

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

ORDER OF MEDICARE APPEALS COUNCIL
Docket Number: M-12-1231

In the case of

King's Daughters
Medical Center

(Appellant)

(Beneficiary)

CGI Federal, Inc. (RAC)

(Contractor)

Claim for

Hospital Insurance Benefits
(Part A)

(HIC Number)

(ALJ Appeal Number)

The Medicare Appeals Council (Council) received the above-captioned case on referral from the Centers for Medicare and Medicaid Services (CMS), by memorandum dated April 12, 2012. The Council has also received a response on behalf of the appellant, dated May 3, 2012. On February 13, 2012, the Administrative Law Judge (ALJ) issued a decision, following a telephone hearing conducted on January 30, 2012, finding that the inpatient hospital services which the appellant provided to the beneficiary from December 7, 2009, through December 8, 2009, were medically reasonable and necessary and, therefore, covered by Medicare.

In the agency referral memorandum, CMS (by and through a contractor, Q2Adminsitrators, LLC) contends that the ALJ's decision contains errors of law material to the outcome of the claim and is not supported by a preponderance of the evidence.

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 and the ALJ's decision is consistent with a preponderance of the record evidence.

STANDARD OF REVIEW

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 may also request that the Council take own motion review if CMS or its contractor participated in the ALJ proceedings and, in CMS's view, the ALJ decision is not supported by a preponderance of record evidence or the ALJ abused his or her discretion. *Id.* 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, in which CMS participated in the ALJ proceedings, the Council will accept review if the decision contains an error of law material to the outcome of the claim, the ALJ abused his or her discretion, the decision is not consistent with a preponderance of the evidence of record, or the case presents a broad policy or procedural issue that may affect the general public interest. 42 C.F.R. § 405.1110(c)(1). 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 December 7, 2009, through December 8, 2009. These hospital inpatient services immediately followed a left heart catheterization (percutaneous transluminal coronary angioplasty of the right coronary artery, stent placement, and balloon angioplasty) following complaints of chest pain and a diagnosis of unstable angina. Dec. at 2; Exh. 6, at 41.

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 "medical record does not establish the need for acute care hospitalization at an inpatient level." Exh. 4, at 47. The intermediary and the Qualified Independent Contractor

(QIC) affirmed this RAC determination. *Id.* at 1-3; Exh. 3, at 1-6.

On further appeal, the ALJ issued a favorable decision, in which he reviewed the evidence of record, made 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. 2, 5-7. The ALJ's determination referred to multiple medical factors, including the beneficiary's history of diabetes, hypertension, chronic obstructive pulmonary disease (COPD), and chest pains, and his diagnosis of unstable angina. *Id.* at 5. The ALJ also found that the left heart catheterization performed on December 7, 2009, revealed 80% stenosis in the right coronary artery and that a subsequent stent placement in the right carotid artery reduced the occlusion from 80% to 0%. *Id.* In addition, the medical record documents the beneficiary's "current crescendo angina/unstable angina, his history of severe peripheral vascular disease (PVD) resulting in the insertion of 2 stents in the femoral artery, a CT of the thorax . . . indicating atherosclerosis, calcific plaques in the coronary arteries and coronary artery disease and a strong family history of 5 brothers having heart problems and all are deceased except one." Exh. 1, at 26. The ALJ also discussed the beneficiary's "risk for post procedure coronary artery occlusion, as well as [risk] for several other complications." Dec. at 5. The ALJ's decision provided a thorough review of or referenced 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. *Id.*

After considering testimony from the beneficiary's treating physician, a physician employed by the RAC, and an independent medical expert, the ALJ afforded "greater weight to the position of the admitting physician" and found the inpatient admission covered. Dec. at 6. In doing so, the ALJ stated that he had considered the contrary opinions of the independent medical expert and RAC physician, but found "no evidence of unreliability in the admitting physician's decision" to admit the beneficiary as an inpatient. *Id.* In summary, the ALJ stated that "[g]iven the Beneficiary's age, medical history and post-operative medical status, the medical records provide a sufficient foundation to support the judgment of the admitting physician." *Id.* at 7.

CMS contends in its agency referral memorandum that the ALJ erred, among other reasons, by:

- "fail[ing] to cite, reference, or consider the relevant requirements articulated in section 424.13 of Title 42 of the CFR and reiterated in CMS Ruling 93-1;"
- "fail[ing] to consider" physician certification, whether the admitting physician's opinion was consistent with the record evidence (including testimony of RAC physician and independent medical expert), the beneficiary's condition upon admission, and whether the "service furnished to the beneficiary during his inpatient hospitalization could have been safely and effectively furnished as outpatient observation services rather than the higher level of inpatient care;" and
- "fail[ing] to consider the bulk of the guidance articulated in" the Medicare Benefit Policy Manual (MBPM), the Medicare Program Integrity Manual (MPIM), and the Medicare Quality Improvement Organization Manual (QIOM) in determining Medicare coverage.

Agency Referral Memorandum at 15-17. Each of these 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 or any evidentiary deficiencies sufficient to overturn the ALJ's findings - the bases for referral identified in the agency's memorandum.

