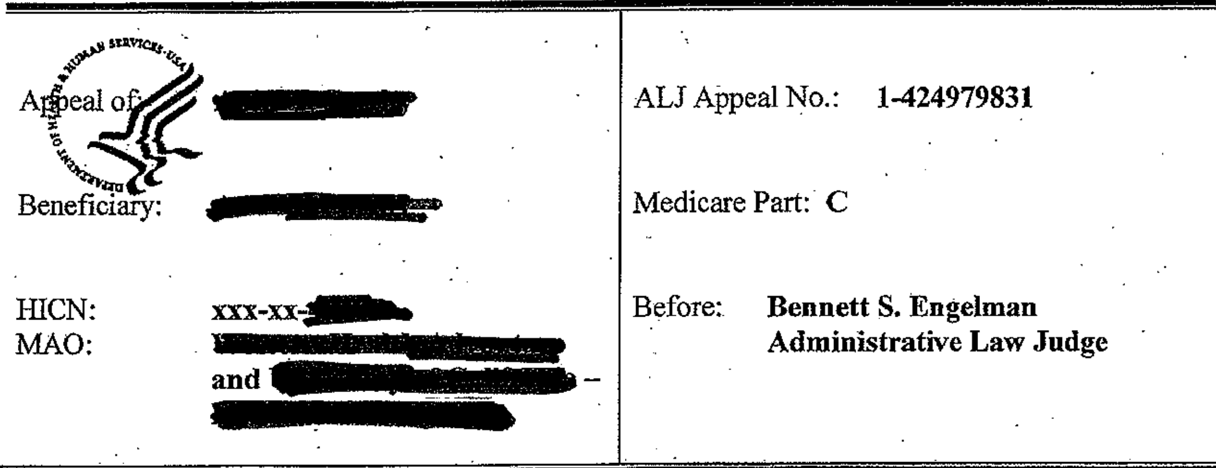
Department of Health and Human Services
OFFICE OF MEDICARE HEARINGS AND APPEALS
Western Field Office
Irvine, CA 92618



Appeal of:	ALJ Appeal No.: **1-424979831**
Beneficiary:	Medicare Part: **C**
HICN: xxx-xx- MAO: and –	Before: **Bennett S. Engelman** **Administrative Law Judge**

AMENDED DECISION

After carefully considering the evidence and arguments presented in the record, a favorable decision is entered for appellant, Mrs. M *THIS AMENDED DECISION IS ISSUED BECAUSE THE WORD 'NOT' WAS MISSING FROM THE BOTTOM OF THE ORIGINAL PAGE 14.*

PROCEDURAL HISTORY

Appellant obtained Medicare supplemental Part A and part B coverage through a local Medicare Advantage Organization, in Sacramento, California (the "Plan"). (Exhibits 12 and 13) Appellant has been a member of the Plan since March 1, 2001. contracted the to provide the Plan's members with medical care through the Hospital (the " and Medical Group (the "Medical Group"). The Medical Group sub-contracts with Hospital – to provide long term acute care hospitalization.

On October 30, 2008, appellant was transferred from the to through the staff initiated appellant's discharge, and on March 4, 2009 issued a Notice of Denial of Medical Coverage, telling appellant that her Medicare covered in-patient care end March 5, 2009. Should appellant remain in the hospital, the cost of all services provided to her after March 5, 2009, would be her

[1] This facility is also known as

financial responsibility. (Exhibit 4) Appellant's representative and daughter, [2] immediately appealed the Medical Group's decision to terminate care under fast-track rules to Health Services Advisory Group, the designated Quality Improvement Organization ("HSAG") in this case. HSAG issued a determination on March 8, 2009, affirming the Medical Group's decision terminating appellant's covered care on March 5, 2009. (Exhibit 7) Disagreeing with the Redetermination, on March 12, 2009, appellant requested reconsideration and HSAG issued its decision on March 12, 2009, reaffirming that appellant's hospital coverage termination and planned discharge by the Medical Group were proper. (Exhibits 8 and 9)

An Administrative Law Judge Hearing (ALJ) request was received by this court on April 30, 2009. (Exhibit 10)

Prior to the hearing, appellant substituted counsel with the entry of Melissa Brown Esq., Elder Care Clinic, University of Pacific McGeorge Law School. Ms. B was assisted by Ryan Cronin-Prather, Sarah Chesteen, Anne Caruana, students of McGeorge Law School.

