

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-1171

In the case of

Claim for

Montefiore Medical Center
(Appellant)

Hospital Insurance Benefits
(Part A)

(Beneficiaries)

(HIC Numbers)

National Government Services
(Contractor)

(ALJ Appeal Numbers)

The Administrative Law Judge (ALJ) issued four individual decisions, each of which was dated March 22, 2010, and concerned an overpayment determination arising from the appellant's claim for inpatient hospitalization services furnished to one Medicare beneficiary in 2007, and to three Medicare beneficiaries in 2008.¹ In each decision, the ALJ determined that: 1) the inpatient services at issue are not medically reasonable and necessary as billed; 2) the beneficiary's condition could have been appropriately treated at a lower, observation level of care; and 3) the appellant is liable for the non-covered services under section 1879 of the Social Security Act (Act). The appellant, through counsel, has asked the Medicare Appeals Council (Council) to review these actions.

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

¹ To maintain privacy, the Council will refer to the beneficiaries by their initials. Their full names and HICNs, as well as the specific dates of service at issue and each corresponding ALJ appeal number, are listed in the attachment to this action.

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 set forth in the appellant's requests for review, and its supplementary position papers. As set forth below, the Council modifies the ALJ's actions to supplement the coverage analyses and more fully address the appellant's contentions. We conclude, however, that the exceptions present no basis for changing the ALJ's ultimate conclusions denying Medicare coverage for the inpatient services at issue.

The Appellant's Submission of New Evidence

As a preliminary matter, the Council must address the appellant's submission of new evidence with each of its four supplementary position papers dated February 11, 2011.

Generally, an appellant must submit all evidence to the Qualified Independent Contractor (QIC) at the reconsideration level of review. 42 C.F.R. §§ 405.966(a)(2), 405.1018, 405.1122(c). If an appellant submits evidence to the Council relating to an issue already considered by the QIC or the ALJ, the Council must determine whether it is new evidence. If it is new evidence, the Council must then decide whether the appellant has good cause for submitting it at this late stage in the appeal proceedings. *Id.*

In this case, Attachment B to each position paper contains an "affirmation" from Joseph S. Braverman, M.D., Director of Emergency Medicine at University Hospital of the Albert Einstein College of Medicine, Weiler Division, Montefiore Medical Center, dated February 8, 2011, in which Dr. Braverman sets forth his credentials and his opinion that the services at issue were reasonable and necessary for each beneficiary. These affirmations constitute new evidence submitted by the appellant on an issue already considered at each prior stage in the appeals process, i.e., whether the services at issue were reasonable and necessary. As the appellant has not asserted any good cause for its late submission of this evidence, the Council excludes Dr. Braverman's affirmations from the record and has not considered them in making this determination. See 42 C.F.R. § 405.1122(c).

The Administrative Record

With the exceptions noted above, the Council marks and enters the remaining documents contained in the MAC Master File into the administrative record as follows:

- Exh. MAC-1 Appellant's four substantively identical initial requests for review, one for each beneficiary, dated May 7, 2010, with attachments
- Exh. MAC-2 All correspondence between the Council and the appellant's counsel regarding issues related to obtaining accurate copies of the administrative record and extensions of time for filing briefs
- Exh. MAC-3 Appellant's supplemental position paper, with attachments A, C, and D, dated February 11, 2011, regarding beneficiary M.S.
- Exh. MAC-4 Appellant's supplemental position paper, with attachments A, C, and D, dated February 11, 2011, regarding beneficiary G.R.
- Exh. MAC-5 Appellant's supplemental position paper, with attachments A, C, and D, dated February 11, 2011, regarding beneficiary A.M.
- Exh. MAC-6 Appellant's supplemental position paper, with attachments A, C, and D, dated February 11, 2011, regarding beneficiary G.F.
- Exh. MAC-7 Appellant's three substantively identical letters, dated April 1, 2011, supplementing information on New York state law, for beneficiaries G.F., G.R., and M.S.
- Exh. MAC-8 Council's April 4, 2011, letter denying the appellant's requests for oral argument

BACKGROUND

The appellant billed Medicare for inpatient hospital services furnished to each of the beneficiaries listed in the attachment to this action. Initially, the Medicare intermediary paid these claims. The intermediary subsequently analyzed its data, detected a potential aberrancy in the appellant's billing patterns, reopened these claims, and requested medical records

as part of a post-payment probe. See, e.g., Claim File Beneficiary G.F. (G.F.), Exh. 2. In April 2009, the intermediary informed the appellant that an overpayment existed in each of these cases. See, e.g., G.F. Exh. 3. Upon redetermination, the intermediary affirmed its prior overpayment determination in each case and held the appellant liable for the non-covered services. See, e.g., G.F. Exh. 4. The QIC also upheld the overpayment in each case finding, for example, that Medicare did not cover the inpatient services as billed because the beneficiary "did not receive medical services which required inpatient level of care. The documentation does not support that inpatient hospital level treatment was required or received for the primary or any co-morbid acute condition, as opposed to observation level care." See, e.g., G.F., Exh. 6.

After conducting a consolidated hearing in these cases on March 18, 2010, the ALJ issued four separate but substantially similar decisions on March 22, 2010. The ALJ determined, in each instance, that the documentation submitted does not support that an inpatient level of care was reasonable and necessary because "there is no documentation of apparent signs and symptoms that precluded observation status, or continuing outpatient care." See, e.g., G.F. Dec. at 6. The ALJ also determined that the appellant's liability for the non-covered services could not be limited under section 1879 of the Act. See, e.g., G.F. Dec. at 7.

On appeal before the Council, the appellant sets forth several reasons for its disagreement with the ALJ's decision in each case. Exhs. MAC-3 through MAC-6. The contentions set forth in each beneficiary's case are summarized as follows:

- 1) The ALJ erred in denying coverage for the inpatient services at issue because the record supports that they were reasonable and necessary.
- 2) The ALJ erred in not limiting the appellant's liability pursuant to section 1879 of the Act.
- 3) In the alternative, the appellant should be paid for observation services under Medicare Part B.

