CMS Referral for Own Motion Review by DAB/MAC

<table>
<thead>
<tr>
<th>Appellant at ALJ Level</th>
<th>ALJ Appeal Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFS of Bastain (c/o Reliant Rehabilitation)</td>
<td>1-932734068</td>
</tr>
</tbody>
</table>

Beneficiary (if not the Appellant) | List attached |
--- | --- |

ALJ Decision Date

January 11, 2013

Health Insurance Claim Number (HICN)*

Specific Item(s) OR Service(s)

Skilled Nursing Facility (SNF) Services

Provider, Practitioner OR Supplier

AFS of Bastain (c/o Reliant Rehabilitation)

Part A

Part B

Rationale for Referral:

AFS of Bastain (Appellant) requested an Administrative Law Judge (ALJ) hearing to review the Medicare Administrative Contractor’s, Palmetto GBA (MAC), and the Qualified Independent Contractor’s, Maximus Federal Services (QIC), denial of Medicare coverage and reimbursement for Skilled Nursing Facility (SNF) services Appellant furnished the beneficiary from October 27 to 31, 2010. The contractors denied Medicare coverage and reimbursement for the SNF services in part because Appellant failed to obtain or submit the physician's certification of the beneficiary’s need for SNF services. The ALJ issued a fully favorable on-the-record decision, finding Medicare coverage existed for the SNF services, and ordering Medicare reimbursement.

The ALJ’s decision contains errors of law material to the outcome of this claim. The ALJ erred as a matter of law in ordering Medicare reimbursement for the SNF services Appellant furnished the beneficiary from October 27 to 31, 2010, without considering the certification requirements articulated in 42 C.F.R. § 424.20. Specifically, the regulations require the beneficiary’s physician to certify the beneficiary requires post-hospital SNF care because the beneficiary’s need for daily skilled services or the beneficiary has been assigned to one of the Resource Utilization Groups (RUG) in compliance with 42 C.F.R. § 409.30. 42 C.F.R. § 424.20(a)(1). In this case, the Plans of Treatment (POT) for the physical therapy (PT), occupational therapy (OT), and speech language pathology (ST) services have been certified by the beneficiary’s physician, but no physician certification of the beneficiary’s need for SNF admittance exists. Furthermore, although the QIC denied Medicare reimbursement on this basis, the ALJ failed to consider the physician certification requirements articulated in 42 C.F.R. § 424.20. Accordingly, the ALJ erred as a matter of law in ordering Medicare reimbursement for the SNF services Appellant furnished the beneficiary from October 27 to 31, 2010, without considering the applicable conditions for Medicare payment. This error of law is material to the outcome of the claim because it results in the ALJ ordering Medicare
reimbursement for SNF services for which the beneficiary’s physician did not certify the beneficiary required.

**Background:**

Appellant furnished the beneficiary with SNF services from October 27 to 31, 2010. ALJ at 1. As part of the beneficiary’s SNF services, Appellant also furnished PT, OT, and ST services. Exh.2 at 1-6, 31-34, 196, 94-99, 198. On initial determination, the MAC denied Medicare coverage and reimbursement for the SNF services because the documentation did not support the RUG code billed, the initial POTs were not submitted, Appellant failed to furnish daily progress notes, the medical documentation did not include the number of participants in the group therapy sessions, and the nursing documentation did not substantiate the beneficiary’s need for SNF services. Exh.1 at 24. As a result of the unfavorable initial determination, Appellant requested a redetermination, maintaining the services were medically reasonable and necessary. Exh.1 at 30-33. Nevertheless, the MAC issued an unfavorable redetermination, denying Medicare coverage and reimbursement for the SNF services Appellant furnished the beneficiary from October 27 to 31, 2010. Exh.1 at 23. The MAC explained Appellant submitted an order for SNF admission but failed to submit the physician’s certification of the beneficiary’s need for SNF services, stating a routine SNF admission order is insufficient to satisfy the physician certification requirements. Exh.1 at 24. The MAC also asserted the PT orders contained an illegible signature and Appellant failed to submit orders for OT and ST services. Id. The MAC noted the POTs for PT, OT, and ST services all contained illegible signatures. Id. Additionally, the MAC held Appellant financially responsible for the noncovered services. Id.