Health Systems counsel, represented the Center and the Medical Group.

Hospital and employees who appeared as witnesses at the hearing on behalf of the hospital were represented by LLP, San Francisco, California.

., in-house counsel, represented the Plan.

Prior to the hearing, several recorded conferences were held with the undersigned's paralegal. In addition two (2) pre-hearing conferences where held before the ALJ. (Exhibit 57)

Because the administrative record received from the lower appeals level was found incomplete,[3] on July 8, 2009, the court served Hospital with a subpoena demanding production of appellant's complete medical records. In response, Hospital submitted 4157 pages of medical and detailed billing records on July 24, 2009. (Exhibits 18-1; 18-2 and 18-3)

Granting appellant's motion, on September 24, 2009, the court issued a subpoena to HSAG for records and documents in order to (a) determine whether HSAG had used any local medical review staff or consultants with relationships and/or associations with the Medical Center, and (b) identify the protocols and assessment tools utilized in arriving at the decision to discharge the appellant. (Exhibit 23). On October 7, 2009, appellant submitted a further motion to compel Hospital to produce certain of its staff members to testify at the hearing, which the court granted. (Exhibit 33)

On October 20, 2009, appellant and the (for itself and its related parties) submitted a joint motion to compel Hospital to produce documents identified as CareEnhanced Review Manager Enterprise ("CERME") and the InterQual/McKesson Manual. The motion was granted by the court on October 21, 2009. (Exhibits 42 and 43)

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[2] Ms. M was assisted by her brother, Esq., a local attorney and member of the California Bar.

[3] The administrative record initially received by the court consisted of merely 191 pages of medical records.

The Notice of Administrative Law Judge Hearing was issued on September 25, 2009, to all parties (Exhibit 24).

Appellant's witness list was proffered to the court on October 28, 2009, and is marked as Exhibit 53.

After all parties were duly notified, an in-person hearing was held on October 29 and October 30, 2009, in Sacramento, California. In attendance at the hearing and representing the parties and witnesses in this appeal were:

For appellant:

Melissa Brown, Esq.
Anne Caruana
Sarah Chesteen
Ryan Cronin-Prather

For the Medical Group d affiliated entities:

Esq.
R.N., Manager, Managed Care

For the Plan :

Esq.,

For Hospital and its staff:

Esq.

During the course of the hearing the following witnesses, appearing in person except as noted below, were called and testified:

M.D.,
M.D.,
R.N., Nursing Administrator,
R.N., Discharge Planner,
, Respiratory Therapist
R.T./C.R.T, R.C.P.R.R.T.,

Esq., and
M.D. (via VTC)

The administrative record in this case consists of Exhibits 1 to 48, which were accepted into evidence and made part of the record without objection. Exhibits 49 through 55 were received and admitted into evidence and made part of the record during the course of the hearing, which was closed on October 30, 2009. The administrative record remained open only to allow appellant's submission of her durable power of attorney. This document was received on November 6, 2009, and was also accepted into evidence as Exhibit 56. Exhibit 57 consists of

three (3) CDs, containing the recordings of the pre-hearing proceedings referred to above. Exhibit 58 consists of two (2) CDs, which serves as the official transcript of the hearing on this case.