Id. The Council will address these contentions with much greater specificity in turn below.

DISCUSSION

On appeal before the Council, the appellant makes several beneficiary-specific contentions regarding reasonableness and necessity, which we will consider individually. The appellant also raises several substantially similar contentions regarding each of the ALJ's decisions, which the Council will address *en masse* wherever possible.

A. THE PROPRIETY OF THE ALJ'S DECISIONS

1. *De Novo* Review

The appellant asserts, in each instance, that "the ALJ failed to conduct a *de novo* review, which was required by the governing regulation." See, e.g., Exh. MAC-6 at 10 (citing 42 C.F.R. § 405.1000(d)). The Council finds no merit in this contention.

In each case, the ALJ made specific, enumerated findings of fact and cited directly to the medical documentation in evidence to support those findings. See, e.g., G.F. Dec. at 2 (citing Exh. 1 at 4-6, 14, 23, 33). In addition, the ALJ included summaries of the redetermination and reconsideration in each case as findings of fact. See, e.g., G.F. Dec. at 2 (Findings of Fact 4 and 5). In doing so, the ALJ merely related the procedural history, or factual background, of each case. If an intermediary, or the QIC, previously determined that a service was not covered by Medicare, the occurrence of that determination is a fact. The ALJ stating the existence of such facts does not in any way indicate that he substituted the prior adjudicator's findings or conclusions for his own.

As noted by the appellant, the ALJ's decisions use the phrases "preponderance of the evidence" and "persuasive evidence." See, e.g., Exh. MAC-6 at 10 (citing G.F. Dec. at 2, 6). When read in context, however, it is clear that the ALJ used these phrases to weigh the relative value of the evidence contained in the administrative record before him. The ALJ's use of these phrases does not reflect, in any manner, that he was deferring to the findings or conclusions made below or applying a standard of review that was other than *de novo*.

A careful review of the ALJ's decisions and the administrative record reveals no evidence that the ALJ deferred to the findings of prior adjudicators or that he did not perform his own *de novo* review of the evidence of record. The Council therefore

concludes that the appellant's contention regarding *de novo* review provides no basis for overturning the ALJ's decisions.

2. *The ALJ's Citations to the Record*

The appellant also asserts, in each instance, that "the ALJ failed to cite to specific evidence from the record supporting his decision." See, e.g., Exh. MAC-6 at 11 (citing 42 C.F.R. § 405.1046). More specifically, the appellant asserts that the ALJ's findings are not supported by the administrative record, are directly contrary to the record, or are merely conclusory in nature. *Id.* After reviewing the ALJ's decisions, however, the Council finds no merit in this contention.

In each decision, the ALJ made specific findings of fact, based upon multiple documents contained in the administrative record. See, e.g., G.F. Dec. at 2 (citing Exh. 1 at 4-6, 14, 23, 33). The ALJ then evaluated his findings against the appellant's exceptions and the relevant legal standards. In each decision, the ALJ determined that the documentation submitted by the appellant did not establish that the inpatient hospital services at issue were medically reasonable and necessary under the applicable authority. The ALJ accordingly concluded that Medicare does not cover the services at issue.

The appellant seems to take issue with the ALJ's failure to cite to several documents contained in each record, but the applicable law does not require that he do so. With respect to a decision, ALJs are required to consider evidence presented during the proceedings, but are not required to evaluate in writing every piece of testimony and evidence submitted. *Stephens v. Heckler*, 766 F.2d 284, 287 (7th Cir. 1985). They are, however, required to make "a minimal level of articulation" as to "their assessment of the evidence . . . in cases in which considerable evidence is presented by the claimant." *Id.* "If a sketchy opinion assures us that the ALJ considered the important evidence, and the opinion enables us to trace the path of the ALJ's reasoning, the ALJ has done enough." *Id.*

An ALJ decision "must be based on evidence offered at the hearing or otherwise admitted into the record." 42 C.F.R. § 405.1046(a). That decision must give "findings of fact, conclusions of law, and the reasons for the decision." *Id.* The ALJ decisions in the instant case satisfy those requirements. It seems as though the appellant is objecting not to the ALJ's evaluation of the evidence discussed in his decision, but to which evidence the ALJ found material in

reaching unfavorable coverage decisions. The Council finds no basis for overturning the ALJ decision based upon contentions concerning the ALJ's review of the record.

B. MEDICARE COVERAGE

Having considered the appellant's contentions as to why it believes that the services it provided were medically necessary for each of the four beneficiaries, the ALJ's decisions, and the medical evidence on which the ALJ based his unfavorable coverage determinations, the Council finds no basis for overturning the ALJ's decisions. See Decs. at 2, 6-7.

1. The New York "Eight-Hour Rule"

In each instance, the appellant asserts that Medicare should cover the inpatient hospital services at issue because, "in New York, outpatient observation services cannot exceed eight hours." See, e.g., Exh. MAC-6 at 10. The appellant reasons that because a New York state regulation requires patients to be either admitted to inpatient care, transferred, or discharged from a facility after eight hours of observation care, and because providers participating in Medicare are required to comply with state law, the services at issue are therefore reasonable and necessary. *Id.* The appellant also notes that in its regulatory agenda, the New York State Department of Health proposes amending the aforementioned regulation to authorize and provide operating standards for observation units. Exh. MAC-7. The appellant contends that this proposed amendment supports its position that the existing New York regulation requires patients to be admitted as inpatients after receiving eight hours of observation care. *Id.*

The Council finds no merit in the appellant's contentions regarding New York's "Eight-Hour Rule." The appellant's reasoning distorts and distracts from the appropriate inquiry, which is whether the services at issue are reasonable and necessary for the diagnosis or treatment of an illness or injury pursuant to section 1862(a)(1)(A) of the Act. A state requiring a provider to take particular action does not bear on Medicare's determination of whether a service is medically reasonable and necessary, which is made in accordance with the Social Security Act and the implementing regulations.

