The Law Offices of
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Health Care Provider
Legal Alert

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DISTRICT COURT REVERSES MEDICARE APPEALS COUNCIL IN IRF COVERAGE DISPUTE

In This Issue:

- **Medicare Claim Appeal**
- **Judicial Review**
- **IRF Coverage Criteria**
- **Medical Necessity**

In a case that shows the benefit of pursuing certain medical necessity denials to the federal courts, an inpatient rehabilitation facility ("IRF") recently brought a successful challenge in U.S. district court to a decision by the HHS Departmental Appeals Board, Medicare Appeals Council ("MAC"). The MAC had affirmed the Administrative Law Judge's ("ALJ's") denial of two claims on grounds that they did not meet the Medicare requirements for IRF coverage. In Teche Specialty Hospital v. Sebelius,[i] the U.S. District Court for the Western District of Louisiana granted the IRF's motion for summary judgment, vacated the MAC's decision, and remanded the claims back to the MAC for further consideration. Hospitals, including IRFs and LTCHs, often challenge payment denials by Medicare contractors where the contractor asserts the lack of medical necessity for inpatient services on the belief that the same services could have been provided at a lower level of care. However, even well-developed appeals can result in unfavorable agency decisions when an ALJ or the MAC, in particular, fail to consider all of the evidence and testimony (or give it sufficient weight), or apply the wrong legal standard. When this happens, it is worth taking the appeal to federal court. Here, the provider was successful in federal court because the MAC ignored valuable testimony from the treating physician at the ALJ level and the provider was able to identify inaccuracies in the MAC's interpretation of the requirement for IRF coverage that there be an expectation of improvement in the beneficiary's condition.

We represent IRFs, LTCHs and other health care providers in Medicare claims appeals at the agency level and the federal courts. Please contact us at the phone number or email address to the left if we can be of any assistance.

Facts and Procedural History. The provider in this case was an IRF located in New Iberia, Louisiana. Wisconsin Physicians Service selected 40 of the provider's claims from 2007 and 2008 for a post-payment audit and determined that 19 of the 40 claims were paid improperly due to a lack of medical necessity and insufficient documentation to support the IRF level of care. The provider was assessed an overpayment of over $300,000 for these 19 claims. The overpayment was appealed unsuccessfully at the redetermination and reconsideration levels. At the ALJ level of appeal, a hearing was held and the treating physician testified on behalf of the provider. The ALJ reversed all but two of the 19 claim denials in favor of the

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provider. An appeal of the two remaining claims to the MAC resulted in unfavorable decisions for the provider. The MAC affirmed the ALJ's findings that in these two cases the beneficiaries did not make progress toward their rehabilitative goals. Furthermore, the MAC found that the two beneficiaries did not need inpatient hospital care because they did not present "with medical conditions requiring the 24-hour availability of a physician."

Medicare Requirements for IRF Coverage at Issue. Medicare requirements for coverage of IRF services underwent substantial changes effective January 1, 2010.[ii] As the dates of service at issue in this case were from 2007 and 2008, the court was tasked with applying the IRF coverage rules that applied for discharges prior to 2010. Medicare rules for IRF coverage for discharges prior to 2010 are outlined in Health Care Financing Administration ("HCFA") Ruling 85-2. At issue in this case were two requirements from HCFA Ruling 85-2. One requirement for IRF coverage in HCFA Ruling 85-2 stated that a beneficiary's condition must require "the 24-hour availability of a physician with special training or experience in the field of rehabilitation." HCFA Ruling 85-2 also required "a conclusion by the rehabilitation team that a significant practical improvement can be expected in a reasonable period of time."

