Exhibit A

Index

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Departmental Appeals Board, MS 6127
Medicare Appeals Council
330 Independence Avenue
Cohen Building, Room G-644
Washington, DC 20201
(202)565-0100/Toll Free:1-866-365-8204

OCT 23 2012

ALJ Appeal Number: 1-934979291
Docket Number: M-12-2368

Missouri Baptist Hospital of Sullivan
600 South Taylor Avenue
Mailstop 90-94-208
St. Louis, MO 63110
Attn: Katherine Kercher-Link

NOTICE OF DECISION OF MEDICARE APPEALS COUNCIL

What This Notice Means

Enclosed is a copy of the decision of the Medicare Appeals Council (Council). If you have any questions, you may contact the Centers for Medicare & Medicaid Services (CMS) regional office or the local Medicare contractor.

Your Right to Court Review

If you desire court review of the Council's decision and the amount in controversy is $1,350 or more (or $1,400 or more for civil actions filed on or after January 1, 2013), you may commence a civil action by filing a complaint in the United States District Court for the judicial district in which you reside or have your principal place of business. *See* § 1869(b) of the Social Security Act, 42 U.S.C. § 1395ff(b). The complaint must be filed within sixty days after the date this letter is received. 42 C.F.R. § 405.1130. It will be presumed that this letter is received within five days after the date shown above unless a reasonable showing to the contrary is made. 42 C.F.R. § 405.1136(c)(2).

If you cannot file your complaint within sixty days, you may ask the Medicare Appeals Council to extend the time in which you may

begin a civil action. However, the Council will only extend the time if you provide a good reason for not meeting the deadline. Your reason must be set forth clearly in your request. 42 C.F.R. § 405.1134.

If a civil action is commenced, the complaint should name the Secretary of Health and Human Services as the defendant and should include the MAC Docket number and ALJ appeal number shown at the top of this notice. 42 C.F.R. § 405.1136(d). The Secretary must be served by sending a copy of the summons and complaint by registered or certified mail to the General Counsel, Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. In addition, you must serve the United States Attorney for the district in which you file your complaint and the Attorney General of the United States. *See* rules 4(c) and (i) of the Federal Rules of Civil Procedure and 45 C.F.R. § 4.1.

Enclosure

cc: Beneficiary
Sheree Kanner, Esq.
Q2A AdQIC Records Management

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-12-2368

In the case of	**Claim for**
Missouri Baptist Hospital of Sullivan (Appellant)	Hospital Insurance Benefits (Part A)
[redacted] (Beneficiary)	[redacted] (HIC Number)
HealthDataInsights, Inc. (RAC) (Contractor)	1-934979291 (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated May 21, 2012, which concerned Medicare coverage for inpatient hospital services furnished to the beneficiary from [redacted], 2010, through [redacted], 2010. The ALJ determined that the inpatient services were not covered under Medicare Part A and that the appellant was liable for the overpayment. The appellant has asked the Medicare Appeals Council (Council) to review this action. The Council admits the appellant's request for review, interim correspondence, and request for escalation into the record as Exhibits (Exhs.) MAC-1 through MAC-3.

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 has considered the record and exceptions raised in the appellant's request for review, but finds no basis to disturb the ALJ's finding that the inpatient hospital admission at issue was not medically reasonable and necessary and is not

covered by Medicare Part A. Thus, the Council adopts the ALJ findings and conclusions on this point. The Council finds that the ALJ erred, however, in concluding that coverage is unavailable to the appellant under Medicare Part B. The Council therefore reverses the ALJ decision on that issue and directs that the contractor review the services at issue and provide payment to the appellant under Medicare Part B for services, if the contractor determines that the services meet coverage standards under Medicare Part B. The Council adopts the ALJ's finding that the appellant is financially liable for the non-covered inpatient stay, and finds that the appellant is liable for the difference between the payment under Medicare Part A and Part B.

AUTHORITIES

An ALJ and the Council are bound by statutes, regulations, national coverage determinations (NCDs), and Medicare Rulings. 42 C.F.R. §§ 405.1060(a)(4) and 405.1063. Neither an ALJ nor the Council is bound by a Local Coverage Determination (LCD) or Medicare program guidance such as program memoranda and manual instructions, "but will give substantial deference to these policies if they are applicable to a particular case." 42 C.F.R. § 405.1062(a). If an ALJ or the Council declines to follow a policy in a particular case, the ALJ or Council decision must explain the reasons why the policy was not followed. 42 C.F.R. § 405.1062(b).

Section 1862(a)(1)(A) of the Social Security Act (Act) provides that notwithstanding any other provisions of title XVIII of the Act, items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are excluded from coverage.

There are no binding statutes, regulations, or NCDs which establish criteria for coverage and payment of inpatient hospital admissions. However, the Medicare Benefits Policy Manual (MBPM)(Pub. 100-02) defines an inpatient as -

> [A] person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as [an] inpatient with

> the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

MBPM Ch. 1, § 10.[1] In discussing the issue of whether a patient requires inpatient care in an acute care hospital, the MBPM 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

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

- 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, § 10.

By contrast, under Medicare guidelines, lower level outpatient observation services may be ordered and covered where inpatient hospital admission is not medically reasonable and necessary:

> Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing 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.
>
> Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

MBPM Ch. 6, § 20.6(A).

CMS, formerly the Health Care Financing Administration (HCFA), 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 Ruling 93-1 (eff. May 18, 1993). Thus, 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.

Section 1879 of the Act provides that, where an item or service is not covered by Medicare because it is determined to be custodial care or not medically reasonable and necessary, in certain instances, the liability of the provider, practitioner, supplier or beneficiary may be limited.

The regulation at 42 C.F.R. section 411.406, CMS (HCFA) Ruling 95-1, and the Medicare Claims Processing Manual (MCPM)(Pub. 100-4), Ch. 30, §§ 40.1 and 40.1.2, address what constitutes evidence that a provider knew, or should have known, that Medicare would not pay for a service:

- A Medicare contractor's prior written notice to the provider denying payment for similar or reasonably comparable services;

- Medicare's general notices to the medical community that Medicare will deny services under all, or certain, circumstances (such notices include, but are not limited to, manual instructions, bulletins, contractor's written guides and directives);

- Provision of services inconsistent with acceptable standards of practice in the local medical community;

- The provider's utilization review committee has informed the provider in writing that such services were not covered; and

- A Medicare contractor previously issued a written notice to the provider that Medicare payment for a particular service or item was denied.

Section 1870 of the Act provides the same standard for determining that a provider or supplier is not "without fault" and is therefore liable for a Medicare overpayment for services for which the provider or supplier is liable under section 1879

of the Act. Medicare Financial Management Manual (MFMM)(Pub. 100-06) Ch. 3, § 90.1.H.

BACKGROUND

The 67-year-old male beneficiary's relevant medical history includes a diagnosis of cholelithiasis, and he was scheduled for a laparoscopic cholecystectomy surgical procedure on [redacted], 2010. Dec. at 2, *citing* Exh. 1, at 3-5, 51-53. Prior laboratory and diagnostic test results and an electrocardiogram (EKG) were "predominately normal" and there were indications of a mild systemic disease, with no other complications noted. *Id., citing* Exh. 1, at 39-41, 64. The beneficiary's condition and procedure were noted as having a low level of severity with a short stay of less than 24 hours. *Id., citing* Exh. 1, at 3-5, 51-53.

The beneficiary had the surgical procedure on [redacted], 2010, and the operation took approximately 20 minutes with "no noted complications, negligible blood loss, and no bile leaks." Dec. at 2, *citing* Exh. 1, at 56-67, 61-62. The operation report states that the beneficiary tolerated the procedure well. *Id.* On the same day, the physician wrote an admission order for overnight monitoring. *Id., citing* Exh. 1, at 33. The beneficiary's vital signs were stable on admission, and the beneficiary's complaints of pain and nausea/vomiting were treated with medication. *Id., citing* Exh. 1, at 7-32. By the next day, the beneficiary's nausea had subsided, he was able to eat, and the physician determined that he was suitable for discharge. *Id.*

The appellant filed a claim with Medicare for inpatient hospital services furnished to the beneficiary for the period at issue. The contractor initially covered the claim and, on December 20, 2010, Recovery Administrative Contractor (RAC) HealthDataInsights reopened the claim and requested documentation from the appellant for services provided to this and other beneficiaries. Exh. 3, at 10-12. On February 4, 2011, the RAC issued an unfavorable determination, finding, in relevant part, that "[t]he medical record did not document pre-existing medical conditions or extenuating circumstances, such as post-operative complications, that made the acute inpatient admission medically necessary. The medical record documents services that could have been provided as outpatient services in

the hospital." *Id.* at 9. On February 17, 2011, the RAC issued an overpayment demand letter. *Id.* at 1-6.

On August 11, 2011, the contractor issued a detailed unfavorable redetermination decision that discussed the medical documentation and found that the documentation did not support an acute inpatient admission and that the beneficiary could have been managed at a lower level of care. Exh. 4, at 3. Following medical review, the Qualified Independent Contractor (QIC) upheld the contractor's unfavorable decision, finding that Medicare coverage criteria were not met for inpatient admission. Exh. 5, at 3. Based on the opinion of the medical review panel, the QIC stated, in relevant part, that "[l]aparoscopic cholecystectomy is not on the CMS inpatient-only list, and is routinely performed as an outpatient surgery." *Id.* at 3. The QIC noted that, in this case, "there was no clinical evidence during or after the procedure that would suggest that an inpatient level of service was required for safe and effective monitoring of the beneficiary following the procedure." *Id.* at 4. The QIC found the inpatient services were not medically reasonable and necessary and the provider financially liable for the non-covered costs. *Id.* at 4-5.

Following a hearing before an ALJ, at which the appellant was represented by a physician and counsel, the ALJ upheld the QIC's finding that the inpatient admission was not medically reasonable and necessary. The ALJ, following a discussion of the medical evidence in the record, found that Medicare coverage criteria for an inpatient hospitalization were not met and that "while in inpatient status, the Beneficiary was provided observation service and medications." Dec. at 12. In finding the services not covered under Medicare Part A, the ALJ noted that hospital patients with known diagnoses who enter a hospital for minor surgery expected to keep them in the hospital for less than 24 hours are considered outpatients for the purposes of Medicare billing. *Id.* at 11, *citing* MPIM Ch. 6, § 10.

The ALJ thus concluded that the services were not covered by Medicare and that the appellant was financially liable for the non-covered services and resulting overpayment. Dec. at 13-14. In reaching these conclusions, the ALJ rejected the appellant's argument that the services could be covered under Medicare Part B, finding the Council's decision *In the Case of O'Connor Hospital* inapposite in this case. *Id.* at 13. On this issue, the ALJ noted that the Medicare Claims Processing Manual

(MCPM)(Pub. 100-04) requires that providers bill correctly for inpatient or outpatient services when submitting the claims. *Id., citing* MCPM Ch. 1, § 50.3.2. The ALJ stated that, "[i]t is expected that hospitals review their decisions to admit patients to inpatient status *before* submitting a Part A claim and determine that the admission does not meet Medicare inpatient admission criteria on their own." *Id.* The ALJ also stated that "[r]ebilling for any service will only be allowed if all claim processing rules and claim timeliness rules are met. There are no exceptions to the rules in the national program." *Id., citing* MCPM Ch. 1, § 70.

In its request for review, the appellant asserts that the ALJ erred in finding that the appellant was not entitled to reimbursement for the services provided. Exh. MAC-1, at 3. The appellant contends that the services were reasonable and necessary and that, if coverage is unavailable under Medicare Part A, "federal law requires that it be made under Part B." *Id.* The appellant requests only that the appellant "be reimbursed under Medicare Part B for the reasonable and medically necessary items and services it provided." *Id.* The appellant later states that "where a hospital furnishes items and services that are reasonable and medically necessary, CMS cannot simply refuse to reimburse the hospital for the bulk of the items and services it provided. If reimbursement is unavailable under Part A, it must be provided under Part B." *Id.* at 4. The appellant contends that, to the extent that Part B coverage denial is based on the provisions of MBPM Ch. 6 § 10, that administrative authority is contrary to the "Medicare Act;" is "invalid for lack of notice and comment rulemaking;" and is arbitrary and capricious. *Id.* at 5-6.

DISCUSSION

A. Payment Under Medicare Part A

The Council has reviewed the medical records in this case, the contentions of the appellant, and the opinions of the medical reviewers at various levels of appeal. The Council finds that the medical evidence in the record does not establish that the inpatient hospital admission at issue was medically reasonable and necessary. The appellant also makes no contention that the services meet Medicare Part A coverage requirements, only that they are reimbursable under Medicare Part B.

The Council is mindful of the beneficiary's medical condition upon admission, and subsequent complaints of nausea and vomiting subsequent to the surgical procedure. However, consideration of these factors, alone, is not determinative of coverage. The Council notes that CMS has determined that laparoscopic cholecystectomy is routinely performed as an outpatient proceeding. Exh. 5, at 3. As noted, the appellant does not contend that the beneficiary's condition warranted inpatient hospitalization services. The Council sees no basis for changing the ALJ's finding that the beneficiary did not meet requirements for coverage under Medicare Part A.

B. Payment Under Medicare Part B

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). This manual section clearly indicates that payment may be made for covered hospital services under Medicare 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 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, § 10 (emphasis added).

Further, the 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.[2] Specifically, the MFMM states:

---

[2] 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.

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 Ch. 3, § 170.1. This manual section demonstrates that CMS contemplated scenarios 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 (Pub. 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:

> 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 [Medicare Administrative Contractors] and [DME MACs], 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, 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.*

For these reasons, the Council finds that the ALJ erred in determining that Medicare Part B coverage is unavailable to the appellant. The appellant is entitled to payment *for otherwise-covered medically reasonable and necessary services* under Medicare Part B. The Medicare Administrative Contractor is directed to review the services at issue for coverage and payment under Part B. The Council does not specify the manner in which the Medicare Administrative Contractor should facilitate such process, e.g., whether the contractor should direct the appellant to re-file the claim under Part B with an itemized list of services, whether the contractor is able to make payment based on the current claim as filed, or by other manner. The Council simply finds that the otherwise-covered and medically reasonable services must be covered and paid in the manner they would have been had they been claimed under Medicare Part B.

Because the Council finds Part B coverage available under the conditions stated above, the Council need not and does not address the appellant's arguments that CMS policy is arbitrary and capricious and otherwise subject to notice and comment rulemaking under the Administrative Procedures Act.

C. Limitation on Liability

The Council notes that the financial cost of the denial of coverage for inpatient hospital services in this case will be offset on implementation by proper reimbursement for otherwise-covered outpatient services. Thus, the financial impact to the appellant will be substantially reduced from that contemplated by the ALJ, QIC, and contractor. The Council finds, however, that the remaining difference between the reimbursable amount for inpatient and outpatient services will remain the financial responsibility of the appellant. The appellant could reasonably have been expected to know -- for all of the reasons previously stated in this decision -- that a hospital inpatient admission was not medically reasonable and necessary in order to furnish all of the required monitoring services following a laparoscopic cholecystectomy procedure where there were no expectations at the time of surgery, more than a limited possibility, that complications would arise and that the beneficiary would remain hospitalized beyond the usual recovery period for this type of surgery. The appellant is liable for any non-covered charges and resulting overpayment.

