

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-1869

In the case of

Claim for

Commissioner, Connecticut
Department of Social Services

(Appellant)

Hospital Insurance Benefits
(Part A)

(Beneficiary)

(HIC Number)

NHIC, Corp.

(Contractor)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated April 21, 2011, which concerned home health services provided to the beneficiary on the dates of service from October 3, 2007 through March 28, 2008, and from May 28, 2008 through September 24, 2008. The ALJ denied coverage for the services under section 1862(a)(1) of the Social Security Act (Act), finding that the nursing services did not require the services of skilled nursing personnel.¹ The ALJ held the provider liable for the non-covered services prior to June 20, 2008, and the beneficiary liable for the non-covered services provided on and after June 20, 2008. The appellant, a state Medicaid agency with appeal rights under the provisions of 42 C.F.R. § 405.908, through its appointed representative, has asked the Medicare Appeals Council (Council) (We) to review the ALJ's 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

¹ NHIC allowed coverage for the home health services provided between May 28, 2008 and June 20, 2008. This determination remained in effect through the ALJ proceedings. Therefore, the dates of service in dispute before the ALJ, and now in dispute before the Council, are October 3, 2007 to March 24, 2008 and the dates of service after June 20, 2008, through September 24, 2008.

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 brief in support of the request are entered into the record as Exhibit (Exh.) MAC-1.

The Council finds that the beneficiary received medically reasonable and necessary skilled nursing services during the dates of service in dispute. The Council reverses the ALJ's decision.

BACKGROUND

New England Home Care provided home health services (nursing visits) to the beneficiary, who has diabetes and is legally blind. This case began with a claim for services furnished from August 6, 2007 to March 28, 2008 and May 28, 2008 to September 24, 2008. The services furnished before October 1, 2007 were considered to be part of the Third Party Liability (TPL) demonstration project and therefore outside the Medicare claims appeals process.² On redetermination, the contractor informed the appellant, Commissioner, Connecticut Department of Social Services, that the services provided before October 1, 2007 were not included in its review. Exh. 3 at 1. The Qualified Independent Contractor (QIC) dismissed the appellant's request for reconsideration as to the dates of service before October 1, 2007. Exh. 4 at 1-2.

The contractor issued a partially favorable decision on the remaining dates of service, and allowed coverage for the home health nursing visits provided from May 28, 2008 to June 20, 2008 as medically reasonable and necessary "for multiple adjustments of the new Humalog insulin and for discontinuing all of the oral hypoglycemic medications." Exh. 3 at 2. The contractor concluded that the Home Health Advanced Beneficiary Notice (HHABN), signed June 20, 2008, was valid and, therefore,

² Under the TPL demonstration project, the Centers for Medicare and Medicaid Services (CMS) and the State of Connecticut agreed to use a sampling approach to determine Medicare's share of the cost of home health service claims for dual eligible beneficiaries that were originally submitted to and paid for by the state's Medicaid agency for fiscal years 2001 through 2007. See CMS Active Project Report, Demonstration of Home Health Agencies Settlement for Dual Eligibles for the State of Connecticut, Project Number 95-W-00086/02. The Active Projects Report is available online at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ActiveProjectReports/index.html?redirect=/ActiveProjectReports>.

found the beneficiary liable for the non-covered services provided after that date, and held the provider liable for the non-covered services that predated the HHABN. *Id.* The QIC upheld the contractor's partially favorable decision, because "no skilled services [were] provided nor were [*sic*] there documentation submitted supporting the medical necessity of these services." Exh. 4 at 3. However, the QIC found the HHABN invalid because it did not identify the beneficiary's health insurance claim number and, therefore, held the provider liable for all of the non-covered services. *Id.* at 3 (reverse side).

