

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-1771

In the case of

Claim for

Village at Cook Springs
(Appellant)

Hospital Insurance Benefits
(Part A); Supplementary
Medical Insurance Benefits
(Part B of A)

(Beneficiaries)

(HIC Numbers)

Cahaba Government
Benefit Administrators
(Contractor)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision, partially favorable to the appellant, dated June 14, 2010. The ALJ's decision concerned the appellant's claims for Medicare coverage of skilled nursing facility (SNF) and outpatient therapy services provided to seven beneficiaries between September 1 and December 31, 2008. The ALJ found that the services provided to three beneficiaries satisfied the applicable Medicare coverage criteria. See Dec. at 8-9 and 22-25. In beneficiary-specific submissions, the appellant has asked the Medicare Appeals Council to review the ALJ's analysis pertaining to three of the remaining four beneficiaries for whom the ALJ found the appellant's documentation had not satisfied Medicare coverage criteria and that the appellant was liable for the resulting non-covered costs. The Council enters the appellant's requests for review into the record as Exhibit (Exh.) MAC-1 (Beneficiary E.K.), Exhibit MAC-2 (Beneficiary E.M) and Exhibit MAC-3 (Beneficiary J.S.).

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).

Following consideration of the beneficiaries' records and the appellant's exceptions, the Council modifies the ALJ's decision to clarify that since **both** the rehabilitative therapy and the nursing services provided to Beneficiaries E.M. and J.S. failed to satisfy the applicable Medicare coverage criteria, no Medicare reimbursement is available for the appellant's claims associated with those beneficiaries.

APPLICABLE LEGAL AUTHORITIES

Coverage for Skilled Nursing Facility Services

The regulatory provisions codified at 42 C.F.R. §§ 409.30 through 409.36 are applicable in determining Medicare coverage of skilled nursing facility (SNF) services, including physical therapy (PT), speech therapy (ST), and occupational therapy (OT). CMS has summarized the conditions for Medicare coverage of SNF services in the Medicare Benefit Policy Manual (MBPM) (IOM Pub. 100-2). The MBPM provides that SNF services are covered under the following circumstances:

- The patient requires skilled nursing services or skilled rehabilitation services; i.e. services that must be performed by or under the supervision of professional or technical personnel
- The patient requires such services on a daily basis;
- As a practical matter, the daily skilled services can be provided only on an inpatient basis in a SNF; and
- The services must be reasonable and necessary for the treatment of a patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs The services must also be reasonable in terms of duration and quantity.

If any one of these four factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, is not covered. For example, payment for a SNF level of care could not be made if a patient needs an intermittent rather than daily skilled service.

MBPM, ch. 8, § 30.

The RUG-III Classification System

In 1998, Medicare began paying for SNF services under a "Prospective Payment System" (PPS). Medicare Program Integrity Manual (MPIM) (IOM Pub. 100-08), ch. 6, § 6.1. The SNF PPS is based on academic studies on case-adjusted payment mixes that linked the amount of payment to the intensity of resources used. 63 Fed. Reg. 26252, 26253-55 (May 12, 1998). PPS covered SNF services include post-hospital SNF services for which benefits are provided under Medicare Part A and all items and services for a SNF inpatient (other than certain services excluded by statute) for which, prior to July 1, 1998, payment had been made under Medicare Part B. The SNF PPS per diem rates use a resident classification system to account for relative resource utilization of different patient types. For this purpose, SNF PPS uses Version III of the Resource Utilization Group (RUG-III) classification system to determine a SNF's per diem rate for all or part of a SNF stay.

The SNF PPS payments are determined based upon a patient's condition and classification in a RUG-III code. *Id.*; see also CMS Resident Assessment Instrument Manual Version 2.0 (RAIM) ch. 6, § 6.2.¹ The RUG-III category classification is based upon a resident assessment conducted using the Minimum Data Set (MDS) 2.0. *Id.* MDS 2.0 is a clinical assessment tool reflecting beneficiary diagnoses, ability to perform activities of daily living (ADLs), and treatments received. *Id.* The RUG-III classification system is based on a hierarchy of major patient types, organized into major categories, including extensive services, special care, and clinically complex. Each category is further differentiated, resulting in specific patient groups used for payment. These groups are assigned using MDS 2.0 resident assessment data. The 3-digit RUG-III code and the 2-digit assessment indicator make up the Health Insurance Prospective Payment System (HIPPS) code that appears on the

¹ The RAIM is found through the link for MDS 2.0 on the CMS website at <http://www.cms.hhs.gov/NursingHomeQualityInits/>.

bill, and is used to determine the SNF PPS payment rate. See 4
MPIM, ch. 6, § 6.2.

