Department of Health and Human Services
OFFICE OF MEDICARE HEARINGS AND APPEALS
Midwestern Region
Cleveland, Ohio

Appeal of:	ALJ Appeal No.: **1-517883673**
Beneficiary:	**Medicare Part A**
HICN:	Before: **P. Arthur McAfee** U.S. Administrative Law Judge

Decision

After carefully considering the evidence and arguments presented in the record and at a hearing, a **FULLY FAVORABLE** decision is entered for (Appellant) with regards to Medicare coverage for acute care facility (ACF) services she received from (Provider) on October 23, 2008, through October 27, 2008 (dates at issue).

Procedural History

Appellant was an inpatient at the Provider's ACF from October 23, 2008 through October 27, 2008. On October 25, 2008, Appellant received notice that her status was being changed from an inpatient to an outpatient. The decision to change her status was appealed. On March 12, 2009, Northeast Health Care Quality Foundation (NHCQF), an independent Quality Improvement Organization (QIO), issued a decision concluding Appellant's inpatient status was warranted on October 25, 2008 (Exhibit 2, page 11). Thus, the QIO determined Medicare would cover Appellant's hospital stay from October 25, 2008 through October 27, 2008 (id.). According to the QIO decision, Appellant was admitted to the Provider's facility on October 23, 2008, at an observation level (Exhibit 2, page 10). The QIO decision did not review the issue of Medicare coverage for the dates of services from October 23, 2008 to October 25, 2008.

On September 23, 2009, MAXIMUS Federal Services, a Qualified Independent Contractor (QIC), issued an unfavorable decision (Exhibit 2). The QIC decision stated the decision was unfavorable because the claim in question had already been processed for payment by Northern Heritage Insurance Company on May 11, 2009 (id.).

On November 2, 2009, Appellant filed a timely request for a hearing by an Administrative Law Judge (ALJ) at the Office of Medicare Hearings and Appeals, Midwestern Field Office in Cleveland, Ohio (See 42 CFR § 405.1014 *providing sixty days following the issuance of a reconsideration decision to file an ALJ Hearing Request*). The amount in controversy satisfies the jurisdictional requirements for an Administrative Law Judge hearing before the Office of Medicare Hearings and Appeals. *See* 42 CFR §§ 405.1002 and 405.1006.

All documentation associated with this appeal has been incorporated into the record as Exhibits 1 through 5. After a thorough review of this documentation, a fully favorable on-the-record decision is granted without the need for a hearing. See 42 CFR § 405.1038(a).

Issue

Whether the documentation demonstrates that the beneficiary continued to required and received ACF services on October 23, 2008, through October 27, 2008, as to qualify the beneficiary for Medicare coverage for the services under Medicare Part A.

Findings of Fact

The beneficiary was admitted to the Provider's ACF facility on October 23, 2008 with a diagnosis of an L1 compression fracture (Exhibit 2, page 14). The physician admission orders indicate the beneficiary's condition was "fair" and she required monitoring and assessment as well as intravenous fluids (id.).

On October 25, 2008, Appellant received notice that her status was being changed from an inpatient to an outpatient. The decision to change her status was appealed (Exhibit 2, page 15). On March 12, 2009, Northeast Health Care Quality Foundation (NHCQF), an independent Quality Improvement Organization (QIO), issued a decision concluding Appellant's inpatient status was warranted on October 25, 2008 (Exhibit 2, page 11). The inpatient designation was deemed appropriate based on the beneficiary's apparent need for multiple doses of intravenous morphine during her stay Exhibit 1, page 14). Thus, the QIO determined Medicare would cover Appellant's hospital stay from October 25, 2008 through October 27, 2008 (id.).

Legal Framework

I. ALJ Review Authority

A. Jurisdiction

The Appellant timely requested a Medicare Part B hearing before an ALJ. 42 CFR § 405.1014. The remaining amount in controversy meets the jurisdictional requirements for a hearing. 42 CFR § 405.1006.

B. Scope of Review

Under the implementation policy for the Center for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS), all initial determinations made in Medicare Part B claims issued by carriers after January 1, 2006, are governed by the Administrative Law Judge Hearing Procedures outlined in 42 CFR § 405.1000 *et seq*. Issues before the Administrative Law Judge include all issues brought out in the initial, redetermination, or reconsideration that was not decided entirely in the Appellant's favor. 42 CFR § 405.1032(c). However, if the evidence demonstrates a new issue has arisen, the Administrative Law Judge will notify the Appellant and will consider it an issue at the hearing. 42 CFR § 405.1032. In addition, if the evidence in the hearing record supports a finding in favor of the appellant and all the parties on every issue, the Administrative Law Judge may issue a hearing decision without holding an oral hearing. 42 CFR § 405.1000(g).

C. Standard of Review

Administrative Law Judges appointed pursuant to Section 1869 of the Social Security Act conduct "de novo" review and adjudication of appeals filed with OMHA (70 Fed. Reg. 36386 (June 23, 2005)).

II. Principles of Law

A. *Statutes and Regulations*

As part of the Social Security Amendments of 1965, Congress established two programs to cover the cost of medical care for the elderly and disabled. The first of these programs provides basic protection against the costs of inpatient hospital and other institutional provider care. Officially the program is called "Hospital Insurance Benefits for the Aged and Disabled" or, more popularly, "basic Medicare" or Medicare Part A". See, 42 U.S.C. Title XVIII §1395 et seq., Chapter 7, subchapter XVIII, Part A—Hospital Insurance Benefits for the Aged and Disabled §§ 1811 – 1821.