As explained in the Medicare Administrative Contractor's (contractor's) "Special Notice" provided by the appellant and

available publicly on the National Government Services website, the New York legislature may determine state policy for hospitals, but the Social Security Act sets Medicare payment policy. See, e.g., Exh. MAC-6 at C-2.² "The New York law is in no way binding on Medicare or its contractors. . . . the law does not purport to require Medicare to cover the hospital stay of any patient admitted as an inpatient under this provision. To the extent that state law required Medicare to cover these stays, it would be preempted by federal law." *Id.* "The admission of patients who could have been managed in an observation stay (had New York State not had the "Eight-Hour Rule" prompting the admission) is considered under Medicare to be not reasonable and necessary." *Id.* Thus, a state may require various procedures be followed; however, those requirements do not automatically render a service reasonable and necessary under the Act, and thus, covered by Medicare.

2. Weight Given to Treating Physician's Medical Opinion

In each case, the appellant also asserts that "the ALJ did not give enough weight to the fact that an admitting physician should consider the probability of an adverse event happening to the [beneficiary]." See, e.g., Exh. MAC-6 at 9. The Council finds no merit in this assertion.

The Centers for Medicare and Medicaid Services (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. Rulings of the agency are binding on ALJs and on the Council. 42 C.F.R. § 405.1063.

² National Government Services issued the "Special Notice for New York Providers: Medical Necessity for Inpatient Stays and Eight-Hour Rule for Observation Services" in July 2010. The Notice is available on their website, <http://www.ngsmedicare.com>, in the section located at Part A > Education and Training > Clinical Education.

Beneficiary G.F.

Before the Council, the appellant asserts that the inpatient hospital services billed for beneficiary G.F. on March 23, through March 24, 2008, were reasonable and necessary given his signs and symptoms, as well as his risk factors for acute coronary syndrome and myocardial infarction. Exh. MAC-6 at 8. More specifically, the appellant asserts that the beneficiary's exertional chest pain prior to presenting at the emergency department, his elevated blood pressure upon admission, and his abnormal EKG rendered his inpatient admission reasonable and necessary. *Id.* After considering the record, however, the Council finds that the ALJ did not err in denying coverage for the services as billed because the medical records in evidence, taken as a whole, do not support the appellant's contentions.

The beneficiary, an 84-year-old male with a past medical history including hypertension, status post-cerebral vascular accident in 2000, seizure disorder, diabetes, benign prostatic hyperplasia, and status post deep vein thrombosis, presented at the emergency department with complaints of left-sided chest pain. G.F. Exh. 1 at 4. It was therefore appropriate, as the emergency department did, to assess the beneficiary's condition to determine whether he was experiencing ischemic heart disease, myocardial infarction, or acute coronary syndrome.

A nursing note at 7:30 PM on March 23, 2008, indicates that the beneficiary complained of left-sided chest pain that had begun the day before, but then "went away" and that he did not experience any shortness of breath. *Id.* at 5 ("Pt denies CP [chest pain] & SOB [shortness of breath] @ this time."). The notes further indicate that cardiac testing had begun and that the nurses would continue to monitor the beneficiary. *Id.* The next entry, at 9:30 PM, indicates that the beneficiary had no complaints, was stable, and also was made aware that he had been admitted and was awaiting bed assignment. *Id.* At 10:19 PM, the nurse administered magnesium sulfate to the beneficiary. *Id.* A physical examination indicated the beneficiary's heart rate was regular, his capillary refill was less than three seconds, his peripheral pulses were palpable, his nail beds were pink, and he experienced no edema. *Id.* at 6. Physician notes from the emergency department reflect that the beneficiary reported episodic chest pain, but "has no ischemic [changes] on EKG" and would be admitted to the telemetry unit. *Id.* at 11, 24.

The observation level of care, required and received by the beneficiary, continued into the night. The "Night Hospitalist

Admission Note" indicates, among other things, that the first set of cardiac enzymes were negative, that the EKG was unchanged from the past, and that acute myocardial infarction was doubted. *Id.* at 24-25. The "Medical Attending Note" from 9:00 AM on March 24, 2008, shows that the beneficiary was resting comfortably with no complaints of pain. *Id.* at 28-29. The attending physician reviewed the beneficiary's medications, and his signs and symptoms, with no new developments noted. *Id.*

The documentation reveals that the beneficiary essentially waited around, comfortably and without complaint, for test results to become available. At the time of his discharge from emergency department at 9:30 AM on March 24, 2008, the nurse reported the beneficiary in no distress and with no complaints. *Id.* at 8. At 10:00 AM, the beneficiary's bed assignment was on hold, and the beneficiary tolerated food and fluids by mouth, with no complaints. *Id.* Physician evaluation continued. *Id.* At 11:00 AM, the beneficiary was noted to be resting comfortably and physician evaluation continuing. *Id.* At 1:00 PM, the beneficiary was finally cleared to transfer to the hospital's inpatient unit, with no distress and no complaints. *Id.*

After being physically moved to the inpatient unit, the observation level of care continued. The inpatient admission database and flowsheet indicates that at 2:00 PM, the beneficiary was evaluated and that his status will continue to be monitored. *Id.* at 33-40. The physical examination notes signed and dated by the physician's assistant on March 24, 2008, indicate that the beneficiary was alert and in "NAD" or no acute or apparent distress. *Id.* at 22-23. These examination notes also reflect that the beneficiary "will definitely go home" upon discharge, and that Dr. Alonso ordered the beneficiary be admitted as inpatient to rule out myocardial infarction. *Id.* The record establishes that the beneficiary's first two sets of cardiac enzymes were negative, and that he was awaiting the results of the third set. If the third set was also negative, the beneficiary was to be discharged home, and instructed to follow up and undergo further cardiac work-up as an outpatient. *Id.* At 6:30 PM, the beneficiary was discharged to home with no signs or symptoms of acute distress and given discharge instructions. He left via wheelchair with family. *Id.* at 40.

