, a claim does not have to be on a form but may be any writing submitted by or on behalf of a claimant, which indicates a desire to claim payment from the Medicare program in connection with medical services of a specified nature furnished to an identified enrollee. It is not necessary that this submission be recorded on a CMS claim form, that the services be itemized or that the information submitted be complete (e.g., a note from the enrollee's spouse, or a bill for ancillary services in a nonparticipating hospital, could count as a claim for payment).

MCPM, Ch. 1 at § 50.1.7 ("Definition of a Claim for Payment"). The writing must contain sufficient identifying information about the enrollee to permit the obtaining of any missing information through routine methods, e.g., file check, microfilm reference, mail or telephone contact based on an address or telephone number in file. Where the writing is not submitted on a claim form, there must be enough information about the nature of the medical or other health service to enable the contractor with claims processing jurisdiction to determine that the service was apparently furnished by a physician or supplier. *Id.*

Recovery Audit Contractor (RAC) Overpayment Adjustment

Additionally, as noted above, the inpatient hospital services at issue were denied as part of an audit recovery based on an overpayment. In its request for review, the appellant contends that the Recovery Audit Contractor (RAC) improperly adjusted the claim in this case. See Exh. MAC-1. The appellant asserts that the RAC indicated it was making an adjustment in this case,

however the adjustment consisted of the entire amount of the claim. *Id.* The appellant contends that pursuant to the RAC statement of Work (SoW), the RAC, when it reached a determination that an overpayment existed, should have offset the inpatient payment to be recovered against allowable outpatient charges. *Id.*

The Council agrees with the appellant's argument. In instructions regarding the Recovery Audit Program, CMS instructed its contractors as follows:

When partial adjustments to claims are necessary, the FI/Carrier/MAC/DME MAC shall downcode the claim whenever possible. The Recovery Auditor will only be paid a contingency payment on the difference between the original claim paid amount and the revised claim paid amount. Some examples include DRG validations where a lower-weighted DRG is assigned, claim adjustments resulting in a lower payment amount, inpatient stays that should have been billed as outpatient, SNF . . . If the system cannot currently accommodate this type of downcoding/adjustments, CMS will work with the system maintainers to create the necessary changes. This includes some medical necessity claims.

See <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/downloads//RACFinSOW.pdf> (emphasis added) (last visited 05/14/2012).

In this case, the appellant submitted a timely claim for services which was paid under Medicare Part A. When the contractor reopened the initial determination and found the claim at issue had been overpaid, it had the same plenary authority (and responsibility) to process and adjust the claim as it did when that claim was first presented and paid. Consistent with the CMS manual provisions discussed above, the contractor shall work with the appellant to take whatever actions are necessary to arrange for billing under Medicare Part B, and thus, offset any Medicare Part A overpayment upon implementation of this case.

Limitation on Liability Provisions

The ALJ found the appellant, and not the beneficiary, liable for the cost of the non-covered services pursuant to section 1879 of the Social Security Act. In the request for review, the

appellant, citing to section 1879 of the Act, the regulation at 42 C.F.R. section 411.406, and CMS Ruling 95-1 asserts that its liability should be limited because "there was no manual, notice, bulletin, or written guidance that states that an inpatient hospital admission would be excluded from coverage by Medicare under [the circumstances of this case]". Exh. MAC-1 at 6. In other words, the appellant asserts that it provided reasonable and necessary inpatient hospital services consistent with all applicable requirements and, therefore, it "did not know and did not have reason to know that these services would not be reimbursed by Medicare." *Id.* The appellant further contends that the ALJ added a "presumption" standard to section 1879 of the Act and asserts that the ALJ's analysis under section 1879 of the Act is an error of law as there was no case-specific examination as required under CMS Ruling 95-1.

Section 1879(a)(2) and 42 C.F.R. §411.400(a)(2) requires evidence that neither the provider nor the beneficiary knew or should have known that the items or services would be excluded from Medicare coverage. Ruling 95-1, issued by CMS (then HCFA), sets forth the policy "for determining if Medicare payment will be made under the limitation on liability provision, section 1879 of the Act, to a provider, practitioner, or other supplier for certain services and items for which Medicare payment is denied." The Ruling states that, "[f]or protection under the limitation on liability provision to be afforded, lack of prior knowledge that Medicare payment for the item or service would be denied must first be established" as follows:

- Whether and when the beneficiary knew or should have known that Medicare payment for the item or service would be denied.
- Whether and when the provider, practitioner, or other supplier knew or should have known that Medicare payment for the item or service would likely be denied.

The appellant's assertion with respect to its "knowledge", or lack thereof, that the claim would be denied is unpersuasive and unavailing. The criteria for determining if a provider knew, or should have reasonably known, if the services were excluded is set forth in 42 C.F.R. 411.406. With respect to the knowledge requirement, the regulation provides that --

A provider, practitioner, or supplier that furnished services which constitute custodial care under

§411.15(g) or that are not reasonable and necessary under §411.15(k) is considered to have known that the services were not covered if any one of the conditions specified in paragraphs (b) through (e) of this section is met:

(b) *Notice from the QIO, intermediary or carrier.* The QIO, intermediary, or carrier had informed the provider, practitioner, or supplier that the services furnished were not covered, or that similar or reasonably comparable services were not covered.

(c) *Notice from the utilization review committee or the beneficiary's attending physician.* The utilization review group or committee for the provider or the beneficiary's attending physician had informed the provider that these services were not covered.