The Medicare Part A program entitles a beneficiary to have payment made to him or her or on his or her behalf for inpatient hospital services or inpatient critical access hospital services. 42 U.S.C. §1395d (a)(1). Section 1862(a)of the Social Security Act states, in pertinent part: "Notwithstanding any other provision of this title, no payment may be made under Part A or Part B for any expenses incurred for items or Services – (1)(A) which, . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. . ." 42 U.S.C. § 1395y(a)(1)(A); see also 42 CFR § 411.15(k)(1).

Title XVIII § 1879 of the Social Security Act provides that when Medicare coverage and payment is excluded pursuant to Section 1862(a)(1) or (a)(9), payment may nevertheless be made for items or services, if neither the beneficiary nor the provider or supplier knew, and could not reasonably be expected to have known, that the items or services would not be covered or payable by Medicare.

B. *Policy and Guidance*

Medicare Part A covers services provided to beneficiaries who are patients in a qualified hospital participating in the Medicare program for up to 90 days in any one "spell of illness". § 1812(a)(1) of the Act. These services are defined as "inpatient" hospital services. Medicare defines "inpatient" as a person who has been admitted to a hospital for bed occupancy for the purpose of receiving inpatient hospital services. A person is considered an inpatient if formally admitted as an inpatient with the expectation of remaining at least overnight and occupying a bed. CMS, *Medicare Benefit Policy Manual (MBPM) (Internet-Only Manual Publ'n 100-2)* ch. 1, § 10. Ultimately, the decision to admit a patient as an inpatient is up to the discretion of the physician or other practitioner responsible for a patient's care at the hospital. *MBPM,* ch. 1, § 10, provides that:

> The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of

facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Generally, review of whether an inpatient hospital admission was medically reasonable and necessary is conducted by a Quality Improvement Organization (QIO). CMS contracts with the QIOs to conduct case review to ensure that care provided to Medicare beneficiaries meets professionally recognized standards of healthcare and that Medicare pays only for services that are reasonable and necessary. CMS has issued a manual for QIOs to provide guidance on the QIO program - CMS, *Quality Improvement Organization Manual (QIOM) (Internet-Only Manual Publ'n 100-10).* Chapter 4, Section 4110 of the QIOM provides the following guidance on review of inpatient hospital admissions:

> QIOs must conduct review of admissions and discharges as specified in 42 CFR 476.71(a)(6). Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient at any time during the stay. The patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

Chapter 4, section 4110 of the *QIOM* further provides the following guidelines on determining the medical necessity and appropriateness of an admission/discharge:

> **A. Determining Medical Necessity and Appropriateness of Admission/Discharge –**
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> ...
>
> The physician reviewer must consider, in his/her review of the medical record, any preexisting medical problems or extenuating circumstances that make admission of the patient medically necessary. Factors that may result in an inconvenience to a patient or family do not, by themselves, justify inpatient admission. When such factors affect the patient's health, consider them in determining whether inpatient hospitalization was appropriate.
>
> Inpatient care rather than outpatient care is required only if the patient's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. Without accompanying medical

> conditions, factors that may cause the patient inconvenience in terms of time and money needed to care for the patient at home or for travel to a physician's office, or that may cause the patient to worry, do not justify a continued hospital stay or justify your approval of a higher-than necessary level of care.

Chapter 7 of the *QIOM* provides the instructions to the QIO with respect to a beneficiary's request for review of the decision at issue in this matter.

Analysis

In this case, the QIO allowed Medicare Part A coverage for inpatient ACF services the beneficiary received from October 25, 2008 to October 27, 2008. The QIO determined that the beneficiary required an inpatient level of care on these dates of service due to the beneficiary's apparent need for multiple doses of intravenous morphine during her stay. On appeal, Appellant is seeking Medicare Part A coverage of the inpatient ACF services she received on October 23, 2008 and October 24, 2008.

Generally, Medicare Part A provides reimbursement for a variety of costs associated with hospital services as long as the services are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. 42 U.S.C. § 1395y(a)(1)(A). According to Chapter 1, § 10 of the MBPM, physicians should order admission for patients who are expected to need hospital care for 24 hours or more. Per chapter 1, § 10 of the MBPM, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors including the patient's medical history and current medical needs. Absent evidence of abuse, fraud or other indication of unreliability, a physician's decision should be upheld.

Given the above requirements, Appellant has met the appropriate coverage requirements for the Appellant's inpatient services she received on October 23, 2008 and October 24, 2008. On October 23, 2008, a physician ordered Appellant to be admitted to the Provider's facility for inpatient care secondary to a diagnosis of an L1 compression fracture. The physician admission orders indicate the beneficiary's condition was "fair" and she required monitoring and assessment as well as intravenous fluids. The documentation provides no foundation to go against the judgment of the admitting physician. Therefore, Appellant has met the appropriate coverage requirements for the beneficiary's inpatient admission on October 23, 2008 as well as the service provided on October 24, 2008. .

Conclusions of Law

Appellant has satisfied the applicable coverage criteria for reimbursement under Part A for the ACF provided to the Beneficiary on October 23, 2008 and October 24, 2008. Therefore, as a matter of law, the ACF services furnished by the Provider were medically reasonable and necessary as defined under §1862(a) of the Act and the documentation requirements of section 1833(e) were sufficiently satisfied for Medicare to provide reimbursement. Thus, all of the ACF services furnished by the Provider from October 23, 2008 to October 27, 2008, are entitled to reimbursement under Medicare Part A

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ORDER

The Medicare Contractor is **DIRECTED** to process the claim in accordance with this decision.

IT IS SO ORDERED.

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Date

P. Arthur McAfee
U. S. Administrative Law Judge