

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DEPARTMENTAL APPEALS BOARD

**DECISION OF MEDICARE APPEALS COUNCIL**  
**Docket Number: M-11-1546**

**In the case of**

Apple Rehab, Inc. &  
Commissioner, Connecticut  
Dept. of Social Services  
\_\_\_\_\_  
(Appellants)

**Claim for**

Hospital Insurance Benefits  
(Part A)  
\_\_\_\_\_

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\_\_\_\_\_  
(Beneficiary)

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\_\_\_\_\_  
(HIC Number)

National Government Services  
\_\_\_\_\_  
(Contractor)

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\_\_\_\_\_  
(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated April 29, 2011, which concerned Medicare coverage for skilled nursing facility (SNF) services provided to the beneficiary from February 2, 2010, through March 3, 2010. The ALJ found that the beneficiary did not have a prior qualifying three-day hospital stay and therefore Medicare did not cover the services provided. Both the SNF provider, Apple Rehab, Inc., (hereinafter "provider"),<sup>1</sup> and the State of Connecticut Department of Social Services (hereinafter "State Medicaid Agency"), have asked the Medicare Appeals Council (Council) to review this action.<sup>2</sup> The Council enters the appellants' requests for review into the record as Exhibit (Exh.) MAC-1 and Exh. MAC-2, respectively.

The Council reviews the ALJ's decision *de novo*. 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's action to the exceptions raised by the party in the request for review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c).

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<sup>1</sup>The provider is also known as Liberty Hall Convalescent Home.

<sup>2</sup>The beneficiary is a dual Medicaid/Medicare enrollee.

As set forth below, the Council reverses the ALJ's decision and finds that the beneficiary had a qualifying three-day hospital stay, and required and received covered daily skilled nursing services during the dates at issue.

### BACKGROUND

For the dates of service at issue, Medicare initially denied coverage. Upon redetermination, the contractor found that Medicare covered the services provided from February 15, 2010, through February 26, 2010. Exh. 2 at 1-2. The contractor denied coverage for the SNF services provided from February 2, 2010, through February 14, 2010, and February 26, 2010, through March 3, 2010. *Id.* The State Medicaid Agency appealed to the Qualified Independent Contractor (QIC) requesting review of the dates for which the contractor denied coverage. On appeal, the QIC denied coverage for all dates of service, finding that the documentation provided did not support a finding that the beneficiary required or received skilled nursing services relative to his prior hospital stay. Exh. 3 at 1-5. The State Medicaid Agency next requested an ALJ hearing, which was held on April 4, 2011. Exh 8. at 1. After which, the ALJ issued a decision finding that the record did not contain evidence that the beneficiary met the three-day qualifying hospital stay requirement, and therefore, he could not make a payment determination under 1833(e) of the Social Security Act. Dec. at 12.

Both the provider and the State Medicaid Agency requested review of the ALJ's decision, each contending that the beneficiary had a qualifying three-day stay. See Exhs. MAC-1; MAC-2. The provider submits, as evidence of the three-day stay, hospital records concerning the beneficiary's December 15, 2009, through December 27, 2009, stay at \*\*\* \*\* Hospital. See *id.* The State Medicaid Agency further contends that it was under a "good faith impression" that the relevant evidence regarding the qualifying three-day hospital stay was contained in the claim file. See MAC-2. Lastly, the State Medicaid agency contends that the beneficiary's SNF stay met the criteria for Medicare coverage. *Id.*

### PROCEDURAL ISSUES

As a preliminary matter, the Council needs to address the documentation submitted with the provider's request for review, See MAC-1 at 2-11. The Council finds the hospital documentation

regarding the beneficiary's January 26, 2010, hospital stay, Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) and Notice of Non-Coverage (NONC) signed on February 1, 2010, are duplicative and already included in the record. See Exh. 6 at 1, Exh. 4 at 156-157, Exh. 1 at 41. The Council further finds, however, that the documents pertaining to the December 2009 hospital stay are new evidence.

When a party submits new evidence before the Council which was not submitted to the QIC prior to the reconsideration decision and which relates to an issue previously considered by the QIC, the Council will only consider such evidence if the party establishes good cause for submitting it for the first time at the Council level. Otherwise, the Council must exclude such evidence from the record. 42 C.F.R. § 405.1122(c). In the instant case, the new evidence submitted directly relate to the reason for which the ALJ denied coverage -- lack of a three-day qualifying hospital stay. This issue was not brought out in any of the determinations below the ALJ level. Since the ALJ based his decision on a new issue, the Council finds good cause for the submission of new evidence and admits the evidence into the record. See MAC-1 at 2-5.

