DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

TDL-12309, 03-28-12

MEMORANDUM

DATE: July 13, 2012

FROM: Acting Director, Medicare Enrollment & Appeals Group
Center for Medicare

Acting Director, Hospital & Ambulatory Policy Group
Center for Medicare

Director, Provider Billing Group
Center for Medicare

Director, Medicare Contractor Management Group
Center for Medicare

SUBJECT: Administrative Law Judge Decisions

TO: All Fiscal Intermediaries (FIs), Carriers, and Part A and Part B Medicare Administrative Contractors (A/B MACs)

There have been a number of Administrative Law Judge (ALJ) decisions in recent months that uphold a claims administration contractor's denial of inpatient services as not reasonable and necessary, but require the contractor to pay for the services on an outpatient basis and/or at an "observation level of care." One representative example of these decisions indicates that:

> "Medicare payment is not appropriate for inpatient hospital care services that were provided to the Beneficiary from November 19 through 20, 2009. Appellant is entitled to downgraded payment at the rate of observation level of care for its services."

Medicare pays for observation services under the outpatient prospective payment system (OPPS). However, observation services are generally bundled and not paid separately. Therefore, the Centers for Medicare & Medicaid Services (CMS) has reasoned that the ALJ's decision requires the claims administration contractor to pay for all services that would be separately payable under the OPPS had the hospital initially billed Medicare for outpatient services on a 13x or 85x type of claim. In this circumstance, the ALJ's order is in conflict with Chapter 6, sections 10 and 20.6 of the Medicare Benefit Policy Manual (Publication 100-02) and Chapter 1, section 50.3 of the Medicare Claims Processing Manual (Publication 100-04).

Chapter 6, sections 10 and 20.6 of the Medicare Benefit Policy Manual (Publication 100-02) specifies a limited list of medical and other health services that may be paid under Medicare Part B when an inpatient admission is "disapproved as not reasonable and necessary (and waiver of liability payment was not made)." Chapter 1, section 50.3 of the Medicare Claims Processing Manual (Publication 100-04) indicates that an "outpatient" means a person who has not been admitted as an inpatient but who is registered on the hospital or critical access hospital (CAH) records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH. By this definition, an inpatient stay that has been disapproved is still a stay for an admitted patient that is not transformed into an outpatient stay. Payment may only be made under the OPPS for patients that are outpatients—that is, a patient that has not been admitted as an inpatient.

The claims administration contractors shall follow the instructions below to effectuate ALJ decisions that uphold determinations that inpatient claims were not medically necessary, but instruct CMS to make payment as if those claims were for outpatient services, including observation care.

1. Within 30 calendar days of receipt of the effectuation notice from the Administrative QIC (AdQIC), contractors shall contact the provider to secure a new replacement claim with the appropriate outpatient HCPCS codes and line item charges representing rendered services, including observation, where appropriate. A line item charge for observation may only be included if there was an order for observation. In the absence of an order for observation, the observation charges should not be included if the ALJ only specified payment for outpatient care or services. However, if the ALJ specified "observation level of care" or "including observation care," line item charges for observation may be added if otherwise appropriate, as the ALJ is specifically substituting the order to admit for the order for observation.

   Note: If a contractor does not receive a replacement claim from the provider within 180 days from the date the contractor contacts the provider, it shall close the case and consider the effectuation complete. These cases and cases that do not meet timely effectuation requirements because the provider did not submit the replacement claim timely shall be reported in the monthly status report (MSR), not the CROWD Report.

2. Cancel/delete the original inpatient claim in CWF to prevent the replacement outpatient claim from being rejected as a duplicate.

3. Process the replacement outpatient claim in the Fiscal Intermediary Shared System (FISS).

4. Bypass or override timely filing requirements and any other edits (including medical review), if necessary, to issue payment.

Contractors shall notify their COR with a copy to the appeals Business Function Lead (BFL) upon receipt and completion of an effectuation of an ALJ decision as described above. Contractors shall include the following information in the notification: Name of Provider, Date

ALJ decision/effectuation notice was received from the AdQIC, Date(s) contractor contacted the provider in order to notify them of the need to submit a replacement claim, Date ALJ decision was effectuated and amount paid, and Date the case was closed in the event that the provider does not submit the replacement claim within 180 days of the contractor requesting it. Contractors shall ensure that there is a way to easily locate the case files in the event more detailed information is needed.

Contractors shall keep a log of all of the above activities and shall also report this in the appeals section of the MSR for the previous month's activities and cumulative year-to-date. Legacy contractors shall submit a similar report via email to Maria Ramirez @ Maria.Ramirez@cms.hhs.gov.

These instructions only apply to the very specific ALJ decisions described above. We note that while these unusual steps are necessary to comply with the ALJ decisions, they are not consistent with Chapter 6, sections 10 and 20.6 of Medicare Benefit Policy Manual (Publication 100-02) and Chapter 1, section 50.3 of the Medicare Claims Processing Manual (Publication 100-04). We are instructing contractors to take action that is inconsistent with CMS policy solely to effectuate these specific ALJ orders. This instruction should not be construed or interpreted as a change in the policy outlined in these manual sections. Contractors should continue to follow existing policy and practices in all situations where there is not a conflicting ALJ order.

NOTE: MEDICARE ADMINISTRATIVE CONTRACTORS (MACs)

A/B MAC Contract Numbers

Jurisdiction F ~ HHSM-500-2011-M0004Z
Jurisdiction H ~HHSM-500-2010-M0001Z
Jurisdiction 1 ~ HHSM-500-2008-M0002Z
Jurisdiction 4 ~ HHSM-500-2007-M0001Z
Jurisdiction 5 ~ HHSM-500-2007-M0002Z
Jurisdiction 8 ~ HHSM-500-2011-M0006Z
Jurisdiction 9 ~ HHSM-500-2008-M0008Z
Jurisdiction 10~HHSM-500-2009-M0004Z
Jurisdiction 11~HHSM-500-2010-M0001Z
Jurisdiction 12~HHSM-500-2008-M0001Z
Jurisdiction 13~HHSM-500-2008-M0004Z
Jurisdiction 14~HHSM-500-2009-M0002Z
Jurisdiction 15~HHSM-500-2010-M0002Z

This Technical Direction Letter (TDL) is being issued to you as technical direction under your MAC contract and has been approved by your Contracting Officer's Representative (COR). This technical direction is not construed as a change or intent to change the scope of work under the contract and is to be acted upon only if sufficient funds are available. In this regard, your attention is directed to the clause of the General Provisions of your contract entitled Limitation of Funds, FAR 52.232-22 or Limitation of Cost, FAR 52.232-20 (as applicable). If the Contractor considers anything contained herein to be outside of the current scope of the

contract, or contrary to any of its terms or conditions, the Contractor shall immediately notify the Contracting Officer in writing as to the specific discrepancies and any proposed corrective action.

Should you require further technical clarification, you may contact your COR. Contractual questions should be directed to your CMS Contracting Officer. Please copy the COR and Contracting Officer on all electronic and/or written correspondence in relation to this technical direction letter. CORs may contact Maria Ramirez at (410) 786-1122 orMaria.Ramirez@cms.hhs.gov if they have questions regarding the content of this TDL.

If you are an FI or carrier and have any questions, please contact Michael Crochunis at (410) 786-3203.

/s/	/s/	/s/	/s/
Arrah Tabe-Bedward	Marc Hartstein	Stewart Streimer	Karen Jackson

cc:
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