

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DEPARTMENTAL APPEALS BOARD

**DECISION OF MEDICARE APPEALS COUNCIL**

**In the case of**

Kaweah Delta Rehabilitation  
Hospital  
\_\_\_\_\_  
(Appellant)

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\_\_\_\_\_  
(Beneficiary)

National Government Services  
\_\_\_\_\_  
(Contractor)

**Claim for**

Hospital Insurance Benefits  
(Part A)  
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\_\_\_\_\_  
(HIC Number)

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(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated January 23, 2009, which concerned rehabilitation hospital services provided to the beneficiary from November 5, 2004 to November 19, 2004. The ALJ concluded that an overpayment was justified for this claim based on a determination that the beneficiary did not require inpatient rehabilitation services at the level of care provided by the appellant hospital. The appellant has asked the Medicare Appeals Council to review this action.

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, because the appellant is not an unrepresented beneficiary. 42 C.F.R. § 405.1112(c). As set forth below, the Council reverses the ALJ's decision.

**CASE BACKGROUND**

This claim for two weeks of inpatient rehabilitation services provided to the beneficiary was initially paid. On June 7, 2007, a Medicare Recovery Audit Contractor found that claim was erroneously paid, resulting in an overpayment determination. The initial levels of appeal upheld the conclusions that the

services were not medically necessary and that appellant was liable for the charges.

The factual findings made by the ALJ include the following information about the beneficiary's medical needs and treatment:

She was 77 years old at the time of this rehabilitation placement and had been suffering for some years from progressive lung disease. ALJ Decision at 2, and record citations therein. Between June and October of 2004, the beneficiary presented repeatedly in emergency rooms with episodes of severe shortness of breath (SOB). Id. She required in-patient hospital admissions in August, September, and finally on October 31, 2004. Id.

On admission to the inpatient rehabilitation facility (IRF) from the hospital, her primary diagnosis was "severe debilitation due to multiple hospitalizations for pneumonia secondary to severe chronic obstructive pulmonary disease [COPD]," with additional diagnoses including diverticulitis, bowel problems and severe muscle wasting in the extremities. Id. The beneficiary also suffered from complaints of "severe fatigue, inability to ambulate, extreme muscle weakness, occasional dyspepsia, frequent constipation, and several tender joints. Id. The initial IRF treatment plan included providing daily occupational and physical therapy, maintaining existing medications (which included oxygen therapy and high doses of steroids), and introducing new medications (including adding Flagyl to existing antibiotics to address possible anaerobic infection, nitroglycerin ointment to address high blood pressure, and other treatments for breathing, possible allergy and bowel issues). Id. at 2-3, and record citations therein. She also entered with a stage II pressure sore on her coccyx, with leukocytosis, hyponatremia, and hypokalemia. Id.

By the end of her two-week stay in the IRF, the beneficiary's "abdominal complaints improved, her energy improved, her eating improved, and she gained five pounds." Id. at 2, and record citations therein. Her coccyx ulcer "responded well to treatment," her leukocytosis "resolved," her hyponatremia "was corrected," and her hypokalemia "was being treated." Id. at 3, and record citations therein.

The ALJ nevertheless concluded that the beneficiary's condition was stable when she was admitted to the IRF and that she had "no active co-morbidities, illness, infection, or complication that

made it reasonable to believe that [she] *required* an [IRF] level of care, rather than a SNF [skilled nursing facility] level of care." ALJ Decision at 10. In support of his conclusion that the level of care was not medically necessary, the ALJ states that she did not have "an exacerbation or exacerbations of her co-morbid chronic medical conditions while in the [IRF]," that the services provided were "not so unique or complicated that they could not have been provided in a SNF," and that the "treating physician" recommended these services at the request of the beneficiary's family because they did not want to place her in long-term care even though these services were "routinely provided" in SNFs. Id.

#### **APPLICABLE LEGAL AUTHORITIES**

Inpatient hospital care is coverage under Part A of Medicare when it meets the description of such services in the statute and regulations so long as the services provided are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." ALJ Decision at 4-5, quoting section 1862(a) of the Social Security Act (Act) and citing applicable statutory and regulatory provisions. The term "hospital" includes an institution "primarily engaged in providing, by or under the supervision of physicians, to inpatients . . . (B) rehabilitation of injured, disabled, or sick persons." Section 1861(e)(1) of the Act.