Following the unfavorable redetermination decision, Appellant requested the QIC conduct a reconsideration, arguing the services were medically reasonable and necessary. Exh.1 at 19-22. The QIC issued an unfavorable reconsideration decision, denying Medicare coverage and reimbursement, stating: “No certification or recertification forms were submitted for review in the case file documentation.” Exh.1 at 12b. Therefore, the QIC concluded the documentation in the medical record did not substantiate the SNF services met Medicare coverage criteria. Id. The QIC found Appellant financially responsible for the noncovered services. Id.

As a result of the unfavorable reconsideration decision, Appellant requested an ALJ hearing. Exh.1 at 1-10. Appellant maintained the medical documentation included sufficient certifications and the physician’s signature attestation and argued the SNF services were medically reasonable and necessary. Id. The ALJ issued a fully favorable on-the-record decision, finding Medicare coverage existed for and ordering Medicare reimbursement for the SNF services Appellant furnished the beneficiary from October 27 to 31, 2010. ALJ at 1. The ALJ found the SNF services were skilled and reasonable and necessary. ALJ at 2, 4. Accordingly, the ALJ found Medicare coverage existed and ordered Medicare reimbursement for the SNF services. ALJ at 4-5.
However, the ALJ did not address the physician certification requirements. This referral requesting the Council accept own motion review follows.

**Applicable Law, Regulation, and Medicare Policy:**

I. ALJ Review

A party dissatisfied with a reconsideration may request a hearing before an ALJ. 42 C.F.R. § 405.1000(a). The ALJ conducts a de novo review and issues a decision based on the hearing record. 42 C.F.R. § 405.1000(d). Further, an ALJ’s “decision must be based on evidence offered at the hearing or otherwise admitted into the record.” 42 C.F.R. § 405.1046(a); see also 42 C.F.R. § 405.1046(a) (“Unless the ALJ dismisses the hearing, the ALJ will issue a written decision that gives the findings of fact, conclusions of law, and the reasons for the decision. The decision must be based on evidence offered at the hearing or otherwise admitted into the record.”). “The issues before the ALJ include all the issues brought out in the initial determination, redetermination, or reconsideration that were not decided entirely in a party’s favor.” 42 C.F.R. § 405.1032(a).

II. Medicare Coverage of SNF Services

The requirements for Medicare coverage of posthospital SNF care are set forth in Subpart C of Part 409 of Title 42 of the CFR. SNF skilled nursing and skilled rehabilitation services are defined as services (1) ordered by a physician, (2) requiring “the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and” (3) are “furnished directly by, or under the supervision of, such personnel.” 42 C.F.R. § 409.31(a). Furthermore, the regulations provide guidance for meeting the level of care requirements:

(b) Specific conditions for meeting level of care requirements.

(1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.

(2) Those services must be furnished for a condition--

(i) For which the beneficiary received inpatient hospital or inpatient CAH services; or

(ii) Which arose while the beneficiary was receiving care in a SNF or swing-bed hospital for a condition for which he or she received inpatient hospital or inpatient CAH services; or

(iii) For which, for an M+C enrollee described in § 409.20(c)(4), a physician has determined that a direct admission to a SNF without an inpatient hospital or inpatient CAH stay would be medically appropriate.

(3) The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF, on an inpatient basis.
42 C.F.R. § 409.31(b). Additionally, 42 C.F.R. § 409.33 provides examples of skilled nursing and rehabilitation services. In order to qualify as skilled nursing services needed on a daily basis, a requirement articulated in 42 C.F.R. § 409.31(b)(1), the skilled nursing or rehabilitation services must be needed seven days a week or, if the skilled services are not available seven days a week, must be needed and provided at least five days a week. 42 C.F.R. § 409.34.

Subpart B of Part 424 of Title 42 of the CFR sets forth “the timing, content, and signature requirements for certification and recertification with respect to certain Medicare services furnished by providers.” 42 C.F.R. § 424.10(b). The Medicare payment conditions for posthospital SNF care are articulated in 42 C.F.R. § 424.20:

Medicare Part A pays for posthospital SNF care furnished by an SNF, or a hospital or CAH with a swing-bed approval, only if the certification and recertification for services are consistent with the content of paragraph (a) or (c) of this section, as appropriate.

