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# HCFA Rulings

Department of Health  
and Human Services

Health Care Financing  
Administration

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Ruling No. 93-1

Date: May 1993

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**HCFA Rulings** are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous statutory or regulatory provisions relating to Medicare, Medicaid, Utilization and Quality Control Peer Review, and related matters.

**HCFA Rulings** are binding on all HCFA components, the Provider Reimbursement Review Board and Administrative Law Judges who hear Medicare appeals. These decisions promote consistency in interpretation of policy and adjudication of disputes.

This Ruling clarifies the position of the Health Care Financing Administration concerning the weight to be given to a treating physician's opinion in determining Medicare Part A coverage of inpatient care in a hospital or skilled nursing facility.

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## MEDICARE PROGRAM

### Hospital Insurance Benefits (Part A)

#### WEIGHT TO BE GIVEN TO A TREATING PHYSICIAN'S OPINION IN DETERMINING MEDICARE COVERAGE OF INPATIENT CARE IN A HOSPITAL OR SKILLED NURSING FACILITY

**Purpose:** This Ruling clarifies the position of the Health Care Financing Administration (HCFA) concerning the weight to be given to a treating physician's opinion in determining coverage of inpatient hospital and skilled nursing facility care. (This Ruling does not by omission or implication endorse the application of the treating physician rule to those types of services that are not discussed in this Ruling.)

**Citations:** Sections 1154, 1156, 1814(a), 1862(a)(1), 1869 and 1879(a) of the Social Security Act (42 U.S.C. 1320c-3, 1320c-5, 1395f(a), 1395y(a)(1), 1395ff and 1395pp(a)); 42 CFR §§405.706(a), 424.10, 424.13, 424.14, 483.20(a) and 483.40.

**Pertinent history:** Two 1991 decisions by the United States Court of Appeals for the Second Circuit remanded cases to the Secretary of the Department of Health and Human Services (the Department) to explain the weight the Department gives to the opinion of the treating physician when making Medicare Part A inpatient hospital coverage determinations. (State of New York o/b/o Holland v. Secretary of Health and Human Services, 927 F.2d 57 (2nd Cir. 1991); State of New York o/b/o Stein v. Secretary of Health and Human Services, 924 F.2d 431 (2nd Cir. 1991).

Under section 1814(a) of the Social Security Act (the Act), a physician's certification of the need for services is a condition for payment of those services to be made under the Medicare program. In the case of inpatient hospital or skilled nursing facility (SNF) services, the physician's certification of the medical need for the services is only the first step in determining whether those services will be covered. A patient usually is admitted to a hospital only upon the advice of the treating physician. Therefore, for inpatient hospital services to be covered under Part A, one

of the following physician certification provisions must be met:

- For inpatient services of hospitals other than psychiatric hospitals, section 1814(a)(3) of the Act and 42 CFR 424.13 provide that a physician certify that the services the patient receives must be furnished on an inpatient basis for the patient's medical treatment or that inpatient diagnostic study is medically required.
- For inpatient services of psychiatric hospitals, section 1814(a)(2)(A) of the Act and 42 CFR 424.14 provide that a physician certify that the inpatient psychiatric services the patient receives are required for diagnostic study or for treatment that could reasonably be expected to improve the patient's condition.
- For inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth, section 1814(a)(2)(D) of the Act provides that a physician certify that because of the individual's underlying medical condition and clinical status or the severity of the dental procedure, hospitalization is

required in connection with the provision of these services.

In addition, 42 CFR 424.13(f) provides that, at the option of a hospital other than a psychiatric hospital, extended stay review by its utilization review committee may take the place of the second and subsequent certifications for cases not subject to the Medicare prospective payment system and for day-outlier cases under the

prospective payment system. Under 42 CFR 424.14(e), the same recertification provision applies for psychiatric hospitals.