CONCLUSION

For the reasons stated above, the Council adopts the ALJ's unfavorable coverage decision and finds that the services furnished to the beneficiary did not require an inpatient admission and are not covered under Medicare Part A. The Council reverses the ALJ's findings that Part B coverage is unavailable and directs the contractor to review the items and services furnished in this case and to provide reimbursement for medically reasonable and necessary and otherwise covered items and services on an outpatient basis under Medicare Part B.

(continued on next page)

The appellant is financially responsible, and may not charge the beneficiary, for any difference in the amount it would have received had the services been covered on an inpatient basis.

MEDICARE APPEALS COUNCIL

Susan S. Yim
Administrative Appeals Judge

Constance B. Tobias, Chair
Departmental Appeals Board

Date: OCT 23 2012

Confirmation Report – Memory Send

Page : 001
Date & Time: 07-20-12 04:55pm
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End time	:	07-20 04:55pm
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PAGES (Incl. cover page 61) Please telephone +1 202 637 5600 if any pages are missing or illegible.

To	ORGANIZATION	FAX NUMBER
Dept. of Health and Human Services	Departmental Appeals Board, MS 6127	202-565-0227
FROM		
Hogan Lovells US LLP	Hogan Lovells US LLP	202-637-5600

July 20, 2012

4:16 pm
Matter ref 68975.0082

MESSAGE
Re: Request for Medicare Appeals Council Review of Unfavorable Decision in ALJ Appeal Number 1-934979291

Hogan Lovells

FAX

Hogan Lovells US LLP
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PAGES (incl. cover page 61) **Please telephone +1 202 637 5600 if any pages are missing or illegible.**

TO	ORGANIZATION	FAX NUMBER
Dept. of Health and Human Services	Departmental Appeals Board, MS 6127	202-565-0227
FROM		
Hogan Lovells US LLP	Hogan Lovells US LLP	202-637-5600

July 20, 2012

4:16 pm

Matter ref 68975.0082

MESSAGE

Re: Request for Medicare Appeals Council Review of Unfavorable Decision in ALJ Appeal Number 1-934979291

July 20, 2012

Via Facsimile

Department of Health and Human Services
Departmental Appeals Board, MS 6127
Medicare Appeals Council
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, DC 20201

Re: Request for Medicare Appeals Council Review of Unfavorable Decision in ALJ Appeal Number 1-934979291

Dear Sir or Madam:

Missouri Baptist Sullivan Hospital, through Sheree Kanner as its Appointed Representative, hereby requests review by the Medicare Appeals Council (MAC) of the unfavorable determination issued in Administrative Law Judge (ALJ) Appeal number 1-934979291. Enclosed please find a completed form DAB-101 for this matter. We also provide the following information in accordance with 42 C.F.R. § 405.1112:

Name of Beneficiary:	[redacted]
Beneficiary's HICN:	[redacted]
Items/Services in Dispute:	Laparoscopic cholecystectomy for cholelithiasis
Dates the Service was Provided:	[redacted]2010 - [redacted]2010
Date of ALJ Decision:	5/21/2012
ALJ Appeal Number:	1-934979291

In addition, a description of the parts of the ALJ decision with which we disagree, together with an explanation of why we disagree, follows.

Finally, please note that for purposes of this request for MAC review and all other purposes related to this administrative appeal, Missouri Baptist Sullivan Hospital has revoked the appointment of representation previously given to Evan Pollack, M.D., FACP, Executive Health Resources, and appointed me as its new representative. Accordingly, we have also enclosed a completed form CMS-1696 for this matter. Please send all future correspondence and direct all future questions regarding this matter to me at the address and phone number provided below.

A copy of this correspondence, including attachments, has been sent this day to Mr. [redacted], Wisconsin Physician Services, HealthDataInsights, and MAXIMUS Federal Services.

Respectfully submitted,

Sheree Kanner /KK

Sheree Kanner
Hogan Lovells US LLP
555 Thirteenth Street, NW
Washington, D.C., 20004
(202) 637-2898

Enclosures:

Request for Review, DAB-101
Appointment of Representative, CMS-1696

cc:

[redacted]

Wisconsin Physicians Service
A Medicare Contractor
Attention: Appeals
P.O. Box 1602
Omaha, NE 68101

MAXIMUS Federal Service, Inc.
QIC Part A West Reconsideration
P.O. Box 62410
King of Prussia, PA 19406

HealthDataInsights
7501 Trinity Peak Street, Suite 120
Las Vegas, NV 89128

Summary

The ALJ in this case determined that Missouri Baptist Sullivan Hospital was not entitled to payment under Medicare Part A for services it provided to [redacted] in [redacted] 2010. The ALJ concluded that Part A payment was unwarranted because the documentation provided did not support the physician's decision to admit the patient as an inpatient. No one disputes that the actual items and services provided to the beneficiary were reasonable and medically necessary.

Federal law requires that Medicare reimburse hospitals for reasonable and medically necessary items and services provided to beneficiaries. Put simply, when a hospital furnishes reasonable and medically necessary items and services, if payment cannot be made under Part A, federal law requires that it be made under Part B. To the extent the ALJ followed CMS guidance prohibiting Part B payment in these circumstances, or simply refused Part B reimbursement without relying on CMS policy, she did so in error. To resolve this appeal in a manner consistent with federal law, the MAC should order that Missouri Baptist Sullivan Hospital be reimbursed under Medicare Part B for the reasonable and medically necessary items and services it provided.

Scope of Review

According to federal regulations, "[t]he MAC will consider all of the evidence in the administrative record." 42 C.F.R. § 405.1108(a). "Upon completion of its review, the MAC may adopt, modify, or reverse the ALJ's decision or remand the case to an ALJ for further proceedings." *Id.*

Statement of Facts

On [redacted], 2010, [redacted], a 67-year-old male, presented at Missouri Baptist Sullivan Hospital (the "Provider") for a laparoscopic cholecystectomy for cholelithiasis. He was admitted as a hospital inpatient. The Provider requested Part A reimbursement for items and services it provided to the beneficiary over a two-day inpatient stay. Upon initial determination, Wisconsin Physician Services (WPS), the Medicare Administrative Contractor in the jurisdiction, allowed Part A payment for the items and services. But HealthDataInsights, the Recovery Audit Contractor (RAC), subsequently determined the inpatient stay was not medically necessary and demanded that the Provider repay $5,591.01. *Attachments 1, 2.* WPS, the Qualified Independent Contractor (QIC), and the Administrative Law Judge (ALJ) concurred. *Attachments 3-5.* Each of these unfavorable decisions also deemed the Provider wholly responsible for the bill. *Id.*

The Provider now concedes for purposes of this appeal that the documentation the Provider submitted was insufficient to establish that, under these particular facts, the beneficiary should have been treated on an inpatient basis. That does not render this appeal moot, however, for the Provider also agrees with all previous adjudicators regarding a separate, crucial fact: The

items and services provided were both reasonable and medically necessary. For example, echoing findings throughout the administrative record, the ALJ concluded both that "[a]dmission to outpatient or observation-level care under Part B was fully justified" and that "treating the Beneficiary at an observation level was medically appropriate." *Attachment 5* at 12. And as we discuss below, where a hospital furnishes items and services that are reasonable and medically necessary, CMS cannot simply refuse to reimburse the hospital for the bulk of the items and services it provided. If reimbursement is unavailable under Part A, it must be provided under Part B.

Statement of the Issues

1. Whether the Provider is entitled to Part B payment for the reasonable and medically necessary items and services it provided to the beneficiary.

2. Whether the CMS policy prohibiting Part B payment for all but a subset of reasonable and medically necessary services is unlawful.

The Provider urges the MAC to answer both questions in the affirmative.

Discussion

The MAC should order reimbursement under Medicare Part B and should declare CMS's contrary policy manual provision invalid.

1. Confronting a soaring number of Medicare Part A denials spurred by the RAC program, some hospitals have requested Part B reimbursement for the reasonable and medically necessary items and services they have provided to beneficiaries. Although several hospitals have received Part B payment, convincing ALJs and the Medicare Appeals Counsel that Part B payment is appropriate for a specific claim, CMS to date has told hospitals and its contractors that Part B payment is not permitted other than for a small subset of items and services provided.

Underlying CMS's refusal to allow Part B payment is not a statute, but a policy document: Chapter 6 § 10 of its Medicare Benefits Policy Manual (MBPM). That manual provision states that when hospital "admission was disapproved as not reasonable and necessary (and waiver of liability payment was not made)," Part B will pay only for a subset of services typically comprising a small portion of the total bill, like diagnostic tests, surgical dressings, splints and casts, outpatient physical therapy, and vaccines. The manual provision instructs, in other words, that hospitals cannot obtain reimbursement for the core services they provide to beneficiaries in these circumstances—for example, observation care, emergency room services, drugs, and surgical procedures—even where it was indisputably reasonable for the hospital to treat the beneficiary the way it did. That in turn means that hospitals remain unreimbursed for millions of dollars' worth of reasonable and medically necessary care. And in this case in

particular, it means that Missouri Baptist Sullivan Hospital cannot be reimbursed for surgical supplies and equipment; anesthesia medications; labor costs for pharmacists, nurses and the like; pain and nausea treatment; or post-surgical observation care[1]—that is, *all* of the hospital resources used for the laparoscopic cholecystectomy performed on [redacted], 2010.

2. The MAC should not rely on CMS's policy here to refuse Part B payment. Instead, the MAC should declare CMS's policy invalid, and should order full Part B payment, for three independent reasons. First, the Medicare Act requires reimbursement for reasonable and medically necessary items and services provided, and CMS's policy accordingly is contrary to the language and purpose of the Act. Second, the policy is invalid for lack of notice and comment rulemaking. Finally, the policy is arbitrary and capricious.

a. The Medicare statute "entitle[s]" Medicare beneficiaries to payment for all reasonable and necessary "medical and other health services," 42 U.S.C. § 1395k(a)(2), except for certain items or services the statute specifically excludes, *see id.* § 1395y. Here there is no doubt that the items and services provided were, in fact, reasonable and medically necessary. The RAC did not question that fact. Nor has any agency adjudicator thereafter. Instead, all of the review entities charged with evaluating the Provider's request for reimbursement determined merely that the Provider did not merit Medicare Part A payment because the beneficiary could have been treated on an outpatient basis. Medicare accordingly must reimburse the Provider under Part B. After all, Section 1395k requires Medicare to pay for reasonable and necessary items and services within the scope of benefits provided to beneficiaries unless there is some statutory limitation or prohibition on payment. No such statutory limitation or prohibition applies in this case.

The Provider accordingly requests Part B payment. It likewise requests that the MAC declare invalid MBPM Chapter 6 § 10, which squarely conflicts with the Medicare Act's language. *See NextWave Personal Commc'ns, Inc.* v. *FCC*, 254 F.3d 130, 149 (D.C. Cir. 2001) (Administrative Procedure Act requires "invalidat[ion] [of] agency action . . . if it conflicts with an agency's own statute"), *aff'd FCC* v. *NextWave Personal Commc'ns, Inc.*, 537 U.S. 293 (2003).

b. CMS's policy is also invalid because CMS promulgated a binding rule without subjecting that rule to public notice and comment. The Administrative Procedure Act requires agencies to afford notice of a proposed rulemaking and an opportunity for public comment prior to a rule's promulgation, amendment, modification, or repeal. 5 U.S.C. § 553. An agency rule promulgated "without observance of procedures required by law" is invalid. *Id.* § 706(2)(D); *Preminger v. Sec'y of Veterans Affs.*, 632 F.3d 1345, 1350 (Fed. Cir. 2008). "When agencies base rules on arbitrary choices"—like the decision to allow payment for *some* services but not for the core services like observation and underlying care—"they are legislating, and so these

[1] Most hospitals would receive a bundled Medicare payment under Part B for the items and services furnished in conjunction with the surgical procedure.

rules are legislative or substantive and require notice and comment rulemaking." *Catholic Health Initiatives* v. *Sebelius*, 617 F.3d 490, 495 (D.C. Cir. 2010) (quotation marks omitted).

For this second reason, the MAC should declare CMS's policy unlawful and order CMS to pay Missouri Baptist Sullivan Hospital under Medicare Part B.

c. CMS's policy is invalid for a third, independent reason: CMS acted arbitrarily and capriciously when it adopted a policy of denying Part B payment for all but the ancillary services listed in MBPM Chapter 6 § 10. In order for an agency's policy or rule to pass muster, "the agency must . . . articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). CMS did not offer *any* explanation for where it drew the reimbursement line in its manual provision, or for why it refuses to reimburse hospitals for items and services everyone agrees were reasonable and medically necessary. And it is far too late now for the agency or its counsel to offer one up: "[A]n agency's action must be upheld, if at all, on the basis articulated by the agency itself." *Id.* at 50 (citing *SEC* v. *Chenery*, 332 U.S. 194, 196 (1947)).

Moreover, whatever unknown and undiscoverable basis CMS had for its policy decision, it made the wrong policy decision. The Medicare program is designed to reimburse hospitals for reasonable and medically necessary services. By denying payment for services claimed under Part A on the ground that they were actually outpatient services under Part B, CMS is admitting that the items and services provided qualify as reasonable and medically necessary, as Part B reimbursement requires—and yet denying payment for that care.

Conclusion

For all of these reasons, the MAC should order CMS to pay Missouri Baptist Sullivan Hospital under Medicare Part B. The only reason CMS has ever cited for not providing such payment—MBPM Chapter 6 § 10—is at odds with the statute itself, invalid for failure to undergo notice and comment rulemaking, and arbitrary and capricious.[2] Missouri Baptist Sullivan Hospital also requests that the MAC declare CMS's policy unlawful.

[2] For these same reasons, any other CMS policy manual provisions that prevent hospitals from obtaining Part B payment for reasonable and medically necessary services, such as Medicare Claims Processing Manual 100-04 Chapter 1 § 50.3, are also invalid.

LIST OF EXHIBITS

Attachment No.	Description
1	Review Results Letter from HealthDataInsights
2	Demand Letter from HealthDataInsights
3	Medicare Appeal Decision from WPS
4	Medicare Appeal Decision from MAXIMUS Federal Services
5	ALJ Notice of Decision

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0950

APPOINTMENT OF REPRESENTATIVE

NAME OF PARTY	MEDICARE OR NATIONAL PROVIDER IDENTIFIER NUMBER
Missouri Baptist Hospital of Sullivan	260115

SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual: Sheree Kanner to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF PARTY SEEKING REPRESENTATION		DATE
Tony Schwarm		07/19/2012
STREET ADDRESS		PHONE NUMBER *(with Area Code)*
751 Sappington Bridge Road		573-468-1343
CITY	STATE	ZIP
Sullivan	Mo	63080

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, Sheree Kanner, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an attorney
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE OF REPRESENTATIVE		DATE
Sheree Kanner/KKE		7/19/12
STREET ADDRESS		PHONE NUMBER *(with Area Code)*
555 Thirteenth Street N.W.		(202) 637-2898
CITY	STATE	ZIP
Washington	DC	20004

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

SIGNATURE	DATE

SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

SIGNATURE	DATE

CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of the Department of Health and Human Services (DHHS) (i.e., an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council (MAC) review, or a proceeding before an ALJ or the MAC as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR §405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for MAC review

Approval of a representative's fee is not required if (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before DHHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

WHERE TO SEND THIS FORM

Send this form to the same location where you are sending (or have already sent) your appeal if you are filing an appeal, grievance if you are filing a grievance, initial determination or decision if you are requesting an initial determination or decision.

