DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-1449

In the case of	**Claim for**
R.B. o/b/o J.B. (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiary)	**** (HIC Number)
Quality Insights of Pennsylvania (Quality Improvement Organization)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated May 10, 2010, which concerned the termination of Medicare coverage of home health services effective January 25, 2010. Finding that the beneficiary is not homebound, the ALJ upheld the termination of coverage effective January 25, 2010. The ALJ further determined that the beneficiary would be liable for any home health services furnished as of January 26, 2010. 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 timely-filed request for review is admitted into the administrative record as Exh. MAC-1. The appellant's subsequent argument in support of the request is admitted into the record as Exh. MAC-2.

For the reasons and bases set forth herein, the Council upholds the ALJ's ultimate determination as to the termination of coverage of home health care services effective January 25, 2010, but provides additional rationale for affirming that determination.

DISCUSSION

Medicare regulations set forth the conditions that a beneficiary must meet to qualify for coverage of home health services. The beneficiary must: a) be confined to the home; b) be under the care of a physician who establishes a care plan; c) be in need of skilled services; d) be under a qualifying plan of care; and e) receive the required services from, or under arrangement with, a participating home health agency. 42 C.F.R. § 409.42(a)-(e); *see also* Social Security Act (Act) §§ 1861(m) and 1814(a)(2)(C).

The ALJ determined that the beneficiary was not homebound and, therefore, did not meet a requisite condition for the purposes of qualifying for Medicare coverage of home health care services. While the ALJ's decision includes a fairly detailed summary of the background and history of this appeal, ALJ hearing testimony, and the medical records in evidence, the ALJ's rationale for his determination that the beneficiary is not homebound within the meaning of the applicable authorities was briefly and summarily stated. The brevity of the ALJ's discussion of this threshold issue seems to have prompted the appellant to raise detailed contentions before the Council. Thus, while we agree with the ALJ's determination that the beneficiary is not homebound, we modify the ALJ's decision to provide additional rationale for affirming the ALJ's determination on this issue.

The beneficiary, a female in her early 50s, has Down's syndrome. She also has chronic obstructive pulmonary disease and is dependent on supplemental oxygen. She requires monthly changes of her tracheotomy and periodic suctioning of the tracheotomy. The beneficiary has been living with her brother and his wife for the past five years. Her sister-in-law is pursing this appeal on her behalf. As the appellant (sister-in-law) testified during the ALJ hearing, she works during the daytime; her husband works evenings. She cannot leave the beneficiary completely alone during the day. Neither the appellant, nor her husband, can afford to stop working or work reduced hours to

stay home with the beneficiary. The appellant explains that about seven hours of home health nursing and aide assistance per week is needed to perform tracheotomy care, bathe the beneficiary daily, and assist with various other activities of daily living. The beneficiary periodically leaves the appellant's and her husband's home for several days to a week at a time to stay with other siblings when the appellant is not available to stay home to look after the beneficiary. ALJ Hearing CD; *see also* Exh. MAC-1 and Exh. 1.

The Council is aware that a physician wrote, with respect to the proposed termination of home health care services, that discontinuing the services "may place the beneficiary's health at significant risk" because the beneficiary has a "history of mental retardation, tracheotomy and chronic bronchitis" and "could suffer pulmonary complications if services [are] D/c'ed." Exh. 1 at 35. Much of the appellant's hearing testimony concerned what home health nursing or aide assistance the beneficiary needs and why. The threshold issue in this case, however, is whether the beneficiary meets Medicare requirements for homebound status, not whether the beneficiary requires, or has received, intermittent skilled nursing services, or the necessity of dependent home health aide services. Also, this case does not present an issue as to whether the beneficiary was under the care of a physician who has established a care plan for the beneficiary. Therefore, while the Council has considered the appellant's arguments addressing all of these issues (Exh. MAC-2), we will confine our discussion, below, to the issue of the beneficiary's homebound status.

The record indicates that the beneficiary leaves home four days every week to engage in "sheltered workshop" activities (music therapy, games, puzzles, social skills development) at an adult day care center, sponsored by a county mental health/mental retardation program. ALJ Hearing CD; Exh. MAC-2. It is apparent that the beneficiary's participation in this program triggered, or was the reason for, the provider facility's determination that the beneficiary is not homebound and, therefore, does not qualify for home health care. Exh. 1 at 32.

In pertinent part, section 1814(a) of the Act provides as follows (emphasis added):

> An individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the

> individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home," the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual. **Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be "confined to his home." Any absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration.** For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration.

For the purposes of this case, the Council will assume that the adult day care center in question is licensed or certified by the Commonwealth of Pennsylvania, or is otherwise accredited to furnish adult day-care services in Pennsylvania in accordance with state and local law. The appellant seems to be asserting as much, in Exh. MAC-2.