The ALJ upheld the QIC's decision on coverage for all dates of service remaining in dispute, leaving in effect the earlier allowance of coverage for the dates of service May 28, 2008 to June 20, 2008. The ALJ concluded that "the record in this case fails to establish the beneficiary's condition necessitated skilled nursing services during the dates of service at issue." *Id.* at 5. The ALJ also found that "skilled nursing was not reasonable and necessary for case management." *Id.* at 6. On the liability issue, the ALJ found the HHABN valid, concluding that the beneficiary was notified that Medicare would not cover the services furnished from June 20, 2008, forward. The ALJ held the provider financially liable for the non-covered services provided before June 20, 2008, and the beneficiary liable for the denied charges for the services furnished on and after that date. *Id.*

AUTHORITIES

To qualify for Medicare coverage of home health services, a beneficiary must be confined to her home and need skilled nursing care on an intermittent basis or physical or speech therapy services or have a continuing need for occupational therapy. See 42 C.F.R. § 409.42; see also Medicare Benefit Policy Manual (MBPM), IOM CMS Pub. 100-02, Ch. 7, § 30. For nursing services to be covered, the services must require the skills of a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse. Conversely, if a service can be safely and effectively performed (or self-administered) by a non-medical person, without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service. A service is not considered a skilled nursing service merely because it is performed by a nurse. See 42 C.F.R. § 409.44(b); MBPM, Ch. 7, § 40.1.

Skilled nursing care must be reasonable and necessary for the treatment of the illness or injury. 42 C.F.R. § 409.44(b)(3). To be considered as such, the services must be consistent with the nature and severity of the beneficiary's illness or injury, his or her particular medical needs, and accepted standards of medical and nursing practice. They must also be reasonable within the context of the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time. 42 C.F.R. §§ 409.44(b)(3)(i)-(iv). The MBPM provides guidance using language similar to that in the regulations:

The skilled nursing service must be reasonable and necessary to the diagnosis and treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the patient's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, and accepted standards of medical and nursing practice. A patient's overall medical condition is a valid factor in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled.

MBPM, Ch. 7, § 40.1.1. The MBPM goes on to state:

The determination of whether a patient needs skilled nursing care should be based solely upon the patient's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time. In addition, skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable.

Id.

The regulations governing home health care services in 42 C.F.R. Part 409, Subpart E, refer to the regulations in Subpart D, which address the requirements for coverage of post-hospital skilled nursing facility care. The regulations within Subpart D include the criteria for determining whether a service is

skilled and examples of the types of services that are considered skilled. See 42 C.F.R. §§ 409.42(c), 409.44(b), 409.32, 409.33.

The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. 42 C.F.R. § 409.32(c). Overall management and evaluation of a care plan may constitute skilled nursing services when, because of a 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). Also, observation and assessment may constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment or for additional medical procedures until his or condition is stabilized. 42 C.F.R. § 409.33(a)(2); see also *id.* § 409.33(b) (providing examples of services that qualify as skilled nursing services) and MBPM, Ch. 7, § 40.1.2.1.

Skilled services may also include teaching and training activities. The test of whether teaching and training activities are skilled relates to the skill required to teach and not to the nature of what is being taught. MBPM, Ch. 7, § 40.1.2.3. Teaching and training activities are reasonable and necessary where they are appropriate to the patient's functional loss, illness, or injury. See *id.*

DISCUSSION

The dates of service remaining in dispute before the Council are October 3, 2007 through March 28, 2008, and the dates after June 20, 2008 through September 24, 2008. Having considered the evidentiary record and the decisional history of this case, the Council concludes that the services furnished during these dates of service were medically reasonable and necessary skilled nursing services and, accordingly, are covered by Medicare. The Council therefore reverses the ALJ's decision.

The rationale given for denying coverage at the redetermination, reconsideration and ALJ levels of review were consistent and similar. First, the reviewers found that the services were not skilled in nature because the nurses performed general

assessments, and provided repetitive teaching of diabetes management, pre-filled insulin syringes, and pre-poured medication. Second, they agreed that the records did not demonstrate significant changes in clinical status, condition, medication, or treatment plan to support ongoing home health skilled nursing services. See Exh. 3 at 2 (redetermination); Exh. 4 at 3 (reconsideration). The ALJ, too, upheld the denial on similar grounds, noting that the beneficiary's condition was "generally" at "baseline" and the record did not document "exacerbations of the beneficiary's conditions which would require skilled nursing services." Dec. at 5-6. Nor did the record indicate that the beneficiary "suffered from significant complications or acute episodes necessitating continued, skilled observation during the period at issue." *Id.* at 6.