If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227).

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) / DEPARTMENTAL APPEALS BOARD Form DAB-101 (08/09)

REQUEST FOR REVIEW OF ADMINISTRATIVE LAW JUDGE (ALJ) MEDICARE DECISION / DISMISSAL

1. APPELLANT (the party requesting review)	2. ALJ APPEAL NUMBER (on the decision or dismissal)
Missouri Baptist Hospital of Sullivan	1-934979291
3. BENEFICIARY*	4. HEALTH INSURANCE CLAIM NUMBER (HICN)*
[redacted]	[redacted]

*If the request involves multiple claims or multiple beneficiaries, attach a list of beneficiaries, HICNs, and any other information to identify all claims being appealed.

5. PROVIDER, PRACTITIONER, OR SUPPLIER	6. SPECIFIC ITEM(S) OR SERVICE(S)
Missouri Baptist Hospital of Sullivan	Laparoscopic cholecystectomy for cholelithiasis

7. Medicare claim type: ☒ Part A ☒ Part B ☐ Part C - Medicare Advantage
☐ Part D - Medicare Prescription Drug Plan ☐ Entitlement/enrollment for Part A or Part B

8. Does this request involve authorization for an item or service that has not yet been furnished?
☐ Yes If Yes, skip to Block 9.
☒ No If No, Specific Dates of Service: [redacted]/2010 - [redacted]/2010

9. If the request involves authorization for a prescription drug under Medicare Part D, would application of the standard appellate timeframe seriously jeopardize the beneficiary's life, health, or ability to regain maximum function (as documented by a physician) such that expedited review is appropriate? ☐ Yes ☐ No

I request that the Medicare Appeals Council review the ALJ's ☒ decision or ☐ dismissal order [check one] dated May 21, 2012. I disagree with the ALJ's action because (specify the parts of the ALJ's decision or dismissal you disagree with and why you think the ALJ was wrong):

Please see attached sheets.

(Attach additional sheets if you need more space)

PLEASE ATTACH A COPY OF THE ALJ DECISION OR DISMISSAL ORDER YOU ARE APPEALING.

DATE	DATE
07/19/2012	07/19/2012
APPELLANT'S SIGNATURE (the party requesting review) Tony Schwarm	REPRESENTATIVE'S SIGNATURE (include signed appointment of representative if not already submitted.) Sheree Kanner/KKE
PRINT NAME Tony Schwarm	PRINT NAME Sheree Kanner
ADDRESS 751 Sappington Bridge Road	ADDRESS 555 13th Street NW
CITY, STATE, ZIP CODE Sullivan, MO 63080	CITY, STATE, ZIP CODE Washington, DC 20004
TELEPHONE NUMBER: 573-468-1343 / FAX NUMBER: / E-MAIL:	TELEPHONE NUMBER: 202-637-2898 / FAX NUMBER: / E-MAIL:

(SEE FURTHER INSTRUCTIONS ON PAGE 2)

Form DAB-101 (08/09)

If you have additional evidence, submit it with this request for review. If you need more time, you must request an extension of time in writing now, explaining why you are unable to submit the evidence or legal argument now.

If you are a provider, supplier, or a beneficiary represented by a provider or supplier, and your case was reconsidered by a Qualified Independent Contractor (QIC), the Medicare Appeals Council will not consider new evidence related to issues the QIC has already considered unless you show that you have a good reason for submitting it for the first time to the Medicare Appeals Council.

IMPORTANT: Include the HICN and ALJ Appeal Number on any letter or other material you submit.

This request must be received within 60 calendar days after you receive the ALJ's decision or dismissal, unless we extend the time limit for good cause. We assume you received the decision or dismissal 5 calendar days after it was issued, unless you show you received it later. If this request will not be received within 65 calendar days from the date on the decision or dismissal order, please explain why on a separate sheet.

You must file your request for review in writing with the Medicare Appeals Council at:

Department of Health and Human Services
Departmental Appeals Board
Medicare Appeals Council, MS 6127
Cohen Building Room G-644
330 Independence Ave., S.W.
Washington, D.C. 20201

You may send the request for review by U.S. Mail, a common carrier such as FedEx, or by fax to (202) 565-0227. If you send a fax, please do not also mail a copy. ***You must send a copy of your appeal to the other parties and indicate that all parties, to include all beneficiaries, have been copied on the request for review. For claims involving multiple beneficiaries, you may submit a copy of the cover letters issued or a spreadsheet of the beneficiaries and addresses who received a copy of the request for review.***

If you have any questions about your request for review or wish to request expedited review of a claim involving authorization of your prescription drug under Medicare Part D, you may call the Medicare Appeals Council's staff in the Medicare Operations Division of the Departmental Appeals Board at (202) 565-0100. You may also visit our web site at www.hhs.gov/dab for additional information on how to file your request for review.

PRIVACY ACT STATEMENT

The collection of information on this form is authorized by the Social Security Act (section 205(a) of title II, section 702 of title VII, section 1155 of Title XI, and sections 1852(g)(5), 1869(b)(1), 1871, 1872, and 1876(c)(5)(B) of title XVIII, as appropriate). The information provided will be used to further document your claim. Information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your claim. Information you furnish on this form may be disclosed by the Department of Health and Human Services or the Social Security Administration to another person or governmental agency only with respect to programs under the Social Security Act and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services, the Social Security Administration, or other agencies.

Attachment 1

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

hdi
Health Data Insights
Region D Recovery Audit Contractor (RAC)

2/4/2011

Review Results Letter

KATHRYN KERCHER-LINK, COMPLIANCE MANAGER
MISSOURI BAPTIST HOSPITAL OF SU
BJC CORPORATE COMPLIANCE
600 SOUTH TAYLOR AVENUE
MAILSTOP 90-94-208
ST LOUIS, MO 63110

Dear Medicare Provider,

The Centers for Medicare & Medicaid Services (CMS) has retained HealthDataInsights, Inc (HDI) to carry out the Recovery Audit Contracting (RAC) program in Region D. The RAC program is mandated by Congress and has a primary goal of identifying Medicare improper payments. Improper payments include overpayments and underpayments. Improper payments may occur because of incorrect coding, lack of sufficient documentation or no documentation, use of an outdated fee schedule or billing for services that do not meet Medicare's coverage and/or medical necessity criteria etc.

Our request for additional medical documentation, detailed in the Additional Documentation Request (ADR) Letter constituted reopening under §1869(b) (1) (G) of the Social Security Act (the Act) and 42 CFR 405.980(a) (1). Our good cause to reopen the claim, if required by 42 CFR 405.980(b) (2), was described in the letter as well.

Based on the medical documentation reviewed for the selected claim(s), HDI found that some of the services you submitted were not reasonable and necessary as required by §1861 of the Act, or did not meet the Medicare coverage requirements as required in §1862 of the Act outlined in the attached Audit Detail page. Along with our claims payment determination, we have made limitations on liability decisions for denials of those services subject to provisions of §1879 of the Act. Those claims for which we determined that you knew, or should have known, that the services were noncovered have been included in the results of this review. In addition, we have made decisions as to whether or not you are without fault for the overpayment under the provisions of §1870 of the Act. Those claims for which you are not without fault have been included in the results of this review. Detailed information regarding each claim and the findings identified during the review are attached to this letter.

If you have additional information to support your claim and wish to discuss this matter, please contact us as soon as possible by fax or mail. and include the Discussion Period Submission Form, which may be found at www.racinfo.com.

Your request to discuss this matter must be in writing and must include evidence to support why you feel the services you provided are covered by Medicare and were properly coded and correctly billed.

HealthDataInsights, Inc
CMS RAC Part A Discussion Period Review
7501 Trinity Peak St, Suite 110
Las Vegas, NV 89128
Fax: (702) 240-5595

The claim(s) identified as improper will be shared with the claim processing contractor and adjustments will be made. After the adjustments are made a demand letter requesting repayment of the improper payment amount will be sent to you.

Thank you for your prompt attention to this matter.

Sincerely,

HealthDataInsights, Inc
Phone: (866) 590-5598

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

AUDIT DETAIL

hdi
Health Data Insights

CONFIDENTIAL

2/4/2011 **Provider Number/Name:** **# 260115** **MISSOURI BAPTIST HOSPITAL OF SU** **Audit ID:** **240856**

Patient ID/Name: [redacted] **DOB:** [redacted]1942 **SEX: M** **Medical Record** [redacted] **Patient Account** [redacted]

Service From Date [redacted]/2010 **Service ThruDate** [redacted]/2010 **Claim Number** [redacted] 02

Presentation:

67M; scheduled admission for 2-3 year history of RUQ abdominal pain that in mainly postprandial, cholelithiasis, for elective laparoscopic cholecystectomy.

Past Medical History:

Cholelithiasis, GERD.

Evaluation/Treatment:

Admit: S/P laparoscopic cholecystectomy; Dilaudid IV PRN x 1, Zofran IV PRN x 1, Percocet PO PRN x 1, continue home medications; operative report: no documented complications, taken to recovery room in satisfactory condition having tolerated the procedure well; nursing progress note: sitting up in bed next morning and feels good, denies nausea and vomiting, ate lunch without nausea, up ambulating in halls, D/C home.

HDI Review Summary:

67 ear old male presented for an elective laparoscopic cholecystectomy for cholelithiasis and was billed as an acute inpatient. Past medical history and the pre-existing conditions were stable. The medical record did not document pre-existing medical conditions or extenuating circumstances, such as post-operative complications, that made the acute inpatient admission medically necessary. The medical record documents services that could have been provided as outpatient services in the hospital. The medical necessity for the inpatient admission is not documented in the medical record.

A-35

Audit Message:

Outpatient services in the hospital billed as acute hospitalization

hdi
Health Data Insights

7501 Trinity Peak Street, Mail Stop #11
Las Vegas, NV 89128
ATTN: FRAUD, ABUSE, AND OVERPAYMENT DEPARTMENT

Return Service Requested

UNITED STATES POSTAGE
02 1P
0006554311
$ 00.44⁰
FEB 04 2011
MAILED FROM ZIP CODE 89128

URGENT: IMMEDIATE ATTENTION REQUIRED

6311081065 0006

Attachment 2

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

hdi
Health Data Insights
Region D Recovery Audit Contractor (RAC)

2/17/2011

Demand Letter

KATHRYN KERCHER-LINK, COMPLIANCE MANAGER
MISSOURI BAPTIST HOSPITAL OF SU
600 SOUTH TAYLOR AVENUE
MAILSTOP 90-94-208
ST LOUIS, MO 63110

Re: MISSOURI BAPTIST HOSPITAL OF SU #260115

Dear Medicare Provider,

The Centers for Medicare & Medicaid Services (CMS) has retained HealthDataInsights, Inc. ("HDI") to carry out the Recovery Audit Contracting (RAC) program in Region D. The RAC program is mandated by Congress aimed at identifying Medicare improper payments.

This letter is to notify you that Medicare has made an overpayment to you, identified and described on the attached AUDIT DETAIL. In order to correct this overpayment, please refund the overpayment amount on the attached audit detail by 3/29/2011.

HDI data analysis of Region D claim data identified claims with improper payments. The reason for the improper payment is listed on the attached audit detail. The results of our data analysis justified reopening your claim under §1869(b)(1)(G) of the Social Security Act and 42 CFR 405.980(a)(1). These results also serve as good cause to reopen the claim, if required by 42 CFR 405.980(b)(2).

Please make the check payable to Medicare and send it with a copy of this letter to the following address:

Regular Mail:	**OverNight Mail:**
WPS Medicare P O Box 1604 Omaha, NE 68101	Provider Reimbursement Wisconsin Physicians Service 3333 Farnam Street, Suite 700 Omaha, NE 68131

To avoid any interest accrual, payment must be made within 30 days from the date of this letter. Providers may request an immediate offset from your claims processing contractor but to avoid interest accrual full payment must be offset within 30 days from the date of this letter. The form is located at http://www.wpsmedicare.com/j5macparta/departments/recovery_audit/_files/immediate_offset_form.pdf. Please see detailed interest section below.

NOTE: If the overpayment is for services that are not medically reasonable and necessary per Medicare standards, and you collected the amount of the overpayment from the beneficiary, the beneficiary has the right to request payment from Medicare. Any such indemnification will be recovered from you.

Key Timeframes

As you review the overpayment, below is some important information and key timeframes (15, 30, 40 and 120 days) to consider:

Immediate:

- **Discussion Period:** The Discussion Period begins with the Review Results Letter for a complex medical record review or with the demand letter for an automated review. The discussion period is the opportunity to submit a statement and accompanying evidence to the RAC indicating why the recoupment should not be initiated. The outcome of the discussion process could change how or if CMS will recoup. The RAC will advise you of its decision in writing. However, the discussion statement is not an appeal of the overpayment determination, and it will not delay/cease recoupment activities. The Discussion Form is located at www.racinfo.com; please fax your discussion materials to:

  Fax: (702) 240-5595

  Phone: (866) 590-5598

15 Days:

- **Rebuttal Process:** Under our existing regulations 42 CFR 405.374, providers, physicians and suppliers have 15 days from the date of this demand letter to submit a rebuttal statement. The rebuttal process provides the debtor the opportunity to submit a statement and accompanying evidence indicating why recoupment should not be initiated. The outcome of the rebuttal process could change how or if CMS will recoup. If you have reason to believe the withhold should not occur on 3/30/2011 you must notify the claim processing contractor before 3/29/2011. CMS will review your documentation. The claim processing contractor will advise you of its decision in writing within 15 days of your request. However, the rebuttal statement is not an appeal of the overpayment determination, and it will not delay/cease recoupment activities.

30 Days:

- **Repayment Plans:** Please contact us immediately if you are unable to refund the entire amount at this time so that we may determine if you are eligible for a repayment plan. Any CMS approved repayment plan would run from the date of this letter. **Recoupment by offset (which starts on day 41) can be averted by submitting a check with your repayment plan application.**

- **Interest Assessment Begins on the 31st Day:** Under Medicare law, 42 CFR 405.378, a refund is required within 30 days from the date of this letter or interest will be assessed. Interest began to accrue as of the date of this demand letter and will continue to accrue at a rate of 10.875%. Beginning on the 31st day interest will be assessed for each full 30-day period payment is not made on time. **If the entire amount is refunded before day 30 no interest will be assessed on the overpayment. Example: An overpayment is identified for $795.45 and a demand letter is sent on 03/01/09. The physician does not remit payment on the overpayment until 04/15/09 (45 days after the date of the initial demand letter). Therefore, on 04/01/09 interest accrues on the $795.45 for one full 30-day period.**

- **Information for those in Bankruptcy:** If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Please contact us immediately to notify us about the bankruptcy so that we may coordinate with CMS and the Department of Justice to assure your situation is handled appropriately. Please supply the name and district under which the bankruptcy is filed if possible.

40 Days:

- **Recoupments:** After 40 days Medicare will begin withholding. NOTE: The withholding of Medicare payments will apply to current and future claims until the full overpayment amount and any applicable interest has been recouped or an acceptable extended repayment request is received.

How to Avoid Paying Interest:

Interest Begins Accruing on the 31st Day: Under Medicare law, 42 CFR 405.378, a refund is required within 30 days from the date of this letter before interest begins accruing. Beginning the 31st day interest will accrue at a rate of 10.875% for each full 30-day period payment is not made on time.