### DISCUSSION

The Council first notes that there is evidence of a three-day qualifying hospital stay in the record before the ALJ, in addition to the new evidence. Specifically, the claim summary report from the Medicare contractor is conclusive evidence from the beneficiary's Medicare utilization record that the beneficiary had a qualifying hospital stay from December 15, 2009, through December 27, 2009. Exh. 7 at 16, Exh. 1 at 16. *Id.* Further, the contractor previously allowed coverage for a SNF stay based on this qualifying stay. The Council therefore concurs with the appellants' contentions that the beneficiary had a qualifying three-day stay.

The State Medicaid Agency further argues that the services met the criteria for Medicare coverage. After reviewing the entire record and auditing the hearing CD, the Council has determined that the file contains sufficient documentation to make a favorable coverage decision. For the following reasons, the Council finds that the services were medically reasonable and necessary, and thus, covered by Medicare.

Medicare regulation 42 C.F.R. 409.32(a) states that a service constitutes skilled care when the service is "so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel." A "beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis" to qualify for Medicare coverage of SNF services. 42 C.F.R. § 409.31(b). The services at issue must be furnished for a condition for which the beneficiary received inpatient hospital services or "which arose while the beneficiary was receiving care in a SNF . . . for a condition for which he received inpatient hospital services." 42 C.F.R. § 409.31(b)(2)(ii). Overall management and evaluation of the care plan constitute "skilled services" when because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. 42 C.F.R. § 409.33(a)(1).

Observation and assessment constitute "skilled services" when the skills of a technical or professional person are required to identify and evaluate the patient's needs for modification of treatment or for additional medical procedures until his or her condition is stabilized. *Id.* at § 409.33(a)(2). As the Medicare Benefit Policy Manual (MBPM) makes clear, observation and assessment satisfies this standard "when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's treatment regimen is essentially stabilized." MBPM (CMS Pub. 100-02), Ch. 8, § 30.2.3.2.

On review of the record, the Council concludes that the beneficiary required and received skilled nursing services during the relevant period. In the instant case, the beneficiary is a deaf mute with Alzheimer's dementia who had difficulty communicating. Exh. 4 at 36, 194, *see also, id.* at 3-25. The record indicates that he had diagnoses of pneumonia, shortness of breath, acute myocardial infarction, atrial flutter, and renal insufficiency. *Id.* at 36, 194; MAC-1 at 3.

The record indicates that the beneficiary was agitated and uncooperative with the staff; he refused foods, fluids and medications on numerous occasions. *Id.* at 3-25. During the dates of service, the beneficiary was on multiple cardiac and

hypertension medications. *Id.* at 36. As such, the nursing staff had to closely monitor him to determine the proper doses of his medication. *Id.* The nursing staff was instructed to administer these medications based on fluctuating blood pressure readings, and to notify the doctor if three consecutive doses of medication were refused or held. *Id.* at 36. On at least thirteen occasions the beneficiary's medications had to be adjusted due to fluctuations in his blood pressure and heart rate. *Id.* at 3-25, *reference* Hearing CD. Psychoactive medication (Trazadone) was also given on an as needed basis. *Id.* at 48.

Additionally, intake and output was also carefully monitored. The beneficiary became sufficiently dehydrated to require intravenous (IV) fluids from February 15, 2010, through February 25, 2010. This is a *per se* skilled nursing service under Medicare regulations. See 42 C.F.R. §409.33(b)(1). *Id.* at 55-60, 70-73, 76-82. The record also shows that after a non-responsive episode, that required a brief admission to the ER, he received oxygen therapy, which required close monitoring. *Id.* at 20-21.

In sum, the Council finds the record supports that there was a reasonable potential for a change in the beneficiary's condition that necessitated skilled nursing care during the relevant dates of service.

#### **DECISION**

It is the decision of the Medicare Appeals Council that the provider furnished medically necessary daily covered skilled nursing services to the beneficiary from February 2, 2010, through March 3, 2010. The ALJ's decision is reversed.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki  
Administrative Appeals Judge

/s/ Susan S. Yim  
Administrative Appeals Judge

Date: November 17, 2011