Assessment Requirements

Following section 1888(e)(6) of the Social Security Act (Act), regarding the PPS, SNFs must provide resident assessment data necessary to develop and implement the payment rates. Resident assessments must be completed according to a prescribed schedule – *i.e.*, on or by the fifth (5-day assessment using the indicator "01"), fourteenth (assessment indicators "07," "17" or "79"), thirtieth (assessment indicators "02" or "29"), sixtieth (assessment indicators "03" or "39"), and ninetieth (assessment indicators "04," "49" or "54") days after admission.

Under the SNF PPS, the amount of payment due for a continued SNF stay in a given period is prospectively determined by the resources required to care for a patient in a previous "look back" or "assessment period," *so long as the SNF stay remains medically necessary*, even if less resources are required to care for the patient during that given period. See generally 63 Fed. Reg. 26252 (May 12, 1998). Any assessment performed after the initial five-day assessment could result in a RUG classification change. The level of services delivered during that assessment period determines the amount of payment due for the next thirty days, unless a new assessment is performed.

The initial presumption of coverage that arises from the beneficiary's first assessment, the 5-day assessment, encompasses only the period from admission through the assessment reference date for the initial 5-day assessment. See 64 Fed. Reg. 41666 (July 30, 1999); see also 42 C.F.R. § 409.30. The rebuttable presumption of coverage based on the 5-day assessment is not intended to create an opportunity for continued payment beyond the point where the services are no longer medically necessary and reasonable. See 64 Fed. Reg. 41666-41668. Thus, whenever a beneficiary is provided with care that does not meet the requirements for Medicare coverage set forth in 42 C.F.R. §§ 409.31 through 409.35, the custodial care exclusion in § 1862(a)(9) of the Act, "takes precedence over other provisions of the program—including any initial presumption made with regard to coverage." 64 Fed. Reg. 41668.

If the contractor determines that all rehabilitation services are no longer reasonable and necessary, or the documentation does not support that any further rehabilitation services were being provided, at some point during the covered days associated

with that MDS, but that other medically necessary skilled services were being provided, the contractor shall determine whether there is a clinical group for which the beneficiary qualifies, and pay the claim according to the correct RUG value, for all covered days from the date that the rehabilitation services are determined to be not reasonable and necessary or not provided. See Medicare Program Integrity Manual (MPIM) (IOM Pub. 100-08), ch. 6, § 6.1.3.

Pursuant to section 1833(e) of the Act, an appellant bears the responsibility for documenting the medical necessity of its claim for coverage. See also 42 C.F.R. § 424.5(a)(6).

BACKGROUND

Pertinent to the three beneficiaries in issue, the appellant submitted claims for Medicare coverage for the various therapy services provided to them in a skilled nursing setting. The Medicare contractor initially denied coverage for the claims as billed, but, for Beneficiaries E.M. and J.S., allowed reimbursement at rates appropriate to down-coded RUG-III levels for otherwise covered SNF stays. The claim for Beneficiary E.K., who was a long-term care resident of the appellant nursing facility and was receiving rehabilitative PT and OT services under Medicare Part B, was denied coverage for the PT services. Upon redetermination, the Medicare contractor upheld its initial denial (E.K.) and downcodings (E.M. and J.S.). The appellant requested reconsiderations by a Qualified Independent Contractor (QIC). As explained in more detail below, the QIC found the claims could not be covered as billed and affirmed the denial and downcodings. Pursuant to the appellant's request, the ALJ conducted a hearing on June 10, 2010, at which the appellant's representative (Facility Executive Director) presented his case. The decision now before the Council followed. To the extent that the ALJ found that certain services were not covered by Medicare, the ALJ held the appellant liable for the resulting non-covered costs pursuant to section 1879 of the Act. See Dec. at 6.