1. 42 C.F.R. § 424.13 does not apply in this case and the ALJ did not err in affording greater weight to the admitting physician's decision for inpatient admission.

a. 42 C.F.R. § 424.13

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 15-16. 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 imply 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.

b. CMS Ruling 93-1.

CMS maintains that the ALJ "failed to consider or abide by the principles set forth in CMS Ruling 93-1" concerning the weight afforded a treating physician with respect to inpatient admissions. Agency Referral Memorandum, at 16. In support, CMS points to the ALJ's statement that "[a]bsent evidence of abuse, fraud or other indication of unreliability, a physician's [inpatient admission] decision should be upheld." *Id.* CMS also notes that CMS Ruling 93-1 "explicitly bars an ALJ's award of presumptive weight to the treating physician's medical opinion in determining whether inpatient hospital services were medically reasonable and necessary," but that opinion must be considered as "one piece of medical evidence . . . equally indicative of the services being medically reasonable and necessary as the other evidence of record." *Id.* at 16-17. CMS points to the contrary opinions of the RAC physician and independent medical expert that the inpatient services were not reasonable and necessary as establishing ALJ error. *Id.* at 17.

The Council disagrees with CMS's analysis of the ALJ's decision. While the ALJ did state that "[a]bsent evidence of abuse, fraud or other indication of unreliability, a physician's [inpatient admission] decision should be upheld" the ALJ went on to evaluate the medical evidence, and made factual findings and conclusions of law concerning coverage. The ALJ's statement about fraud and abuse were not material to his evaluation of the evidence. The ALJ found that the RAC physician and the independent medical expert disagreed with the admitting physician decision concerning inpatient admission and the beneficiary's medical condition at the time of admission. Dec. at 6. The ALJ also noted that the appellant's representative had objected to certain aspects of this testimony and pointed to medical records that supported the beneficiary's unstable angina. *Id.* The ALJ also quoted, in two block paragraphs, the post-hearing written statement of the admitting physician, which explained how the beneficiary's medical condition presented "a very high risk for post procedural complications," including a "great risk for thrombus, bleeding and contrast induced nephrotoxicity," and which included references to the beneficiary's medical history, including a "CT report of severe coronary vascular disease and class 3 angina." *Id.*

The ALJ then stated:

Base[d] on the overall record, the undersigned gives *greater weight* to the position of the admitting physician and finds the inpatient admission of this Beneficiary was medically appropriate. . . . In the present case, an independent medical expert and a physician under the employ of the designated RAC disagreed with the admitting physician's decision to admit this Beneficiary. Their opinion was considered in reaching this decision but not followed as there is no evidence of unreliability in the admitting physician's decision to admit this individual.

Given the Beneficiary's age, medical history, and post-operative medical status, the medical records provide a sufficient foundation to support the judgment of the admitting physician.

Id. at 6-7 (emphasis supplied).

Contrary to CMS's contentions, the ALJ did not afford "presumptive weight" to the admitting physician's decision to admit the beneficiary as an inpatient following the catheterization procedure. Instead, the ALJ considered the admitting physician's written statement and supporting record evidence with the contrary opinions of the RAC physician and medical expert and decided to afford the admitting physician's decision "greater weight." The ALJ's analysis in reaching this conclusion was consistent with CMS Ruling 93-1's requirement that a treating physician's opinion be evaluated in light of the information available at the time the admission decision is made and "in the context of the evidence in the complete administrative record."

Moreover, in this case, that the ALJ had the benefit of input from three medical experts - an independent medical opinion and a RAC physician's opinion, along with the treating physician's contrary opinion - tends to support, not weigh against, a conclusion that the adjudicator adhered to the letter and intent of Ruling 93-1. The core underlying principle of Ruling 93-1 is that a *treating* physician's opinion is not the dispositive or determinative evidence on the issue of medical necessity of inpatient admission. The Ruling does not state that the ALJ may not accord any weight to the treating physician's opinion. The ALJ who decided this case had a full, developed evidentiary

foundation on which to make the medical necessity determination, and he made that determination in accord with the Ruling.

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.*

As discussed in the previous section, the ALJ considered all of the relevant evidence in the administrative record, having identified the central question in the case as whether there was sufficient evidence (documentation) to establish that the inpatient hospital services following the surgery were medically reasonable and necessary. It is not necessary for the Council to again reiterate all points considered and discussed in the ALJ's factual findings and analysis. The ALJ weighed all of the relevant factors 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.

3. *An ALJ is not required to "cite, reference, or consider" every possible legal or policy source in issuing a decision that is 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. Dec. at 5. The fact that the ALJ quoted only a portion of section 10 (see Dec. at 3-4) 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, if, as in this case, the agency is raising legal error material to the outcome of the claim as one of two bases for asking the Council to take own motion review, 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 also explain how the ALJ's failure to adhere to section 405.1062 resulted in a legally erroneous outcome.¹

In conclusion, the Council finds that there is no legal error in the ALJ's decision and that the ALJ's decision is consistent with a preponderance of the record evidence. There are also no other bases for the Council to accept own motion review in this case. Accordingly, the ALJ's February 13, 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 26, 2012

¹ 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. There are no statutes, regulations, or National Coverage Determinations (NCDs) which establish criteria for coverage of inpatient hospital admissions. 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.