(a) Content of certification--

(1) General requirements. Posthospital SNF care is or was required because--

(i) The individual needs or needed on a daily basis skilled nursing care (furnished directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services that, as a practical matter, can only be provided in an SNF or a swing-bed hospital on an inpatient basis, and the SNF care is or was needed for a condition for which the individual received inpatient care in a participating hospital or a qualified hospital, as defined in § 409.3 of this chapter; or

(ii) The individual has been correctly assigned to one of the Resource Utilization Groups designated as representing the required level of care, as provided in § 409.30 of this chapter.

(b) Timing of certification.

(1) General rule. The certification must be obtained at the time of admission or as soon thereafter as is reasonable and practicable.

(e) Signature. Certification and recertification statements may be signed by--

(1) The physician responsible for the case or, with his or her authorization, by a physician on the SNF staff or a physician who is available in case of an emergency and has knowledge of the case; or

(2) A physician extender (that is, a nurse practitioner, a clinical nurse specialist, or a physician assistant as those terms are defined in section
1861(aa)(5) of the Act) who does not have a direct or indirect employment relationship with the facility but who is working in collaboration with a physician. For purposes of this section--

(i) Collaboration.

(A) Collaboration means a process whereby a physician extender works with a doctor of medicine or osteopathy to deliver health care services.

(B) The services are delivered within the scope of the physician extender's professional expertise, with medical direction and appropriate supervision as provided for in guidelines jointly developed by the physician extender and the physician or other mechanisms defined by Federal regulations and the law of the State in which the services are performed.

(ii) Types of employment relationships.

(A) Direct employment relationship. A direct employment relationship with the facility is one in which the physician extender meets the common law definition of the facility's “employee,” as specified in § 404.1005, § 404.1007, and § 404.1009 of title 20 of the regulations. When a physician extender meets this definition with respect to an entity other than the facility itself, and that entity has an agreement with the facility for the provision of nursing services under § 409.21 of this subchapter, the facility is considered to have an indirect employment relationship with the physician extender.

(B) Indirect employment relationship.

(1) When a physician extender meets the definition of a direct employment relationship in paragraph (e)(2)(ii)(A) of this section with respect to an entity other than the facility itself, and that entity has an agreement with the facility for the provision of nursing services under § 409.21 of this subchapter, the facility is considered to have an indirect employment relationship with the physician extender.

(2) An indirect employment relationship does not exist if the agreement between the entity and the facility involves only the performance of delegated physician tasks under § 483.40(e) of this chapter.

...
III. Limitation on Billing

The regulations also limit the amounts a provider may bill the beneficiary:

[T]he provider agrees not to charge a beneficiary for any of the following:

(a) Services for which the beneficiary is entitled to have payment made under Medicare.

(b) Services for which the beneficiary would be entitled to have payment made if the provider—

(1) Had in its files the required certification and recertification by a physician relating to the services furnished to the beneficiary;

42 C.F.R. 489.21.

Discussion:

The ALJ erred as a matter of law in ordering Medicare coverage of the SNF services Appellant furnished the beneficiary from October 27 to 31, 2010. Specifically, the ALJ failed to consider the certification requirements articulated in 42 C.F.R. § 424.20. This error of law is material to the outcome of the claim because it results in the ALJ ordering Medicare reimbursement for SNF services without considering whether the conditions for Medicare payment were satisfied.

As a condition for Medicare payment, the physician must certify the beneficiary’s need for SNF services on a daily basis or the beneficiary was correctly assigned to a RUG. 42 C.F.R. § 409.20.

In this case, the physician did not certify the beneficiary’s need for SNF services. The administrative record contains POTs for the rehabilitation services Appellant furnished the beneficiary, but no certification of the beneficiary’s need for SNF services. Furthermore, the QIC in this case denied Medicare reimbursement for the SNF services Appellant furnished the beneficiary because the medical documentation did not include a physician certification of the beneficiary’s need for SNF services. However, the ALJ failed to address any of the certification requirements.

Accordingly, the ALJ erred as a matter of law in ordering Medicare reimbursement for the SNF services Appellant furnished the beneficiary from October 27 to 31, 2010, without considering the applicable conditions for Medicare payment. This error of law is material to the outcome of the claim because it results in the ALJ ordering Medicare reimbursement for SNF services for which the beneficiary’s physician did not certify the beneficiary required.
Conclusion:

Based on the foregoing, we believe the ALJ's decision contains errors of law material to the outcome of these claims. Therefore, we refer the ALJ's decision to the Council and request own motion review.