ANALYSIS

Preliminary Evidentiary Issue

Pertinent to the cases now before the Counsel, the ALJ excluded from evidence documentation submitted by the appellant, for the first time, after the Qualified Independent Contractor's (QIC's) reconsiderations. The ALJ uniformly ruled that the -

Appellant has not provided good cause for the admission of the documentation contained in Exhibit 3 of this beneficiary file, most of which is duplicative of documentation found in Exhibits 1 and 2. Consequently, Exhibit 3 is excluded from evidence pursuant to 42 C.F.R. §§ 405.966, 405.1018 and 405.1028.

Dec. at 10, 13 and 18.

As noted above, the appellant has submitted beneficiary-specific requests for review. However, each request for review is accompanied by additional medical documentation. Similar to proceedings before an ALJ, pursuant to 42 C.F.R. §§ 405.1122(c)(1) and 405.1122(c)(2), if a party submits new evidence to the Council with its request for review, the Council must determine if good cause exists for the submission of that evidence, for the first time, to the Council.

In its requests for review, the appellant neither offered an explanation for the submission of the additional medical documentation with its requests for review, nor did it identify those submissions as "new" documentation, documentation already in the record, or documentation previously excluded by the ALJ. Consequently, each of the following beneficiary-specific coverage analyses contains a ruling on the admissibility of the appellant's accompanying documentary submissions.

Beneficiary-Specific Claims

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Beneficiary E.K.

Issue: Outpatient PT (Part B of A)

Dates of Service: September 4-30, 2008

Evidentiary Ruling

The ALJ's analysis included a ruling excluding evidence pertinent to the claim involving Beneficiary E.K. See Dec. at 10. However, the Exhibit List in Beneficiary E.K.'s case folder, at the mark for "Exhibit 3," indicates that there was no post-QIC reconsideration documentation submitted for Beneficiary E.K. Additionally, there are no physical documents under the "Exhibit 3" cover in the beneficiary's record.² Consequently, the documentation submitted with the appellant's request for review is not an attempt to submit previously excluded evidence. Moreover, the documentation submitted with the appellant's request for review of this beneficiary is duplicative of material already in this beneficiary's record. Accordingly, the appellant's documentary submission to the Council accompanying its request for review associated with Beneficiary E.K. is not new evidence and will be retained in the record.

Coverage

The beneficiary, who was a long-term care patient at the appellant facility, received PT services during the dates of service at issue.³ The beneficiary's medical history included a primary diagnosis of hemiparesis and was otherwise significant for cerebral vascular accident, dementia, depression, seizure disorder, and esophageal reflux. Dec. at 13.

The QIC issued an unfavorable reconsideration finding that the treatment in issue did not require the skills of a physical therapist nor was it reasonable and necessary, particularly when the beneficiary had been receiving ongoing occupational therapy services. The QIC noted that the record did not contain documentation of the "beneficiary's prior functional status," and that the beneficiary had retained deficits from an earlier stroke which affected her left side such that a decline in the functional status of her left arm could not, as the appellant contended, be attributed to a left arm sprain. The QIC found

² Unless otherwise indicated the Council's references to "Exhibits" are to those in beneficiary-specific claim files.

³ The beneficiary also received OT services, which were found covered by the contractor and are not at issue before the Council.

that the appellant's documentation, which consisted of an evaluation, two progress notes, and daily treatment encounter notes, did not support the necessity of skilled PT services. The QIC also held the appellant liable for the non-covered costs under section 1879 of the Act. Exh. 1 at 2-7.

The ALJ denied coverage finding that the beneficiary's "prior level of function is not identified" and the current "level of function indicates no change from the baseline." Based on testimony and the limited documentation available, the ALJ found that the beneficiary began the period of service requiring "minimum assistance in most activities" and remained at that level throughout. The ALJ noted that, at the hearing, the appellant's representative had conceded that "essential documentation is not contained in the . . . record." Characterizing the services provided to the beneficiary as "repetitious in nature and not requiring the skills of a licensed therapist," the ALJ denied coverage for the PT services provided to this beneficiary. Dec. at 13-14.

In its request for review, the appellant asserts that the record does, in fact, document that the beneficiary sustained a fall in the facility on September 2, 2008, resulting in a "left upper extremity sprain," and that it can be assumed that "prior to this fall she did not have a left upper extremity sprain." The appellant maintains that this event constituted a "new physical decline which warranted Physical Therapy . . . intervention in order to ensure continued safety and independence." Exh. MAC-1 at 1. The appellant contends that, contrary to the ALJ's findings, the beneficiary demonstrated "slow but steady progress" reflecting gains in "safety, balance and overall functional mobility." The appellant asserts that the documentation of record, present throughout all levels of review, demonstrates the clear need for the skills of a physical therapist to provide the beneficiary with "rehabilitation services to promote safety and maximize functional independence in . . . [the beneficiary's] environment." Exh. MAC-1 at 1-2.

