DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
Baptist Health Care (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiaries)	**** (HIC Numbers)
HeathDataInsights, Inc. (Recovery Audit Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued separate decisions, each dated January 22, 2009, pertaining to hospital services provided to nine beneficiaries. The decisions concerned overpayments assessed concerning hospitalizations related to the replacement of automatic implantable cardioverter defibrillators (AICD) provided to seven beneficiaries from February 3, 2005, through October 6, 2006, and hospitalizations for cardiac-related services provided to two beneficiaries from May 2, 2003, through September 15, 2003.[1]

In each case the ALJ determined that there was insufficient evidence in the record to support a finding that the hospitalization was medically reasonable and necessary. Further the ALJ found that the appellant had acquired knowledge that hospitalization for such services would likely be excluded by Medicare. Thus, the appellant was found liable for the non-covered services in each case. The appellant has asked the Medicare Appeals Council (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). The appellant's nine requests for

[1] For a complete list of beneficiaries, dates of service and corresponding types of service, see Appendix A.

review, each dated March 17, 2009, have been entered into the record as Exhibits (Exh.) MAC-1 through MAC-9.

BACKGROUND

Initially, the Medicare fiscal intermediary paid the appellant's claims for the beneficiaries' hospitalizations. *See e.g.,* beneficiary A.B. case file, Exh. 1 at 17. Subsequently, HealthDataInsights, Inc. (HDI), a Centers for Medicare & Medicaid Services (CMS) Recovery Audit Contractor (RAC) determined that the services should have been provided to the beneficiaries in an outpatient setting and, thus, the inpatient hospitalizations were not medically reasonable. *Id*. Upon appeal, the fiscal intermediary upheld the RAC's determinations, finding that the initial claims were paid in error. *Id*. at 11. The appellant then requested reconsideration by a Qualified Independent Contractor (QIC), which found that, while the management of care received by the beneficiaries was foreseeable, the medical documentation in each case does not support the medical necessity for the acute hospitalizations. *Id*. at 3.

In response to the QIC's decisions, the appellant requested an ALJ hearing, which was held on January 13, 2009. *See e.g.,* beneficiary A.B. case file, Exh. 3. The ALJ found that the issue of whether the RAC had good cause to reopen claims that had been paid four years prior to the date of reopening had been addressed by the Council in Critical Care of North Jacksonville.[2] *See e.g.,* beneficiary A.B. case file, Dec. at 7. The ALJ cited CMS' reopening policy, as interpreted by the Council, i.e., that the regulations at 42 C.F.R. § 405.926(l) and § 405.980(a)(5) do not permit an ALJ to rule on whether the RAC had good cause to reopen a determination. *Id.* Thus, the ALJ stated that he would not address whether the RAC had good cause to reopen the claims at issue in his January 22, 2009, decisions. *Id*.

The ALJ found that the appellant had not established that the nine inpatient hospitalizations at issue had been medically reasonable and necessary. *Id*. at 7-8.[3] Further, the ALJ

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[2] Critical Care of North Jacksonville (February 29, 2008) can be found on the Council's webpage at http://www.hhs.gov/dab/macdecision/

[3] Additionally, the ALJ found that hospitalization for two beneficiaries, who were not included in the appellant's request for review, was medically reasonable and necessary. The ALJ also issued an unfavorable determination for one beneficiary, similar to those at issue. However, the appellant did not request review for this beneficiary. Thus, the Council's decision is

concurred with the QIC in finding the appellant liable for the non-covered services for each beneficiary at issue. *Id.; See also* beneficiary A.B. case file, Exh. 1 at 4.

DISCUSSION

In its nine separate requests for review, each dated March 17, 2009, the appellant solely contests the ALJ's findings concerning liability pursuant to Section 1879 of the Social Security Act (Act) and/or Section 1870 of the Act. Exhs. MAC-1 through MAC-9. The Council therefore adopts the ALJ's findings of non-coverage without further discussion. *See e.g.,* beneficiary A.B. case file, Dec. at 7-8.

In determining beneficiary liability, the regulation codified at 42 C.F.R. §411.404 provides that a beneficiary who receives services that are not reasonable and necessary "is considered to have known that the services were not covered if . . . written notice has been given to the beneficiary, or to someone acting on his or her behalf, that the services were not covered because they did not meet Medicare coverage guidelines." As a preliminary matter, the Council notes that there is no indication that the appellant provided written notice to any of the beneficiaries stating that the services at issue would not be covered by Medicare. Thus, the Council finds that none of the beneficiaries whose claims were included in the overpayment determinations are liable for any of the non-covered services.