Providers can avoid interest accrual by paying by check or requesting early offset by day 30. The form to request early offset is located on your MAC's website at http://www.wpsmedicare.com/j5macparta/departments/recovery_audit/_files/immediate_offset_form.pdf. This does not affect your appeal rights. You may still file an appeal for up to 120 days from the date of the demand letter. If the provider's appeal is sustained, the provider will be refunded the amount paid by day 30 plus interest at a rate of 10.875% for each full 30-day period following the payment date.

How to Stop Recoupment:

Even if the overpayment and any assessed interest have not been paid in full you can stop Medicare from recouping any payments if you act quickly and decidedly. Medicare will permit providers, physicians and suppliers to stop recoupment at several points. The first occurs if Medicare receives a valid and timely request for a redetermination within 30 days from the date of this letter. If the appeal is filed later than 30 days, we will also stop recoupment at whatever point that an appeal is received but Medicare may not refund any recoupment already taken.

Medicare will again stop recoupment if, following an unfavorable or partially favorable redetermination decision, you decide to act quickly and file a valid request for reconsideration with the Qualified Independent Contractor (QIC). The address and details on how to file a request for reconsideration will be included in the redetermination decision letter.

What are the timeframes to stop recoupment:

First Opportunity: To avoid the recoupment, the appeal request must be filed within 30 days of this letter. We request that you clearly indicate on your appeal request that this is an overpayment appeal and you are requesting a redetermination. Send your appeal request to:

WPS Medicare
Part A Redeterminations
P O Box 1602
Omaha, NE 68101

Second Opportunity: If the redetermination decision is 1) unfavorable Medicare can begin to recoup no earlier than the 61st day from the date of the Medicare redetermination notice (Medicare Appeal Decision Letter) or 2) if the decision is partially favorable, we can begin to recoup no earlier than the 61st day from the date of the Medicare revised overpayment Notice/Revised Demand Letter or, 3) if the appeal request was received and validated after the 60th day Medicare will stop recoupment. The address and details on how to file a request for reconsideration will be included in the redetermination decision letter.

What Happens following a reconsideration by a Qualified Independent Contractor.

Following decision or dismissal by the QIC, if the debt has not been paid in full, Medicare will begin or resume recoupment whether or not you appeal to any further level.
NOTE: Even when recoupment is stopped, interest continues to accrue.

120 Days:

- **Appeals Must be Filed WITHIN 120 days** If you disagree with the overpayment decision, you may file an appeal. You have the option to appeal all of the claims from the overpayment letter or only part of the claims in the overpayment letter. An appeal is a review performed by people independent of those who have reviewed your claim so far. There are multiple levels of appeals. The first level of appeal is" called a **"redetermination."** A redetermination must be filed within 120 days of the date you receive this letter (presume five days following date of this letter). However, if you wish to avoid recoupment from occurring and assessment of interest of this overpayment you need to file your request for redetermination within 30 days from the date of this letter as described above.
- **Filing an Appeal:** A request for a redetermination along with a copy of this letter should be, mailed to:

WPS Medicare
Part A Redeterminations
P O Box 1602
Omaha, NE 68101

NOTE: Interest continues to accrue throughout the appeals process.

Thank you for your cooperation and prompt attention to this overpayment. If you have any questions regarding this letter or would like to discuss the overpayment identification, please direct your inquiry to Provider Services at (866) 590-5598.

Sincerely,

HealthDataInsights, Inc

Notice: "Good Cause" Language: Why HealthDataInsights, Inc. (HDI) Selected These Claims

The attached CMS New Issue Proposal form lists references, guidelines, and improper payment data supporting good cause for correcting these improper payments.

Pursuant to applicable Medicare reopening regulations, including without limitation the Medicare Claims Processing Manual, Chapter 34, Section 10[1], the claims noted on the attached Audit Detail were selected for review for an underpayment or overpayment, as applicable, for the following reasons:

1. There is New and Material Evidence that was not available or known at the time of the determination or decision and may result in a different conclusion; and
2. The evidence that was considered in making the determination or decision clearly shows on its face that an Obvious Error was made at the time of the determination or decision.

New and Material Evidence and Obvious Error made at the time of the initial determination include:

a. Improper or incorrect application of Medicare billing or coding requirements;
b. The medical or other necessary records associated with the claim were not reviewed prior to the initial determination, a coverage or coding determination based upon the information on the claim and its attachments could not be made and there is a high probability that the records do not support the services paid or the service is not covered, and copies of medical records are therefore needed to provide support for the claim; and
c. At the time of the initial determination, data analysis techniques, editing and/or review processes were not applied to the claim.

HDI has reviewed the claims noted on the attached Audit Detail. In accordance with CMS regulations, HDI's data analysis techniques coupled with periodic OIG Reports (www.oig.hhs.gov/oei/reports/oei-03-01-00430.pdf; www.oig.hhs.gov/oei/reports/oei-07-06-00340.pdf, www.oig.hhs.gov/oei/reports), quarterly PEPPER Reports (The Program for Evaluating Payment Patterns Electronic Report, see http://www.PEPPERResources.org/), National and Local Coverage Determinations (NCD/LCD), Coding Clinic, CPT, CPT Assistant, DRG Expert, and National Correct Coding Initiatives Edits (NCCI) resources do not support the services paid, the services would therefore not be covered, and a billing or coding error therefore exists.

A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are separate and distinct from the appeals process. Reopenings are a discretionary action on the part of the contractor. A contractor's decision to reopen a claim determination is not an initial determination and is therefore not appealable. Pub 100-4, Chapter 34, § 10

hdi
Health Data Insights

7501 Trinity Peak Street, Mail Stop #11
Las Vegas, NV 89128
ATTN: FRAUD, ABUSE, AND OVERPAYMENT DEPARTMENT

Return Service Requested

URGENT: IMMEDIATE ATTENTION REQUIRED

89110@1035 0006

Health Data Insights

AUDIT DETAIL

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Provider Number: 260115 **Provider Name: MISSOURI BAPTIST HOSPITAL OF SU**

ISSUE: HDI Data Analysis of CMS Region D claim data identified claims with improper payments. Based on the instructions in the Medicare Benefit Policy Manual, Chapter 1, "when patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered outpatients for coverage purposes regardless of: the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight." The results of our data analysis justified reopening your claim under §1869(b) (1) (G) of the Social Security Act and 42 CFR 405.980(a) (1). These results also serve as good cause to reopen the claim, if required by 42 CFR 405.980(b) (2).

Admit Date:	Discharge Date:	Claim Number	Discharge Status	New Discharge Status	Audit Message:	Overpayment Amount Requested:
Audit ID:	240856					
PatientID/Name:	[redacted]			DOB: [redacted]1942	AR Number: [redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	Outpatient services in the hospital billed as acute hospitalization	$5,591.01

A-44

CMS Sensitive Information – requires special handling - CONFIDENTIAL

If you have any questions, please call HealthDataInsights at (866) 590-5598

Attachment 3

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

August 11, 2011

Evan Pollack, MD, FACP
Executive Health Resources
Government Appeals and Regulatory Affairs Medicare
4 Campus Boulevard
Newtown Square PA 19073

Medicare Number of Beneficiary:
[redacted]

MEDICARE APPEAL DECISION

Dear Evan Pollack:

This letter is to inform you, as representative for Missouri Baptist Hospital of Sullivan, of the decision on your Medicare Appeal. An appeal is a new and independent review of a claim. You are receiving this letter because you requested an appeal for short term care hospital service(s).

This appeal decision is unfavorable. Our decision is that this claim is not covered by Medicare.

More information on the decision is provided below. If you disagree with the decision, you may appeal to a qualified independent contractor. You must file your appeal, in writing, within 180 days of receiving this letter. However, if you do not wish to appeal this decision, you are not required to take any action.

For more information on how to appeal, see the section of this letter entitled, "Important Information About Your Appeal Rights." A copy of this letter was also sent to [redacted]. Wisconsin Physicians Service was contracted by Medicare to review your appeal.

Summary of the Facts

Provider Name:	Missouri Baptist Hospital of Sullivan
Date(s) of Service:	[redacted], 2010 to [redacted], 2010
Type(s) of Service:	Short Term Care Hospital

- A claim was submitted for short term care hospital service(s).
- An initial determination on this claim was made on April 8, 2010.
- This claim was reopened and a revised decision was issued on February 18, 2011.

- The short term care hospital services were denied because the Recover Audit Contractor (RAC) found that the inpatient services should have been billed as outpatient.

- We received a request for a redetermination on June 16, 2011.

Documentation Received with Request

- Appointment of Representation
- Correspondence from Health Data Insights (HDI)

Decision

We have determined that the above claim is not covered by Medicare. We have also determined that the provider is responsible for payment for any service(s) that remain denied.

Explanation of the Decision

The one day of short term care hospital (STCH) services received from [redacted], 2010, to [redacted], 2010, was reviewed. The STCH services were initially denied by the Recovery Audit Contractor (RAC) as the medical records failed to show compelling information to justify the STCH inpatient stay according to Medicare regulations as billed. The STCH services remain denied.

This decision was made in accordance with the Centers for Medicare & Medicaid Services (CMS) Manual System, Publication 100-8, Medicare Program Integrity Manual, Chapter 6, Section 6.5. This regulation requires that the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis. In addition the contractor will review the medical record for medical necessity and diagnosis related groups (DRG) validation. The purpose of DRG validation is to ensure that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical record.

Upon review, this patient was admitted to the STCH on [redacted], 2010, for scheduled laparoscopic cholecystectomy. The records supported that the patient had a history of right upper quadrant abdominal pain which had increased in intensity and frequency over the past year. On the date of admission the patient was in no acute distress. On the date of admission, [redacted], 2010, the patient underwent laparoscopic cholecystectomy without complication. The patient received routine post operative care, including management of nausea and pain. Vital signs were stable. The patient was discharged to home on [redacted], 2010, with a plan to follow-up as an outpatient on [redacted], 2010.

The records did not support that the patient presented with a significant medical risk that would require the inpatient hospital level of care to treat the above conditions. The documentation supported that the patient experienced an uncomplicated presentation upon admission. Medicare regulation stipulates that

the services must be medically reasonable and necessary and be furnished in the most appropriate setting for the services provided.

The documentation did support the DRG billed of 419, laparoscopic cholecystectomy without common duct exploration without complications and comorbidities or major complications and comorbidities. The diagnosis determined to be chiefly responsible for the beneficiary's need for services on the deemed date of admission was the principal diagnosis of 575.11, chronic cholecystitis. The records did not support that the procedure completed required inpatient status according to Medicare guidelines.

In conclusion, in accordance with CMS Manual System, Publication 100-8, Medicare Program Integrity Manual, Chapter 6, Section 6.5, the services provided from [redacted], 2010, to [redacted], 2010, were determined as not medically reasonable and necessary for an inpatient level of care to an STCH facility.

Medicare Regulations and References Used for Decision

- Centers for Medicare & Medicaid Services (CMS) Manual System, Publication 100-2, Medicare Benefit Policy Manual, Chapter 1, Inpatient Hospital Services Covered Under Part A, Section 10 - Covered Inpatient Hospital Services Covered Under Part A
- Centers for Medicare & Medicaid Services (CMS) Manual System, Publication 100-8, Medicare Program Integrity Manual, Chapter 6, Intermediary Medical Review (MR) Guidelines for Specific Services, Section 6.5 - Medical Review of Inpatient Hospital Claims
- Centers for Medicare & Medicaid Services (CMS) Manual System, Publication 100-10, Quality Improvement Organization Manual, Chapter 4, Case Review, Section 4210 – Outlier Review
- Centers for Medicare & Medicaid Services (CMS) Manual System, Publication 100-4, Medicare Claims Processing Manual, Chapter 3, Inpatient Hospital Billing
- Title XVIII of Social Security Act, Section 1879(a) – Limitation on Liability of Beneficiary Where Medicare Claims are Disallowed
- Code of Federal Regulations, Title 42 - Public Health, Volume 2, Section 421.100 – Intermediary functions
- Title XVIII of Social Security Act, Section 1862(1)(A) – Exclusions from Coverage and Medicare as Secondary Payer
- Social Security Act – Obligations of Health Care Practitioners and Providers of Health Care Services; Sanctions and Penalties; Hearings and Review, Section 1156
- Social Security Act – Payment To Hospitals For Inpatient Hospital Services – Subsection 1886 (f)(2)

Who is Responsible for the Bill?

We have reviewed the claim with regard to the issue of whether the services were reasonable and necessary. We found that the services were not reasonable and necessary.

After determining that the service/item will not be covered by Medicare, we must determine who is liable for the denied service/item. Section 1879 of the Social Security Act requires that we must determine if the beneficiary and provider or supplier either knew or could reasonably been expected to know that the service/item would not be covered under 1862(a)(1), 1862(a)(9), or 1879(g) of the Social Security Act. The service(s) affected by these provisions are those that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member or custodial care. Section 1879 of the Social Security Act permits Medicare payment to be

made on behalf of a beneficiary to a provider or practitioner or supplier who has accepted assignment of certain service(s) for which payment would otherwise not be made under Medicare. Medicare may make payment under this situation if neither the beneficiary nor the provider, practitioner, or supplier knew, or could reasonably have been expected to know, that the services were excluded.

After reviewing the claim for short term care hospital service(s), we have determined that [redacted] did not know, and could not have been expected to know, that these services were excluded from coverage. However, we find that the documentation did not support that the service(s) were medically reasonable and necessary, and the provider knew, or could have been expected to know, that these services were excluded. We also find that the provider did not notify the beneficiary in writing, before the services were furnished, that Medicare likely would not pay for the service(s). Because of this, the provider is held liable for the charges for the denied service(s).

We have also determined under Section 1870 of the Social Security Act that the provider is not without fault in regards to this overpayment. We have determined that the provider is liable because they were informed about Medicare coverage and billing guidelines through the references noted in the "Explanation of Decision" section of this letter. Therefore, they were aware of correct billing and coverage criteria for the service(s) billed.

If you do not agree with this determination regarding the liability, on the basis that the services were necessary, or on the basis that the provider did not know, and could not reasonably have been expected to know, that Medicare would not pay for the service(s), or on the basis that they notified the beneficiary in writing, before the services were furnished, that Medicare likely would not pay for the service(s), you may request a reconsideration within 180 days of receipt of this notice, at which time you may present any new evidence that would have a material effect on this determination. Our office, or your social security office, will assist you if you need help in requesting a reconsideration.

What to Include in Your Request for an Independent Appeal

For [redacted], 2010 to [redacted], 2010:

- Records to support that the patient met Medicare regulations for admission to an STCH facility

Special note to Medicare physicians, providers, and suppliers only: Any additional evidence as indicated in this section should be submitted with the request for reconsideration. All evidence must be presented before the reconsideration is issued. If all additional evidence as indicated above and/or otherwise is not submitted prior to issuance of the reconsideration decision, you will not be able to submit any new evidence to the administrative law judge or further appeal unless you can demonstrate good cause for withholding the evidence from the qualified independent contractor.

NOTE: You do not need to resubmit documentation that was submitted as part of the redetermination. This information will be forwarded to the QIC as part of the case file utilized in the reconsideration process.

Sincerely,

Loretta Lee
Redetermination Rep
Wisconsin Physicians Service
A Medicare Contractor

CC: [redacted]

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

Your Right to Appeal this Decision: If you do not agree with this decision, you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claim so far. The next level of appeal is called a reconsideration. A reconsideration is a new and impartial review performed by a company that is independent from Wisconsin Physicians Service.