The appellant's arguments for coverage are not supported by the evidence of record. As noted throughout the earlier stages of the claims review process, the appellant's documentation lacks the level of detail necessary to support a claim for Medicare coverage of PT services. The documentation for Beneficiary E.K. reveals that the beneficiary made, at most, minimal progress during the period of services in issue. Moreover, as both the QIC and the ALJ noted, without documentation of the beneficiary's prior level of function there is no basis for

finding that the beneficiary had endured a significant decline⁹ in functional status. While the beneficiary's weekly progress summaries do contain notations of "Baseline/Previous" function, there is no basis of origination of these markers. The Council understands the context of the appellant's comment that "[w]e can assume that prior to this fall . . . [the beneficiary] did not have a left upper extremity sprain." However, without more precise documentation it is not possible to determine what short-term incapacity may have resulted from the sprain versus long-term incapacity from the stroke. As noted above, pursuant to section 1833(e) of the Act and the implementing regulation at 42 C.F.R. § 424.5(a)(6), an appellant bears the responsibility for documenting the medical necessity of its claim for coverage.

As described above, the regulations governing skilled therapy services provide generally that, to be covered by Medicare, a skilled service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. As the ALJ noted the progress recorded in the beneficiary's weekly progress summaries is generally minimal, and does not, in the Council's view, document significant improvement. *Compare* Exh. 1 at 51, 54, 60 and 63. For example, up to at least the September 18, 2008, weekly summary, the beneficiary was too unstable to participate in gait training. A comparison of the weekly progress summaries for September 11, 2008, and October 2, 2008, demonstrates very little measurable progress. Similarly, the beneficiary's therapy progress notes also do not evidence meaningful progress. *Id.* at 55, 57, 61 and 67

Accordingly, we conclude that the ALJ did not err in finding that the physical therapy provided to Beneficiary E.K. was not reasonable and necessary and, accordingly, not covered by Medicare.

Beneficiary E.M.

Issues: SNF Coverage (Part A)

Dates of Service: December 1-31, 2008

New Evidence

The ALJ's analysis contained a ruling excluding evidence pertinent to the claim involving Beneficiary E.M. Dec. at 18. The excluded evidence is contained at Exhibit 3 of Beneficiary E.M.'s case folder. The appellant has submitted additional medical documentation with its request for review. However, the

appellant neither offered an explanation for the submission of 10 additional medical documentation with its request for review, nor did it identify this submission as "new" documentation, documentation already in the record or documentation excluded by the ALJ. *See, generally, Exh. MAC-2.*

Pursuant to 42 C.F.R. §§ 405.1122(c)(1) and (2), if a party submits new evidence to the Council with its request for review, the Council must determine if good cause exists for the submission of that evidence at that point in the claim appeals process. Absent a showing of good cause for the submission, the Council excludes from evidence the documentary submissions accompanying the appellant's request for review of the claim associated with Beneficiary E.M.⁴ However, in the interest of completeness, the excluded documentation will be retained in the record with Exhibit MAC-2.

Coverage

The beneficiary's medical history was significant for a total right knee replacement (November 3, 2008), after which she was admitted to an inpatient rehabilitation facility (IRF) from November 6-21, 2008. While in the IRF, the beneficiary was diagnosed with dysphagia, and was treated for atrial fibrillation, anxiety/depression, hypertension and anemia. Upon discharge from the IRF, the beneficiary's muscle strength was rated at 4+/5 and she was able to ambulate 200 feet with a rolling walker and minimal assistance. Dec. at 18.