CMS has developed guidance on how to determine whether stays in IRFs are reasonable and necessary and stresses that each beneficiary's individual care needs must be carefully assessed, without reliance on any general rules of thumb as to diagnosis, specific treatments, or screens. Medicare Benefit Policy Manual (MBPM), Pub. 100-02, Chap. 1, § 110.1. In general, patients need hospital-level rehabilitative services, if they require a relatively intense rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade their ability to function. There are two basic requirements that must be met for inpatient hospital stays for rehabilitation care to be covered:

1. The services must be reasonable and necessary (in terms of efficacy, duration, frequency, and amount) for the treatment of the patient's condition; and

2. It must be reasonable and necessary to furnish the care on an inpatient hospital basis, rather than in a less intensive facility such as a SNF, or on an outpatient basis.

MBPM, Ch. 1, § 110.1.

On admission, IRFs are to evaluate the appropriateness of its services for the beneficiary using a Patient Assessment Instrument (PAI). MBPM, Ch. 1, § 110.3. The core criterion for screening a patient for IRF services is that the "patient requires and receives 'a more coordinated, intensive program of multiple services than is generally found out of a hospital.'" MBPM, Ch. 1, § 110.4. In that regard, CMS advises that a "patient probably requires a hospital level of care if they have either one or more conditions requiring intensive and multi-disciplinary rehabilitation care, or a medical complication in addition to their primary condition, so that the continuing availability of a physician is required to ensure safe and effective treatment." Id.

CMS also provides a set of screening criteria to be used at the initial claims review level to identify cases that "clearly involve a hospital level of rehabilitative care" without requiring further review. Id. The manual makes clear that failing to satisfy any of these criteria does not imply that the claim should be denied, but only that it should be reviewed by a physician who will determine medical necessity, reasonableness, and appropriateness based on their own judgment without reference to these criteria. Id.; see Hooper v. Sullivan, 1989 WL 107497, at 1 (D. Conn. 1989)(specific criterion of 3 hours/day of therapy is not meant to create irrebuttable presumption of noncoverage.). The criteria, which were cited by the ALJ, are as follows:

1. "24-hour availability of a physician with special training or experience in the field of rehabilitation," evidenced by medical record documentation of physician involved at least every 2-3 days during stay. (The manual notes that this "degree of physician involvement . . . is greater than is normally rendered to a patient in a SNF . . . .");
2. "24-hour availability of a registered nurse with specialized training or experience in rehabilitation;"
3. At least 3 hours per day of physical or occupational therapy on at least 5 days per week;

4. A multi-disciplinary care team approach, including at least the physician, rehabilitation nurse and therapist;
5. Documentation of a coordinated program of care, including at least biweekly team conferences;
6. An expectation based on the assessment of "significant practical improvement . . . in a reasonable period of time," although not necessarily to complete independence; and
7. Realistic goals, which for most Medicare patients would mean "self-care or independence in the activities of daily living; i.e., self-sufficiency in bathing, ambulation, eating, dressing, homemaking, etc., or sufficient improvement to allow a patient to live at home with family assistance rather than in an institution," so that "the aim of the treatment is achieving the maximum level of function possible."

MBPM, Ch. 1, §§ 110.4.1-110.4.7.

#### **ANALYSIS**

The ALJ finds that the beneficiary did need rehabilitation services but questions the need for them to be provided in a hospital-level setting. The facts of the beneficiary's multiple and complex medical problems with muscle wasting, digestive illness resulting in inadequate nutrition, severe debilitation and COPD and pneumonia causing repeated crises and hospitalizations in a short period of time would seem, on their face, to demonstrate a need for IRF services. She appears both to have suffered from more than one condition creating a need for "intensive and multi-disciplinary rehabilitation care," and to have had multiple medical complications in addition to her primary admitting condition (severe debilitation) justifying a need for "continuing availability of a physician is required to ensure safe and effective treatment." Either situation is presented in the manual as probably demonstrating a need for hospital-level rehabilitation. MBPM, Ch. 1, § 110.4.

