DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
Elmhurst Care Center (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiary)	**** (HIC Number)
National Government Services (Contractor)	**** (ALJ Appeal Number)

INTRODUCTION

The Administrative Law Judge (ALJ) issued a decision dated March 27, 2009, which concerned Medicare coverage and payment for skilled nursing facility (SNF) services provided to the beneficiary from February 1, 2008, through February 12, 2008. The ALJ determined that the services were covered by Medicare as reasonable and necessary, but that Medicare could not make payment due to the lack of physician certification of medical necessity. 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, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c). As set forth below, the Council reverses the ALJ's decision.

APPLICABLE LEGAL STANDARDS

Medicare Part A pays for posthospital SNF care when the physician certifies that the beneficiary needs daily skilled nursing or rehabilitation services that, as a practical matter,

can only be provided on an inpatient basis in a SNF and the "care was needed for a condition for which the individual received inpatient care in a participating hospital . . . ." 42 C.F.R. § 424.20(a)(1)(i); *see also* Medicare General Information, Eligibility and Entitlement Manual (GIEEM)(Pub. 100-01), Ch. 4, § 40; Medicare Benefit Policy Manual (MBPM)(Pub. 100-02), Ch. 8, § 40.[1] The physician certification must be obtained at admission "or as soon thereafter as is reasonable and practicable," with recertifications required within 14 days of admission and every 30 days thereafter. 42 C.F.R. § 424.20(d). Recertifications must indicate, in relevant part, "[t]he reasons for the continued need" for SNF care, the estimated time that the beneficiary will need to remain in the SNF, and "[p]lans for home care, if any." 42 C.F.R. § 424.20(c).

CMS issued administrative authority interpreting these regulations. In relevant part, "[t]here is no requirement for a specific procedure or form as long as the approach adopted by the facility permits verification that the certification and recertification requirement is met." MBPM, Ch. 8, § 40. "*Certification or recertification statements may be entered on or included in forms, notes, or other records that a physician . . . normally signs in caring for a patient, or on a separate form.*" *Id.* (emphasis supplied). When a SNF's failure to obtain the required certification is not the result of the medical necessity (or lack of necessity) of the services,[2] but is instead the result of the physician's refusal to certify for other reasons, "the SNF cannot charge the beneficiary for covered items or services." *Id.* "The routine admission order established by a physician is not a certification of the necessity for post-hospital extended care services . . . . There must be a separate signed statement indicating that the patient will require on a daily basis SNF covered care." *Id.*

[1] Manuals issued by the Centers for Medicare & Medicaid Services (CMS) can be found at http://www.cms.hhs.gov/manuals.

[2] "If a physician refuses to certify because, in his/her opinion, the patient does not require skilled care on a continuing basis for a condition for which he/she was receiving inpatient hospital services, the services are not covered and the facility can bill the patient directly. The reason for the physician's refusal to make the certification must be documented in the facility records." GIEEM, Ch. 4, § 40.

DISCUSSION

Except as modified herein, the Council adopts and incorporates by reference the ALJ's statements of procedural history, issues, findings of fact, and principles of law, and the ALJ's findings that the services at issue are reasonable and necessary and covered by Medicare. The Council does not adopt the ALJ's findings and conclusions concerning the issue of payment.

The beneficiary was admitted to the appellant SNF on January 18, 2008, following a qualifying inpatient hospitalization at *** Center where she was treated for breast cancer. Dec. at 2; *see* Exh. 2, at 111-10. In relevant part, the physician signed an "Admitting History and Physical Examination," dated January 19, 2008, which included the history of present illness, examination findings, admitting impressions (diagnoses) and medications, plan of care with short-term and long-term goals, and discharge plan. Exh. 2, at 109-08. The beneficiary's admitting diagnosis was Stage 4 breast cancer metastasized to the bone and liver, with secondary diagnoses of diabetes mellitus, hypothyroidism, osteoporosis, and depression. Dec. at 2; Exh. 2, at 171, 108-09.

The record contains a "Physician's Order Form" dated January 18, 2008, which includes physician orders for skilled physical and occupational therapy five days a week, as well as "resident education training." Exh. 2, at 97. The physician signed this form beneath a certification which reads: "*I have reviewed the above order(s) and certify a need for this/these service(s) for the next 28 days.*" *Id.* (emphasis supplied). The physician order form was also signed and dated January 18, 2008, by four registered nurses. *Id.* The record also contains multiple physician orders dated from January 23, 2008, through discharge orders dated February 12, 2008. *Id.* at 107-98, 96.

The occupational therapist conducted an initial evaluation, dated January 18, 2008, signed by the physician on the same date, which contains orders for skilled occupational therapy services five days a week. Exh. 4, at 231. The physician also signed an Occupational Therapy Progress Report, dated February 2, 2008, with the plan to "Continue Restoration OT as Prescribed." *Id*. at 229. The physician signed orders discharging the beneficiary from occupational therapy on February 12, 2008. *Id.* at 234.

The physical therapist conducted an initial evaluation, dated January 18, 2008, with orders for skilled physical therapy five days a week. Exh. 4, at 228-27. The physician signed the initial evaluation and dated his signature January 18, 2008, beneath a certification which reads: "*I certify the need for these services furnished under this plan of treatment and while under my care.*" *Id.* at 227 (emphasis supplied). The physician also signed a Physical Therapy Progress Report dated February 1, 2008, with the plan to "Continue Restorative PT as prescribed." *Id.* at 224. The physician signed a Physical Therapy Discharge Summary dated February 12, 2008, discharging the beneficiary from physical therapy to her home. *Id.* at 226.

The record contains a "Comprehensive Care Plan" reflecting entries for the admitting date, January 18, 2008, as well as additional entries for the 14-day follow-up assessment on February 7, 2008. Exh. 2, at 166-40. The physician initialed the care plan, which the remainder of the beneficiary's care planning team also signed, on February 7, 2008. *Id.* at 164.

The record contains reports for psychiatry, oncology, optometry, psychotherapy, and ophthalmology consultations signed by both the consulting physician and the attending physician between January 19, 2008, and February 4, 2008. Exh. 2, at 86-79.

Based on the above-noted evidence, the Council concludes that the certification requirements for the skilled nursing and rehabilitative services were met for the period February 1, 2008, through February 12, 2008. The record documents that the physician repeatedly signed certifications and physician's orders which indicate that the beneficiary needed and continued to need daily skilled nursing and rehabilitation services as an inpatient in a skilled nursing facility for a condition for which the beneficiary had received inpatient hospital care. Treatment goals over a course of time were established as a part of this process. These documents, as noted above, are consistent with the content and timing requirements for certification and recertifications.

While CMS authority indicates that a SNF may use a separate form for physician certifications and recertifications, CMS also made clear that certification of the necessity for skilled services on an inpatient basis in a SNF may be "indicated by" notes, orders, and other documents that have been signed by the physician. The Council finds that the medical records in this case satisfy those requirements. Accordingly, the Council finds

that reimbursement may be made for the covered skilled services provided to the beneficiary from February 1, 2008, through February 12, 2008.

DECISION

It is the decision of the Medicare Appeals Council that reimbursement may be made for the skilled nursing and rehabilitative services provided to the beneficiary at the appellant SNF during the period February 1, 2008, through February 12, 2008.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: September 29, 2009