Upon reconsideration, the QIC upheld the Medicare contractor's earlier downcoding of the services provided to the beneficiary. The QIC found that the PT grid notes showed the beneficiary to be at baseline status with restorative services not required. The beneficiary remained at a constant OT level throughout the period of service and the ST evaluation did not find any problems/difficulties with swallowing. Generally, the QIC found the beneficiary to be at a reasonable level of modified independence given her age and medical history. Specifically, the QIC concluded that "Medicare coverage criteria were not met for the RUG III levels originally billed. The previously downcoded RUG III levels of RHB 11, RMB07 and PAI02 must be affirmed." Exh. 1 at 2-5. The QIC held the appellant liable

⁴ Here, as well as in the case of Beneficiary J.S., in making this ruling the Council is excluding duplicative medical records, but will consider the earlier copies of such documents already entered into the record. *See, generally, Exh. 2* in claim folders for Beneficiaries E.M. and J.S.

for the resulting non-covered costs pursuant to section 1879 of¹¹ the Act. *Id.* at 6.

Generally, the ALJ concluded that the appellant had not demonstrated "by a preponderance of the evidence" that the various therapy services at issue were medically reasonable and necessary. Relative to PT, the ALJ found that, on December 18, 2008, the beneficiary was put on a functional maintenance program; her "PT Grids" showed limited progress in gait and ambulation and she met her bed mobility goals "almost immediately." Further, the beneficiary required encouragement for PT activities. Based on the evidence, the ALJ reasoned that the beneficiary had plateaued prior to the period of service in issue and that the PT in question was geared toward increasing the beneficiary's strength and endurance which could have been provided in a restorative nursing setting. Dec. at 18-19.

Similarly, in the context of OT, the ALJ found that the beneficiary made "no significant progress," had plateaued prior to the period of service and could have received OT services in a restorative nursing setting. Dec. at 19.

Regarding ST the ALJ noted that beneficiary was given a BS (barium swallow) with no noted results and that the beneficiary reported no difficulty swallowing. The beneficiary was examined and otherwise found to have oral motor strength and coordination within normal limits as well as appropriate bolus manipulation and mastication skills. The beneficiary was discharged from ST on December 12, 2008. The ALJ found that a skilled level of ST was not necessary as the beneficiary had "very mild" laryngeal weakness and, while at times requiring two swallows, was otherwise able to consume a diet of regular consistency with no coughing or throat clearing. Dec. at 19.

The ALJ then concluded that absent a demonstrated need for skilled therapy services, the appellant must prove that the beneficiary required and received daily skilled nursing services. The ALJ concluded that the nursing services provided to the beneficiary were no more than custodial. The ALJ then concluded that because the rehabilitative therapy services were not medically reasonable and necessary, Medicare was required to "remove" the therapy services from consideration in calculating the appropriate RUG III categories. Consequently, the ALJ found that the Medicare contractor had properly downcoded the level of available reimbursement for this claim. Dec. at 20-21.

In general, in its request for review the appellant argues that¹² the beneficiary's post-hospitalization decline in her functional abilities necessitated skilled intervention. The appellant insists that the beneficiary made excellent progress throughout her therapeutic regimen and was ultimately able to return home at her highest functional potential. Consequently, the appellant requests that the beneficiary be returned to her "originally billed RUG levels." Exh. MAC-2 at 4.

The appellant asserts that the beneficiary made steady progress throughout physical therapy while receiving progressive resistance strengthening exercises to improve lower body, strength and balance, as well as "significant . . . education regarding safety awareness." The appellant further contends that the fact that the beneficiary required "encouragement and reassurance does not prevent her from being a candidate for therapy." Exh. MAC-2 at 1-2.

Regarding occupational therapy, the appellant asserts, generally, that it had "provided documentation that OT provided progressive resistance strengthening exercises to improve strength, balance, and endurance with adjustments week to week regarding . . . [various] activities of daily living" Exh. MAC-2 at 2. The appellant notes that OT also provided significant patient education regarding safety and the use of adaptive equipment that could only be provided by licensed professional therapists. *Id.*

Addressing speech therapy, the appellant indicates that while the beneficiary was admitted with physician's orders for a mechanical soft diet, the beneficiary requested an upgrade to a "regular diet." Consequently, it was necessary to conduct a ST evaluation to ensure the beneficiary's ability to tolerate the upgraded diet. Exh. MAC-2 at 2.

The appellant's documentation does not demonstrate the medical necessity for any of the therapy services in issue. Regarding physical therapy, the beneficiary generally made limited progress. See Exh 2 at 58-59. The beneficiary's weekly progress summaries chronicled her as an unwilling, resistant participant who - "requests to return to room frequently" (12/3/08), required "encouragement + reassurance" (12/11/08), was placed on a functional maintenance program (12/18/08), and was noted for inconsistent participation (12/26/08). See Exh. 2 at 56 and 60-63.

