

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-2407

In the case of

San Joaquin Valley
Rehabilitation Hospital

(Appellant)

Claim for

Medicare Advantage (MA)
(Part C)

(Beneficiary/Enrollee)

(HIC Number)

Anthem Blue Cross and Blue
Shield/Anthem Blue Cross and
Blue Shield SmartValue
Private Fee For Service Plan

(MA Organization (MAO)/MA
Plan)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a hearing decision on June 27, 2011, on the provider's request for hearing. The ALJ determined that the MA plan in which the beneficiary was enrolled was not required to cover an inpatient rehabilitation hospital stay from October 31, 2009, through November 6, 2009. The ALJ further found that the "part C provider is not liable for the services." The provider has asked the Medicare Appeals Council to review the ALJ's decision.

The regulation codified at 42 C.F.R. § 422.608 states that "[t]he regulations under part 405 of this chapter regarding MAC [Medicare Appeals Council] review apply to matters addressed by this subpart to the extent that they are appropriate." The regulations "under part 405" include the appeal procedures found at 42 C.F.R. part 405, subpart I. With respect to Medicare "fee-for-service" appeals, the subpart I procedures pertain primarily to claims subject to the Medicare, Medicaid and SCHIP Benefits Act of 2000 (BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). 70 Fed. Reg. 11420, 11421-11426 (March 8, 2005). The Council has determined, until there is amendment of 42 C.F.R. part 422 or clarification

by the Centers for Medicare & Medicaid Services (CMS), that it is "appropriate" to apply, with certain exceptions, the legal provisions and principles codified in 42 C.F.R. part 405, subpart I, to this case.

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 provider's timely-filed request for review is admitted into the record as Exh. MAC-1. The Council has not received any response from the MAO or the enrollee. For the reasons set forth below, the Council affirms the ALJ's determination that the services are not covered.

DISCUSSION

The beneficiary had a right total knee replacement on October 28, 2009. Her immediate postoperative course in the hospital was "essentially unremarkable." Exh. 12 at 7. She was "transferred routinely" to the appellant acute care inpatient acute rehabilitation facility (IRF) on October 31, 2009. *Id.* She was discharged to home on November 6, 2009, improved, and without significant complications.

The MAO, and the Independent Review Entity (IRE) on reconsideration, determined that the care was not covered because the care needed could have been provided in a less intense setting. Exhs. 2, 4, and 5. The IRE noted that the evidence did not support the medical necessity of a hospital level of care with oversight by a physician specially trained in rehabilitation or acute rehabilitation nursing care. Further, the enrollee did not require intensive therapy or a multidisciplinary approach.

The provider appealed to the ALJ. Previously, the provider had waived "any right to collect payment" from the enrollee. Exh. 4 at 38. This waiver is required in order for the provider to have the right to a hearing. 42 C.F.R. §§ 422.574(b), 422.600.

The ALJ found that the enrollee's condition on admission was not remarkable, that the measures of functional deficits were incomplete but any deficits were nonetheless minimal, and that

there was no medical necessity for the services provided. The ALJ held that the appellant had not met its burden of proof.

The provider's request for review suggests that the pre-admission screen documents the need for an inpatient stay, in which the IRF's physicians concurred. The combined care of rehabilitation nursing, intense therapy, and physician oversight expedited her discharge home in a safe and efficient manner.

MA plans, stated generally, follow Medicare coverage guidelines. A MAO offering a Medicare Advantage (MA) plan must provide enrollees with "basic benefits," which are all items and services covered by Medicare Part A and Part B available to beneficiaries residing in the plan's service area. 42 C.F.R. § 422.101(a). A MA plan must comply with NCDs, LCDs, and general coverage guidelines included in original Medicare manuals and instructions. 42 C.F.R. § 422.101(b). By regulation, NCDs are also binding on ALJs and the Medicare Appeals Council. 42 C.F.R. § 405.1060. Rulings issued by the Administrator of the Centers for Medicare & Medicaid Services are also binding on ALJs and the Council. 42 C.F.R. § 401.108, 405.1063(b).

CMS Ruling 85-2, in effect during the period at issue, provides eight criteria for coverage of inpatient rehabilitation hospital services.¹ Exh. 6. As pertinent herein, the patient's condition must require close medical supervision by a physician with specialized training or experience in rehabilitation. The physician must be available 24 hours per day. The medical record should reflect frequent and direct medically necessary involvement in the patient's care. These requirements were also reflected in Medicare Benefit Policy Manual (MBPM), IOM 100-02, ch. 1, sec. 110.4.2, as in effect during the period at issue.

The Council concurs with the ALJ that the IRF services were not medically reasonable and necessary. The enrollee did not require the close medical supervision by a physician with specialized training or experience in rehabilitation, available on a 24 hour a day basis. The hospital discharge summary and daily IRF notes reflect that the enrollee was medically stable, and did not need frequent and direct medically necessary physician involvement in her care, to the extent that IRF care was required. There were no complex medical issues that required the close medical supervision by a physician with

¹ Ruling 85-2 was rescinded effective for IRF discharges occurring on or after January 1, 2010. See, e.g., MLN Matters MM6699.

specialized training or experience in rehabilitation, available on a 24 hour a day basis. The required level of medically reasonable and necessary care could have been provided in a less intense setting, rather than in an extended inpatient rehabilitation hospital stay.

Accordingly, the MAO is not required to cover the care under the terms of the MA Plan. The provider therefore remains financially liable.

Based on the foregoing, the Council adopts the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: October 6, 2011