In summary, the appellant has not identified or explained which inpatient acute care services were medically required and received while the beneficiary was waiting in a bed, resting comfortably for his test results to become available. The

record simply does not document any interventions by physicians other than ordering cardiac testing and ongoing monitoring.

The appellant also takes issue with the ALJ's observation that a physician ordered the beneficiary's admission to inpatient care at 9:30 AM on March 24, 2008, and that he was actually transferred around 2:00 PM that day. Exh. MAC-6 at 10. The appellant asserts that the ALJ failed to note that the physician ordered admission during a telephone consultation at 6:40 PM on March 23, 2008. *Id.* The documentation cited by the appellant, however, does not support its assertions on this point. The emergency department clinical work-up contains a note indicating that a call was placed to "Dr. Alonso's service at 6:40 PM." G.F. Exh. 1 at 15. It does not state, as the appellant asserts, that Dr. Alonso gave an admitting order at that time. A call being left with a physician's answering service alone does not necessarily indicate that the physician was involved in care. Similarly, the inpatient physical examination notes which reflect "admit" and "Dr. Alonso" are dated March 24, 2008. *Id.* at 23, 28-29. However, regardless of whether the admission order occurred at 6:40 PM, or 9:00 AM the following day, the beneficiary's condition did not require, and he did not receive, an acute level of inpatient care.

Having considered the record as a whole, the Council fully concurs with the ALJ's findings and conclusion in this case. Beneficiary G.F.'s condition required medical attention due to symptoms and his cardiac risk factors, but the record supports the ALJ's findings and conclusions that the beneficiary could have been appropriately treated at an outpatient, observation level of care. Thus, the inpatient services at issue were not medically reasonable and necessary as billed by the appellant.

3. Beneficiary A.M.

Before the Council, the appellant asserts that the inpatient hospital services billed for beneficiary A.M. on February 5, through February 6, 2008, were reasonable and necessary given her signs and symptoms, as well as her risk of complications given her post-operative status. Exh. MAC-5 at 6. More specifically, the appellant asserts that the beneficiary's nausea, vomiting, and inability to manage acute epigastric pain at home, combined with her being one-week post meniscal knee surgery and two-weeks post esophagogastroduodenoscopy (EGD) rendered her inpatient admission reasonable and necessary. *Id.* After considering the record, however, the Council finds that the ALJ did not err in denying coverage for the services as

billed because the medical records in evidence, taken as a whole, do not support the appellant's contentions.

In this instance, the beneficiary, a 41-year-old female with a past medical history of gastritis, depression, and anxiety, presented with complaints of severe epigastric pain, which she rated as a 10 out of 10. A.M. Exh. 1 at 5, 7-10. The beneficiary reported that she had undergone meniscal knee surgery one week earlier, and an EGD two weeks earlier. *Id.* at 17, 23-24. It was therefore appropriate, as the emergency department did, to assess the beneficiary's current condition and rule out any adverse events potentially related to the recent medical procedures she underwent. The record, however, does not support that the beneficiary received or required acute care such as that provided in an inpatient setting.

While we concur with the appellant that a history of gastritis does not, alone, preclude an acute exacerbation of symptoms that require inpatient hospitalization, the records in this case simply do not support that inpatient hospitalization was reasonable or necessary. The beneficiary presented to the emergency department at approximately 11:00 AM on February 5, 2008. *Id.* at 5. She complained of pain that was 10 out of 10. *Id.* at 9. Later notes reflect that the beneficiary reported that she had eaten Chinese food prior to the onset of vomiting and that her pain was 8 out of 10 in intensity, constant, non-radiating, and burning type, which was typical of her gastritis pain. *Id.* at 23. Interestingly, a still later note indicates that the beneficiary denied consuming spicy foods or coffee prior to the episode. *Id.* at 17.

While in the emergency department, the beneficiary underwent blood tests, and was given oral medications and intravenous fluids and pain medications. *Id.* at 6-15. The attending physician's physical examination at 2:00 AM relates that the beneficiary was lying in bed in mild distress. *Id.* at 23. The physician instructed the beneficiary to continue her medications, resume her regular diet, avoid spicy foods, and stop smoking. *Id.* at 24. The nursing notes similarly reveal that by 2:00 AM on February 6, 2008, the beneficiary's condition was stable and that she had no complaints. *Id.* at 9.

After being transferred to the inpatient unit, the observation level of care provided to the beneficiary continued. The physical examination revealed that the beneficiary was in no acute or apparent distress and was comfortable. *Id.* at 21. The attending physician noted that the beneficiary was able to eat a

full breakfast. *Id.* at 25. In short, the documentation does not indicate any acute care received. *Id.* at 17-22.

Before the Council, the appellant asserts that the ALJ's decision "was tainted by the QIC having made an incorrect finding of fact. . . . Specifically, the QIC concluded that the inpatient admission was not supported by the record because 'the symptoms had resolved prior to admission.'" Exh. MAC-5 at 9 (citing A.M. Exh. 6 at 4). The appellant also takes issue with what it describes as the QIC's "dismissive characterization of this patient's acute symptoms" that has "influenced the ALJ's review." *Id.* at 10. The record indicates that, at the time of her inpatient admission at approximately 2:00 AM, the beneficiary was "lying in bed in mild distress." A.M. Exh. 1 at 23. Thus, the QIC's statement is not entirely accurate as the beneficiary continued to experience pain-related symptoms at the time of her admission. The Council however finds this error to be harmless as the ALJ conducted a *de novo* review of the record and did not base his coverage determination on the QIC's statement regarding the beneficiary's symptoms or its characterization of the evidence alone. The ALJ determined, and we fully concur, that the clinical documentation in evidence does not support a finding that the beneficiary's condition required an acute, inpatient level of care.