The appellant claims, however, that the ALJ failed to adequately apply the limitation of liability provisions of § 1879 of the Act, 42 C.F.R. § 411.406, CMS Ruling 95-1 and a prior Council decision. *See e.g.,* Exh. MAC-1 at 1. Section 1879 of the Act is applicable when an item or service is not covered by Medicare because it is determined to be custodial care, or not medically reasonable and necessary pursuant to sections 1862(a)(1) or (a)(9) of the Act. The statute provides that the liability for a non-covered item or service may be limited when a provider, practitioner, supplier, or beneficiary did not know, and could not have been reasonably expected to know, that the item or service would be found not covered by Medicare on the basis of sections 1862(a)(1) or (a)(9). 42 C.F.R. § 411.400.[4]

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limited to those beneficiaries for whom the appellant has requested review. *See* Appendix A.

[4] The Council notes that since an overpayment was assessed for the above-described services, section 1870 of the Act would apply as well.

In accordance with regulations at 42 C.F.R. § 411.406 and CMS Ruling 95-1, the Medicare Claims Processing Manual (MCPM), CMS Pub. 100-4, Ch. 30, §§ 40.1 and 40.1.2 (in part) provide guidance concerning what constitutes evidence that a provider knew or should have known that Medicare would not pay for a service:

- A Medicare contractor's prior written notice to the provider of Medicare denial of payment for similar or reasonably comparable services,

- Medicare's general notices to the medical community of Medicare payment denial of services under all or certain circumstances (such notices include, but are not limited to, manual instructions, bulletins, contractor's written guides and directives),

- Provision of services inconsistent with acceptable standards of practice in the local medical community,

- The provider's utilization review committee informed the provider in writing that the services were not covered, and

- A Medicare contractor previously issued a written notice to the provider that Medicare payment for a particular service or item is denied. This also includes notification of Quality Improvement Organization (QIO) screening criteria specific to the condition of the beneficiary for whom the furnished services are at issue and of medical procedures subject to preadmission review by the QIO.

See MCPM §§ 40.1 and 40.1.2; *See also* 42 C.F.R. 411.406 and CMS Ruling 95-1 at page 18.[5]

In each request for review, the appellant cites the Council's findings in Niobrara Valley Hospital for the proposition that it should not be held liable for non-covered services based on the result of a post payment review because "post payment review

[5] CMS, then known as the Health Care Financing Administration (HCFA) issued Ruling 95-1 in December 1995. Ruling 95-1 explains the requirements for determining if Medicare payment will be made under the limitation on liability provisions, section 1879 of the Act, to a provider for certain services and items for which Medicare payment is denied. Ruling 95-1 can be found at www.cms.hhs.gov/Rulings/downloads/hcfar951.pdf

does not constitute knowledge."[6] *See e.g.,* Exh. MAC-1 at 3. While our prior decisions are not precedental, the Council agrees that the principles of limitation of liability are relevant to the claims at issue. The Council agrees with the appellant that the performance of a post payment review itself cannot constitute knowledge of non-coverage of services provided and billed for prior to the assessment of the overpayment.

In these cases, however, the ALJ did not claim that the provider had knowledge that Medicare would not pay for the services based on a post-payment review, but on the fact that CMS had issued relevant manuals, bulletins and written guidelines. *See e.g.,* beneficiary A.B. case file, Dec. at 8. We discuss these guidelines below.

Medicare Coverage of Hospitalization for AICD Services

The Council first notes that there was no dispute at any level of appeal that the seven beneficiaries at issue required hospital attention for their automatic implantable cardioverter defibrillators. The sole issue throughout the appellant's appeals was whether the beneficiaries' *inpatient* hospitalizations were medically reasonable and necessary at the time of their admissions to the appellant's facility.

