DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
Pacificare/Secure Horizons Medicare Advantage (Appellant)	Medicare Advantage (MA) (Part C)
**** (Enrollee)	**** (HIC Number)
Pacificare/Secure Horizons Medicare Advantage (MA Organization (MAO))	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated March 5, 2009. The decision concerned whether the MAO was required to provide the enrollee with coverage for continued skilled nursing facility (SNF) services after February 22, 2006. The ALJ found that the SNF stay from February 23, 2006, through April 26, 2006 was medically reasonable and necessary. Accordingly, the ALJ concluded that the MAO must reimburse the enrollee for the amount she had paid to the SNF, minus any copayment obligation, from February 23, 2006, through April 26, 2006. The ALJ further concluded that the MAO shall reimburse the enrollee for the amount paid to *** for occupational therapy services that L.T. had provided to the enrollee from March 30, 2006, through April 26, 2006. The appellant MAO has asked the Medicare Appeals Council to review that decision.

The regulation codified at 42 C.F.R. § 422.608 states that "[t]he regulations under part 405 of this chapter regarding MAC review apply to matters addressed by this subpart to the extent that they are appropriate." The regulations "under part 405" include the appeals process found at 42 C.F.R. part 405, subpart I, and the expedited determinations and reconsiderations of provider service terminations process found at 42 C.F.R. part 405, subpart J. With respect to Medicare "fee-for-service" appeals, the subpart I and J procedures pertain primarily to

claims subject to the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), 70 Fed. Reg. 11420, 11421-11426 (Mar. 8, 2005). The Council has determined, until there is amendment of 42 C.F.R. part 422 or clarification by the Centers for Medicare & Medicaid Services (CMS), it is "appropriate" to apply, with certain exceptions, the legal provisions and principles codified in 42 C.F.R. part 405, subparts I and J to this case.[1] The Council reviews this matter *de novo*.

The Council has carefully considered the record which was before the ALJ, and the appellant's request for review dated May 29, 2009. No response to the request for review has been received from the enrollee. The Council enters the request for review into the record as Exh. MAC-1. The Council granted the enrollee two extensions of time to respond to the notice of proposed decision issued on July 9, 2009. No substantive response has been received.

The Council adopts and incorporates herein by reference the ALJ's statements as to the Procedural History, Issue, Findings of Facts, and Legal Framework. The Council does not adopt the ALJ's Analysis and the Conclusions of Law. The Council reverses the ALJ's decision favorable to the enrollee, and finds that the enrollee did not receive a covered level of daily SNF care after February 22, 2006.

ANALYSIS

A MAO offering a Medicare Advantage (MA) plan must provide enrollees with "basic benefits," which are all items and services covered by Medicare Part A and Part B available to beneficiaries residing in the plan's service area. 42 C.F.R. § 422.101(a). A MA plan must comply with NCDs, LCDs, and general coverage guidelines included in original Medicare manuals and instructions. 42 C.F.R. § 422.101(b). By regulation, NCDs are also binding on ALJs and the Medicare Appeals Council. 42 C.F.R. § 405.1060. An MAO may specify the networks of providers from whom enrollees receive services. 42 C.F.R. § 422.112(a). This is known as a "lock-in" provision. The plan must maintain and monitor a network of appropriate

[1] As noted by CMS, "the provisions that are dependent upon qualified independent contractors would not apply since an independent review entity conducts reconsiderations for MA appeals." 70 Fed. Reg. 4676 (January 28, 2005).

providers that is sufficient to provide adequate access to covered services to meet the needs of the population served. 42 C.F.R. § 422.112(a)(1). A MA plan may impose cost-sharing such as copayments. 42 C.F.R. §§ 422.2, 422.100(d), 422.111(b)(2).

The enrollee was admitted to the SNF on January 17, 2006, after a hospitalization that began on November 29, 2005. Initially she received a covered level of daily skilled nursing services, occupational therapy, and physical therapy. The therapy services were both discontinued on February 9, 2006, pursuant to the order of the treating physician. Exh. 12 at 356.[2] Restorative Nursing Assistance was ordered instead to assist the enrollee with a maintenance exercise program. Id. at 419. As provided in the regulations at 42 C.F.R. § 409.(d)(13), this is an unskilled service that does not require the special skills of a licensed therapist.

On February 20, 2006, the enrollee's daughter and attorney–in-fact was given notice that covered SNF services would end February 22, 2006. *Id.* at 206-208. The notice further advised that the enrollee may have to pay for any services received after that date. The SNF social worker arranged for the daughter to tour "custodial unit station 2", and the daughter agreed to a transfer to custodial care on February 22, 2006. *Id.* at 41, 191; see also, Exh. 18.