The appellant also relies on the fact that the beneficiary underwent two EKGs, each of which revealed some abnormalities. Exh. MAC-5 at 8. The clinical notes from the treating physicians and nurses however do not reveal that the medical professionals treating the beneficiary focused on the EKGs or explain how those results may have influenced a decision to admit the beneficiary to inpatient care. The record contains no evidence to explain why the beneficiary could not be treated and monitored in an outpatient, observation status.

In summary, the appellant has not identified or explained which inpatient acute care services were required and received during the period of service at issue. The record simply does not document any interventions by physicians other than ordering testing and ongoing monitoring.

Further, the Council finds no merit in the appellant's assertions that the ALJ inappropriately focused on the beneficiary's past medical history (she had been diagnosed with gastritis three years earlier) and that he diminished the acute nature of the beneficiary's condition. See Exh. MAC-5 at 7. The ALJ weighed the medical documentation in evidence and

concluded that it did not support a finding that the services at issue were reasonable and necessary. As set forth above, we concur in this assessment.

Finally, the appellant takes issue with the ALJ's citing to a generic discharge summary in his findings of fact. Exh. MAC-5 at 8. The appellant asserts that this discharge summary contained no detailed information yet was cited for two out of five findings of fact. *Id.* The appellant's characterization of the ALJ's findings of fact and the medical evidence upon which they were based is inaccurate. The ALJ indeed cited to a document located at A.M. exhibit 1, page 1 for the propositions that the beneficiary's admitting diagnosis was gastritis and that she was discharged at approximately 1:30 PM on February 6, 2008. A.M. Dec. at 2. This is accurate. The document located at A.M. exhibit 1, page 1 is a somewhat basic hospital form entitled "Summary Sheet," but the fact that it summarizes the beneficiary's hospital stay does not negate that it lists an admitting diagnosis (gastritis) and a time and date of discharge (1:30 PM on February 6, 2008). The appellant has not asserted that the document it provided to support coverage contained incorrect information or was otherwise not trustworthy. Moreover, this admitting diagnosis is corroborated by the emergency department physician, whose notes indicate the clinical impression/diagnosis to be "gastritis." A.M. Exh. 1 at 14. Thus, the ALJ did not err in citing to the hospital's summary sheet, or in referring to the beneficiary's diagnosis as "gastritis" as opposed to "acute gastritis."

Having considered the record as a whole, the Council fully concurs with the ALJ's findings and conclusions in this case. Beneficiary A.M.'s condition required medical attention due to her symptoms including pain, but the record supports the ALJ's findings and conclusions that the beneficiary could have been appropriately treated at an outpatient, observation level of care. Thus, the inpatient services at issue were not medically reasonable and necessary as billed by the appellant.

4. Beneficiary G.R.

Before the Council, the appellant asserts that the inpatient hospital services billed for beneficiary G.R. on November 23, through November 24, 2007, were reasonable and necessary given her signs and symptoms, as well as her risk factors for acute coronary syndrome and myocardial infarction. Exh. MAC-4 at 8. More specifically, the appellant asserts that the beneficiary's tachycardia (rapid heart rate), chest pain, elevated blood

pressure upon admission, and her abnormal EKG rendered her inpatient admission reasonable and necessary. *Id.* After considering the record, however, the Council finds that the ALJ did not err in denying coverage for the services as billed because the medical records in evidence, taken as a whole, do not support the appellant's contentions.

The beneficiary presented at the emergency department at 9:50 AM on November 23, 2007. G.R. Exh. 1 at 1, 9. The emergency department physician's notes state that upon examination at 10:45 AM, the beneficiary complained of radiating chest pain that worsened with exertion, but that she did not experience any associated symptoms, i.e., no shortness of breath, nausea, vomiting, palpitations, or dizziness. *Id.* at 17. The physician indicated the intent to admit the beneficiary to telemetry to rule out myocardial infarction and consider "PE" (likely pulmonary embolism) if the beneficiary continued to be tachycardic despite pain control. *Id.* at 17. The physician ordered an EKG, chest x-ray, three sets of cardiac enzymes, and supplemental oxygen, as well as cardiac and pain control medications. *Id.* At 11:00 AM, the beneficiary was given nitroglycerin. *Id.* at 13. By 12:30 PM, the beneficiary was no longer experiencing chest pain, had no complaints, her blood pressure was only slightly elevated (135/90), and her pulse was 82 beats per minute, which is within normal range. *Id.* at 20. By 1:30 PM, the beneficiary was comfortable in bed and eating lunch. *Id.* at 13. At 2:00 PM, she was up to use the restroom, in stable condition, and "not in any distress." *Id.*

A physician's assistant note from 3:50 PM indicates that the beneficiary's EKG revealed sinus tachycardia but was unchanged from an earlier test performed in May 2006. *Id.* at 30. The note indicates that the beneficiary "is admitted for chest pain" but it also reveals that the beneficiary was waiting for additional cardiac enzyme testing, and that the course of action was to continue cardiac monitoring as well as monitoring for the return of chest pain and/or tachycardia. *Id.* at 30-31. At 4:30 PM, a bed in the inpatient unit became available and the beneficiary was informed of her admission. *Id.* at 13. The beneficiary was stable, denied any pain at that time, and began additional IV medication. *Id.* The clinical documentation from the beneficiary's time in the emergency department does not contain any evidence to support that she required an acute, inpatient level of care at the time she was discharged from the emergency department, and transferred to the inpatient unit, at approximately 5:00 PM.