The beneficiary's weekly progress summaries for occupational therapy show the beneficiary to have remained at a steady functional level specifically a "minimum" level of assistance throughout the period of service. See Exh. 2 at 70, 73 and 75-77.

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As the appellant notes, the beneficiary was placed in speech therapy not in response to a particular medical injury or condition, but rather because she requested an upgrade in her dietary consistency from the "mechanical soft diet" prescribed by her physician to a regular diet. Exh. MAC-2 at 2. An evaluation showed the beneficiary to have, at most, "mild difficulty swallowing." Exh. 2 at 78. The beneficiary was in speech therapy approximately one week, having been discharged on December 8, 2008. *Id.* at 78-79 and 86.

The beneficiary's therapy-specific documentation does not demonstrate the medical necessity of any of the claimed therapy services. Improvement in the beneficiary's condition, without more, does not establish that therapy is medically reasonable and necessary, and very little improvement occurred during the dates of service at issue. Instead, the applicable guidance provides that therapy in a SNF is reasonable and necessary if there is an expectation that the beneficiary's condition will "improve materially in a reasonable and generally predictable period of time." MBPM, ch. 8, § 30.4.1.1.

Moreover, the mere fact that a beneficiary's condition may improve does not establish that the services rendered are skilled. Rather, "[t]he services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified ... therapist." MBPM, ch. 8, § 30.4.1.1. For example, it is possible for a beneficiary's mobility or independence to improve as a result of participating in repetitive exercises or assistive walking, neither of which requires the skill of a licensed therapist.⁵

For these reasons, we conclude that the ALJ did not err in finding that the PT, OT and ST services provided were not reasonable and necessary and, accordingly, not covered by Medicare.

⁵ See, e.g., MBPM, ch. 8, § 30.4.1.2., which provides: "Repetitious exercises to improve gait, or to maintain strength and endurance, and assistive walking are appropriately provided by supportive personnel, e.g., aides or nursing personnel, and do not require the skills of a physical therapist. Thus, such services are not skilled physical therapy."

The ALJ next determined that, absent documentation of the medical necessity of the questioned therapy services, the burden fell on the appellant to otherwise demonstrate the medical necessity of skilled nursing services. See Dec. at 20. Citing 42 C.F.R. § 409.34(a)(1)), the ALJ indicated that in order for skilled nursing services to be payable under Medicare Part A, they must be furnished on a daily basis. The ALJ noted that while a break of one or two days was permissible in the context of skilled rehabilitation services, no such break was permitted in the context of skilled nursing. Based upon the nursing notes, the ALJ found that the care provide to the beneficiary was custodial as the beneficiary was stable, and there was no evidence of medical complications or that the nursing staff was treating any acute medical condition. Dec. at 20. However, the ALJ then concluded that the appellant should be reimbursed at the downcoded levels indicated by the Medicare contractor and QIC. Dec. at 21.

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). As noted above, the burden is always on an appellant to document the medical necessity of claims for coverage. See section 1833(e) of the Act and 42 C.F.R. § 424.5(a)(6). The appellant did not contest the ALJ's finding that the beneficiary's nursing services did not meet Medicare coverage criteria. See, generally, Exh. MAC-2.

The ALJ's conclusion, that the appellant's claim should be reimbursed at a down-coded rate, is inconsistent with his findings that both the therapy services in issue were not covered by Medicare and that the beneficiary was otherwise only receiving custodial nursing care. Those findings leave no basis for downcoding as the principle in downcoding is that the SNF stay is otherwise covered, albeit at a lesser rate of reimbursement than that initially sought. However, where neither skilled nursing nor rehabilitative therapy are medically reasonable and necessary nor furnished on a daily basis, the SNF stay itself is not covered at any RUG-III level and is denied.

The Council agrees with the ALJ that the speech therapy services provided to Beneficiary E.M. were not adequately documented and thus, were not medically reasonable and necessary on a daily basis. Absent a challenge to the ALJ's finding that the nursing services provided to Beneficiary M.S. were custodial and thus not covered by Medicare, the Council can only affirm the ALJ's

finding relative to the nature of the nursing services provided¹⁵ to Beneficiary E.M. Accordingly, this claim for SNF coverage is denied in its entirety.

Beneficiary J.S.