The ALJ found that the change in the level of care was medically inappropriate because the enrollee had not reached her maximum potential in physical therapy and occupational therapy. Dec. 14-15. The ALJ disagreed with the assessments of the treating physician, treating physical therapist, and treating occupational therapist that daily skilled services were no longer medically reasonable and necessary. *Id.* at 14-16. The ALJ concluded that skilled therapy should have continued after February 22, 2006. The ALJ further concluded that less-than-daily occupational therapy performed by L.T. was skilled and medically reasonable and necessary. That ALJ therefore held that the SNF stay from February 23, 2006, through April 26, 2006, the 100th day of the benefit period, was medically

[2] The ALJ did not paginate the exhibits. The Council has paginated Exhibit 12, which consists of 800 pages of medical records from the SNF and hospital. For the convenience of the parties, the Council is including a copy of the paginated Exhibit 12, with a copy of the proposed decision. The parties should cite the specific page number if they refer to the medical evidence in any response to the proposed decision.

reasonable and necessary. The ALJ further declined to order that the MAO reimburse the enrollee for prescription medication, enteral nutrition, and damages. Dec. at 17-18. The Council affirms the ALJ's conclusion not to expand the scope of the issues before him.

The regulations at 42 C.F.R. §§ 409.30(b) and 409.36 provide that the enrollee must *need* and *receive* a covered level of SNF care within thirty days of discharge from the hospital or within thirty days of the last period of covered SNF care. A covered level of care is defined as services ordered by a physician that require the skills of technical and professional personnel such as nurses and therapists, or both, on a daily basis, 42 C.F.R. § 409.31. The daily skilled services must also be services that, as a practical matter, can only be provided in the SNF on an inpatient basis. Id. at (b)(3). The MA plan's Evidence of Coverage (EOC) mirrors the coverage requirements of Original Medicare. Exh. 23, EOC at 30; *see also Id.*, the Schedule of Benefits at 9. Inpatient stays to provide custodial care are specifically not covered. *Id.*, EOC at 30.

The Council has carefully reviewed the medical record and finds that the weight of the evidence does not support a conclusion that the enrollee required daily skilled care from February 23, 2006, through April 26, 2006. The custodial level of care ordered by the treating physician was appropriate for the enrollee's condition at that time. Even if we were to assume that the enrollee *required* daily skilled care for the period at issue, and we do not so assume, the ALJ committed an error of law in finding that continued SNF services were covered without ever determining that the enrollee actually *received* a covered level of care on a daily basis.[3] The treating physician never ordered any daily skilled nursing or therapy services after the enrollee moved to the custodial care unit, and there is no evidence that any were furnished. *See* physician notes in Exh. 12 at 404-409; physician orders at 394-403; nurse's notes at 17-52; weekly nursing summaries at 53-94. The ALJ's conclusion that skilled care should have been furnished is insufficient to find that a continued covered level of care was medically reasonable and necessary for an additional two months. The MAO therefore has no responsibility to pay for the SNF services.

[3] The Council's previous remand order of May 1, 2008, specifically directed the ALJ to determine "whether the services the beneficiary *required and received* during the period at issue constituted skilled, medically reasonable and necessary and/or rehabilitation services." Exh. 6, emphasis supplied.

The ALJ further erred in finding that the MAO is responsible for the occupational therapy services from L.T. These services were not daily services. Further, they did not begin until March 30, 2006, and were not furnished within thirty days after the last episode of covered SNF care. Therefore, they cannot be covered SNF services.

The Council has further considered whether these services could be covered as outpatient occupational therapy services, and finds that they cannot. First, there is no plan of treatment that meets the requirements of 42 C.F.R. § 410.61(c). Specifically, the plans of treatment in the record do not contain any meaningful goals. Exh. 17 and 18. Second, there is no evidence that L.T. meets the qualifications for a covered therapist. 42 C.F.R. § 410.59(c). Third, occupational therapy provided by a therapist in private practice is not covered when furnished in a SNF. *Id.* at (c)(1)(iii). Finally, there are no medical records documenting that the services were medically reasonable and necessary, or an itemized bill on which to base payment.

DECISION

It is the decision of the Medicare Appeals Council that the enrollee, and not the MAO, is responsible for the costs of SNF care from February 23, 2006, through April 26, 2006, and for the cost of any services from L.T. during that period. The ALJ's decision is reversed.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: November 2, 2009