ISSUES

The issues in this appeal are:

1. Whether the care and treatment of Mrs. M at [redacted] a long term acute care hospital, "reasonable and necessary" from March 5, 2009 through April 21, 2009? If no, were the termination of her in-patient care on March 5, 2009, and the proposed hospital discharge to a lower level of care on that date proper?
2. Did the review by HSAG, the QIO in this case, deny the appellant with due process of law in the manner it affirmed her discharge from [redacted] Hospital?
3. Were the InterQual/CERME (CareEnhance Review Manager Enterprise) reports used as a basis to discharge Mrs. M ?
4. Was the Notice of Denial of Medical Coverage issued on March 4, 2009, properly and/or timely served on Mrs. M or her designated family member?

FINDINGS OF FACT

The evidence of record establishes the following facts by a preponderance of the evidence:

Appellant's requests for Redetermination, Reconsideration and ALJ review were timely.

1. The continued level of care Mrs. M received at [redacted] from March 5 through April 21, 2009, was "reasonable and necessary," and the termination of her in-patient hospital care on March 5, 2009, was improper.

This record is voluminous due to the multiple serious medical conditions suffered by Mrs. M . Prior to her transfer to [redacted] for long term acute care, appellant was at [redacted] Medical Center for a number of needs, including a total right hip replacement after a fracture from a fall; myocardial infarction during hip surgery; and coronary by-pass grafting times four (4) shortly thereafter. Further complicating her medical status, appellant suffered a cerebrovascular accident affecting cognition, tongue strength and her ability to swallow, requiring a tracheostomy with tube placement and percutaneous gastrotomy tube placement (PEG) for feeding. Needing further in-patient care, on October 30, 2008, she was transferred to [redacted] for long term acute hospital care. Her primary physician at [redacted] was L , M.D., a [redacted] assigned to [redacted] Dr. is Board Certified in Pulmonary Medicine.

Medicare coverage benefits for appellant's care at [redacted] were terminated on March 5, 2009. Thus, at issue is whether Mrs. M medical status on March 4-5, 2009, met the medical criteria for proper discharge from [redacted] to a 'lower level' of care as contended by the Plan, the [redacted] Medical Center and the Medical Group. To determine whether there was medical justification for the discharge, the medical records near that date require

examination as well as the testimony of: Dr. L Dr. P , a physician appearing on behalf of the appellant, Board Certified in Physical Medicine and Rehabilitation; and . B , M.D., Board Certified in Pulmonary Medicine, a medical advisor to the Administrative Law Judge.

A review of the 'Physician's Progress Notes' dated March 3, 2009, shows that Mrs. M contracted another urinary tract infection (UTI) and under A/P (assessment and plan) Dr. L ordered: 'start cefepime'. (Exhibit 18-2; page 75) The patient's INR was still low indicating that her blood thinner medication, Coumadin (warfarin) was at the therapeutic level. There is also reference to 'Resp failure', continue protocol. (Exhibit 18-2, page 215) The antibiotic was begun on March 4, 2009. (Exhibit 18-2, page 214) There are many reports of Interdisciplinary Team Meeting (IDT) reports and there was a meeting conducted on March 4, 2009. Of note is that Dr. L did not attend this meeting. However, consistent with medical status throughout her stay at Kindred Hospital there is another reference to: 'weak cough, copious secretions, suctioning 2x a shift and resist Psuesudomas (sic) in sputum.' (Exhibit 18-2, page 213) Dr. L acknowledged in her testimony that she wrote: 'Pt currently stable for transfer level of care that can care for trach, IV antibiotic, trach suctioning + physical rehab (OT/PT/ST). (Exhibit 18-2, page 212)

Dr. L testified that she was the one with authority at [redacted] to discharge a patient. However, she was approached by a discharge planner, most likely [redacted], to approve the decision and write the discharge orders. The only 'family meeting' she attended was one conducted on February 6, 2009, where there was some discussion of placement at a 'sub acute' facility in the 'bay area' approximately 90 miles away. The import of the meeting was to increase children involvement in physical therapy to increase Mrs. M participation. (Exhibit 18-2, page 243)

Dr. L further testified that she had the sole authority to discharge Mrs. M and that she agreed with the discharge planner, , and completed the 'Physicians Progress Notes' dated March 5, 2009, apparently at the request of Ms. K , as Dr. L does not have any present memory of the conversation. While Dr. L stated that she believed that Mrs. M was 'stable' she acknowledged that the patient had just been diagnosed with another infection for which she prescribed IV antibiotic cefepime the same day. Finally Dr. L relied on the discharge planner to find a facility that would be capable of providing all the required services and care Dr. L ordered and documented in her discharge note. Dr. L did not know anything about [redacted] Nursing Home other than it must be located in Lincoln, California.