Issues: SNF Coverage (Part A)

Dates of Service: September 1-18, 2008

New Evidence

The ALJ's analysis contained a ruling excluding evidence pertinent to the claim involving Beneficiary J.S. Dec. at 10. The excluded evidence is contained at Exhibit 3 of Beneficiary J.S.'s case folder. The appellant has submitted additional medical documentation with its request for review. However, the appellant neither offered an explanation for the submission of additional medical documentation with its request for review, nor did it identify this submission as "new" documentation, documentation already in the record or documentation excluded by the ALJ. See, generally, Exh. MAC-3.

Pursuant to 42 C.F.R. §§ 405.1122(c)(1) and (2), if a party submits new evidence to the Council with its request for review, the Council must determine if good cause exists for the submission of that evidence at that point in the claim appeals process. Absent a showing of good cause for the submission, the Council excludes from evidence the documentary submissions accompanying the appellant's request for review of the claim associated with Beneficiary J.S. However, in the interest of completeness, the excluded documentation will be retained in the record with Exhibit MAC-3.

Coverage

The beneficiary's medical history was significant for dementia, atrial fibrillation, diabetes, hypertension, esophageal reflux, Bell's palsy and difficulty walking, including a history of falls.

The Medicare contractor's redetermination was limited to a review of ST services. However, upon reconsideration, the QIC found no PT notes for the look back periods in review. Without a documented prior level of function, the QIC found it impossible to determine if the beneficiary had experienced "a significant functional decline to warrant skilled therapy interventions." Regarding OT, the QIC could not find occupational therapy notes and "the submitted documentation did

not support a complex functional deficit to warrant skilled therapy intervention." Similarly, for ST, the QIC found that without "a prior level of function relative to the beneficiary's cognitive status documented in objective measurable terms it is not possible to determine that the beneficiary had experienced a significant functional decline to warrant skilled therapy interventions." The QIC next found that because the appellant had not adequately documented the medical necessity of the therapy services, "Medicare cannot cover the SNF services for this beneficiary at the rate originally billed: and we affirm the previously downcoded RUG III levels of PB107 and PB102." The QIC held the appellant liable for the resulting non-covered costs pursuant to section 1879 of the Act. Exh. 1 at 3-7. 16

During the ALJ hearing, the appellant "conceded the issues of PT and OT . . . [limiting its] challenges [to] the determination that [the] ST services . . . were not reasonable and necessary." Dec. at 10. The ALJ also noted that hearing testimony "revealed that the beneficiary's prior hospitalization was due to behavioral issues." Dec. at 11. The ALJ indicated that the beneficiary's August 18, 2008, Minimum Data Set (MDS) identified "no memory recall deficits with the exception of short term memory issues." *Id.* at 10. The beneficiary's baseline function was identified as "60% sequencing, 70% follow direction and 50% problem solving" Moreover, although the speech therapist indicated that the plan for the beneficiary was to regain previous level of function, there was no identified prior level of function. Dec. at 10. The ALJ found that, on September 8, 2008, the beneficiary's level of function was "75% sequencing, 85% follow direction and 65% problem solving." The ALJ recognized that the beneficiary's September 18, 2008, "Updated Plan of Progress for Outpatient Rehabilitation," which also served as her "documentation of discharge," indicated that the beneficiary "had met goals up to 100% accuracy" without identifying the goals. *Id.* at 11; see also Exh. 2 at 61. The ALJ also characterized "the ST weekly notes" as "very general . . . [showing] only the current status." Dec. at 11; see also Exh. 2 at 66-70. Consequently, the ALJ concluded that the appellant's documentation did not demonstrate that the ST services in issue were medically reasonable and necessary. Dec. at 11.

Turning to skilled nursing services and the appropriate RUG III classification, the ALJ concluded that absent a demonstrated need for skilled therapy services, the appellant must prove that the beneficiary required and received daily skilled nursing services. The ALJ concluded that the nursing services provided

to the beneficiary were no more than custodial. The ALJ then ¹⁷ concluded that because the rehabilitative therapy services were not medically reasonable and necessary, Medicare was required to "remove" the therapy services from consideration in calculating the appropriate RUG III categories. Consequently, the ALJ found that the Medicare contractor had properly downcoded the level of available reimbursement for this claim to PB107 and PB102. Dec. at 11-12.