(d) *Notice from the provider, practitioner, or supplier to the beneficiary.* Before the services were furnished, the provider, practitioner or supplier informed the beneficiary that—

- (1) The services were not covered; or
- (2) The beneficiary no longer needed covered services.

(e) *Knowledge based on experience, actual notice, or constructive notice.* It is clear that the provider, practitioner, or supplier could have been expected to have known that the services were excluded from coverage on the basis of the following:

- (1) Its receipt of CMS notices, including manual issuances, bulletins, or other written guides or directives from intermediaries, carriers, or QIOs, including notification of QIO screening criteria specific to the condition of the beneficiary for whom the furnished services are at issue and of medical procedures subject to preadmission review by a QIO.
- (2) Federal Register publications containing notice of national coverage decisions or of other specifications regarding noncoverage of an item or service.
- (3) Its knowledge of what are considered acceptable standards of practice by the local medical community.

The appellant's position with respect to liability is belied by the program guidance discussed above and throughout this action. As a provider participating in the Medicare program, the appellant is considered to have constructive knowledge of CMS manual instructions, bulletins, contractors' written guides, and directives, as well as standards of practice in conjunction with Medicare reimbursement policies. See Medicare Claims Processing Manual, (IOM Pub. 100-04), ch. 30, §§ 40.1 and 40.1.1. The appellant is obligated to familiarize itself with the applicable law and Medicare policy regarding coverage requirements. While the four MBPM factors to be considered when making a decision to admit a patient as an "inpatient" (*i.e.*, severity of signs and symptoms, medical predictability of an adverse occurrence, need for outpatient diagnostic studies appropriately outpatient services and availability of diagnostic procedures at the time and location of presentation) are not an exhaustive list of criteria, the record here does not indicate that the beneficiary showed severity of signs and symptoms and/or a medical predictability of an adverse occurrence. Moreover, the beneficiary's documentation otherwise indicates that the care provided during the hospital stay was not of such intensity that it could be furnished safely and effectively only on an inpatient basis.

The Council also notes with respect to the regulations at 42 C.F.R. § 411.406(c) that the case manager within the provider's utilization review group initially indicated that the beneficiary did not meet the provider's inpatient admission criteria. The record shows that although the beneficiary was admitted as an inpatient at 00:55:00 on September 7, 2009, the hospital's care management indicated in a Medical Necessity Note at 01:32:33 that the "[beneficiary] does not meet [inpatient] criteria per 2009 [InterQual]". Exh. 14 at 1. The case manager further noted that she would call Executive Health Resources (EHR) in the morning with the beneficiary's clinical, labs, and information for a determination of status. *Id.* The record indicates that EHR did not make a medical necessity determination until after 3pm on September 7, 2009, at which time Dr. B-D reviewed the case and recommended inpatient status. *Id.* However, by the time Dr. B-D determined that the beneficiary's inpatient status was appropriate, the beneficiary's vitals had substantially improved, which further supports the conclusion that the beneficiary did not require inpatient admission. *Id.* Thus, the Council finds that the ALJ did not err in finding that the limitation of liability provision of section 1879 did not apply to the appellant.

The appellant further argues that the liability of the provider should be waived under section 1870 of the Act. Section 1870(b) provides that recoupment of an overpayment to a provider or supplier may be waived if the provider or supplier was without fault in receiving the overpayment.

CMS guidance published in the MFMM explains that a provider or supplier is considered to be without fault --

if it exercised reasonable care in billing for, and accepting, the payment; i.e.,

- It made full disclosure of all material facts; and
- On the basis of the information available to it, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or, if it had reason to question the payment; it promptly brought the question to the FI or carrier's attention.

MFMM, IOM 100-06, Ch. 3, § 90. The MFMM goes on to explain that a provider or supplier is not without fault if it billed, or Medicare paid for, services that the provider or supplier should have known were not covered:

In general, the provider should have known about a policy or rule, if:

- The policy or rule is in the provider manual or in Federal regulations,
- The [contractor] provided general notice to the medical community concerning the policy or rule, or
- The [contractor] gave written notice of the policy or rule to the particular provider.

Generally, a provider's allegation that it was not at fault with respect to payment for noncovered services because it was not aware of the Medicare coverage provisions is not a basis for finding it without fault if any of the above conditions is met.

MFMM, Ch. 3, § 90.1.H.

In the present case, the appellant should have known that the services furnished to the beneficiary did not qualify for Medicare coverage as inpatient hospital services. The Council therefore concurs with the ALJ that the appellant is therefore not deemed to be without fault in receiving the overpayment. Accordingly, recovery of any overpayment that may still exist after offsetting the Medicare Part B payment for outpatient services will not be waived.

DECISION

It is the decision of the Council that the appellant is entitled to Medicare reimbursement under Medicare Part B for the outpatient services furnished to the beneficiary from September 7, 2009 to September 8, 2009. The contractor shall work with the appellant to take whatever actions are necessary to arrange for billing under Medicare Part B, and thus, offset any Medicare Part A overpayment upon implementation of this case. The appellant's liability for any remaining non-covered costs is not limited under section 1879 of the Act. Additionally, the appellant is deemed to be at fault for the overpayment at issue and therefore not eligible for waiver of recovery pursuant to section 1870(b) of the Act. The ALJ's decision is modified in accordance with the foregoing discussion.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

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

Date: May 17, 2012