Dr. P , Board Certified in Physical Medicine and Rehabilitation, testified as a witness for the appellant. No objections were made to her professional qualifications. She testified that in her private practice she participated in chart reviews and placement of her patients in the appropriate level of care. Dr. P testified that Mrs. M was not stable on March 4, 2009, as she had been just been diagnosed with another UTI, started on another course of IV antibiotics, and continued to need frequent tracheal suctioning, with Mrs. M records showing that within the weeks leading up to March 4-5, 2009, there had been 'copious' secretions. For example, on February 27, 2009, Dr. L notes 'copious non-yellow secretion on trach dressing.' (Exhibit 18-2, page 211) Dr. P prepared a chart admitted into evidence as Exhibit 51. A review of the chart with her testimony demonstrates continued needed suctioning and different complications in Mrs. M blood chemistries such as WBC count abnormally high on March 25 and increasing on March 28. Dr. P further testified that given the length of time Mrs. M was in [redacted] Hospital and her history of waxing

and waning of symptoms, a period longer than a day or two was insufficient to determine whether the current IV medication was appropriate and effective. Dr. P also questioned whether about a week after a notation of copious secretions showed that this patient was 'stable' enough to be discharged to a lower level facility. Dr. P did agree that by April 21, 2009, the date of Mrs. McC actual discharge from there was a sufficient period of time free from recurrent infection and further respiratory compromise that she could have been safely discharged, in this case home with 24 hour care. However, she was not in agreement that Mrs. M was to be discharged on March 5, 2009.

B , M.D., Board Certified in Internal Medicine and Pulmonary Disease testified as a medical advisor to the Administrative Law Judge. Dr. B reviewed the entire record and listened to the testimony of Dr. L and Dr. P via video teleconferencing. He participated by asking questions of each witness. He believes that Mrs. M was a frail elderly woman who around March 5, 2009, was beginning another round of IV antibiotics. He agreed with Dr. P assessment that a longer period of time free from infection and copious secretions was necessary to support a finding that Mrs. M C was stable and capable of being discharged to a lower level of care. He is experienced in treating his own patients in nursing homes and skilled facilities and most of these types of facilities in his area of Tucson, Arizona, would not have sufficient skilled staff to care for Mrs. M He agreed that Mrs. M was not 'stable' enough to be discharged on March 5, 2009. He testified that the arrangements for 24 hour care the family had planned for her at home were appropriate, opining that by April 21, 2009, she had had a sufficient period of time without exacerbations to be safely discharged to home.

Other witnesses testified and provided some additional facts. , Respiratory Therapist (RT) and , RT, testified that they were employed by Hospital and provided treatment to Mrs. Mc and that they provided the treatment consistent with the physicians' orders. Mrs. M needed frequent suctionings but they had no current memory of any extraordinary treatments they provided at hospital.

RN, testified that since November 2008 she was the nurse administrator for and before then had held other positions with the hospital. She remembered speaking with Dr. L about the discharge of Mrs. M but did not recall exactly when that was or the nature of their conversation. **Dr. L testified that she most likely would have discussed Mrs. M discharge with 'management' but she did not clearly remember with whom or when.** Ms. U also testified that the so-called InterQual/CERME reports[4] were required but they were 'guidelines' and that the decision to discharge a patient was the responsibility of the primary treating physician. She had no participation in the decision to discharge Mrs. M