In its request for review, the appellant generally references an "Attached" "history and physical" from the beneficiary's physician indicating that the beneficiary "had memory loss and difficulty concentrating consistent with dementia." Exh. MAC-3 at 1. The appellant asserts that his information indicates that the beneficiary "had newly worsening cognition both prior to and following" her hospitalization. The appellant maintains that the beneficiary deserved the opportunity to improve her memory. The appellant also concedes that the beneficiary met her goals by September 11, 2008, but indicates that her therapist re-evaluated her and determined that she continued to exhibit cognitive defects requiring skilled treatment. The appellant contends that it requires a trained skilled therapist to constantly review and update, as needed, a beneficiary's plan of care. The appellant also challenges the ALJ's characterization of the weekly speech therapy notes as general, noting that they contain information regarding previous and current week's status regarding identified goals. Additionally, the appellant maintains that, pursuant to 42 C.F.R. § 409.31(b)(2)(ii), in spite of having been hospitalized for "behavioral defects," the beneficiary was otherwise eligible for ST for cognitive defects. Exh. MAC-3 at 1-2.

The appellant's documentation relative to the speech therapy services provided to the beneficiary for the period September 1-18, 2008, contains general assertions of progress but no specific identification of the manner, *i.e.* the treatment, by which that progress was achieved. See Exh. 2 at 61-62 and 65-67. That is, there is no evidence that the performance of the services provided necessitated skilled professionals. As the ALJ noted, the appellant's documentation is couched in general terms and does not provide an adequate basis for determining that the beneficiary required skilled speech therapy services.

The ALJ next determined that absent documentation of the medical necessity of the questioned speech therapy services, the burden fell on the appellant to otherwise demonstrate the medical

necessity of skilled nursing services. See Dec. at 11. Citing¹⁸ 42 C.F.R. § 409.34(a)(1)), the ALJ indicated that in order for skilled nursing services to be payable under Medicare Part A, they must be furnished on a daily basis. The ALJ noted that while a break of one or two days was permissible in the context of skilled rehabilitation services, no such break was permitted in the context of skilled nursing. Based upon the nursing notes, the ALJ found that the care provide to the beneficiary was custodial as the beneficiary was stable, and there was no evidence of medical complications or that the nursing staff was treating any acute medical condition. Dec. at 11. However, the ALJ then concluded that the appellant should be reimbursed at the downcoded levels indicated by the Medicare contractor and QIC. *Id.* at 12.

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). As noted above, the burden is always on an appellant to document the medical necessity of claims for coverage. See section 1833(e) of the Act and 42 C.F.R. § 424.5(a)(6). The appellant did not contest the ALJ's finding that the beneficiary's nursing services did not meet Medicare coverage criteria. See, generally, Exh. MAC-3.

The ALJ's conclusion, that the appellant's claim should be reimbursed at a down-coded rate, is inconsistent with his findings that both the speech therapy services in issue was not medically reasonable and necessary on a daily basis and that the beneficiary was otherwise only receiving custodial nursing care. Those findings leave no basis for downcoding as the principle in downcoding is that the SNF stay is covered, albeit at a lesser rate of reimbursement than that initially sought. However, where neither skilled nursing nor rehabilitative therapy services are medically reasonable and necessary or furnished on a daily basis, the SNF stay itself is not covered at any RUG-III level and is denied.

The Council agrees with the ALJ that the speech therapy services provided to Beneficiary J.S. were not adequately documented and thus, were essentially custodial. Absent, a challenge to the ALJ's finding that the nursing services provided to Beneficiary J.S. were custodial and thus not covered by Medicare, the Council can only affirm the ALJ's finding relative to the nature of the nursing services provided to Beneficiary J.S. Accordingly, this claim is denied in its entirety.

The appellant did not raise any contention with respect to the ALJ's conclusions that, pursuant to section 1879 of the Act, the appellant was liable for the non-covered costs associated with its claims. Consequently, the Council affirms the ALJ's conclusions on liability.

CONCLUSION

For the reasons explained above, the Council concludes that the physical therapy services provided to Beneficiary E.K. were not covered by Medicare. The Council further concludes that the skilled nursing facility services provided to Beneficiaries E.M. and J.S. were not covered by Medicare. The appellant is liable for all non-covered costs.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

/s/ Leslie A. Sussan
Deputy Chair
Departmental Appeals Board

Date: June, 14, 2012