For SNF services, section 1814(a)(2) of the Act specifies that payment for SNF services may be made only if a physician, or nurse practitioner or clinical nurse specialist working with a physician, certifies that an individual needs daily skilled nursing care or other skilled rehabilitation services, which as a practical matter can only be provided in a SNF on an inpatient basis, for any condition for which the individual was receiving inpatient hospital services before transfer to the SNF.

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In the case of SNF services, 42 CFR 483.20(a) provides that an individual will be admitted to a SNF only if the SNF has a physician order for the individual's immediate care at the time of admission. Under 42 CFR 483.40, a physician must sign a recommendation that an individual be admitted to a SNF, and each SNF resident must remain under the care of a physician. A physician must supervise the medical care of each resident, visit each resident at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. At each visit, the physician must review the resident's total program of care, including medications and treatments. The physician must also write, sign, and date progress notes at each visit, and sign and date all orders. Under 42 CFR 483.40(c) and (e), after the initial physician visit, a physician may delegate alternate visits to a physician assistant, nurse practitioner, or clinical nurse specialist.

The general approach to coverage that underlies these certification requirements can be traced back to the Congressional committee reports that accompanied the enactment of the Medicare program in 1965. The Senate Finance Committee emphasized "that the physician is to be

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the key figure in determining utilization of health services -- and ... it is a physician who is to decide upon admission to a hospital, order tests, drugs, and treatments, and determine the length of stay." (Report of the Committee on Finance, U.S. Senate, to accompany H.R. 6675, the Social Security Amendments of 1965 (S. Rep. No. 404, Part I, 89<sup>th</sup> Cong., 1st Sess. 46 (1965)).) This reasoning is repeated in regulations at 42 CFR 424.10.

However, meeting the coverage rule requiring the physician's certification does not guarantee that the care provided will be covered. In order to be covered under Medicare Part A, the care must also be "reasonable and necessary". There has always been a statutory prohibition against payment under the Medicare program for services that "... are not reasonable and necessary for the diagnosis or treatment of illness or injury...". (See section 1862(a)(1) of the Act). Section 1869(a) of the Act makes clear that the final decision concerning entitlement to benefits is the Secretary's alone:

The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A or

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part B, and any other determination with respect to a claim for benefits under part A or a claim for benefits with respect to home health services under part B shall be made by the Secretary in accordance with regulations prescribed by him.

See also State of New York o/b/o Bodnar v. Sullivan, 903 F.2d 122, 125 (2d Cir. 1990); see also Goodman v. Sullivan, 891 F.2d 449, 450-51 (2d Cir. 1989).

The Medicare Part A fiscal intermediary or the peer review organization (PRO) acts as a medical review entity for the Secretary. (See section 1154 of the Act for a description of the functions of peer review organizations.) Historically, these entities have been given very wide discretion in deciding whether or not an inpatient hospital stay or skilled nursing stay was "reasonable and necessary" for the diagnosis or treatment of a particular patient's condition. The medical review entity is charged with acting in accordance with the Medicare law, regulations, national coverage instructions, and accepted standards of medical practice. The decisions of these entities will be the final decisions in such matters unless they are appealed under section 1869 of the Act.

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In the vast majority of cases, if the attending physician's certification of the medical need for the services is consistent with other records submitted in support of the claim for payment, the claim is paid. However, if the medical evidence is inconsistent with the physician's certification, the medical review entity considers the attending physician's certification only on a par with the other pertinent medical evidence. The review entity also considers factors such as the condition of the patient upon admission, the nature of the primary diagnosis, the existence of co-morbid conditions, or the actual course of the patient during the confinement (including treatment and progress toward recovery). This function helps insure that each practitioner complies with the basic obligations mandated by section 1156(a) of the Act:

It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act--

- 1) will be provided economically and only when, and to the extent, medically necessary;
- 2) will be of a quality which meets professionally recognized standards of health care; and