RN, testified that she was the discharge planner at who took over for C after Mrs. M was not discharged on March 5, and there was a rift between Ms. C and the M family. She explained the use of InterQual/CERME reports and how the data is input by her from a patient's chart. She emphasized that these reports were only 'guidelines' and that the authority to discharge a patient was the treating physician. She was the person who contacted Nursing home as they were one of four (4) in the Sacramento are that took 'trach' patients. She called them, provided some information over the

4 A separate discussion of these reports is in another section of this Decision.

telephone and sent them a recent medical chart note. **She further explained how she also visited patients at their then current facility to determine whether** that patient was one could accept. That was the protocol that Dr. B said should have been used to determine Mrs. M eligibility to be transferred to While Ms. S said there 'was a bed' at there is no evidence anyone from evaluated Mrs. M at There is only hearsay evidence in this record as to whether had sufficient professional staff to meet the discharge criteria clearly specified in Dr. L March 5th note or that found her to be an eligible patient. Mrs. M. was not merely a patient with a trach but a seriously ill patient with multiple co-morbidities. Ms. S participated in the planning to discharge Mrs. M near the end of April 2009, and met with several family members to arrange for the discharge to home.

appellant's son, testified that he visited his mother about once or twice per week and at times complained to the staff about her cleanliness. At times he observed her being suctioned and when he learned about the chart at the foot of his mother's bed, there were times she was suctioned and no notation was made in her chart. He was not contacted by Hospital staff about his mother's discharge.

, daughter, was the child the family designated to be the contact person for Hospital staff and visited her mother frequently. She communicated almost daily with all of her siblings either directly or by contacting another sibling who then communicated with the others. She frequently observed her mother begin suctioned and saw that notations were not always 'charted'. Hospital's decision to discharge her mother on March 5 came as a shock as there was no consultation with her or others family members, except at a meeting in early February. She contacted but the staff failed to answer all her questions. It was clear from her conversations that although took 'trach' patients, **they did not have any respiratory therapists on staff that could provide suctioning more than twice per shift.** Their nursing staff was also limited, and only took 'trach' patients on a case by case basis. She also contacted and visited the facility. They too accepted 'trach' patients but could not provide the frequency of suctioning Mrs. M needed.

There was much discussion and argument about the proximity of to the M family. While there's little dispute about the actual number of miles, is further away than Hospital, with a greater driving time because of the roads necessary to travel. The Administrative Law Judge finds this issue to be a moot point because while may have had a 'bed', no staff from actually evaluated Mrs. M at to determine whether she was a patient would accept. Ms. S testified that it was Hospital protocol to actually visit a potential patient and determine whether, after evaluation, would accept such patient. Dr. B testified that that was the protocol for the Arizona facilities where he treats patients. The Administrative Law Judge finds that while was contacted by Hospital, Mrs. M was not in fact accepted as a patient.

The Administrative Law Judge has also considered at least two other factors in concluding that Mrs. M medical circumstances on March 5, 2009, did not support a medically safe discharge on that date. The testimony of various witnesses establishes that she was placed in 'room 19' at the Hospital because it was located near the nurse's station to ensure that Mrs. M was closely monitored, which the nursing knew needed to be done because of her health status. This placement allowed more observation than other rooms at Mrs. M remained in room 19 until discharge home on April 21, 2009, presumably indicating

that she *continued* to require close monitoring. While Dr. L was the primary treating physician other staff physicians treated Mrs. M in Dr. L absence. The primary basis for her proposed discharge was that she has achieved medical improvement and her need for care would therefore be lessened. However, Dr. C another physician who intermittently treated Mrs. M , noted on March 30, 2009: '...trach dependent, trach secretions recently decreased. Episodes of tracheobronchitis. *Few real changes since I last saw her several weeks ago.*' (Exhibit 18-2, p.194, emphasis added.)

2. Did the review by HSAG, the QIO in this case, provide the appellant with due process of law in the manner it affirmed the discharge of Mrs. M from ?

