

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of

Claim for

Commissioner, Connecticut
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 January 8, 2009, which concerned Medicare coverage for skilled nursing facility (SNF) services furnished to the beneficiary by *** Center (provider) from February 5, 2008, through March 5, 2008. The ALJ determined Medicare did not cover the services at issue and that the beneficiary was liable for the non-covered services. 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 Council has considered the record and exceptions set forth in the appellant's request for review dated February 26, 2009, and its accompanying memorandum of law dated May 4, 2009. These submissions are entered into the record as Exh. MAC-1, and Exh. MAC-2, respectively. As set forth below, the Council reverses the ALJ's decision.

BACKGROUND AND PROCEDURAL HISTORY

The medical evidence indicates the beneficiary was a 52-year-old female, suffering from disorganized type schizophrenia. She had resided at *** Center for over six years prior to the dates of service at issue. Exh. 3 at 216-17. In October 2007, the beneficiary suffered from agranulocytosis, an adverse side effect from her anti-psychotic medication, clozapine. *Id.* She was subsequently admitted to an inpatient facility and thereafter to a psychiatric specific inpatient facility prior to returning to the SNF on January 15, 2008. *Id.*

On February 1, 2008, the provider sent the beneficiary's conservator a Notice of Noncoverage and a SNF Determination on Continued Stay explaining that beginning on February 5, 2008, Medicare would no longer cover the nursing services because they were not skilled. Exh. 4; Exh. 6.

Medicare denied the claim initially and upon redetermination because the provider failed to provide sufficient documentation. Exh. 6. On appeal, the Qualified Independent Contractor (QIC) reviewed the subsequently submitted medical records, determining "[n]o daily skilled therapy services were ordered or received for the dates in review". Exh. 8. The QIC review panel found:

The beneficiary was alert with intermittent confusion and hallucinations[...] The beneficiary received occasional as needed oral medications for anxiety and restlessness. Oral intake was adequate. [...] The submitted documentation did not support any acute symptoms related to qualifying hospital stay. Nursing care was custodial.

Exh. 8 at 235. The QIC concluded the provider was liable for the cost of the noncovered services and found that the Notice of Noncoverage and the SNF Determination on Continued Stay were invalid. *Id.*

The provider requested an ALJ hearing which was held on January 5, 2008. Dec. at 2. In his decision the ALJ concluded the beneficiary neither required nor received skilled care from February 5, 2008, through March 5, 2008, because the beneficiary's medical conditions "were ongoing medical issues that required custodial care and not skilled observation". Dec. at 7.

The ALJ also addressed the question of liability by examining the validity of the Notice of Medicare Non-Coverage and the SNF Determination of Continued Stay. Finding the documents valid, he determined the provider had adequately notified the beneficiary's representative regarding the potential for noncoverage. Dec. at 7. The ALJ held the beneficiary liable for the noncovered services. *Id.*

LEGAL AUTHORITY

Medicare Part A covers "post-hospital extended care services for up to 100 days during any spell of illness." Section 1812(a)(2) of the Social Security Act (Act). "Post-hospital extended care services" are defined as those furnished to an individual after transfer from a hospital where she was an inpatient for not less than three consecutive days before discharge. Section 1861(i) of the Act. The services must be furnished for a condition for which the beneficiary received inpatient hospital services. 42 C.F.R. § 409.31(b)(2)(ii).

Section 1861(h) of the Act defines extended care services as including physical, occupational therapy or speech/language pathology services, and "nursing care provided by or under the supervision of a registered professional nurse." Medicare regulations codified at 42 C.F.R. §§ 409.30 - 409.35 set forth the criteria for Medicare coverage of post-hospital SNF care. Section 409.31(b) requires that the beneficiary need skilled nursing or skilled rehabilitation services, or both, on a daily basis. Further, section 409.33 provides specific examples of skilled nursing and rehabilitation services, including overall management and evaluation of a care plan and observation and assessment of the patient's changing condition. In applying the regulatory standards, it is necessary not only to determine whether the services are skilled, but also whether, in light of the patient's condition as a whole, services such as management and evaluation of a patient's care plan or observation and assessment are skilled services. See also, The Medicare Benefit Policy Manual (MBPM), (CMS Pub. No. 100-02), Ch. 8, § 30.

DISCUSSION

On appeal before the Council, the appellant seeks Medicare coverage for the SNF services provided to the beneficiary from February 5, 2008, through February 23, 2008¹. Exh. MAC-2 at 2.

¹ The appellant is not requesting review of the SNF services provided from February 24, 2008, through March 5, 2008. Exh. MAC-2 at 2.

The ALJ did not provide any detail in the hearing decision as to which evidence in the clinical record he relied upon to form the basis for his conclusion. After a careful review of the record, the Council finds the ALJ erred in concluding that none of the services provided during the stay at issue met the requirements for skilled care.