HCFA Ruling 85-2 was rescinded in 2009 and replaced with new coverage rules located at 42 C.F.R. § 412.622. The current rules for IRF coverage state in relevant part:

> In order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a *reasonable expectation* that the patient meets all of the following requirements *at the time of the patient's admission to the IRF*—
> …
> (ii) Generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program. . . . Benefit from this intensive rehabilitation therapy program is demonstrated by measurable improvement that will be of practical value to the patient in improving the patient's functional capacity or adaptation to impairments. . . .
> …
> (iv) Requires physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

42 C.F.R. § 412.622(a)(3) (emphasis added). The current IRF coverage standards do not provide that the beneficiary's condition must require the 24-hour availability of a rehabilitation physician. Under the current rules, the beneficiary must require physician supervision with at least three face-to-face visits a week. The current requirements also require that there be a reasonable expectation that the beneficiary will actively participate and

benefit from rehabilitation services. HCFA Ruling 85-2 required an expectation of "significant practical improvement." Despite the changes to IRF coverage requirements as a result of the regulation and the rescission of HCFA Ruling 85-2, there are enough similarities between the prior and existing requirements to make this an instructive case for other IRFs. More importantly, all providers can benefit from the court's reasoning and an understanding of why the court was willing to reverse the agency's final decision by the MAC.

District Court's Analysis. The district court vacated the MAC's decision in both of the denied claims for two primary reasons. First, the MAC held in each case that the IRF level of care was unwarranted because the beneficiaries did not have "medical conditions requiring the 24-hour availability of a physician." The court found that the MAC's decisions failed to acknowledge evidence that the beneficiaries' conditions did require the IRF level of care. At the ALJ hearing, the treating physician's testimony detailed numerous medical conditions and complications of each beneficiary. The court noted that the treating physician "provided uncontroverted testimony at the [ALJ] hearing that inpatient rehabilitation services were reasonable and necessary and could not have provided at a lower level of care."[iii] The treating physician concluded that the beneficiaries met the requirements for IRF coverage. However, the MAC's decisions did not address or acknowledge all of the medical conditions that were submitted into evidence through the physician's uncontroverted testimony. The court therefore concluded that the "MAC has not pointed to *any* evidence inconsistent with [the treating physician's] testimony, nor to *any* evidence supporting a contrary conclusion, nor to *any* other cause for discounting [the treating physician's] testimony."[iv] The court also acknowledged the "physician judgment rule" in Social Security cases decided in the Fifth Circuit, which requires that great weight be afforded to the treating physician's professional opinion.

Second, the court determined that the MAC's decisions must be vacated due to an incorrect application of the IRF coverage requirement in HCFA Ruling 85-2 that there must be "a conclusion by the rehabilitation team that a significant practical improvement can be expected in a reasonable period of time." The MAC had upheld the denials based on a finding that neither beneficiary made progress towards their rehabilitative goals. The court found that the MAC improperly rewrote this coverage rule to require "significant practical improvement" when the actual rule only required an *expectation* of "significant practical improvement."[v] Neither the prior coverage criteria nor the current regulation require actual improvement. The current regulation requires a *reasonable expectation at the time of admission* that the beneficiary will actively participate in and benefit from the intensive rehabilitation therapy program, demonstrated by measurable improvement.[vi] CMS originally proposed the IRF coverage regulation without the "reasonable expectation" language but decided to include it at the request of several commenters. In this case, the court faulted the MAC with trying to impose a higher standard than Medicare requires.

[i] No. 6:13–1120, 2014 WL 4639527 (W.D. La. Sept. 15, 2014).
[ii] *See* Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2010, Final Rule, 74 Fed. Reg. 39762, 37688-98 (Aug. 7, 2009).
[iii] No. 6:13–1120, 2014 WL 4639527 at *7.
[iv] *Id.* at *8.
[v] *See id.* at *9.
[vi] *See* 42 C.F.R. § 412.622(a)(3)(ii).

About Us

The Law Offices of Jason M. Healy PLLC is a Washington, D.C. based law firm serving national and local clients. We focus primarily on legal issues affecting health care providers and welfare benefit plans. We help health care providers and their trade associations understand Medicare and Medicaid laws and regulations, and address compliance matters. We also represent health care providers in reimbursement audits, appeals, litigation, and transactions. We help sponsors of welfare benefit plans understand and comply with federal and state laws and prepare plan documents. Located in Washington, DC, just minutes from the Department of Health and Human Services, Congressional offices, and the White House, we are well positioned to provide legal support for advocacy efforts. Our Principal, Jason M. Healy, is a health care lawyer with over 15 years of experience with the array of legal issues facing health care providers.