Initially it is noted that HSAG failed to fully comply with a subpoena issued by this court requesting records and identification of the physician(s) who reviewed the Mrs. M records and issued opinions or at least their specialty so that an analysis of their opinions could be properly be made. HSAG basically ignored the subpoena and failed to respond by either asserting statutory or regulatory defenses or by providing the information requested. (Exhibit 23)

The March 5, 2009 coverage termination and discharge decision by was affirmed by HSAG in a redetermination letter dated March 8, 2009, and reaffirmed in its reconsideration decision of March 12, 2009. (Exhibits 7 and 9) During the preparation for the Administrative Law Judge hearing, HSAG responded to a request for clarification and a slightly more detailed explanation of the opinions was made by R , M.D. on October 7, 2009. Dr. R still failed to comply with a subpoena to produce records and the identity (ies) of the reviewing doctors, the records they actually relied on in the decision to discharge and terminate coverage on March 5, 2009, and the reviewing doctors' qualifications. (Exhibit 23)

The response and explanation by Dr. R demonstrates a significantly limited *independent review of the approximately 6000 pages of medical records in this case.* Dr. R cites physical therapy notes; wound care notes and the single physician note of Dr. L dated March 5, 2009, as the basis of HSAG's opinion to uphold the discharge of Mrs. M on March 5, 2009. (Exhibit 33) Citing the physical therapy notes demonstrates an inadequate review of the serious conditions of Mrs. M he recurrence of urinary tract infections requiring several different intravenous antibiotics and the tracheostomy tube requiring frequent skilled suctioning. It appears that HSAG merely adopted the opinion of Dr. L and did not make an independent review and as such denied Mrs. M 'due process of law' by <u>not</u>: making an independent review and also failing to state the 'reasons for the QIO decision' as provided under 42 CFR 480.139(b); providing the identity of the medical records used to make the decision; and disclosing at a minimum the qualifications of the HSAG contracted physician(s) making the decision.

3. The InterQual and CERME Reports were used to justify the discharge of Mrs. M and the termination of her Medicare in-patient care coverage.

According to the McKesson website and testimony received during the hearing, the InterQual and CareEnhance Review Manager Enterprise (CERME) are proprietary tools developed by McKesson and employed in various medical settings for use in health care management assessment, discharge planning and coverage denial management programs. Information is

obtained from patient medical charts and from other captured data which is input into a software program that generates a summary report. (Exhibit 54)

Ms. S testified that she was trained to input data into this system. She explained that she had to review medical charts and make determinations as to what information should be input. The reports were merely 'guidelines' as to a patient's eligibility for continued placement at Hospital. Prior to her being placed in charge of Mrs. M case, the inputs were done by C . Dr. L testified that she knew little about these reports and it was the exercise of her own professional judgment as to when to discharge a patient.

The Administrative Law Judge has sealed the reports in this case as the computer programs are proprietary and not available to the public. However, the Administrative Law Judge has reviewed them with particular attention to the information provided in those reports generated in close proximity to the proposed discharge date of March 5 and they generally support Mrs. M needed the level of care provided at It is of note that although Ms. C was listed as a witness and would have been produced for testimony by counsel for the - and its affiliates, neither side called her to testify. Since this was an adversarial hearing the Administrative Law Judge did not require her production but Ms. C seems to be a key witness in the decision to discharge Mrs. M

The Administrative Law Judge does not pretend to know how the InterQual system works but listening to Ms. S testify, the inputs are very subjective. The inputs by Ms. C from February 23, 2009 through March 9, 2009 (Exhibit 54, pages 9 -21) are inconsistent with the known medical treatment being received by Mrs. M . The check marks indicated that a certain criterion was selected by the person inputting the data. Ms. C did not include 'Respiratory interventions, >= two:' The Administrative Law Judge finds that Mrs. M received at least 6 suctionings per day (twice per shift), but most likely many more that were not 'charted.' This lack of accurate data may have led to the InterQual CERME report indicating that "Intensity of Service NOT met' on February 26, 2009 (Exhibit 54, page 12) and March 2, 2009 (page 14) and March 5, 2009, (page 16). The intervention line was not checked on any of those dates. (Exhibit 54, pages 13, 15, and 17)