The appellant specifically claims that it had no notice that the services at issue would not be covered by Medicare. *See e.g.,* Exh. MAC-1 at 3. The appellant cites the Federal Register to support its claim that it had no knowledge that Medicare would not cover the services at issue, and, to the contrary, believed that Medicare could cover inpatient replacement of automatic implantable cardioverter defibrillators (AICDs). *See e.g., Id*. at 4. For example, in the final rule regarding the Prospective Payment System (PPS) for Hospital Outpatient Services, CMS established that AICDs would be placed on the outpatient list in cases of "only the simplest and least resource intensive procedure" cases. *See* 65 Fed. Reg. 18462 (April 17, 2000). In addition to describing the new process, the notice discussed that CMS would establish and maintain an "Appendix E" to its yearly PPS update with a list of HCPCS/CPT codes that would remain covered only on an inpatient basis. *Id*. In pertinent part, the notice explains that:

[6] In the case of Niobrara Valley Hospital (March 27, 2003) can be found on the Council's webpage at http://www.hhs.gov/dab/macdecision/

> In the future, as part of our annual update process, we will be working with professional societies and hospital associations, as well as with the expert outside advisory panel that we will be convening as required by new section 1833(t)(9)(A) of the Act, to reevaluate procedures on the "inpatient only" list and we will propose to move procedures to the outpatient setting whenever we determine it to be appropriate. For example, a decreasing length of inpatient stay for a procedure may signal that it is appropriate for consideration for payment under the outpatient PPS. If hospitals find that surgeons are discharging patients successfully on the day of surgery, they should bring this to our attention as well, because hospitals may become aware of this trend before our payment data disclose it. Thus, assignment of a "C" payment status indicator in this final rule should not be considered as a permanent or irrevocable designation.

Id.

During each of the years of services at issue, 2003, 2005 and 2006, AICD was included on "Appendix E" as a "C" class inpatient service. *See e.g.,* CMS Hospital PPS update, CMS 1427P, "Appendix E," November 19, 2004;[7] *See also* InterQual Guidelines for Surgery and Procedures in the Inpatient Setting., IMPT-3, CMS Impatient List, Exh. MAC-1 at 6.

The appellant also presents the June 1, 2006, statement of the Florida Medical Quality Assurance, Inc., (FMQAI), the CMS contracted Florida QIO. Exh. MAC-1 at 5. FMQAI alerted hospitals within its jurisdiction that

> [a]s of July 1, 2006, FMQAI will no longer be uniformly allowing these procedures to be billed as inpatient services.... The medical record must contain information that documents the need for an inpatient level of care. Those cases that appear to be routine, expected discharge within 24 hours and which do not substantiate SI & IS criteria will be considered for impatient billing denial.

See "PTCA, PCI and AICD Pacemaker Billing," FMQAI, June 1, 2006.

[7] Appendix E to the Hospital PPS update can be found at http://www.cms.hhs.gov/hospitaloutpatientpps/downloads/cms-1427-p_addE.pdf

In summary, the appellant states that

> Considering the FMQAI policy at the time of [the services at issue], the guidance from the InterQual Guidelines for Surgery and Procedures in the Inpatient Setting, and the cited guidance of the Federal Register, we assert that the provider had neither actual nor constructive knowledge that the [admissions] would not be considered covered [services].

See e.g., Exh. MAC-1 at 4.

The Council agrees, in part, and finds that the provider did not know, and did not have reason to know, that Medicare would not cover automatic implantable cardioverter defibrillators services provided in an inpatient hospital setting until FMQAI issued its notice that effective July 1, 2006, these services would no longer be "uniformly allowed." *See* "PTCA, PCI and AICD Pacemaker Billing," FMQAI, June 1, 2006. Thus, the Council reverses the ALJ's findings concerning liability for beneficiaries B.A., R.M., J.P., T.S. and J.W., finding that neither the beneficiaries nor the provider knew or could have reasonably been expected to know that the inpatient hospitalizations would not be covered. Similarly, the Council finds that the appellant was without fault in causing any overpayment for the above claims. Accordingly, the appellant is not required to refund to Medicare the payments for the hospitalizations for the above beneficiaries.

For the two beneficiaries whose AICD services were provided after July 1, 2006, the Council finds that the provider knew, or should have known, that the services would not be covered by Medicare. As recounted above, the provider did not provide notice of non-coverage for these two beneficiaries. Accordingly, the provider is liable for the non-covered services and is not without fault for causing the overpayments.

Medicare Coverage of Hospitalization for Cardiac, Non-AICD Services

As stated above, the appellant does not request review of Medicare coverage for the services at issue for beneficiaries A.J. and J.M. *See* Exhs. MAC-8, MAC-9. Thus, the Council adopts

the ALJ's findings that the hospitalizations for cardiac services were not medically reasonable and necessary.

In these cases, the appellant specifically contends that it disagrees with the ALJ's decisions regarding Section 1870 of the Act, specifically challenging the RAC's right to reopen the determinations concerning A.J. and J.M. *See e.g.,* Exh. MAC-8 at 1. Specifically, the appellant argues that the RAC is limited in its right to reopen claims after three calendar years after the Medicare contractor's initial payment, citing the Medicare Financial Management Manual. *Id*. at 2.