Additional evidence in the record but not discussed by the ALJ documents that the beneficiary met the advisory criteria set out in the manual as well. The record contains a PAI signed by the treating physician listing nine co-morbid conditions. Ex. 8, at 739.<sup>1</sup> The PAI shows the resident on intake as requiring total

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<sup>1</sup> The ALJ did not discuss any of the statements or testimony of the treating physician in his findings of fact or analysis. His factual findings relied

assist with walking and bladder control and minimal-level assistance with transfers, bathing, dressing, and toileting. Ex. 8, at 740. Progress notes by the treating physician for visits and adjustments to medication, oxygen use and other treatments are documented every day from November 8, 2004 through the discharge date on November 19, 2004. Ex. 8, at 705-712. Physician orders for medication or treatment changes appear in the record for November 5 (thorough orders on admission), November 6 (two separate times), November 7, November 9 (two separate times), November 17, and November 19 (discharge orders). Ex. 8, at 693-701. The medical and nursing records provided by the appellant support its assertion that, in order to address the combined effects of SOB and resulting anxiety which interfered with improving mobility and endurance, rehabilitative nurses had to monitor oxygen saturation closely (repeatedly in a single day), administer as needed medications, and coordinate respiratory treatment with the physician regularly. Ex. 8 passim. Furthermore, close monitoring of heart rate was required due to multiple episodes of sinus tachycardia and daily weight checks and active nutritional interventions were needed to address the contribution of malnutrition to her debilitation. Id. These records establish the availability of and need for 24-hour physician and registered nurse capacities. No question was raised about the beneficiary's receipt of at least 3 hours per day of physical and occupational therapy.

On entry, a comprehensive multidisciplinary initial evaluation was performed and appropriate goals and modalities were articulated in writing, and concluded that the beneficiary's rehabilitation potential for the identified goals was "good." Ex. 8, at 713-19. Daily plans of care record identified needs and collected data as to each, the actions taken that shift to address every area, the patient's responses in each area, daily assessment of the level of assistance or intervention the patient required, multidisciplinary activity flow sheets, and specific focus notes on areas of concern. Ex. 8 at 740-855. A written team conference report for November 12, 2004, documents the presence of the physician, two therapists, two registered nurses, and the social worker reviewing the beneficiary's medical and psychosocial status, identifying specific treatment

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almost entirely on his reading of seven pages constituting the beneficiary's history and physical findings on admission and her discharge summary. Ex. 1, at 12-18. The ALJ did not explain why he apparently disregarded several hundred pages of underlying medical records along with the only medical testimony, since no other expert appeared.

goals, planning specific interventions, and assessing how to remove remaining barriers to discharge. Ex. 8, at 747. This documentation establishes that a multidisciplinary team approach was used and documented and coordinated with team conferences at least biweekly.

The reasonableness of the expectation for improvement and of the goal set for the beneficiary to regain the ability to function in her home setting with family support is established by the ample documentation of the progress actually made by the beneficiary in a two-week period. The ALJ recognized that the intensive interventions had resulted in resolving or improving multiple medical issues and in successfully addressing her weakness and nutritional deficits. ALJ Decision at 2-3. On admission, the beneficiary required two liters of oxygen airflow to maintain adequate saturation while her treating physician testified at the hearing that she was able to reduce the airflow to 1 liter by discharge despite her higher level of activity. Compare Ex. 8, at 713 with Hearing CD. A discharge evaluation form records that the beneficiary had achieved modified independence (i.e., may require use of a device but not outside assistance) in all areas of self-care and toilet transfer, had complete bowel control and improved bladder control, and had moved from total assist for walking to modified independence in walking and from no ability to negotiate stairs to the ability to climb stairs with maximal assist. Ex. 8, at 720. The treating physician testified that all of the resident's discharge goals were achieved.

The ALJ made no finding that any of the advisory criteria were not met. The reasons which the ALJ gave for rejecting the need for this level of care, as explained above, may be summarized as follows:

- (1) The beneficiary was stable on admission to the IRF.
- (2) The beneficiary did not have "active" co-morbidities, illnesses, infections, or complications.
- (3) The beneficiary did not suffer an exacerbation while in the IRF.
- (4) The beneficiary's needs could have been met in a SNF.
- (5) The placement was made at the family's request to avoid a long-term care placement.

The ALJ does not explain why, even if true, being medically stable on admission would disqualify the beneficiary from coverage for IRF services. Nor does the ALJ explain the basis