The appellant asserts that the "beneficiary required and received the type of skilled care necessary for Medicare coverage and payment." Exh. MAC-2 at 4. The appellant specifically argues the beneficiary "needed and received daily skilled observation and assessment, and management and evaluation of her care plan until her condition stabilized." *Id.* The applicable regulation at 42 C.F.R. § 409.33(a) discusses how management and evaluation of a care plan constitutes skilled care, "when, in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety."

The appellant points to the beneficiary's unstable mental status and the numerous medication changes as evidence of the need for and provision of skilled services. Exh. MAC 2 at 5-6. The medical records do show that the provider's staff developed, managed, and evaluated the physician ordered overall care plan on a daily basis to ensure the beneficiary's medical safety and the safety of the provider's staff and other residents. The staff did this by checking on the patient every 15 minutes per physician orders², ensuring she was not harming herself or other residents³, and deciding when to update her treating physician or the MedOptions clinician as to significant physical and behavioral changes. See Nursing Notes at Exh. 4.

During the dates of service at issue the beneficiary received four Behavioral Health Follow-Up examinations by MedOptions clinicians. Exh. 3 at 186-89. On February 8, 2008, three days after the skilled care supposedly halted, the MedOptions clinician noted that the beneficiary was more confused than on the prior occasions, aggressive when delusional, and "not really improved ... the Abilify trial was not long enough[,] psychiatrist exam recommended." Exh. 3 at 186. Two days later, on February

² Per the physician order sheet, 15 minute checks instituted upon readmission and reinstated on February 11, 2008. Exh. 3 at 192, 198.

³ For a short time, the beneficiary exhibited sexually inappropriate behavior manifesting itself once by her getting into bed with a male resident. Exh. 3 at 188.

11, 2008, the MedOptions clinician visited the patient again to address recent sexually inappropriate behavior. *Id.* at 188. At that time, the clinician started the patient on Abilify and ordered the staff to continue to monitor her mood and behavior. *Id.* The clinician returned two days later to address issues of confusion and abnormal speech. The clinician's notes explain the beneficiary "has not returned to baseline since the Clozapine was discontinued," also noting she "ne[v]er really had an adequate trial of Abilify and decompensated prior to the appropriate/therapeutic dose was reached." *Id.* at 187. The Council finds the frequency and intensity of these documented visits, combined with monitoring and evaluation by the provider's staff in the interim, provides sufficient evidence to show that the management and evaluation of the beneficiary's care plan required and constituted skilled care.

The appellant has also offered support from the record that the Minimum Data Set (MDS) completed by the provider's staff on February 13, 2008, provides further evidence of the frequency and high level of care provided to the beneficiary. Exh. MAC-2 at 5; Exh. 3 at 208. The appellant contends the MDS shows the beneficiary's condition was medically complex and that she was neither psychologically nor medically stable. Exh. MAC-2 at 5-6. The Council agrees with the appellant that the MDS is consistent with the facility's records, in that it records the beneficiary's unstable condition and her need for skilled care.

In its brief, the appellant also chronicles the beneficiary's mental instability and resulting medication changes, arguing that these events taken as a whole, amount to skilled observation and assessment. Exh. MAC-2 at 6-9. The Policy Manual addresses when staff observation and assessment qualifies as skilled care. This occurs, "when the likelihood of change in a patient's condition require[s] skilled nursing [...] to identify and evaluate the patient's need for possible modification of treatment [...], until the patient's treatment regimen is essentially stabilized." The Council agrees with the appellant and finds that for the time period at issue, the *** staff provided the type of services anticipated by Chapter 8, Section 30 of the MBPM by monitoring the beneficiary's physical and mental condition to determine a safe and effective prescription regimen. This included updating the treating physician regularly and resulted in seven medication changes over the course of the sub-period. Exh. 3 at 198. In addition, each of the four behavioral health evaluations discussed above also indicated that the beneficiary's prescriptions required

monitoring. Exh. 3 at 186-189. The Council finds these services were necessary to return the beneficiary to a stable condition⁴.

Finally, as the appellant has not raised any exception to the finding of liability, the Council will adopt the liability determination of the ALJ, finding the Beneficiary liable for the time period not on appeal, without further discussion.

DECISION

It is the decision of the Medicare Appeals Council that Medicare will cover the services provided to the beneficiary from February 5, 2008, until February 23, 2008. The ALJ's determination will remain in effect regarding services from February 24, 2008, to March 5, 2008. The beneficiary remains liable for the noncovered services for that time period.

MEDICARE APPEALS COUNCIL

/s/ M. Susan Wiley
Administrative Appeals Judge

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: July 28, 2009

⁴ The Council agrees with the Appellant that the beneficiary reached a stable condition beginning on February 25, 2008. The nursing notes begin to decline in number starting at that time, and the bed alarm order that had been in effect was revoked as well. Exh. 9 at 359-361; Exh. 3 at 200.