

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of

Claim for

Commissioner, CT Department
of Social Services

(Appellant)

Hospital Insurance Benefits
(Part A)

(Beneficiary)

(HIC Number)

National Government Services

(Contractor)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated February 25, 2009, which concerned Medicare coverage for skilled nursing facility (SNF) services furnished to the beneficiary from November 8, 2007, through November 15, 2007. The ALJ denied Medicare coverage for those dates of service, finding that no skilled nursing care was provided. The ALJ also determined that the beneficiary is responsible for the costs of the noncovered services, because her representative (her daughter) signed a valid advance beneficiary notice and a valid Medicare Notice of Provider Non-Coverage, on her behalf. The appellant has asked the Medicare Appeals Council to review this action.

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). The appellant's Request for Review and supporting memorandum of law will be made a part of the record as Exhibit (Exh.) MAC-1.

The appellant is a State Medicaid agency subrogated to the rights of the beneficiary in this matter. The appellant contends that the ALJ erred by failing to address the fact that during the week of November 8 to November 15, 2007, the beneficiary required and received daily observation and assessment of a changing condition, as well as intramuscular injections, a direct skilled nursing service according to 42 C.F.R. § 409.33(b)(1). See also 42 C.F.R. § 409.33(a)(2) (observation and assessment of the patient's changing condition constitutes a skilled nursing service).

DISCUSSION

Medicare covers SNF services if the beneficiary requires skilled nursing or skilled rehabilitation services on a daily basis. Such services must be ordered by a physician and must be so inherently complex that only technical personnel can perform them safely. 42 C.F.R. §§ 409.30 - 409.36.

The beneficiary in this case (age 88) was a long-term nursing home resident prior to her hospitalization from August 16 through 21, 2007, for a seizure, mental status change, and possible sepsis. Exh. 10 at 212-14. She was also evaluated and treated in the hospital for diabetes, depression, and anxiety, and evaluated by a neurologist and a cardiologist. The beneficiary's hospital physician consulted with her representative about the possible insertion of a feeding tube, given the fact that she was often not eating or taking her medications. *Id.* at 212.

Upon the beneficiary's August 21, 2007 discharge from the hospital, she began receiving daily SNF care, including physical therapy (PT) and occupational therapy (OT), as well as skilled nursing. She was discharged from PT and OT on September 23, 2007. Exh. 2 at 57, 53. However, for some period of time thereafter, it appears that she continued receiving skilled nursing services. On October 15, 2007, the SNF notified her representative that the SNF services would likely no longer be covered by Medicare, and the representative signed a SNF Determination of Continued Stay and Notice of Medicare Provider Non-Coverage forms on October 15 and 16, 2007. Exh. 3 at 157-61.

The SNF subsequently submitted a claim for the November 1 through 15, 2007 dates of service as noncovered. The contractor denied the claim initially and on redetermination because no

medical records had been forwarded in support of the claim. Exh. 4 at 173-76. The appellant requested reconsideration by the Qualified Independent Contractor (QIC) (Exh. 5), and the QIC denied coverage on the ground that it lacked medical records from the beneficiary's hospital inpatient stay. Exh. 5 at 152-56. The appellant next filed a request for an ALJ hearing. Exh. 6.

When the ALJ heard this case on February 5, 2009, appellant sought Medicare coverage for the services provided to the beneficiary from November 8, 2007, through November 15, 2007. Dec. at 2, n.1.¹ After carefully considering the record and the appellant's exceptions, the Council finds that the ALJ erred in not recognizing that skilled nursing services were furnished to the beneficiary from November 9, 2007, through November 13, 2007. The pertinent medical records state that on November 9, 2007, the treating physician ordered an antibiotic to be administered to the beneficiary via intramuscular injection daily for five days. Exh. 2 at 103, 119. The medication was administered via intramuscular injections from November 9, 2007, through November 13, 2007. Exh. 2 at 7, 99-103. Intramuscular injections constitute skilled nursing services. 42 C.F.R. § 409.33(b)(1); see also Medicare Benefit Policy Manual (MBPM), CMS Pub. 100-2, Chapter 8, Section 30.3.

In addition, the appellant correctly contends that the skilled nursing services provided on November 9, 2007, through November 13, 2007 included observation and assessment of the patient's changing condition, because the beneficiary refused foods and medications, became combative, became sufficiently dehydrated to require IV fluids, pulled out the IV in her arm and had to have it reinserted, had a seizure-like episode, and released her lap belt and fell from her wheelchair. Exh. 2 at 100-103. In addition, because she was not eating, her physician consulted with her representative about possible insertion of a feeding tube. Exh. 2 at 100-103. For the foregoing reasons, the Council finds that the SNF services provided to the beneficiary from November 9, 2007, through November 13, 2007, are covered by Medicare.

¹ Although the appellant initially requested an ALJ hearing on Medicare coverage for the beneficiary's SNF services from November 1, 2007, through November 15, 2007 (Exh. 6 at 265), at the hearing and thereafter the appellant's attorney limited the dates to November 8, 2007, through November 15, 2007. CD Recording of Hearing; Dec. at 2, n.1; Appellant's Memorandum of Law, filed with the Council on June 20, 2009.

However, contrary to the appellant's assertions, the Council finds that the record does not support a finding that the beneficiary met the level of care requirements for SNF services for November 8, 14, and 15, 2007. Specifically, the medical documentation indicates that skilled nursing care was not required after November 13, 2007 (see Exh. 2 at 117, 99-100), because at that point the beneficiary's cognitive, neurological, and behavioral status improved. See Exh. 2 at 99-100, and 65. Because she had stabilized, the beneficiary no longer required skilled observation and assessment or other skilled nursing services. See MBPM, Chapter 8, Section 30.2.3.2. The Council also finds that on November 8, 2007, the beneficiary's condition had not yet become unstable, and she did not receive skilled nursing services that day. See Exh. 2 at 103 (nursing notes). In summary, the medical records do not demonstrate that the beneficiary required or received skilled nursing services on November 8, 14, and 15, 2007.

With respect to liability for the costs of services on dates that are not covered by Medicare (November 8, 14, and 15, 2007), the Council concurs with the ALJ that the beneficiary is responsible for those noncovered costs. The beneficiary's representative read and signed both a SNF Determination of Continued Stay and a Notice of Medicare Provider Non-Coverage, informing her that Medicare probably would not pay for the SNF services after October 17, 2007. Exh. 3 at 157-61. As the ALJ pointed out, these notices meet the requirements of 42 C.F.R. § 411.404 and put the beneficiary on notice of Medicare noncoverage. Therefore, payment cannot be made or waived pursuant to section 1879 of the Act, and the beneficiary is liable for the noncovered charges.

DECISION

It is the decision of the Medicare Appeals Council that the skilled nursing care the beneficiary needed and received at the SNF from November 9, 2007, through November 13, 2007, is covered by Medicare. However, the beneficiary did not require or receive skilled nursing care at the SNF on November 8, 2007, and on November 14 and 15, 2007; those dates of service are not covered by Medicare. The beneficiary, whose representative read and signed valid notices explaining that further Medicare coverage probably would not be available, is liable for the noncovered costs from November 1 through 8, 2007, and November

14 and 15, 2007. The ALJ's decision is reversed in part and affirmed in part.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: September 14, 2009