In spite of over 6000 pages of medical records and 2 days of testimony, the Administrative Law Judge is left to ponder who initiated the discharge of Mrs. M Dr. L did not initiate it and neither did any of the other witnesses that testified. It appears that Ms. at least participated in that decision. The 'Reviewer's Comments: -- C , on 03-05-2009 06:13 PM—SNF bed available and family refusing to transfer from LYAC setting. Denial from insurance received and given (sic) to patient's family.' (Exhibit 54, page 17) Even though the Administrative Law Judge cannot determine whether the inaccurate inputs would have changed the outcome of 'NOT met' but given the other reports with that input the result may have been 'MET.' The Administrative Law Judge therefore concludes that Ms. C used these reports to report to 'insurance' that the CERME reports supported discharge and got the authority to initiate the discharge of Mrs. M

4. The 'Notice of Denial of Medical Coverage' was 'served' on one of Mrs. M daughters, not the daughter who was the 'point of contact', but not until March 6, 2009.

The actual 'Notice' cannot be adequately discussed unless the context of the question of Mrs. M benefits being terminated and her proposed discharge from Hospital on March 5, 2009, is understood. Based on the clear testimony of several witnesses, the reported average stay for Hospital patients with a 'trach' is 28 days. Being admitted on October 30, 2008, Mrs. M had been a patient for more than four (4) months by March 5, 2009, the designated date of her discharge.

There was a 'family meeting' on February 6, 2009, at which Dr. L attended and there was some discussion about discharge but the emphasis of the meeting was to encourage family members to became more involved in their mother's physical, occupational and speech therapies as Mrs. M would not always fully participate. (Exhibit 18-2, page 243) It was decided that her two (2) daughters would urge their mother to work harder and they did so after that meeting.

The testimony also shows that and various professional staff conducted Interdisciplinary Team Conferences (IDT) to discuss each patient's needs and progress. The notes of the IDT conferences after February 6, 2009, show consistent references to have family input into the discharge planning. On February 19, 2009, the statement is: 'But needs to transfer - need to discuss with family' (Exhibit 18-2, page 229); February 25, 2009, 'to have family meeting to discuss snf (skilled nursing facility)' (Exhibit 18-2, page 221); and March 4, 2009, 'to have family meeting to discuss snf, have bed at for next week' (Exhibit 18-2, page 213).

There was no 'family meeting' after February 6, 2009, and Dr. L did not attend any IDT meeting as it was not protocol at that time but apparently it is now policy to have the physicians attend. While it may not be legally required, it seems like common sense and good policy to include family members in major decisions including the discharge of a patient. The notations of the staff described above found in the written evidence support Mrs. D testimony that the decision to discharge her mother on March 5, 2009, was a shock.

The technical 'due process' regulations and case law making decisions like discharge are a matter of 'due process of law' governed by 42 CFR 483.12 (a) (4). The "Notice" was mailed to appellant's daughter, but not received until March 6, 2009. (Exhibit 4, page 4) Thus the earliest effective date would have been that date. The aforementioned regulation also requires several mandatory factors that are to be included. (42 CFR 483.12 (a) (6)) One of the most significant is: "(i) the reason for the transfer or discharge ...." As argued by the appellant's attorneys' the reasons given were insufficient. (Exhibit 47, page 6) The pertinent Regulation states: "... the reasons for the move in writing *and in language and manner they understand.*" First, Dr. L didn't know anything about so she could not conclude that it would be 'medically safe.' Secondly, the decision to discharge Mrs. M was not initiated by Dr. L and she was only asked by C to write her requirements of the facility or to home to which Mrs. M may be discharged.

Based on the evidence of record related to the Notice, the Administrative Law Judge finds that it did **NOT** comply with 42 CFR 483.12 (a) (4) and (a) (6) for the reasons stated in this Decision.