How to Appeal: To exercise your right to an appeal, you must file a request, in writing, within 180 days of receiving this letter. Under special circumstances, you may ask for more time to request an appeal. You may request an appeal by using the form enclosed with this letter.

If you do not use this form, you can write a letter. You must include: your name, your signature, the name of the beneficiary, the Medicare number, a list of service(s) or item(s) that you are appealing and the date(s) of service, and any evidence you wish to attach. You must also indicate that Wisconsin Physicians Service made the redetermination. You may also attach supporting materials, such as those listed in item 10 of the enclosed Reconsideration Request Form, or other information that explains why this service should be paid. Your doctor may be able to provide supporting materials.

If you want to file an appeal, you should send your request to:

Maximus Federal Service Inc
QIC Part A West Reconsideration
PO Box 62410
King of Prussia PA 19406

Who May File an Appeal: You or someone you name to act for you (your appointed representative) may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you.

If you want someone to act for you, you may visit http://www.medicare.gov/basics/forms/default.asp to download the "Appointment of Representative" form, which may be used to appoint a representative. Medicare does not require that you use this form to appoint a representative. Alternately, you may submit a written statement containing the same information indicated on the form. If you are a Medicare enrollee, you may also call 1-800-MEDICARE (1-800-633-4227) to learn more about how to name a representative.

Other Important Information: If you want copies of statutes, regulations, policies, and/or manual instructions CMS used to arrive at this decision, or if you have any questions specifically related to your appeal, please write to us at the following address and attach a copy of this letter.

Wisconsin Physicians Service
A Medicare Contractor
Attention: Appeals
PO Box 1602
Omaha NE 68101

Resources for Medicare Enrollees: If you want help with an appeal, or if you have questions about Medicare, you can have a friend or someone else help you with your appeal. You can also contact your State health insurance assistance program (SHIP). You can find the phone number for your SHIP in your "Medicare & You" handbook, under the "Helpful Contacts" section of www.medicare.gov Web site, or by calling 1-800-MEDICARE (1-800-633-4227). Your SHIP can answer questions about payment denials and appeals.

For general questions about Medicare, you can call 1-800-MEDICARE (1-800-633-4227), TTY/TDD: 1-877-486-2048.

Remember that specific questions about your appeal should be directed to the contractor that is processing your appeal.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

Redetermination/Appeals Number: L77X42-9R9160

Reconsideration Request Form

Directions: If you wish to appeal this decision, please fill out the required information below and mail this form to the address shown below. At a minimum, you must complete/include information for items 1, 2a, 6, 7, 11 & 12, but to help us serve you better, please include a copy of the redetermination notice with your request.

Maximus Federal Service Inc
QIC Part A West Reconsideration
PO Box 62410
King of Prussia PA 19406

1. Name of Beneficiary: _____
2a. Medicare Number: _____
2b. Claim Number (ICN/DCN, if available): _____
3. Provider Name: _____
4. Person Appealing: ☐ Beneficiary ☐ Provider of Service ☐ Representative
5. Address of Person Appealing: _____
6. Item or service you wish to appeal: _____
7. Date of Service: From ____/____/____ To ____/____/____
8. Does this appeal involve an overpayment? ☐ Yes ☐ No
9. Why do you disagree? Or what are your reasons for your appeal? (Attach additional pages, if necessary): _____
10. You may also include any supporting material to assist your appeal. Examples of supporting materials include:
    ☐ Medical Records ☐ Office Records/Progress Notes ☐ Copy of the Claim
    ☐ Treatment Plan ☐ Certificate of Medical Necessity
11. Name of Person Appealing: _____
12. Signature of Person Appealing: _____ Date: ____/____/____

Contractor Number: 52280

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

August 11, 2011

[redacted]

Provider Name: Missouri Baptist Hospital of Sullivan
Date(s) of Service: [redacted], 2010 to [redacted], 2010
Type(s) of Service: Short Term Care Hospital
Medicare Number of Beneficiary: [redacted]

An appeal was requested by Evan Pollack for the service(s) you received as noted above. Attached is a copy of the appeal decision letter.

This letter is for your records only. You are not required to take any action as a result of this decision.

Sincerely,

Loretta Lee
Redetermination Rep
Wisconsin Physicians Service
A Medicare Contractor

Attachment 4

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

EXECUTIVE HEALTH RESOURCES
RECEIVED
MAR 06 2012
DOCUMENT CONTROL GROUP

Medicare Appeal Number: 1-880744756

MAXIMUS Federal Services

If you have questions, write or call:

MAXIMUS Federal Services
QIC Part A West
P.O. Box 62410
King of Prussia, PA 19406

Provider Inquiries

Visit: www.q2a.com
Or
Call: 484-688-8900

Beneficiary Inquiries

Call:

1-800-MEDICARE
Or
1-800-633-4227

Who we are:

We are MAXIMUS Federal Services. We are experts on appeals. Medicare hired us to review your file and make an independent decision.

March 2, 2012

EXECUTIVE HEALTH RESOURCES
ATTN: MEDICARE APPEALS DEPARTMENT
4 CAMPUS BLVD.
NEWTOWN SQUARE, PA 19073

RE: Beneficiary: [redacted]
HIC #: [redacted]
Appellant: Executive Health Resources

Dear Executive Health Resources:

This letter is to inform you of the decision on your Medicare Appeal. An appeal is a new and independent review of a claim. You are receiving this letter because you requested an appeal for inpatient services provided to [redacted], the beneficiary, on [redacted], 2010 to [redacted], 2010.

The appeal decision is unfavorable. Our decision is that your claim is not covered by Medicare. We have determined that the provider is liable. Please see below regarding further appeal rights.

More information on the decision is provided below. You are not required to take any action. However, if you disagree with the decision, you may appeal to an Administrative Law Judge (ALJ). You must file your appeal, in writing, within 60 days of receipt of this letter. For more information on how to appeal, see the page titled "Important Information About Your Appeal Rights." The amount still in dispute is estimated to exceed the amount required to file an appeal at the ALJ Hearing level.

A copy of this letter was also sent to the beneficiary.

MAXIMUS Federal Services (MAXIMUS) was contracted by Medicare to review your appeal.

Appeal Details at Issue

Document Control Number	Provider	Dates of Service
[redacted]	Missouri Baptist Hospital Of Sullivan	[redacted], 2010 to [redacted], 2010

Summary of the Facts

Missouri Baptist Hospital Of Sullivan, the provider, billed for inpatient services provided to the beneficiary on [redacted], 2010 to [redacted], 2010. Upon initial determination, Wisconsin Physician Services, the Medicare Administrative Contractor with jurisdiction, allowed payment for the services. However, HealthDataInsights (HDI), a Recovery Audit Contractor (RAC), determined that an overpayment had occurred. At redetermination Wisconsin Physician Services denied payment for services again on August 11, 2011. MAXIMUS received a request for reconsideration on January 4, 2012.

Decision

We have determined that Medicare does not cover the claim for the inpatient services provided to the beneficiary on [redacted], 2010 to [redacted], 2010. We have also determined that the provider is responsible for payment for the inpatient services at issue.

Explanation of the Decision

The issue is whether the inpatient services provided to the beneficiary on [redacted], 2010 to [redacted] 2010 met Medicare criteria for coverage.

Inpatient hospital care, rather than hospital 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. For inpatient care, the medical record must indicate that inpatient care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis. (Medicare Program Integrity Manual, Publication 100-8, Chapter 6, Section 6.5.2)

For inpatient hospital care, admitting physicians or other practitioners should use a 24-hour period as a benchmark, i.e., they should order inpatient admission for patients who are expected to need such care for 24 hours or more, and treat other patients on an outpatient

basis. However, the decision whether to admit as an inpatient is a complex medical judgment, which includes consideration of a variety of factors, including:

- The patient's medical history and current medical needs;
- The types of facilities available to inpatients and outpatients, the hospital's bylaws and admission policies, and the relative appropriateness of treatment in each setting;
- The severity of the signs and symptoms exhibited by the beneficiary;
- The medical probability of something adverse happening to the beneficiary;
- The need for diagnostic studies that are appropriately outpatient services to assist in assessing the need for inpatient admission; and
- The availability of diagnostic procedures at the time when and at the location where the beneficiary presents.

(Medicare Benefit Policy Manual, Publication 100-2, Chapter 1, Section 10).

Outpatient observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether a patient will require further treatment as a hospital inpatient, or if s/he can be discharged from the hospital. Thus, a patient receiving hospital observation services may improve and be released, or be admitted as an inpatient. In the majority of cases, the decision whether to admit as an inpatient or discharge can be made in less than 48 hours, usually in less than 24 hours. (Medicare Benefit Policy Manual, Publication 100-2, Chapter 6, Section 20.6; Medicare Claims Processing Manual, Publication 100-4, Chapter 4, Section 290).

In this case, Wisconsin Physician Services determined that the services failed to meet Medicare criteria for coverage because the services were not reasonable and medically necessary. When requesting this appeal, the appellant argued that the services were reasonable and necessary and met Medicare coverage criteria.

A panel of licensed healthcare professionals reviewed this case and determined that the services at issue did not meet Medicare coverage criteria.

The beneficiary had a medical history that was significant for cholelithiasis and Gastroesophageal Reflux Disease (GERD). The beneficiary was admitted for an elective laparoscopic cholecystectomy (removal of the gall bladder). There were no acute signs or symptoms at the time of admission and no uncontrolled comorbid conditions. The procedure note documented that the gallbladder was withdrawn in its entirety. There was negligible blood loss and the beneficiary tolerated the procedure well. The Post-Anesthesia Care Unit (PACU) course was uneventful and the beneficiary was admitted to the hospital with orders for routine monitoring of vital signs, intravenous fluids, and pain and antiemetic medication as necessary. The beneficiary was discharged home the following day. There was documentation from the physician stating the beneficiary was admitted as an inpatient for nausea.

Medicare coverage criteria were not met for an inpatient hospital level of care. Laparoscopic cholecystectomy is not on the CMS inpatient-only list, and is routinely performed as an outpatient surgery. Some patients may require an inpatient admission for this procedure when

there is an unanticipated complication during the procedure, bleeding or other problems following the procedure, or active comorbidities that require complex management. In this case, however, there was no clinical evidence during or after the procedure that would suggest that an inpatient level of service was required for safe and effective monitoring of the beneficiary following the procedure. There was no mention of hypotension, chest pain, arrhythmia, significant bleeding, fever, ileus, or other new symptoms or complications. Given the lack of complications during and immediately following the procedure, the beneficiary was at low risk for subsequent complications and could have been safely monitored overnight on observation status, to watch for any signs of complications such as bleeding or other issues.

The inpatient hospital services at issue were not reasonable and medically necessary. The beneficiary must demonstrate signs and/or symptoms severe enough to warrant medical care and must receive services of such intensity that they could be furnished safely and effectively only on an inpatient basis. The documentation submitted for review did not support that the beneficiary required an inpatient level of care. Therefore, Medicare cannot cover the inpatient hospital services at issue.

Additional Information

Medicare requires that all evidence be presented before the reconsideration is issued. On further appeal, an ALJ will not consider any new evidence unless you show good cause for not presenting the evidence to the Qualified Independent Contractor (QIC). This requirement does not apply to beneficiaries, unless a provider or supplier represents the beneficiary. (42 Code of Federal Regulations Section 405.966).

You can receive copies of statutes, regulations, policies, and/or manual instructions we used to arrive at this decision. For instructions on how to do this, please see 'Other Important Information' on the page titled "Important Information About Your Appeal Rights."

Who is Responsible for the Bill?

Because we determined that the services in question did not meet Medicare coverage criteria, under the Social Security Act, Title 18, Section 1879, we must determine whether the beneficiary and/or provider knew or could reasonably have been expected to know that the services would not be covered under Medicare.

The case file did not include an Advance Beneficiary Notice or any other documentation that the beneficiary had been given prior written notice that Medicare would not pay for the inpatient services at issue. Therefore, we have concluded that the beneficiary in this case did not know, or could not reasonably have known, that any of these items or services would not be covered by Medicare, and the beneficiary is not financially responsible for these noncovered charges.

Since we have found that the beneficiary is not liable, we must next determine whether the provider should be held liable for any of these noncovered items or services. The provider has received or has access to CMS notices, including manual issuances, bulletins, of other written

guides or directives from Medicare contractors, describing the basis for excluding certain services from Medicare coverage. Similarly, the provider has access to Federal Register publications containing notice of national coverage decisions or of other specifications regarding noncoverage of an item or service. Therefore, we have determined that the Missouri Baptist Hospital Of Sullivan is responsible for payment of the inpatient services because it knew, or could reasonably have been expected to know, that Medicare payment for the service or item would be denied. (CMS Medicare Claims Processing Manual, Publication 100-4, Chapter 30, Section 40.1).

If you have any questions, please call the phone number on the front of this letter. For information on how to appeal this decision, please see the page entitled "Important Information About Your Appeal Rights."

Sincerely,

Maddy S. Gruber

Maddy S. Gruber, J.D., B.S.N.
Project Director

MSG/NC/JK

cc:

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

Your Right to Appeal this Decision

If you do not agree with this decision, you may file an appeal. An appeal is a review performed by people independent of those that have reviewed your claim so far. The next level of appeal is called an Administrative Law Judge (ALJ) Hearing. At this hearing, you or your representative may represent your case before an ALJ.

You must have at least **$130** still in dispute. This appeal can be combined with others to reach this total, if the other claims were appealed and decided within 60 days of this new request for an appeal, and involve similar or related services.

How to Appeal

To exercise your right to appeal, you must file a request in writing within **60 days** of receiving this letter. Under special circumstances, you may ask for more time to request an appeal.

In your request you must include: (1) The name, address, and Medicare health insurance claim number of the beneficiary, (2) The name and address of the person appealing, if the person is not the beneficiary, (3) The name and address of the representative, if any, (4) The appeal number listed on the front page of this notice, (5) The dates of service, (6) The reasons why you disagree with the decision, (7) Any and all evidence you wish to submit and the date it will be submitted, (8) A statement that you have sent a copy of this request to the other parties to the appeal, and (9) If you wish to combine claims to meet the **$130** amount, include a list of the claims.

ALJ hearings are usually held by video-teleconference (VTC) to make sure you get a hearing and decision as fast as possible. VTC hearings reduce travel time for you, ALJs, and witnesses. If you do not want a VTC hearing, you may ask for a hearing in person, which will be granted for good cause. Your request must be in writing. Your request must give a good reason why you don't want a VTC hearing. If your request for an in-person hearing is granted, a hearing will be held and a decision issued as soon as possible. However, you give up the right to get a decision in the 90-day time limit that usually applies to ALJ decisions. If you want to file an appeal, you should send your request, along with the first page of this decision to:

HHS OMHA Centralized Docketing
200 Public Square, Suite 1260
Cleveland, OH 44114-2316

Please direct your inquiries to any one of the following toll-free numbers.
Arlington, VA: 866-231-3087
Cleveland, OH: 866-236-5089
Irvine, CA: 866-495-7414
Miami, FL:866-622-0382

Who May File an Appeal

You or someone you name to act for you (your **appointed representative**) may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you.

If you want someone to act for you, you and your appointed representative must sign, date and send us a statement naming that person to act for you. Call 1-800-MEDICARE to learn more about how to name a representative.

