

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

ORDER OF MEDICARE APPEALS COUNCIL
Docket Number: M-12-1005

In the case of

Claim for

Spokane Washington Hospital
Company, LLC d/b/a
Deaconess Hospital

(Appellant)

Hospital Insurance Benefits
(Part A)

(Beneficiary)

(HIC Number)

Wisconsin Physicians Service
Insurance Corp.

(Contractor)

(ALJ Appeal Number)

The Medicare Appeals Council received the above-captioned case on referral from the Centers for Medicare and Medicaid Services (CMS), dated March 23, 2012. The Council has also received a response on behalf of the appellant, dated April 12, 2012. On January 31, 2012, the Administrative Law Judge (ALJ) issued a decision, based solely on the written record, finding that the inpatient hospital services which the appellant provided to the beneficiary from January 14, 2010, through January 15, 2010, were medically reasonable and necessary, and therefore covered by Medicare.

In the agency referral memorandum, CMS (by and through a contractor, Q2Administrators, LLC) contends that the ALJ's decision contains errors of law material to the outcome of the claim.

The Council has carefully considered the record that was before the ALJ, as well as the CMS agency referral memorandum and the appellant's response. The Council has decided not to review the ALJ's decision because there are no errors of law material to the outcome of the claim.

APPLICABLE LEGAL AUTHORITIES

42 C.F.R. § 405.1110(a) provides, in pertinent part, that CMS or any of its contractors may refer a case to the Council for it to consider reviewing the ALJ's action any time within 60 days after the date of the ALJ's decision. Section 405.1110(b) provides that CMS or its contractor may refer a case to the Council if, in their view, the decision contains an error of law material to the outcome of the claim or presents a broad policy or procedural issue that may affect the public interest. CMS's referral must state the reason CMS believes that the Council should review the case on its own motion. 42 C.F.R. § 405.1110(b)(2).

In cases (such as this one) in which CMS did not participate in the ALJ proceedings or appear as a party, the Council will accept review if the decision or dismissal contains an error of law material to the outcome of the claim or presents a broad policy or procedural issue that may affect the general public interest. 42 C.F.R. § 405.1110(c)(2). In deciding whether to accept review, the Council will limit its consideration of the ALJ's action to the exceptions CMS raises. *Id.*

DISCUSSION

The appellant provided inpatient hospital services to the beneficiary from January 14, 2010, through January 15, 2010. These hospital inpatient services immediately followed a surgical percutaneous intervention to open the occluded segment of the beneficiary's common iliac artery (with stent placements in the left and right common iliac arteries) after a diagnosis of claudication in both legs. Exh. 11 at 34-67.

The contractor initially allowed coverage for these services. A Recovery Audit Contractor (RAC) later reviewed these services and determined that they were not covered because, the RAC stated, the inpatient admission was not medically reasonable and necessary, and the services should have been billed as outpatient services. Exh. 11 at 216. The intermediary and the Qualified Independent Contractor (QIC) affirmed this RAC determination. *Id.* at 18-22, 29-31.

On further appeal, the ALJ issued a favorable, on the record decision, in which he reviewed the evidence of record, made detailed findings of fact with respect to the medical reasons for the inpatient hospitalization subsequent to the surgery, and

determined that the inpatient hospital services were medically reasonable and necessary. Dec. 1-3, 7-9. The ALJ's determination referred to multiple medical factors, including the beneficiary's lengthy history of heart disorders, diseases, and surgeries; his co-morbidities of diabetes, chronic obstructive pulmonary disease, and hyperlipidemia; his diagnosis of claudication in both legs related to an occluded segment of his common iliac artery; the multiple attempts required during surgery to place two stents in his proximal right common iliac artery and left common iliac artery; his absent pedal pulses bilaterally before the procedure, and persisting on the left post-procedure; and his repeated drops in oxygen saturation levels during the surgery. *Id.* In addition, the medical record documents the beneficiary's left ventricular dysfunction, ejection fraction of 20%, need for blood thinners, obesity, and smoking, among other complicating factors. *Id.* The ALJ's decision provided a thorough review of these medical facts, applying several of the relevant legal criteria, including those enunciated in Pub. 100-2, Medicare Benefit Policy Manual, Chapter 1, Section 10.