CMS explained in its discussion on reopening claims for fraud or similar fault that when the proposed new appeals regulations were published, stating that "[s]ince a reopening of an initial determination is an administrative action to correct erroneous payment, there is no requirement for a burden of proof." Medicare Program: Changes to the Medicare Claims Appeal Procedures; Proposed Rule, 67 Fed. Reg. 69311, 69327 (Nov. 15, 2002). In the final rule, CMS considered and expressly declined to establish an evidentiary burden of proof to reopen or to create enforcement mechanisms for the good cause standard beyond CMS evaluation and monitoring of contractor performance. Medicare Program: Changes to the Medicare Claims Appeal Procedures; Interim Final Rule, 70 Fed. Reg. 11419, 11453 (Mar. 8, 2005). A contractor's decision on whether to reopen is final and not subject to appeal. 42 C.F.R. §§ 405.926(l), 405.980(a)(5). This lack of jurisdiction extends to whether or not the contractor met good cause standards for reopening set forth in 42 C.F.R. § 405.980(b)(2).

The ALJ also cited the relevant CMS' reopening policy that does not permit an ALJ [or the Council] to rule on whether the RAC had good cause to reopen a determination. *See e.g.,* beneficiary A.J. case file, Dec. at 8. The Council agrees and finds unpersuasive the appellant's argument that it should be found without fault pursuant to Section 1870 of the Act because the RAC lacked good cause to reopen.

Section 1870 of the Social Security Act (Act) provides, *inter alia*, that --

> (b) where –
>
> > (1) more than the correct amount is paid under this title to a provider of services . . . and

> the Secretary determines (A) that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services . . . , or (B) that such provider of services . . . was without fault with respect to the payment of such excess over the correct amount . . .
>
> proper adjustments shall be made, under regulations prescribed . . . by the Secretary . . . .

Section 1870(b) of the Act applies to overpayments made by providers and suppliers, such as the appellant, and therefore is applicable here. Section 1870(b) provides waiver of liability for an overpayment in certain circumstances where a provider or supplier is "without fault." The Medicare Financial Management Manual (MFMM) (CMS Pub. 100-06), instructs that a provider or supplier is "without fault" when the provider or supplier:

> exercised reasonable care in billing for, and accepting the payment; *i.e.*;
>
> • It made full disclosure of all material facts; and
> • On the basis of the information available to it, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or, if it had reason to question the payment; it promptly brought the question to the [fiscal intermediary's] attention.

MFMM, Ch. 3 § 90.

The Council agrees with the ALJ and finds that the appellant is "not without fault in regards to the overpayment received and liability is not waived under Section 1870 of the Act." *Id*. at 9. Medicare had issued various relevant instructions and regulations concerning cardiac-related hospitalizations during the dates of service at issue, including but not limited to, the instructions from the FMQAI and in the InterQual Guidelines that the appellant submitted in support of its arguments concerning the defibrillator-related hospitalizations. Thus, the appellant is not without fault and is responsible for the overpayments

assessed concerning the non-covered services provided to beneficiaries A.J. and J.M..

CONCLUSION

The Council agrees with the ALJ in part and modifies the ALJ's nine decisions dated January 22, 2009 as follows. The Council finds that the provider did not know, or have any reason to know, that Medicare would not cover automatic implantable cardioverter defibrillators services until FMQAI issued its notice that effective July 1, 2006, these services would not longer be "uniformly allowed." Thus, the Council reverses the ALJ's findings concerning liability for beneficiaries B.A., R.M., J.P., T.S. and J.W., and finds that the intermediary may not collect an overpayment for the inpatient hospital services provided to those beneficiaries during the periods at issue.

For the two beneficiaries whose AICD services were provided after July 1, 2006, the Council finds that the provider knew, or should have known, that the services would not be covered by Medicare. Thus, the provider is liable for the non-covered services, and therefore responsible the resulting overpayment, concerning the hospital stays for beneficiaries J.D. and A.D..

The Council agrees with the ALJ in finding that the appellant is "not without fault in regards to the [remaining] overpayment received" concerning beneficiaries A.J. and J. M. pursuant to Section 1870 of the Act. The hearing decision is modified accordingly.

MEDICARE APPEALS COUNCIL

/s/ M. Susan Wiley
Administrative Appeals Judge

/s/ Gilde Morrison
Administrative Appeals Judge

Date: June 26, 2009