The services provided during the home health visits did include checking the beneficiary's blood sugar levels, cardiovascular status, and vital signs, and pre-filling of medications - which the prior reviewers determined did not require skilled nurses to perform. See, e.g., Dec. at 3 (findings of fact). However, in the Council's view, the ALJ's decision emphasized the nature of some of the services themselves, which the ALJ and the contractors determined did not require skilled personnel, without adequate consideration of the context of the beneficiary's medical status. Moreover, that the beneficiary has a chronic medical condition, the principal diagnosis being diabetes, which the ALJ summarily stated was stable or at baseline (or without significant complications, acute changes), does not rule out consideration for coverage of the home health services as reasonable and necessary skilled nursing services. And, having fully considered the evidence, the Council does not agree with the ALJ that the beneficiary's medical status appeared stable, without significant complications or changes. We conclude that the weight of the medical evidence indicates otherwise. The beneficiary was provided skilled nursing visits necessary for the observation and assessment of a changing medical condition, as well as overall management of the beneficiary's care.

The 72-year-old beneficiary's principal diagnosis is diabetes. Her medical conditions also include hypertension, hypercholesterolemia, and legal blindness. See, e.g., Exh. 1 at 4. As the appellant acknowledges in its brief, the beneficiary tested blood sugar levels on her own. Exh. MAC-1 at 5. However, the records dated within the first of the two periods at issue (October 3, 2007 to March 24, 2008) include numerous indications of fluctuating blood sugar levels which the nurses

monitored and assessed. On multiple occasions during this period, the nurses had the beneficiary see her doctor with her blood sugar logs or sent logs evidencing fluctuating blood sugar levels to the beneficiary's endocrinologist. As a result of these actions taken by the nurses, the beneficiary's insulin dosage was adjusted numerous times during this period. See, e.g., Exh. 1 at 8, 9 (November 2007, two increases in dosage of Lantus, subcutaneous solution), 16 (another increase in dosage, December 2007). In fact, once in late November 2007, the beneficiary went to the emergency room with hyperglycemia, indicating that the beneficiary's medical condition was not stable and did present complications. *Id.* at 15.

Moreover, the records dated within this period include numerous documented instances of changes in the beneficiary's medication schedule, as well as problems related to compliance with taking diabetic medications (to include Starlix) as directed, and reports of difficulty using a talking glucometer, all for which the nurses provided ongoing monitoring, assessment, and instructions to take the medications as directed. See, e.g., *id.* at 9, 10, 21, 25, 59, 67, 75, 232. The instructions the nurses provided to the beneficiary were appropriate for the beneficiary's medical condition, in particular, for the management of diabetes. See MBPM, Ch. 7, § 40.1.2.3.

As for the second period remaining in dispute (dates after June 20, 2008, through September 24, 2008), the nurses continued to observe, assess, and manage the beneficiary's medical condition, particularly for compliance with new diabetic medication (Humalog insulin) in light of her history of medication compliance issues and fluctuating blood sugar levels. See Exh. 1 at 36, 37; and 412 (noting that the beneficiary "finds odd reasons to block what the doctors would like to do") and 446 (noting that the beneficiary is "forgetful" and defensive about compliance with regimen). See also generally *id.* at 108-110, 387-447. The nurses' visit notes for this period also indicate that the nurses assessed the beneficiary's reports of changes in her urine. The nurses contacted the beneficiary's doctor to obtain permission to take a urine sample for analysis. The beneficiary was given Cipro for a urinary tract infection, and the nurses thereafter continued to monitor her for compliance with medication for this infection. See *id.* at 417, 421, 425.

Based on the foregoing, the Council concludes that the beneficiary was provided medically reasonable and necessary home health skilled nursing services. Inasmuch as the Council has

reversed the ALJ's denial of coverage for all dates remaining in dispute, the Council need not address the issues related to the liability question, including the prior findings as to validity of the HHABN furnished to the beneficiary.

DECISION

The Council reverses the ALJ's decision in accordance with the foregoing discussion.

Medicare coverage is available for the home health skilled nursing services furnished to the beneficiary from October 3, 2007 to March 28, 2008 and the dates of service after June 20, 2008 through September 24, 2008.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

/s/ Constance B. Tobias, Chair
Departmental Appeals Board

Date: August 23, 2013