Help With Your Appeal

If you want help with an appeal, or if you have questions about Medicare, you can have a friend or someone else help you with your appeal. You can also contact your State Health Insurance Assistance Program (SHIP). You can call 1-800-MEDICARE (1-800-633-4227) for information on how to contact your local SHIP. Your SHIP can answer questions about payment denials and appeals.

Other Important Information

If you want copies of statutes, regulations, policies, and/or manual instructions we used to arrive at this decision, please write to us at the following address and attach a copy of this letter:

MAXIMUS Federal Services
QIC Part A West
P.O. Box 62410
King of Prussia, PA 19406

If you need more information or have any questions, please call us at the phone number provided on the front of this notice.

[6]

Other Resources To Help You

1-800-MEDICARE (1-800-633-4227),
TTY/TDD: 1-800-486-2048

Attachment 5

Department of Health and Human Services
Office of the Secretary

OFFICE OF MEDICARE HEARINGS AND APPEALS

Mid-Atlantic Field Office
1700 N. Moore Street, Suite 1600
Arlington, VA 22209
703-235-0638 (Office Main Number)
703-235-0701 (Main Fax Number)

May 21, 2012

Missouri Baptist Hospital of Sullivan
Attn: Katherine Kercher-Link
600 South Taylor Ave
Mailstop 90-94-208
St. Louis, MO 63110

Subject: **Notice of Decision – Unfavorable**

Dear Ms. Kercher-Link:

Enclosed is the decision of the Administrative Law Judge (ALJ) on your Medicare appeal. ALJ Number **1-934979291**. Please carefully review this notice and the attached decision.

Your Appeal Rights

If you do not agree with the ALJ's decision, you may appeal the decision by filing a Request for Review with the Medicare Appeals Council (MAC). Other parties to your appeal may also ask the MAC to review the ALJ's decision. In some cases, the Centers for Medicare and Medicaid Services (CMS) or its contractors may also ask the MAC to review the ALJ's decision, or the MAC otherwise may decide to review the ALJ's decision on its own motion. If no party appeals, and the MAC does not review the ALJ's decision at the request of CMS or its contractors or otherwise review the ALJ's decision on its own motion, the ALJ's decision is binding on all parties and you will have no right to ask a federal court to review the ALJ's decision.

If you are not already represented, you may appoint an attorney or other person to represent you in any filings or proceedings before the MAC. Legal aid groups may provide legal services at no charge. If you or your representative have not completed or submitted an *Appointment of Representative* (Form CMS-1696), please contact the MAC for further instructions or to obtain a form.

What to Include in Your Request for Review

Your appeal must identify the parts of the ALJ's decision with which you disagree, and explain why you disagree. For example, if you believe that the ALJ's decision is inconsistent with a statute, regulation, CMS ruling, or other authority, you should explain why the decision is inconsistent with that authority.

You may submit a Request for Review with the MAC in either of the following two ways:

1. Complete and submit the enclosed *Request for Review* (Form DAB-101).

2. Submit to the MAC a written request that contains all of the following information:

   - The beneficiary's name and telephone number;
   - The beneficiary's Medicare Health Insurance Claim Number (HICN);
   - The item or service in dispute;
   - The specific date(s) the item(s) or service(s) were provided;
   - The date of the ALJ decision;
   - The ALJ appeal number;
   - The parts of the ALJ's decision with which you disagree and an explanation of why you disagree; and
   - Your name and signature and/or the name and signature of your representative.

Please send a copy of the ALJ's decision with your Request for Review.

When and Where to File the Request for Review

You must submit your request to the MAC **within sixty (60) days** of receipt of this notice. The MAC will assume you received this notice five (5) days after the date indicated at the top of this notice unless you show that you received this notice at a later date. If you file your Request for Review late, you must establish that you had good cause for submitting the request late.

Your Request for Review should be mailed to:

Department of Health and Human Services
Departmental Appeals Board
Medicare Appeals Council, MS 6127
Cohen Building Room G-644
330 Independence Ave., S.W.
Washington, D.C. 20201

Alternatively, you may fax your request to (202) 565-0227. If you send a fax, please **do not** also mail a copy. ***You must always send a copy of your Request for Review to the other parties to***

your ALJ hearing. If you do not have the addresses of the other parties, please contact our office.

What Procedures Apply to the MAC's Review of Your Appeal

The Medicare regulations at 42 C.F.R. Part 405, Subpart I, apply to this case.

How the MAC May Respond to Your Request for Review

The MAC will limit its review to the issues raised in the appeal, unless the appeal is filed by an unrepresented beneficiary. The MAC may change the parts of the ALJ's decision that you agree with. The MAC may adopt, change, or reverse the ALJ's decision, in whole or in part, or it may send the case back to an ALJ for further action. The MAC may also dismiss your appeal.

Where to Obtain Additional Information About the MAC

Additional information about the MAC is available on the Departmental Appeals Board's website at http://www.hhs.gov/dab/reconsiderationqic.html. You can also obtain additional information by contacting the MAC at (202) 565-0100.

Questions About the Decision

If you would like additional information concerning the attached decision, please call or write this office at: 1700 N. Moore Street, Suite 1600, Arlington, VA 22209.

Robin Thompson
Paralegal

Enclosures:
OMHA-152, Decision
OMHA-156, Exhibit List
DAB-101, Request for Review

cc: Executive Health Resources, Inc. - Attn: Angela Holmes
Health Data Insights - Region D RAC Recovery
Maximus Federal Services Part A QIC West

Department of Health and Human Services
OFFICE OF MEDICARE HEARINGS AND APPEALS
Mid-Atlantic Field Office
Arlington, Virginia

Appeal of:	**Missouri Baptist Hospital of Sullivan**	ALJ Appeal No.:	**1-934979291**
		QIC Appeal No.:	**1-880744756**
Beneficiary:	[redacted]	Medicare Part:	**A**
HICN:	[redacted]	Before:	**Leslie Holt** **U.S. Administrative Law Judge**

DECISION

Medicare Part A does not cover the Beneficiary's inpatient hospital services rendered from [redacted], 2010 to [redacted], 2010 because, pursuant to Title XVIII §§ 1862(a)(1)(A) and 1815(a) of the Social Security Act, the documentation does not support the contention that the services were reasonable and necessary for treatment of the Beneficiary's condition. Specifically, the services were not reasonable and necessary because there is no evidence of inpatient treatment or diagnostic testing sufficient to warrant payment. Accordingly, an **UNFAVORABLE** decision is entered for Missouri Baptism Hospital of Sullivan ("Appellant").

PROCEDURAL HISTORY

The Appellant submitted a claim for the inpatient admission services provided to the Beneficiary from [redacted], 2010 to [redacted], 2010 and the claim was initially paid by Medicare. On February 17, 2011, the Carrier issued a letter to the Appellant requesting overpayment recoupment for services billed to Medicare. (Exh. 3). Based on review of the file, the submitted claim should have been denied which resulted in an overpayment of $5591.01. (*Id.*).

The Contractor upheld the overpayment upon redetermination on August 11, 2011. (Exh. 4, pp. 1-5). Appellant requested reconsideration from Maximus Federal Services, the Qualified Independent Contractor (QIC). The QIC upheld the overpayment on March 2, 2012, stating that the initial level of service could have been safely performed at the observation level of care or as an outpatient. (Exh. 5, pp. 1-5). The QIC found the Provider liable for the services. *Id.*

On March 23, 2012, the Appellant filed a timely request for hearing by an Administrative Law Judge ("ALJ") at the Office of Medicare Hearings and Appeals. (Exh. 6, pp. 1-5). The amount in controversy meets the statutory requirements for a hearing before OMHA. *42 C.F.R. § 405.1006.* A telephonic hearing was held on May 10, 2012. Dr. Melissa Urrea and Charles Koch, Esquire, from Executive Health Resources, represented the Appellant and provided argument and testimony. All parties were sworn and the exhibits were admitted without objection.

Health Data Insights, RAC, as a CMS contractor, chose to participate in the hearing as a non-party participant pursuant to 42 C.F.R. § 405.1010(c). (*See* Exh. 7). Dr. Peter Gurk was present at the hearing for Health Data Insights.

Maximus Federal Services, as a CMS contractor, chose to participate in the hearing as a non-party participant by being present at the hearing and submitting a position paper pursuant to 42 C.F.R. § 405.1010(c). The position paper was admitted into evidence. (*See* Exh. 8). Stephanie Barr, Esquire, was present at the hearing for Maximus Federal Services.

ISSUES

Whether Medicare Part A covers the Beneficiary's inpatient hospital services rendered on the dates of service, and if not, whether the Beneficiary or Appellant is liable for any non-covered services.

FINDINGS OF FACT

1. The Appellant is seeking reimbursement for hospital inpatient admission services provided to the Beneficiary on [redacted], 2010 to [redacted], 2010.

2. The Beneficiary, 67 years-old, complained of right upper quadrant pain and vomiting. Diagnostic studies revealed cholelithiasis. The Beneficiary was scheduled to have a laparoscopic cholecystectomy performed on [redacted], 2010. The Beneficiary's illness and procedure was noted as having "one" level of severity and requiring a short stay for less than 24 hours. (Exh. 1, pp. 3-5, 51-53).

3. The lab work and EKG performed on [redacted], 2010 were predominantly normal. The ASA stage assigned by the anesthesiologist was 2, indicating mild systemic disease, such as reflux, bilateral hand tremors and hyperproteinemia. No other complications or conditions were noted. (Exh. 1, pp. 39-41, 64).

4. On [redacted], 2010, the Beneficiary had a laparoscopic cholecystectomy lasting approximately twenty minutes with no noted complications, negligible blood loss, and no bile leaks. The Operative notes indicate that the Beneficiary tolerated the procedure well. (Exh. 1, pp. 56-57, 61-62).

5. On [redacted], 2010, the physician ordered admission for overnight monitoring. (Exh. 1, p. 33).

6. Nurses monitored the Beneficiary and noted that his vital signs were stable during admission. The Beneficiary complained of pain and was given medication with good effect. The Beneficiary also complained of nausea and vomiting and was given medication with good effect. By [redacted], 2010, the nausea had subsided and the Beneficiary was able to eat. (Exh. 1, pp. 7-32).

7. On [redacted], 2010, the physicians deemed the Beneficiary sufficiently stable for discharge. (Exh. 1, pp. 1, 65).

LEGAL FRAMEWORK

I. Administrative Law Judge Authority, *Jurisdiction, Scope of Review and Standard of Review*

An individual or organization that is dissatisfied with a reconsideration of a Carrier's initial determination is entitled to a hearing before the Secretary provided there is a sufficient amount in controversy and a request for hearing is filed in a timely manner. Title XVIII § 1869(b)(1)(A) of the Act. The Secretary administers the nationwide hearings and appeals system through the Office of Medicare Hearings and Appeals ("OMHA"). Administrative Law Judges ("ALJs") within OMHA issue the final decisions of the

Secretary, except for decisions reviewed by the Medicare Appeals Council. *See* 74 Fed. Reg. 65297 (December 9, 2009).

All initial determinations by the Centers for Medicare and Medicaid Services ("CMS") contracted Intermediaries or Carriers *prior* to January 1, 2006, are governed by the ALJ hearing procedures set forth at 20 C.F.R. §§ 404.929 through 404.961 *and* 42 C.F.R. §§ 405.720 and 405.855. Initial determinations by the CMS contracted Intermediaries or Carriers *after* January 1, 2006, are governed by the ALJ hearing procedures set forth at 42 C.F.R. §§ 405.1000 through 405.1054.

With respect to the dates of service at issue, a request for ALJ hearing meets the amount in controversy requirement if it comports with 42 C.F.R. § 405.1006(b)(1). A request for ALJ hearing is timely if filed within sixty days after receipt of the notice of the Qualified Independent Contractor ("QIC") decision. *See* 42 C.F.R. § 405.1002(a)(1).

OMHA is staffed with ALJs who are qualified and appointed pursuant to the Administrative Procedure Act. They act as independent finders of fact in conducting hearings pursuant to Title XVIII § 1869 of the Act. ALJs conduct 'de novo' hearings of the facts and law. *See* 42 C.F.R. § 405.1000(d); 74 Fed. Reg. 65,316 (Dec. 9, 2009).

Issues before the ALJ include all the issues brought out in the initial determination, redetermination, or reconsideration that were not decided entirely in Appellant's favor. However, if the evidence presented before or during the hearing causes the ALJ to question a favorable portion of the determination, he or she will notify Appellant and will consider it an issue at the hearing. 42 C.F.R. § 405.1032(a). The ALJ may decide a case on the record and not conduct an oral hearing if the evidence in the hearing record supports a finding in favor of appellants on every issue. 42 C.F.R. § 405.1038(a).

II. Principles of Law – *Part A Inpatient Hospital Services, Statutes and Regulations*

Title XVIII, Part A of the Act sets out the Hospital Insurance Benefits for the Aged and Disabled, which provides coverage for a variety of medical services. Significantly, Part A benefits provided to an individual shall consist of entitlements to have payment made to him, or on his behalf, inpatient hospital services or inpatient critical access hospital services for up to 150 days during any spell of illness minus 1 day for each day of such services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made). Title XVIII § 1812(a)(1) of the Act. The Act also sets forth the definition of "hospital" at Title XVIII § 1861(e) and the definition of "inpatient hospital services" at Title XVIII § 1861(b).

Notwithstanding any other provision of Title XVIII of the Act, no payment may be made under Part A or Part B for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Title XVIII § 1862(a)(1)(A) of the Act.

Title 42 of the Code of Federal Regulations sets forth regulations promulgated by CMS for Medicare program implementation. *See* 42 C.F.R. § 400 *et. seq.* In pertinent part, 42 C.F.R. §§ 409.10 through 409.18 state the regulations that are applicable to Medicare Part A inpatient hospital services. 42 C.F.R. § 409.10 provides that "inpatient hospital or inpatient CAH services" means the following services furnished to an inpatient of a participating hospital or of a participating CAH or, in the case of emergency

services or services in foreign hospitals, to an inpatient of a qualified hospital: (1) Bed and board; (2) Nursing services and other related services; (3) Use of hospital or CAH facilities; (4) Medical social services; (5) Drugs, biologicals, supplies, appliances, and equipment; (6) Certain other diagnostic or therapeutic services; (7) Medical or surgical services provided by certain interns or residents-in-training; and (8) Transportation services, including transport by ambulance. 42 C.F.R. § 409.10(a).

Additionally, 42 C.F.R. § 424.13(a) provides, "Requirements for inpatient services of hospitals other than psychiatric hospitals" states that "Medicare Part A pays for inpatient hospital services of hospitals other than psychiatric hospitals only if a physician certifies and recertifies the continued hospitalization of the patient for medical treatment or medically required inpatient diagnostic study."

Title XVIII § 1870 of the Social Security Act provides the authority for waiver of overpayments and other payment adjustments for incorrect payments on behalf of individuals. Overpayments shall not be recovered with respect to an individual who is "without fault" and where such recoupment "would be against equity and good conscience."