Nevertheless, CMS contends in its agency referral memorandum that the ALJ erred by:

- "fail[ing] to cite reference or consider the relevant requirements articulated in section 424.13 of Title 42 of the C.F.R.;"
- "fail[ing] to consider whether the beneficiary's course of treatment [after surgery] included services and treatments more intensive than those available in outpatient observation services," and "fail[ing] to consider the beneficiary's stable condition" following surgery" (*citing* CMS Ruling 93-1); and
- "fail[ing] to cite, reference, or consider" a number of the parts of the section 10 of Chapter 1 in the Medicare Benefits Policy Manual (Pub. 100-2, MBPM), the Medicare Program Integrity Manual (MPIM), and the Medicare Quality Improvement Organization Manual (MQIOM).

Agency Referral Memorandum at 14-16. Each of these three contentions is addressed below. None of the contentions has merit. More to the point, the agency has not identified any error of law material to the outcome of the claim - the sole basis for referral identified in the agency's memorandum.

1. 42 C.F.R. § 424.13 does not apply in this case.

Although CMS claims that the ALJ in this case erred by "failing to cite or reference" the requirements in 42 C.F.R. § 424.13, section 424.13 does not apply in this case. CMS errs in asserting that this section of the Medicare regulations requires, as a condition of coverage, that the record contain certain statements (i.e., as to why the beneficiary is being admitted as a hospital inpatient, how long a stay is expected, and what plans exist for post-hospital care) when a beneficiary is admitted for the first time in a short stay. See Agency Referral Memorandum at 14. By its terms, section 424.13 does not apply to this initial hospital admission. Section 424.13 states, in pertinent part:

§ 424.13 Requirements for inpatient services of hospitals other than psychiatric hospitals.

(a) *Content of certification and recertification.*

Medicare Part A pays for inpatient hospital services of hospitals other than psychiatric hospitals only if a physician certifies and recertifies the following:

(1) The reasons for either ---

(i) Continued hospitalization of the patient for medical treatment or medically required inpatient diagnostic study; or

(ii) Special or unusual services for cost outlier cases (under the prospective payment system set forth in subpart F of part 412 of this chapter).

(2) The estimated time the patient will need to remain in the hospital.

(3) The plans for posthospital care, if appropriate.

42 C.F.R. § 424.13(a). The physician in this case could not provide "reasons for continued hospitalization," because the beneficiary had just been admitted. Nor could the physician provide "reasons for special or unusual services for cost outlier cases." There is nothing in the record to indicate this was identified as a cost outlier case. Therefore, section 424.13 of the regulations does not apply here.

Furthermore, section 424.13 goes on to provide that for cases that are not subject to the prospective payment system, the certification is required no later than the 12th day of hospitalization, and the first recertification is required no later than the 18th day of hospitalization. *Id.* at

§ 424.13(d)(1),(2). For cases that are subject to the prospective payment system, the certification is required *the day after* the hospital reasonably assumes the case meets day-outlier criteria; or the date on which the hospital requests cost outlier payment, or twenty days into the hospital stay, whichever is earlier. *Id.* at § 424.13(e). None of these provisions state or infer that in a case such as the one at issue here, the hospital should provide certification in the medical record *during a stay that lasts twenty-four hours or less*. Again, the plain language of the regulation is simply inapplicable in this case. In addition, the structure and contents of the Medicare regulations make clear that the provisions in 42 C.F.R. § 424.13 are conditions for payment of Medicare claims, not conditions for Medicare coverage.