Before the Council, the appellant takes issue with the ALJ's statements that the records did not indicate cardiovascular or respiratory problems at the time of her admission to inpatient care. Exh. MAC-4 at 8-9. The record, however, supports the ALJ's findings and conclusions. Specifically, the inpatient admission "database and flowsheet" completed at 5:00 PM on November 23, 2007, contains two boxes which support the ALJ's statements. G.R. Exh. 1 at 43-49. The box labeled CARDIAC/VASCULAR reports that the beneficiary had a regular pulse rhythm, her pulse was palpable and normal, her capillary refill was normal (less than three seconds), and that she had no chest pain, palpitations, pacemaker, dizziness, or edema. *Id.* at 44. The INTERVENTIONS/ACTIVITY section reports that the staff was to monitor the beneficiary's cardiac rate/rhythm and peripheral pulses and her IV. *Id.* The following box, labeled RESPIRATORY/CHEST/NECK, reports that the beneficiary had clear breath sounds, was not short of breath, did not depend on supplementary oxygen, and did not have a cough, orthopnea, night sweats, or cyanosis. *Id.* The corresponding INTERVENTIONS/ACTIVITY section reports that the beneficiary was to receive supplementary oxygen via nasal canula and keep the head of her bed elevated. *Id.* Staff was to monitor the beneficiary's airway, pulse oximetry, and mouth care. *Id.* Thus, the Council finds no merit in this contention.

Following her transfer to the inpatient unit, the beneficiary's condition was monitored and assessed. By 5:45 PM, the beneficiary's IV fluids were discontinued, and although the notes are difficult to read, they appear to state that the beneficiary had dinner with no nausea or vomiting. *Id.* at 50. At 6:30 PM, the beneficiary had no complaints or distress. *Id.* The remaining nursing interventions involved treatment and monitoring of low blood glucose levels. *Id.* at 50-51. The beneficiary was discharged at 1:33 pm, the following day. *Id.* at 1. Interestingly, both the beneficiary and nurse signed and dated the discharge forms "November 23, 2007." *Id.* at 7.

Having considered the documentation as a whole, the Council fully concurs with the ALJ's findings and conclusions in this case. Beneficiary G.R.'s condition required medical attention due to her symptoms and cardiac risk factors, but the record supports the ALJ's findings and conclusions that the beneficiary could have been appropriately treated at an outpatient, observation level of care. Thus, the inpatient services at issue were not medically reasonable and necessary as billed by the appellant.

5. Beneficiary M.S.

Before the Council, the appellant asserts that the inpatient hospital services billed for beneficiary M.S. on May 7, through May 8, 2008, were reasonable and necessary given his signs and symptoms, as well as his risk factors for acute coronary syndrome and myocardial infarction. Exh. MAC-3 at 8. More specifically, the appellant asserts that the beneficiary's chest pain, elevated blood pressure, and significant cardiac history rendered his inpatient admission reasonable and necessary. *Id.* After considering the record, however, the Council finds that the ALJ did not err in denying coverage for the services as billed because the medical records in evidence, taken as a whole, do not support the appellant's contentions.

Initially, the appellant takes issue with the ALJ's finding that, upon arrival and examination, the beneficiary denied shortness of breath and chest pain symptoms. *Id.* at 8 (citing M.S. Dec. at 2). The Council concurs with the appellant that the discharge instructions referenced by the ALJ, and located at M.S. exhibit 1 at page 5, do not provide a basis for such a finding. See M.S. Exh. 1 at 13 (the beneficiary arrived at the emergency department at 5:20 PM, complaining of right-sided chest pain but no shortness of breath, nausea, or vomiting). The Council however holds this factual error harmless as the record supports the ALJ's ultimate conclusion denying coverage for the services as billed. Although the beneficiary initially reported chest pain that, at its worst, rated either 8/10 or 10/10, the emergency department clinical work-up notes reveal that, by 9:46 PM, the beneficiary's vital signs were stable and he denied experiencing chest pain or shortness of breath. M.S. Exh. 1 at 24, 28, 38, 46.

The appellant also takes issue with the ALJ's apparent reliance on post-admission, or discharge, documentation because that information would not have been available to the treating physician at the time he or she was making the decision to admit the beneficiary. Exh. MAC-3 at 9. The appellant's point is well taken. In this instance, however, the record contains adequate evidence from the emergency department to support a finding that the beneficiary's condition did not require an acute, inpatient level of care. The "Resident Admission Note" dated May 7, 2008, states that the EKG revealed an old T-inversion, with no new findings. *Id.* at 34. It also reflects that the beneficiary had pain at the site of his pacemaker since its placement one month prior. *Id.* The treatment plan was to continue monitoring beneficiary, continue his home medications,

and repeat testing in the morning. *Id.* at 35. The resident's impression was a "low likelihood of ACS [acute coronary syndrome]". *Id.* Moreover, the cardiology consultation conducted in the emergency department states that the EKG revealed normal sinus rhythm and no changes from prior tests. *Id.* at 40. It also questioned whether the beneficiary's chest pain may have been musculoskeletal, rather than cardiac, in nature. *Id.*

Moreover, after being physically moved to the inpatient unit, the beneficiary continued to require and receive an observation level of care. The physical examination notes reveal that the beneficiary was to be discharged home in the morning if the next set of cardiac enzymes were negative and there had been no changes in the repeat EKG. *Id.* at 33. The repeat EKG revealed no changes from prior abnormalities. *Id.* at 31. The inpatient "database and flowsheet" forms do not list any cardiac or vascular interventions beyond monitoring and IV care. *Id.* at 47. The "Medical Attending Admission Note" dated May 8, 2008 indicates that the beneficiary's chest pain was likely musculoskeletal in nature, and that he was stable for discharge to home. *Id.* at 38. These records make clear that the beneficiary was essentially admitted as an inpatient to wait for additional test results to become available.

In summary, the appellant has not identified or explained which inpatient acute care services were required and received while the beneficiary was waiting comfortably for his test results to become available. The record simply does not document any interventions by physicians other than ordering cardiac testing and ongoing monitoring, both of which could have been safely conducted on an outpatient, observational basis.