III. Principles of Law – *Part A Inpatient Hospital Services, CMS Policy and Guidance*

Medicare Part A covers services provided to beneficiaries who are patients in a qualified hospital participating in the Medicare program for up to 90 days in any one "spell of illness". Title XVIII § 1812(a)(1) of the Act. These services are defined as "inpatient" hospital services. Medicare defines "inpatient" as a person who has been admitted to a hospital for bed occupancy for the purpose of receiving inpatient hospital services. A person is considered an inpatient if formally admitted as an inpatient with the expectation of remaining at least overnight and occupying a bed. CMS, *Medicare Benefit Policy Manual (MBPM) (Internet-Only Manual Publ'n 100-02) Chapter 1, § 10.* Ultimately, the decision to admit a patient as an inpatient is up to the discretion of the physician or other practitioner responsible for a patient's care at the hospital. *MBPM 100-02,* ch. 1, § 10, provides that:

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 for 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 to 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.

CMS, *Medicare Program Integrity Manual (MPIM) (Internet-Only Manual Publ'n 100-08) Chapter. 6, § 6.5.2.* states that medical review of acute inpatient prospective payment system hospital or long-term care hospital claims are to be based on data analysis and prioritized medical review strategies. Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. The beneficiary

must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

In determining medical necessity and appropriateness of admission, the reviewer shall consider, in review of the medical record, any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary. Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission. When such factors affect the beneficiary's health, consider them in determining whether inpatient hospitalization was appropriate.

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. Without accompanying medical conditions, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, or that may cause the beneficiary to worry, do not justify a continued hospital stay.

When it is determined that the beneficiary did not require an inpatient level of care on admission, but that the beneficiary's condition changed during the stay and inpatient care became medically necessary, the first day on which inpatient care is determined to be medically necessary is deemed to be the date of admission. The deemed date of admission applies when determining cost outlier status (i.e., days or services prior to the deemed date of admission are excluded for outlier purposes) and the diagnosis determined to be chiefly responsible for the beneficiary's need for covered services on the deemed date of admission is the principal diagnosis. The claim is then adjusted according to the diagnosis determined to be responsible for the need for medically necessary care to have been provided on an inpatient basis. When you determine that the beneficiary did not require an inpatient level of care at any time during the admission, deny the claim in full.

CMS, *Quality Improvement Organization Manual (QIOM) (Internet-Only Manual Publ'n 100-10).* Chapter 4, Section 4110 of the QIOM provides the following guidance on review of inpatient hospital admissions:

QIOs must conduct review of admissions and discharges as specified in 42 CFR 476.71(a)(6). Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient at any time during the stay. The patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

HCFA Ruling 93-1 clarifies the position of the Health Care Financing Administration (now CMS) concerning the weight to be given to a treating physician's opinion in determining coverage of inpatient hospital and skilled nursing facility care. The physician's certification of the medical need for inpatient hospital services is only the first step in determining whether those services will be covered. A patient usually is admitted to a hospital only upon the advice of the treating physician.

Notably, HCFA Ruling 93-1 identifies the physician as an central figure when determining whether inpatient hospital services meet the coverage requirements of Title XVIII § 1862(a)(1)(A) of the Act. This long-standing, general approach to coverage can be traced to the Congressional committee reports that accompanied the enactment of the Medicare program in 1965. The Senate Finance Committee emphasized "that the physician is to be the key figure in determining utilization of health services--and ... it is a physician who is to decide upon admission to a hospital, order tests, drugs, and treatments, and determine

the length of stay." (Report of the Committee on Finance, U.S. Senate, to accompany H.R. 6675, the Social Security Amendments of 1965 (S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 46 (1965)).

HCFA Ruling 93-1 recognizes that as a result of the relationship that develops between a physician and his or her patient, the physician is in a unique position to incorporate complete medical evidence in patient medical records, including his or her opinions and the pertinent medical history of the patient. In effect, a treating physician controls the documentation supporting his or her opinion as to appropriate treatment. Thus, OMHA's final determination should not be based solely on the physician's opinion, but should reflect its evaluation of all documentation contained in the medical record.

The information provided by the physician, including the initial certification of inpatient care, the accompanying medical history, medical assessment, discharge notes, and any subsequent certification by a hospital or a skilled nursing facility's utilization review committee, is considered evidence, but not presumptive evidence, that an admission is reasonable and necessary. Thus, no presumptive weight is assigned to the treating physician's medical opinion in determining the medical necessity of inpatient hospital admission under Title XVIII §1862(a)(1) of the Act. A treating physician's opinion will be evaluated in the context of the evidence in the complete administrative record.

HCFA Ruling 93-1 acknowledges that whether the course of treatment was reasonable and necessary may frequently turn on the comprehensiveness of the evidence furnished by the physician as to the condition of the patient and the medical factors that bear upon his or her treatment. Furthermore HCFA Ruling 93-1 notes that, in the vast majority of cases, if the attending physician's certification of the medical need for the services is consistent with other records submitted in support of the claim for payment, Medicare covers the claim.

HCFA Ruling 93-1 provides that the determination of whether a beneficiary is entitled to Part A benefits in accordance with Title XVIII § 1862(a)(1)(A) of the Act is ultimately a determination that shall be made by the Secretary through designated medical review entities, such as QIOs, in accordance with regulations prescribed by the Secretary. Thus, in accordance with HCFA Ruling 93-1, meeting the foregoing physician's certification requirement does not guarantee that the care provided will be covered. If the medical evidence is inconsistent with the physician's certification, the medical review entity considers the attending physician's certification only on a par with the other pertinent medical evidence. The review entity also considers factors such as the condition of the patient upon admission, the nature of the primary diagnosis, the existence of co-morbid conditions, or the actual course of the patient during the confinement (including treatment and progress toward recovery).

IV. Principles of Law – *Liability*

Under Title XVIII §1879 of the Act, Beneficiary and/or Provider liability for noncovered Medicare services may be limited under particular circumstances. In pertinent part, limitation of liability may apply to items or services that are excluded under Title XVIII §§1862(a)(1)(A) and 1862(a)(9) of the Act, or by reason of a coverage denial described in subsection 1879(g).

Pursuant to Title XVIII §1879(a)(2) of the Act, Medicare will limit the Beneficiary's liability for noncovered services if he or she did not know, and could not reasonably have been expected to know, that said services were noncovered. Title XVIII § 1879(a)(2) of the Act also limits the Provider and or Supplier's liability for noncovered services if it did not know, and could not reasonably have been expected to know, that said services were noncovered. When both the Beneficiary and the Provider's

liability may be limited under Title XVIII § 1879 of the Act, Medicare payment will be made as though §§1862(a)(1)(A), 1862(a)(9) or 1879(g) of the Act did not apply. Federal regulation sets forth the criteria for determining whether a beneficiary and/or provider knew that services were excluded from coverage as custodial care or as not reasonable and necessary. 42 C.F.R. §§ 411.404 and 411.406.

V. Principles of Law – *Overpayments, Statute and Regulation*

If it is determined upon post-payment review that an overpayment exists, after considering all applicable coverage and payment issues, the Administrative Law Judge must determine the liability for the overpayment. Section 1870 of the Act provides, in pertinent part:

(a) Any payment under this title to any provider of services or other person with respect to any items or services furnished any individual shall be regarded as a payment to such individual.

(b) Where— (1) more than the correct amount is paid under this title to a provider of services or other person for items or services furnished an individual and the Secretary determines (A) that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or (B) that such provider of services or other person was without fault with respect to the payment of such excess over the correct amount, or

(2) any payment has been made under section 1814(e) to a provider of services or other person for items or services furnished an individual, proper adjustments shall be made, under regulations prescribed (after consultation with the Railroad Retirement Board) by the Secretary, by decreasing subsequent payments—.

(c) There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1814(e)) with respect to an individual who is without fault or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), if such adjustment (or recovery) would defeat the purposes of title II or title XVIII or would be against equity and good conscience

VI. Principles of Law – *Overpayments, CMS Policy & Guidance*

The CMS promulgates Medicare Manuals, which represent CMS' program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives. The CMS program components, providers, contractors, Medicare Advantage organizations and state survey agencies use the manuals to administer CMS programs.

The Medicare Financial Management Manual ("MFMM"), Pub. 100-6, Ch. 3, sets forth applicable CMS guidance regarding Medicare overpayment waivers. In pertinent part, § 70.3 provides that once the contractor has concluded that an overpayment exists (that is, a finding that payment cannot be made under the waiver of liability provisions) it makes a §1870(b) determination regarding whether the provider/beneficiary was without fault with respect to the overpayment. If a provider was without fault with respect to an overpayment it received it is not liable for the overpayment; therefore, it is not responsible for refunding the amount involved.

The MFMM, Ch. 3, § 90 further elucidates the circumstances under which a provider will be found without fault. In pertinent part, CMS provides that the fiscal intermediary or carrier considers a provider without fault, if two criteria are satisfied: 1. The Provider exercised reasonable care in billing for, and accepting, the payment; i.e., it made full disclosure of all material facts; and 2. The Provider 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 on the basis of the information available to it, including but not limited to the Medicare instructions and regulations.

The MFMM, Ch. 3, § 90.1 sets forth examples in which Providers are deemed at fault for Medicare Overpayments. In pertinent part, § 90.1(H) discusses circumstances in which the Provider billed, or Medicare paid the Provider for services that the Provider should have known were non-covered. For services that are medically unnecessary or custodial, CMS directs the fiscal intermediary or carrier to apply the 1879 limitation on liability criteria in determining whether the Provider should have known that the services were not covered and, therefore, whether the Provider was at fault for the overpayment. For services other than those that are medically unnecessary or custodial, CMS states that the Provider should have known about a policy or rule if: 1. The policy is in the provider manual or Federal regulation; 2. The Medicare contractor provided general notice to the medical community concerning the policy or rule; or 3. The Medicare 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.

ANALYSIS

a. Discussion of Facts and Law

At issue in this case is the Beneficiary's inpatient hospitalization from [redacted], 2010 to [redacted], 2010. The QIC issued an unfavorable reconsideration and stated the initial level of service could have been safely performed at the observation level of care or as an outpatient. (Exh. 5, pp. 1-5). The Appellant contends that the decision to admit the Beneficiary was appropriate because the Beneficiary presented with specific symptoms and comorbidities that increased his risk for complications after his surgery. (Exh. 9). The Appellant contests the reopening by the RAC. It further states that the services rendered were reasonable and necessary, that the Appellant's liability for the claims should be waived, and if none of these positions prevail, at least the Appellant should have a right to reimbursement under Part B for the outpatient services rendered.

The regulations at 42 C.F.R. § 405.980 provide a stratified structure for reopening. Pursuant to 42 C.F.R. § 405.980(a)(1)(i)a CMS contractor may reopen an initial determination or redetermination. The authority for an ALJ to reopen is limited to a revision of an ALJ hearing decision. 42 C.F.R. §§ 405.980(a)(1)(iii). Notably, the ALJ does not have authority to reopen or revise an initial determination or redetermination. The regulations at 42 C.F.R. § 405.926 set forth actions that are not initial determinations and not appealable. Included among them is a "contractor's . . . decision to reopen or not reopen an initial determination." 42 C.F.R. § 405.926(l). This lack of jurisdiction extends to whether the contractor met good cause standards for reopening in 42 C.F.R. § 405.980(b)(2). The regulation at 42 C.F.R. § 405.980(a)(5) further states that"[t]he contractor's, QIC's, ALJ's, or MAC's decision on whether to reopen is final and not subject to appeal."

The Medicare Program Integrity Manual (MPIM), CMS Pub. 100-08, Ch. 3, § 3.6.B makes clear that when conducting a post-payment review of claims, contractors must adhere to reopening rules. However

the ALJ does not have jurisdiction to review that aspect of the contractor's action. A contractor's decision on whether to reopen is final and not subject to appeal. 42 C.F.R. §§ 405.926(l); 405.980(a)(5). This restriction extends regardless of whether the contractor met the good cause standards for reopening set forth in 42 C.F.R. § 405.980(b)(2). CMS has expressly stated that the enforcement mechanism for good cause standards lies within its evaluation and monitoring of contractor performance, not the administrative appeals process. See, Interim Final Rule with Comment Period, 70Fed. Reg. 11,420, 11,453 (Mar. 8, 2005). Thus, a contractor's decision on whether to reopen is final and not subject to review.

One of the most difficult conceptual hurdles to understanding Medicare reimbursement policy concerns the distinction between *coverage* under Medicare and *payment* under Medicare. Pursuant to Title XVIII §§1812(a)(1) and 1861(b) of the Act, Medicare Part A recipients are entitled to coverage for inpatient hospital services for up to 90-days during any spell of illness, in addition to 60 lifetime reserve days. However, Title XVIII §1862(a)(1)(A) of the Act limits coverage for services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the function of a malformed body member.

Independent of the foregoing coverage provisions, Medicare Part A imposes conditions and limitations on payment for otherwise covered services. Under Title XVIII § 1814(a)(3) of the Act, Medicare may pay for inpatient hospital services (other than inpatient psychiatric hospital services) only if a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose. *See also* 42 C.F.R. § 424.13. The requirement that medical treatment, or that inpatient diagnostic study is medically required is echoed in the *Medicare Program Integrity Manual (MPIM) (Internet-Only Manual Publ'n 100-08) Chapter 6, § 6.5.2* wherein it states that the beneficiary must demonstrate signs or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

The distinction between Medicare coverage and payment for inpatient hospital services is pertinent insofar as Title XVIII § 1814(a)(3) informs the criteria by which inpatient hospital coverage is assessed. As a documentary matter, the physician's certification is a condition of *payment*. On the other hand, the content of the certification is a condition of *coverage*. Specifically, pursuant to 42 C.F.R. § 424.13(a) and MPIM, 100-08, Chapter 6, § 6.5.2, Medicare Part A covers inpatient hospital services if the beneficiary required inpatient medical treatment or inpatient diagnostic study. Conversely, where inpatient medical treatment or inpatient diagnostic study is not medically required or furnished, the corresponding inpatient hospital services will be excluded from coverage pursuant to Title XVIII § 1862(a)(1)(A) of the Act.

HCFA Ruling 93-1 clarifies the position of the Health Care Financing Administration (now CMS) concerning the weight to be given to a treating physician's opinion in determining coverage of inpatient hospital and skilled nursing facility care. The physician's certification of the medical need for inpatient hospital services is only the first step in determining whether those services will be covered. A patient usually is admitted to a hospital only upon the advice of the treating physician.

Notably, HCFA Ruling 93-1 identifies the physician as an central figure in determining whether inpatient hospital services meet the coverage requirements of Title XVIII § 1862(a)(1)(A) of the Act. This long-standing, general approach to coverage can be traced to the Congressional committee reports that accompanied the enactment of the Medicare program in 1965. The Senate Finance Committee emphasized "that the physician is to be the key figure in determining utilization of health services--and ... it is a physician who is to decide upon admission to a hospital, order tests, drugs, and treatments, and determine

the length of stay." (Report of the Committee on Finance, U.S. Senate, to accompany H.R. 6675, Social Security Amendments of 1965 (S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 46 (1965)).

OMHA's determination as to whether the hospital admission was reasonable and necessary is confined to the medical record associated with the inpatient stay, which is a discrete past event. With that in mind, HCFA Ruling 93-1 recognizes that as a result of the relationship that develops between a physician and his or her patient, the physician is in a unique position to incorporate complete medical evidence in patient medical records, including his or her opinions and the pertinent medical history of the patient. In effect, a treating physician controls the documentation supporting his or her opinion as to appropriate treatment. Thus, OMHA's final determination should not be based solely on the physician's opinion, but should reflect its evaluation of all documentation contained in the medical record.