The fact that the beneficiary leaves home to participate in adult day-care activities at such a facility does not, by itself, disqualify her from being determined to be homebound for the purposes of Medicare coverage of home health care services. As CMS explained in its manual guidance, "[a]ttendance at adult day care centers" to receive, for instance, needed medical care, may be considered "absences [from home] attributable to the need to receive health care treatment" that do not disqualify a beneficiary from being considered homebound. Medicare Benefit Policy Manual (MBPM), CMS Pub. 100-02, Ch. 7, § 30.1.1. We are not questioning that activities like music therapy, games, and social skills development would provide the beneficiary

psychosocial or therapeutic benefits.[1] Also, regularly going to an adult day-care center could provide an additional benefit by placing her, at least temporarily, in the care of individuals who are not immediate family members, but nonetheless may be familiar with the beneficiary's condition and needs, while the appellant and her husband are working outside their home.

The more pertinent issue, as it pertains to the beneficiary's engagement in adult day-care activities outside the home, is the frequency and the duration of the trips outside the home. The record does not indicate specifically how many hours per day or each week the beneficiary spends engaging in adult day-care activities outside the home. But the appellant has testified that the beneficiary regularly leaves home four days every week to engage in such activities, and has done so for about two years. ALJ hearing CD.[2]

Stated generally, a beneficiary will be considered homebound if he or she has a condition due to an illness or injury that restricts the ability to leave home except with the aid of, for instance, supportive devices such as crutches, canes, wheelchairs, and walkers, or the use of special transportation, or the assistance of another person, or if leaving home is medically contraindicated. *See* MBPM, Ch. 7, § 30.1.1.

The record does not indicate a medical determination that leaving home is medically contraindicated for this beneficiary. *See generally* Exh. 1; ALJ hearing CD (nurse's testimony that the beneficiary periodically leaves home for doctor's visits). We acknowledge nurse visit notes indicating that the beneficiary is not homebound. *Id.* at 16; *see also id*. at 28 (January 4, 2010, nurse visit notes indicating that the beneficiary "moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move"). Nor does the record indicate that the beneficiary's oxygen-dependent status/tracheotomy

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[1] We need not engage in a discussion of whether music therapy, games, or social skills development constitute necessary "medical" care. The Act contemplates that "health care treatment," including regular absences from home to participate in "therapeutic" or "psychosocial" treatment in an adult day-care program, would not disqualify a beneficiary from being determined to be homebound. The MBPM mirrors the language found in the Act.

[2] The beneficiary apparently had other insurance that covered her home health services, including aide services, until January 2010. *See* Exh. 1 at 6. The appellant is trying to get the beneficiary admitted into a county-sponsored home health aide services program. The beneficiary is on a waiting list for admission into such a program. ALJ Hearing CD.

physically impedes her ability to leave the home, or regularly take county-sponsored transportation to go to the adult day-care center. *See, e.g., id.* at 6. The beneficiary apparently takes the county-sponsored transportation on her own, after the appellant gives the beneficiary a morning bath. ALJ hearing CD. The records in evidence do not explicitly address whether Down's syndrome manifestations present special concerns about the beneficiary's safety in using county transportation without another family member.[3]

Finally, we note that the record in this case does not reflect a physician's determination or statement, or certification, to the effect that the beneficiary is confined to the home consistent with Medicare program requirements. *See* regulations concerning conditions for Medicare reimbursement for home health services, in 42 C.F.R. sections 409.41(b) and 424.22(a)(1)(ii). The Council finds no physician's determination in the record that there "exists a normal inability to leave the home and, consequently, leaving home would require a considerable and taxing effort." MBPM, Ch. 7, § 30.1.1. We are aware of a nurse's hearing testimony to the effect that a doctor determined that it would be appropriate for the beneficiary to receive tracheotomy care at home. Assuming that a doctor did so determine, that would not warrant a conclusion that the doctor determined that the beneficiary is homebound within the meaning of the applicable Medicare requirements. It could very well mean that a doctor, considering the beneficiary's and appellant's circumstances, determined that receiving tracheotomy care at home would meet both the beneficiary's medical needs and her family members' preferences.[4]

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[3] It is possible that the transportation is by a van or bus specially designated to transport similarly situated individuals to county adult day-care center(s).

[4] Program guidance does contemplate some flexibility with respect to beneficiary-specific situations that call for the provision of medical care outside the home, without jeopardizing a beneficiary's homebound status for the purposes of Medicare coverage of home health care. For instance, if certain medical services cannot be provided in the home because necessary equipment cannot be made available within the home, then arrangements may be made to obtain such services, on an outpatient basis, at a hospital, skilled nursing facility, or rehabilitation center. However, even in such situations, the beneficiary must otherwise meet homebound status requirements and, to receive such outpatient services, a homebound beneficiary generally will need the use of supportive devices, special transportation, or the assistance of another person to travel to the appropriate facility. MBPM, Ch. 7, § 3.1.1.

Based on the foregoing, the Medicare Appeals Council finds and concludes that the beneficiary is not homebound within the meaning of the applicable law, regulations, and program guidance. The Council therefore upholds the ALJ's determination that the beneficiary does not qualify for home health care services. The Council does not disturb the ALJ's determination that termination of Medicare coverage of home health services effective January 25, 2010, was proper. We modify the ALJ's decision in accordance with the foregoing discussion.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

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

Date: December 17, 2010