In addition, the appellant disputes what it characterizes as the ALJ's failure to consider the medical predictability of something adverse happening to the beneficiary. Exh. MAC-3 at 10. In this instance, the beneficiary, a 71-year-old male, with a history of smoking, myocardial infarction, hypertension, stents, abdominal aortic aneurysm, and a procedure to implant an automatic defibrillator, arrived at the emergency room via ambulance complaining of chest pain. M.S. Exh. 1 at 13, 40. It was therefore appropriate, as the emergency department did, to assess the beneficiary's condition to determine whether he was experiencing acute coronary syndrome. The appellant however has not explained why the beneficiary could not have been observed and monitored in an observational setting until such time as

additional symptoms or complications emerged, at which point he could then be admitted as an inpatient.

The appellant also asserts that the ALJ's decision "appears to have been tainted by the QIC having made an incorrect finding of fact. . . . Specifically, the QIC concluded that the inpatient admission was not supported by the record because 'the physician's notes state the likelihood of acute coronary syndrome was low.'" Exh. MAC-3 at 9 (citing M.S. Exh. 6 at 2). On review, M.S. Exhibit 6 at page 2 contains an appointment of representative form submitted by the appellant along with its request for ALJ hearing. The Council has reviewed the QIC's reconsideration, located in the record at M.S. Exhibit 5, pages 1 through 6, and cannot locate the quotation or finding of fact referenced by the appellant. Nonetheless, if the QIC's reconsideration contained such a statement, it would be supported by the record. The "Resident Admission Note" dated May 7, 2008, states "low likelihood of ACS." M.S. Exh. 1 at 35.

Having considered the record as a whole, the Council concurs with the ALJ's findings (with the exception noted above) and conclusions in this case. Beneficiary M.S.' condition required medical attention due to his presenting symptoms and his cardiac risk factors, but the record supports the ALJ's findings and conclusions that the beneficiary could have been appropriately treated at an outpatient, observation level of care. Thus, the inpatient services at issue were not medically reasonable and necessary as billed by the appellant.

As set forth in detail above, the Council concurs with the ALJ that the medical documentation provided in each case does not support an inpatient level of care. See Decs. at 2, 6-7. The appellant has not provided any documentation to support a finding that the beneficiaries required or received an acute, inpatient level of care on the dates of service at issue. Each beneficiary required hospital-based medical treatment, but that treatment could have been safely and appropriately provided in the form of outpatient observation services for continued monitoring and if symptoms did worsen, the beneficiary could have been admitted at that time. The Council therefore finds no reason to overturn the ALJ's coverage determinations and upholds the overpayments at issue.

C. LIMITATION ON LIABILITY

Before the Council, in each instance, the appellant asserts:

Even if the inpatient hospital services were not reasonable and necessary, [it is] entitled to be paid for these services under the limitation on liability provision set forth in Social Security Act § 1879, since neither [it] nor the beneficiary knew or reasonably could have known that inpatient hospital services would be denied as not reasonable and necessary under the particular facts of this case.

See, e.g., Exh. MAC-6 at 11. The appellant further asserts that the ALJ erred as a matter of law in holding it liable for the non-covered services at issue because it did not issue an Advanced Beneficiary Notice (ABN) and the medical record does not provide "clear and obvious evidence" that the services at issue would not be covered. *Id.* at 13-14. After considering the record and the appellant's contentions, the Council finds that the ALJ did not err in holding the appellant liable for the non-covered services at issue.

Section 1879 of the Act provides that a beneficiary or supplier may be liable for the cost of an item or service that is not "reasonable and necessary" based upon prior knowledge of noncoverage. Act at § 1879(a); 42 C.F.R. §§ 411.400, 411.404, 411.406; Medicare Claims Processing Manual (MCPM), Pub. 100-04, Ch. 30, § 40. A beneficiary is deemed to have knowledge of noncoverage if the supplier provides written notice to the beneficiary explaining why it believes that Medicare will not cover the item or service. 42 C.F.R. § 411.404(b). A supplier is deemed to have knowledge of noncoverage, in part, when it informs the beneficiary before furnishing the item or service that it is not covered. 42 C.F.R. § 411.406(d)(1). A supplier also has actual or constructive knowledge of noncoverage based upon "[i]ts receipt of CMS notices, including manual issuances, bulletins, or other written guides or directives from [Medicare contractors]" and "[i]ts knowledge of what are considered acceptable standards of practice by the local medical community." 42 C.F.R. §§ 411.406(e)(1),(3).

Section 1879 of the Act limits a provider's liability where it did not know, and could not reasonably be expected to know, that Medicare did not cover the services at issue. However, as a provider participating in the Medicare program, the appellant is considered to have constructive knowledge of CMS manual instructions, bulletins, contractors' written guides, and directives. MCPM, Ch. 30 at §§ 40.1, 40.1.1. Thus, the appellant's assertions that it did not have actual knowledge of Medicare's likely non-coverage based on its failure to issue an

ABN to any of the beneficiaries or the content of the medical records it submitted in support of its charges are unavailing. A provider furnishing services to Medicare beneficiaries is expected to be familiar with general medical standards for inpatient admission.

The appellant also asserts that its liability should be limited because the New York Quality Improvement Organization (QIO), IPRO, announced its implementation of the Milliman Care Guidelines effective January 1, 2009, after the dates of service at issue in this case. See, e.g., Exh. MAC-6 at 15. The appellant has not explained how this is relevant to our inquiry. The fact that the QIO issued this announcement after the dates of service at issue does not absolve the appellant from the constructive knowledge it possessed as a provider participating in the Medicare program, discussed above. Moreover, the instant cases arose not in the QIO context, but from a post-payment probe review based upon the detection of possibly aberrant billing patterns. See, e.g., G.F. Exhs. 2-3.