2. *The ALJ did consider all of the evidence in the record, including whether the record supports the beneficiary's need for inpatient (as opposed to outpatient) hospital services.*

The ALJ fully considered all of the evidence in the administrative record, having identified the central question in the case as whether there was sufficient evidence to establish that the inpatient hospital services following the surgery were medically reasonable and necessary, as opposed to the alternative of outpatient services which the RAC contended would have been sufficient. It is not necessary for the Council to reiterate all of the points considered and discussed in the ALJ's factual findings and legal analysis, or to quote extensively from the ALJ's findings and analysis. The ALJ's decision speaks for itself. The ALJ weighed all of the relevant factors, in detail, within the context of the guidelines in MBPM, Chapter 1, Section 10, and concluded, with considerable support from the record, that the post-surgical inpatient hospital services were reasonable and necessary in accordance with section 1862(a)(1)(A) of the Social Security Act.

As noted, the agency did not participate in the ALJ proceedings. Therefore, the Council exercises own motion review of the ALJ's decision if the decision contains legal error material to the outcome of the claim, or presents a broad policy or procedural issue that may affect the general public interest. 42 C.F.R. § 405.1110(c)(2). If the agency had participated in the ALJ proceedings, the Council may also exercise own motion review if the ALJ's decision is inconsistent with the preponderance of the evidence or constitutes an abuse of discretion. *Id.* The agency's contention that the ALJ did not fully consider the

evidence to determine medical necessity of the inpatient hospitalization is, in this case, no more than an assertion that the ALJ's coverage allowance was not consistent with the preponderance of the evidence. The basis for referral was legal error material to the outcome of the claim. But the agency has not demonstrated legal error.

3. *An ALJ is not required to "cite, reference, or consider" every possible legal or policy source in issuing a decision that is already well-reasoned and complete.*

As noted above, the agency referral memorandum also contains an assertion that the ALJ erred when he "failed to cite, reference, or consider" a number of the parts of section 10 of Chapter 1 in the Medicare Benefits Policy Manual (Pub. 100-2, MBPM); the Medicare Program Integrity Manual (MPIM); and the Medicare Quality Improvement Organization Manual (MQIOM). This is a somewhat novel, but unavailing contention. An ALJ who identifies the key legal issues, most important legal and policy authorities, and relevant facts (as the ALJ did in this case), is not required to "cite, reference, or consider" every possible legal or policy source.

First of all, the ALJ did consider the factors in section 10, Chapter 1, of the MBPM; this is apparent from the contents of his decision. The fact that the ALJ quoted only a portion of section 10 (see Dec. at 7) does not change that. Second, the provisions cited by CMS in the MPIM and the MQIOM are of secondary importance, and their contents, to the extent they bear on the instant case, overlap with the provisions in section 10, Chapter 1, of the MBPM. See, e.g., Pub. 100-8, MPIM, Chapter 6, § 6.5.2(A); and Pub. 100-10, MQIOM, Chapter 4, § 4110.

Moreover, where, as here, the standard for taking own motion review is whether the ALJ's decision contains error of law material to the outcome of the claim, it is not enough for the agency to merely assert that the ALJ did not expressly cite or discuss certain non-binding policy materials like CMS manual provisions. The agency also must be prepared to articulate whether, in the given case, the ALJ should have, but did not, accord those materials substantial deference consistent with 42 C.F.R. section 405.1062(a), or explain the reasons for not doing so in accordance with section 405.1062(b), and then explain how

the ALJ's failure to adhere to section 405.1062 resulted in a legally erroneous outcome.¹

In conclusion, the Council finds no legal error in the ALJ's decision, and there is no basis for the Council to accept own motion review in this case. Accordingly, the ALJ's January 31, 2012 decision is binding. The Council refers the case to Q² Administrators for effectuation of the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

Date: June 19, 2012

¹ There are no statutes, regulations, or National Coverage Determinations (NCDs) which establish criteria for coverage of inpatient hospital admissions. An ALJ and the Council are bound by statutes, regulations, NCDs, and Medicare Rulings. 42 C.F.R. §§ 405.1060(a)(4) and 405.1063. In the absence of statutes, regulations, or binding coverage policies that set forth specific coverage criteria for inpatient hospital admissions, the Council has long held that the MBPM, Chapter 1, Section 10 inpatient hospitalization provisions are to be applied to decide coverage of inpatient hospital admissions. The ALJ has done so in this case.