LEGAL FRAMEWORK

I. ALJ Review Authority

A. Jurisdiction

An individual who, or an organization that, is dissatisfied with the reconsideration of an initial determination is entitled to a hearing before the Secretary of the Department of Health and Human Services (HHS), provided there is a sufficient amount in controversy and a request for hearing is filed in a timely manner. Social Security Act (Act) § 1869(b) (1) (A).

In implementing this statutory directive, the Secretary has delegated his authority to administer the nationwide hearings and appeals system for the Medicare program to OMHA. *See* 70 Fed. Reg. 36386, 36387 (June 23, 2005). The ALJs within OMHA issue the final decisions of the Secretary, except for decisions reviewed by the Medicare Appeals Council. *Id.*

A hearing before an ALJ is only available if the remaining amount in controversy is $110 or more. *See* CMS Rul. 02-1, 67 Fed. Reg. 62478, 62480 (Oct. 7, 2002); 71 Fed. Reg. 2247 (Jan.13, 2006). The request for hearing is timely if filed within sixty days after receipt of a Carrier Hearing Officer decision. *See* 20 C.F.R. § 404.933(b) (1).

B. Scope of Review

"The issues before the administrative law judge include all the issues brought out in the initial, reconsidered or revised determination that were not decided entirely in [the appellant's] favor. However, if evidence presented before or during the hearing causes the administrative law judge to question a fully favorable determination, he or she will notify [the appellant] and will consider it an issue at the hearing." 20 C.F.R. § 404.946(a).

C. Standard of Review

"The [Office of Medicare Hearings and Appeals]...is staff[ed] with Administrative Law Judges who conduct 'de novo' hearings...." 70 Fed. Reg. 36386 (June 23, 2005); *see also In re Atlantic Anesthesia Associates, P.C.*, MAC (June 2004) ("An ALJ qualified and appointed pursuant to the Administrative Procedure Act acts as an independent finder of fact in conducting a hearing pursuant to section 1869 of the Act. This requires *de novo* consideration of the facts and law.").

D. Policy

Section 1871(a)(2) of the Act states that unless promulgated as a regulation by CMS, no rule, requirement, or statement of policy, other than an National Coverage Determination (NCD), can establish or change a substantive legal standard governing the scope of benefits or payment for services under the Medicare program. *See also* 42 C.F.R. § 405.860. However, in lieu of binding regulations with the full force and effect of law, CMS and its contractors have issued policy guidance that describe criteria for coverage of selected types of medical items and services in the form of manuals and local medical review policies ("LMRPs") or local coverage determinations ("LCDs").

An ALJ is not bound by an LCD, but must give substantial deference to the policy. 42 CFR § 405.1062.

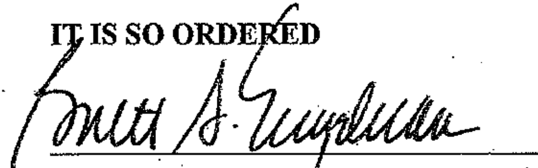
ANALYSIS

The request for hearing was timely filed and there is a sufficient amount in controversy. The appeal is therefore properly before the undersigned ALJ in the OMHA Western Field Office. For the reasoning set forth in the body of this Decision the Administrative Law Judge finds the discharge of Mrs. M[redacted] was unjustified on March 5, 2009.

CONCLUSIONS OF LAW AND ORDER

It is the decision of the Administrative Law Judge that Mrs. [redacted] treatment at [redacted] Hospital Sacramento on and after March 5, 2009 until actual discharge on April 21, 2009 was "reasonable and necessary." Mrs. [redacted] is not financially responsible for her care at [redacted] Hospital – Sacramento from March 5, 2009 through April 21, 2009. [redacted] and/or [redacted] are financially responsible for her care during this time period.

IT IS SO ORDERED



Dated: DEC 9 2009

Bennett S. Engelman
Administrative Law Judge