- 3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

In determining whether the health care services provided were reasonable and necessary, the medical review entity confines its review to the medical record associated with the inpatient stay, which is a discrete past event. There is no opportunity for a physical examination of the patient by the medical review entity. No judgment of the probable future course of the patient, such as whether the patient could reasonably be expected to participate in substantial gainful activity, is expected. The only questions that can be considered based on the evidence in the medical record are the reasonableness and necessity of the patient's admission to the institution and the necessity of his or her continued stay. Both are discrete past events that can only be reviewed from a documentary medical record. Although the physician must make prospective judgments about the need for initial and continuing inpatient care, the medical review entity has the benefit of hindsight in reviewing a case retrospectively. For this reason, the review criteria set forth in regulations, Rulings, and other pertinent guidelines

recognize that a physician's opinion and medical judgment should be evaluated in terms of the information available to the physician at the time.<sup>1</sup> These criteria recognize that medical judgments may not always be clear cut at any given point in time and permit reasonable leeway in questionable situations, as long as the evaluation is diligent and ongoing. Section 1879(a) of the Act provides for a limitation of liability if neither the provider nor the patient knows, or could reasonably be expected to know, that the care is not covered because it is not reasonable and necessary or constitutes custodial care.

As a result of the relationship that develops between a physician and his or her patient, the physician is in a unique position to incorporate complete medical evidence in

patient medical records, including his or her opinions and the pertinent medical history of the patient. In effect, a treating physician controls the documentation supporting his or her opinion as to appropriate treatment. In creating the medical

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<sup>1</sup> For example, HCFAR 85-2 contains detailed criteria for use in distinguishing inpatient rehabilitative care in rehabilitation hospitals as opposed to skilled nursing and other levels of care. The information used to evaluate the need for this inpatient rehabilitative care, given in HCFAR 85-2, should be reflected in the patient's medical record.

assessment, medical history, and discharge notes that become part of the medical record, the physician has ample opportunity to explain in detail why the course of treatment was appropriate in the context of that patient's acute condition and medical history. In addition, the physician has the opportunity to describe and explain aspects of the patient's medical history that may not otherwise be apparent. Thus, the physician is responsible for ensuring that the patient's record includes complete medical information, and this information is the basis for determining the appropriateness of the prescribed treatment. The final determination by the medical review entity should not be based solely on the physician's opinion, but should reflect its evaluation of all documentation contained in the medical record.

We note that the criteria governing how the medical review entity makes its determination do not discount the role of the treating physician. Frequently, the medical review

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entity's determination of whether the course of treatment was reasonable and necessary may turn on the comprehensiveness of the evidence furnished by the physician as to the condition of the patient and the medical factors that bear upon his or her treatment.

To summarize, in order to fulfill its obligations to determine whether payment should be made for Part A benefits, the medical review entity "looks behind" the information provided by the treating physician and makes an initial determination based on all the evidence available from the medical record. The information provided by the physician, including the initial certification of inpatient care, the accompanying medical history, medical assessment, discharge notes, and any subsequent certification by a hospital or a skilled nursing facility's utilization review committee, is considered evidence, but not presumptive evidence, that an admission or continued stay is reasonable and necessary. (See 42 CFR 405.706(a).) However, the medical review entity is still responsible for judiciously applying the review criteria published by the Department to the accompanying medical evidence.

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**Ruling:** It is HCFA's Ruling that no presumptive weight should be assigned to the treating physician's medical opinion in determining the medical necessity of inpatient hospital or SNF services under section 1862(a)(1) of the Act. A physician's opinion will be evaluated in the context of the evidence in the complete administrative record. Even though a physician's certification is required for payment, coverage decisions are not made based solely on this certification; they are made based on objective medical information about the patient's condition and the services received. This information is available from the claims form and, when necessary, the medical record which includes the physician's certification.

EFFECTIVE DATE

This Ruling is effective May 18, 1993

DATED: May 18, 1993

William Toby  
Acting Deputy Administrator,  
Health Care Financing Administration