The information provided by the physician, including the initial certification of inpatient care, the accompanying medical history, medical assessment, discharge notes, and any subsequent certification by a hospital or a skilled nursing facility's utilization review committee, is considered evidence, but is not considered presumptive evidence that an admission is reasonable and necessary. Thus, no presumptive weight is assigned to the treating physician's medical opinion in determining the medical necessity of inpatient hospital admission under Title XVIII §1862(a)(1) of the Act. A treating physician's opinion will be evaluated in the context of the evidence in the complete administrative record.[1]

In light of the physician's relationship with the patient and unique control over clinical documentation, HCFA Ruling 93-1 acknowledges that whether the course of treatment was reasonable and necessary may frequently turn on the comprehensiveness of the evidence furnished by the physician as to the condition of the patient and the medical factors that bear upon his or her treatment. Furthermore HCFA Ruling 93-1 notes that, in the vast majority of cases, if the attending physician's certification of the medical need for the services is consistent with other records submitted in support of the claim for payment, Medicare covers the claim.

However, HCFA Ruling 93-1 provides that the determination of whether a beneficiary is entitled to Part A benefits in accordance with Title XVIII § 1862(a)(1)(A) of the Act is ultimately a determination that shall be made by the Secretary through designated medical review entities, such as QIOs, in accordance with regulations prescribed by the Secretary. Thus, in accordance with HCFA Ruling 93-1, meeting the foregoing physician's certification requirement does not guarantee that the care provided will be covered. If the medical evidence is inconsistent with the physician's certification, the medical review entity considers the attending physician's certification only on a par with the other pertinent medical evidence. The review entity also considers factors such as the condition of the patient upon admission, the nature of the primary diagnosis, the existence of co-morbid conditions, or the actual course of the patient during the confinement (including treatment and progress toward recovery).

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[1] The "treating physician rule" was developed by case law and subsequently codified in regulations adopted by the Social Security Administration (SSA) for use in disability determinations. The current rule provides that SSA will "give more weight to opinions from...treating sources," 20 C.F.R. §§404.1527(d)(2), 416.927(d)(2). Friedman v. Secretary of the Dept. of HHS, 819 F.2d 42, 45 (2nd. Cir. 1987) states that "there is insufficient evidence in the instant case to put that rule in issue." Indeed, the United Sates Supreme Court has recently held that the "treating physician rule" is not applicable to private benefit plans deciding whether an individual is entitled to disability benefits under ERISA benefit plans. *See,* Black & Decker v. Nord, 538 U.S. 822, 123 Sup. Ct. 1965 (2003). Neither statute nor regulations extend the "treating physician rule" to Medicare coverage determinations and there is insufficient reason or evidence to place such a rule in practice in this case.

The Appellant argues that the decision to admit must be based on the Beneficiary's condition at the time of admission and the decision to admit the Beneficiary was appropriate because the Beneficiary required monitoring and testing indicative of an inpatient level of care. (Hearing CD). Thus, Appellant asserts that the condition of the patient upon admission, the nature of the primary diagnosis, the existence of co-morbid conditions and the actual course of the patient during the admission should result in full reimbursement under Part A for the Diagnostic Related Group claimed by the hospital in its bill. *Id.*

The Beneficiary, 67 years-old, was diagnosed with cholelithiasis and was recommended to have a laparoscopic cholecystectomy. (Exh. 1, pp. 51-53). The Beneficiary's illness and procedure was noted as having "one" level of severity and was noted as requiring a short stay or less than 24 hours. (Exh. 1, pp. 3-5). The ASA stage assigned by the anesthesiologist was 2, indicating mild systemic disease, such as reflux, bilateral hand tremors, and hyperproteinemia. (Exh. 1, p. 64). On [redacted], 2010, the Beneficiary had a laparoscopic cholecystectomy lasting approximately twenty minutes with no noted complications or bile leaks and negligible blood loss. (Exh. 1, pp. 56-57, 61-62). On [redacted], 2010, the physician ordered admission for overnight monitoring. (Exh. 1, p. 33).

While it is accurate to state that under CMS's MBPM 100-02, Chapter 1, §10, "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 to 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. performance of such services 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."

HCFA Ruling 93-1, 42 C.F.R. § 424.13(a) and MPIM, 100-08, Chapter 6, § 6.5.2 clarifies the position of CMS concerning the weight to be given to a treating physician's opinion in determining coverage of inpatient hospital and skilled nursing facility care. The physician's certification of the medical need for inpatient hospital services is only the first step in determining whether those services will be covered. The mere fact of the presence of admission orders is not dispositive. No presumptive weight is assigned to the treating physician's medical opinion in determining the medical necessity of inpatient hospital admission under Title XVIII §1862(a)(1) of the Act. A treating physician's opinion will be evaluated in the context of the evidence in the complete administrative record. Thus, the final determination should not be based solely on the physician's opinion, but should reflect an evaluation of all documentation contained in the medical record.

When patients with known diagnoses enter a hospital for a specific minor surgical procedure that is expected to keep them in the hospital for only a few hours (less than 24), they are considered **outpatients** for coverage purposes regardless of: the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight. MPIM, 100-08, Chapter 6, § 10. The evidence demonstrates that this was a scheduled procedure for a known diagnosis that lasted only twenty minutes and was noted to be completed without complications or bile leaks and negligible blood loss. (Exh. 1, pp. 51-53, 56-57, 61-62). It was noted in the medical record that a short stay lasting less than 24 hours was expected for the procedure. (Exh. 1, pp. 3-5). Accordingly, there is insufficient evidence in the record that the Beneficiary was expected to stay in the hospital for more than 24 hours or had *specific* risks of

complications particular to the Beneficiary's condition. In fact, the Beneficiary was assigned a 2 on the ASA classification system and only reflux, bilateral hand tremors and hyperproteinemia were noted as chronic conditions that may affect the procedure. (Exh. 1, p. 64). Finally, the Beneficiary's pre-operative lab work was normal and the Beneficiary's operation was without complication. (Exh. 1, pp. 39-41, 56-57, 61-62). Accordingly, Medicare would expect the Beneficiary to be considered an outpatient in accordance with MPIM, 100-08, Chapter 6, § 10.

Further, the documentation does not support that hospital-level treatment was required or received for any comorbid acute conditions, as opposed to observation-level care. The Beneficiary was in no acute distress after the surgery, was alert and oriented, being treated with pain and nausea medication, and monitored by nurses. (Exh. 1, pp. 7-32). The administration of pain medication and post-operative monitoring for complications are not inherently inpatient treatments. Further, it appears that the physician ordered admission for "overnight monitoring" and no inpatient treatments or studies were expected to be performed. Therefore, the Beneficiary did not require nor did he receive treatment that required inpatient admission. Admission to outpatient or observation-level care under Part B was fully justified and inpatient admission was not reasonable and necessary.

While in inpatient status, the Beneficiary was provided observation service and medications. The Beneficiary's condition was not critical and did not require hospital admission. The Beneficiary's condition, including pain and nausea, could have been monitored at an observation level. Therefore, treating the Beneficiary at an observation level was medically appropriate. If the Beneficiary developed complications, the Beneficiary could have been transferred to an inpatient level of care. Therefore, the inpatient admission of the Beneficiary from [redacted], 2010 to [redacted], 2010 was not medically necessary and reasonable as required by Title XVIII § 1814(a)(3), 42 C.F.R. § 424.13(a), MPIM, 100-08, Chapter 6, § 6.5.2, MBPM, 100-02, Chapter 1, § 10 and Title XVIII § 1862(a)(1)(A) of the Act.

b. Limitation of Liability

Under Title XVIII §1879 of the Act, Beneficiary and/or Provider liability for noncovered Medicare services may be limited under particular circumstances. In pertinent part, limitation of liability may apply to items or services that are excluded under Title XVIII § 1862(a)(1)(A) of the Act. For reasons explained above the services in this case are ultimately noncovered pursuant to Title XVIII § 1862(a)(1)(A) of the Act; therefore, Title XVIII §1879 of the Act may apply.

Pursuant to Title XVIII §1879(a)(2) of the Act, Medicare will limit the Beneficiary's liability for noncovered services if he or she did not know, and could not reasonably have been expected to know, that said services were noncovered. Title XVIII § 1879(a)(2) of the Act also limits the Provider or Supplier's liability for noncovered services if it did not know, and could not reasonably have been expected to know, that said services were noncovered. When both the Beneficiary and the Provider's liability may be limited under Title XVIII § 1879 of the Act, Medicare Part payment will be made as though §§1862(a)(1)(A), 1862(a)(9) or 1879(g) of the Act did not apply.

Under regulation, a beneficiary who receives services that are not reasonable and necessary under Title XVIII § 1862(a)(1)(A) of the Act is considered to have known that the services were not covered if written notice of noncoverage was furnished by one of the following: 1. The QIO, intermediary, or carrier; 2. The group or committee responsible for utilization review for the provider that furnished the services; or 3. The provider, practitioner, or supplier that furnished the service. 42 C.F.R. § 411.404.

The Appellant argues that if the inpatient admission is not found to be reasonable and necessary, that the observation services provided should be covered under Part B as a partially favorable decision. The Appellant cites a MAC decision to support its argument.[2] While MAC decisions are not precedential and are not binding upon Administrative Law Judges in cases other than the one at issue, the decision does raise issues that should be addressed. The MAC decision held that an ALJ *may* find that observation services provided during an inpatient admission are warranted and can be paid separately under Part B. *See* In the Case of O'Connor Hospital. The decision does not, however, hold that an ALJ is obligated to do so. *See id.*

As is noted in the Medicare Benefit Policy 100-02, Chapter 6, §20.6, observation care is a well-defined set of specific, clinically appropriate services, which include ongoing 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. When a physician orders that a patient receive observation care, the patient's status is that of an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient receiving observation services may improve and be released, or be admitted as an inpatient.

Upon internal review performed before the claim was initially submitted and upon the hospital determining that the services did not meet its inpatient criteria, an inpatient status may not be automatically changed to observation status. Hospitals are required to report observation charges under revenue code 0760 as a general classification category and revenue code 0762 for the observation room. Other ancillary services performed while the patient receives observation services are reported using appropriate revenue codes and HCPCS codes as applicable. See, Medicare Claims Processing Manual, 100-04, Chapter 4, § 290.2.1. Providers can bill for Inpatient Part B services, also known as ancillary services, but only for the services on the list in the Medicare Benefit Policy Manual, 100-02, Chapter 6, § 10. Rebilling for any service will only be allowed if all claim processing rules and claim timeliness rules are met. There are no exceptions to the rules in the national program. Normal timely filing rules can be found in the Medicare Claims Processing Manual, Chapter 1, § 70.

Medicare Claims Processing Manual 100-04, Chapter 1, § 50.3 requires that Providers correctly bill their claims at the outset as to the patient's status as inpatient or outpatient. In certain circumstances when the hospital's internal review subsequently determines that an inpatient admission does not meet hospital criteria and that the patient would have been registered as an outpatient under ordinary circumstances, Medicare created Condition Code 44. Medicare guidelines only allow an inpatient admission to be changed to an outpatient admission under Condition 44 when a Part A claim for inpatient admission is not submitted. *See* Medicare Claims Processing 100-04, Chapter 1, § 50.3.2. It is expected that hospitals review their decisions to admit patients to inpatient status *before* submitting a Part A claim and determine that the admission does not meet Medicare inpatient admission criteria on their own. Therefore, the principle underlying O'Connor Hospital is unavailable to the Appellant in this case.

Further, in this case, the hearing record contains no evidence that the Beneficiary received written notice of non-coverage for the non-covered services at issue. The Beneficiary therefore did not know, nor was

[2] Medicare Appeals Council, In the Case of O'Connor Hospital, February 1, 2010.

the Beneficiary reasonably expected to know that the services at issue were non-covered. Accordingly, pursuant to Title XVIII § 1879 of the Act, the Beneficiary is not liable for the non-covered services.

A Provider or Supplier who furnishes services that are custodial is considered to have known that the services were not covered if 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. 42 C.F.R. § 411.406(b). Significantly, the regulations also confer constructive knowledge of noncoverage to the provider, practitioner, or supplier based on any 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; or 3. Its knowledge of what are considered acceptable standards of practice by the local medical community. 42 C.F.R. § 411.406(e).

The Appellant in this case is a Provider who had constructive notice of Part A inpatient hospital service coverage rules. This presumption is based on the widely published Medicare statute, Medicare regulations and CMS policy manuals cited in the "Principles of Law" section above. Pursuant to 42 C.F.R. § 411.406, the Appellant should have known that Medicare Part A would not cover the Beneficiary's services furnished in the hospital. Accordingly, pursuant to Title XVIII §1879 of the Act, the Appellant is liable for the non-covered services.

c. Waiver of Recovery for Overpayments

Title XVIII § 1870 of the Act governs the recovery of overpayments. Title XVIII § 1870(b) provides for a waiver of recovery of an overpayment to a supplier if it is "without fault" in incurring the overpayment. The MFMM provides that the Contractor considers a provider without fault, if it exercised reasonable care in billing for, and accepting, the payment 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. MFMM, *supra*, §90. The Appellant was aware of the criteria for inpatient admissions as provided in Medicare statutes, regulations and guidelines. Therefore, the Appellant cannot be found without fault in creating the overpayment under Title XVIII § 1870, and a waiver of recoupment of the overpayment is not warranted.

Title XVIII § 1870(c) which provides a waiver of recoupment of overpayment where it is "against equity and good conscience" is not applicable to this case since Title XVIII § 1870(c) applies to a waiver of overpayments made to beneficiaries, and not providers or supplies that are deemed at fault.

CONCLUSIONS OF LAW

Medicare Part A does not cover the Beneficiary's inpatient hospital services rendered from [redacted], 2010 to [redacted], 2010 because, pursuant to Title XVIII §§ 1862(a)(1)(A) and 1815(a) of the Social Security Act, the documentation does not support the contention that the services were reasonable and necessary for treatment of the Beneficiary's condition. Specifically, the services were not reasonable and necessary because there is no evidence of inpatient treatment or diagnostic testing sufficient to warrant payment pursuant to Title XVIII § 1814(a)(3), 42 C.F.R. § 424.13(a), MPIM, 100-08, Chapter 6, § 6.5.2, MBPM, 100-02, Chapter 1, § 10 and Title XVIII §1862(a)(1)(A) of the Act. Furthermore, since payment cannot be

made pursuant to Title XVIII §1879 and the Appellant has been overpaid, the Appellant is not without fault with respect to the overpayment and is, accordingly, liable for the overpayment pursuant to Title XVIII §1870(b).

ORDER

The Medicare Contractor is **DIRECTED** to process the claim in accordance with this decision.

SO ORDERED.

Dated: MAY 21 2012

Leslie Holt
U.S. Administrative Law Judge

Enclosures: Form OMHA-56, *List of Exhibits*

Department of Health and Human Services
OFFICE OF MEDICARE HEARINGS AND APPEALS
Mid-Atlantic Field Office
Arlington, Virginia

Appeal of:	**Missouri Baptist Hospital of Sullivan**	ALJ Appeal No.:	**1-934979291**
		QIC Appeal No.:	**1-880744756**
Beneficiary:	[redacted]	Medicare Part:	**FFS-Part A**
HICN:	[redacted]	Before:	**Leslie Holt** **U.S. Administrative Law Judge**

EXHIBIT LIST

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Dated: April 19, 2012 Appeal No.: 1-934979291