for his assertion that the beneficiary was stable. The statement appears to be based on a statement in the QIC decision that the admission history showed that the beneficiary's "vital signs were stable" and she did not "present in acute distress." Ex. 13, at 1023. No legal authority appears to require that beneficiaries must have unstable vital signs and be in acute distress in order to need hospital-level rehabilitation. Here, in fact, the treating physician testified that the vital signs recorded on the history are not stable or medically appropriate and that they called for medical intervention, which he proceeded to provide. Hearing CD. Her pulse was 110; her temperature was 99.4; her respirations were 36; and her blood pressure was 119/64. Ex. 8, at 684, 860. The physician testified that the temperature was significantly elevated (as it had been frequently in the recent past) when viewed in light of the high level of steroids she was taking which should have caused a lowering of temperature. Hearing CD. The record reflects that cooling interventions were begun to bring down her temperature. The physician also testified that her respirations should have been closer to 14-15 than 35. Hearing CD. The record reflects, and the physician testified to, extensive efforts to teach breathing techniques and manage "air hunger" and anxiety in order to reverse shallow breathing which was leading to toxic accumulation of carbon dioxide impacting cognition and function. Hearing CD; Ex. 8 passim. The blood pressure reading led to immediate medication changes to try to lower her blood pressure. The physician opined that the beneficiary was "not medically stable," and that considerable thought was given to whether she was well enough to undertake the intensive rehabilitation program even with the extensive medical support in the IRF. Hearing CD.

As already discussed, the beneficiary had extensive co-morbidities and suffered from multiple chronic and acute illnesses. The treating physician testified at length to the interactions among these problems and the importance of managing all of them aggressively in order to maximize the likelihood of success in rehabilitation. Hearing CD.

The ALJ does not explain why, even if true, not having an exacerbation of a co-morbidity during her stay would disqualify the beneficiary from coverage for IRF services. In addition, he cites no factual basis for this assertion. The treating physician directly denied the accuracy of this claim and reported that in fact the beneficiary suffered exacerbations in multiple areas requiring active interventions. Hearing CD. The

record supports the physician's testimony, showing an electrocardiogram on November 6, 2004 in response to an increase in SOB, a chest X-ray on November 8, 2004 due to racing heart, and an abdominal scan on November 18, 2004 due to abdominal pain. Ex. 8, at 860, 869, and 871.

If the beneficiary's needs could indeed have been met in a SNF, that would justify non-coverage of care in an IRF. The ALJ provided no basis, however, for his conclusory statement that a SNF setting would have been appropriate. The treating physician opined that it would have been unsafe for this beneficiary to have received rehabilitation services in a SNF setting. Hearing CD. He testified that, in his experience, a SNF could not provide multiple medication and treatment changes daily. *Id.* He further testified that he did not believe that the level of nursing care that this beneficiary required could be routinely provided at a SNF. *Id.* In this regard, the appellant submitted a data analysis identified as based on "OSHPD LTC Annual Disclosure Reports," which covered collective financial and staffing information on the 13 SNFs in the same county as its IRF during 2004. Ex. 8, at 661-64. Based on this data, the appellant calculates that registered nurses in those SNFs spend, on average, only 0.13 "productive hours per patient day." *Id.* at 663. By contrast, the appellant asserts that at the relevant time its registered nurses spent 3.86 productive hours per patient day. Appellant's Request for Review (RR) at 3. While it might be possible to question the basis for the physician's knowledge of SNF capabilities or the accuracy of the data analysis, no conflicting expert testimony or other inconsistent evidence appears in the record.

The ALJ does not explain why the family's wish that the beneficiary not need long-term care and that she receive rehabilitation at the IRF to avoid that outcome undercuts the evidence that the beneficiary needed that level of care. The ALJ states that the "treating physician" recommended the IRF services "at the request" of the family, which implies that the physician acted to accommodate the family rather than based on independent medical judgment. ALJ Decision at 10. The treating physician directly denied that implication. Hearing CD. He testified, and the record corroborates, that the recommendation for IRF services did not come from him, but rather from the hospitalist treating the beneficiary and from a consulting pulmonologist. Hearing CD; Ex. 8, at 683. The family wish to see the beneficiary able to return home rather have her placed in a long-term care facility is certainly not a sufficient basis

to justify IRF care, but neither are we aware of any rule that the family's desire precludes coverage of IRF care if otherwise appropriate. The appellant states that many families request rehabilitation services at its facility but that "in every instance only those who meet the criteria for admission after a careful preadmission screening are accepted." RR at 4. CMS's manual explicitly identifies as a "reasonable goal" for IRF services "sufficient improvement to allow a patient to live at home with family assistance rather than in an institution." MBPM, Ch. 1, §§ 110.4.7.

### **CONCLUSION**

We conclude that the ALJ's reasons for denying coverage were all legally irrelevant, factually unsupported by substantial evidence on the record as a whole, or both. We conclude that the evidence of record establishes that the IRF services at issue were medically reasonable and necessary and are covered by Medicare.

MEDICARE APPEALS COUNCIL

/s/ Leslie A. Sussan, Member  
Departmental Appeals Board

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

Date: May 13, 2009