In addition, the appellant references the "Special Notice" issued by the contractor in July 2010, regarding the so-called "Eight Hour Rule" to suggest that it could not have reasonably known that Medicare did not cover the services at issue until its 2010 issuance. See, e.g., Exh. MAC-6 at 15. The Council finds no merit in this contention. The intermediary's issuance of an educational notice to alleviate confusion in the provider community does not mean that, prior to its issuance, the appellant should not have reasonably known that the services it was billing were not reasonable and necessary consistent with then-existing Medicare coverage guidelines.

Finally, the appellant asserts that it could not have been expected to know that Medicare would not cover the services at issue because the contractor paid for these services initially and because other ALJs have subsequently issued favorable decisions granting Medicare coverage for the services as billed. See, e.g., Exh. MAC-6 at 15. The Council however finds no merit in this contention. The fact that the contractor initially paid the claims as billed does not provide a basis to limit a provider's liability. To hold otherwise would render all claims review fruitless. Such an outcome is clearly contrary to the intent of Congress, which has provided both authority and funding for various forms of pre-payment and post-payment review of Medicare claims. In addition, the fact that other ALJs have granted Medicare coverage for other claims involving similar services does not control here. Each ALJ decision is based on

case-specific facts arising from a specific claim, which requires an individual determination as to whether the medical necessity requirements are met. Thus, the fact that an ALJ may have issued a decision granting Medicare coverage in another case regarding similar services is not dispositive of whether the appellant knew or had reason to know that the Medicare would not cover the services at issue in the present cases.

For these reasons, the Council finds that the ALJ did not err in finding that the limitation of liability provision of section 1879 did not apply to the appellant. Accordingly, the appellant remains liable for the non-covered services pursuant to section 1879 of the Act.

D. WAIVER OF RECOUPMENT

The appellant initially asserted that it was "without fault" with respect to the overpayments at issue and therefore entitled to a waiver of Medicare's recovery pursuant to section 1870 of the Act. Exh. MAC-1. The appellant subsequently indicated it no longer wished to pursue such a waiver. Exhs. MAC-3-MAC-6. Accordingly, the Council will not consider the applicability of section 1870 of the Act to this case. 42 C.F.R. § 405.1112(c).

E. PAYMENT FOR OBSERVATION SERVICES

In the event that the Council did not find in its favor, as occurred here, the appellant requests that the Council order that it be paid for the observation and underlying care under Medicare Part B pursuant to the Council's decision in the case of *O'Connor Hospital* (Feb. 1, 2010).³ Exhs. MAC-1, MAC-3-MAC-6.

CMS has expressly stated that Part B payment may be made if Part A payment is denied. For example, the Medicare Benefits Policy Manual (MBPM) indicates that payment may be made for covered hospital services under Part B, if a Part A claim is denied for any one of several reasons. MBPM, CMS Pub. 100-02, Ch. 6 at § 10 ("Part B payment could be made for these services if . . . the admission was disapproved as not reasonable and necessary (and waiver of liability payment was not made)"); see also MBPM, Ch. 1 at § 10.

³ The Council's action, *In the Case of O'Connor Hospital*, is available at http://www.hhs.gov/dab/divisions/medicareoperations/macdecisions/mac_decisions.html (last visited May 5, 2011).

For the purposes of this decision, a Part A Medicare Administrative Contractor processes both Part A and Part B claims from providers.⁴ Section 1816 of the Act and the implementing regulations recognize that not all claims are "clean claims" that will be paid promptly as billed. The regulation in effect at the time of service provides that:

The intermediary takes appropriate action to reject or adjust the claim if -

- (i) The intermediary or the QIO determines that the services furnished or proposed to be furnished were not reasonable, not medically necessary, or not furnished in the most appropriate setting; or
- (ii) The intermediary determines that the claim does not properly reflect the kind and amount of services furnished.

42 C.F.R. § 421.100(a)(2).

Further, the Medicare Financial Management Manual (MFMM) recognizes that additional action may be necessary by both the intermediary and provider to properly adjust, or offset, the amount due under Part B against a Part A overpayment. See MFMM, CMS Pub. 100-06, Ch. 3 at § 170.1 (if Part B benefits are payable, the intermediary shall arrange for billings under Part B and use any Part B benefit as an offset against the Part A overpayment). This manual section demonstrates that CMS contemplated scenarios, like the instant one, in which a contractor would offset at least a portion of an overpayment recovery as the result of other benefits due to the provider.

In this case, the appellant submitted timely claims for services which were paid under Part A. When the intermediary reopened the determination on the initial claims at issue here, it had the same plenary authority to process and adjust the claim as it did when that claim was first presented and paid. The intermediary's revised initial determination states that the documentation supported an outpatient observation status. See, e.g., G.F. Exh. 3 at 3. The QIC also found that outpatient observation status would have been an appropriate course of treatment. See, e.g., G.F. Exh. 7 at 69. In each instance, the

⁴ The functions performed by intermediaries during the period at issue have been transitioned to Medicare Administrative Contractors (MACs). See 42 C.F.R. §§ 421.100, 421.104.

ALJ concluded that "observation care would have been appropriate." See, e.g., G.F. Dec. at 6. The Council's instant action does not disturb these conclusions.

Each record contains a printout of the line item bill. G.F. and G.R. Exhs. 3 at 3; A.M. and M.S. Exhs. 2 at 3. The intermediary needs only supplementary information in order to process a Part B claim for the very same services identified on the original Part A claim. Consistent with the CMS manual provisions discussed above, the contractor shall work with the provider to take whatever actions are necessary to arrange for billing under Part B, and to offset any Part A overpayment. The contractor shall issue a new initial determination upon effectuation. 42 C.F.R. § 405.1046(c).

CONCLUSION

Consistent with the foregoing discussion, the Council modifies the ALJ's decisions to correct harmless errors and supplement the analysis provided. The Council however concurs with the ALJ's conclusions, denying coverage for the inpatient services at issue, allowing coverage at the outpatient observation level, and holding the appellant liable for any overpayment arising from the difference between the covered and non-covered services.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

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

Date: May 10, 2011