

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DEPARTMENTAL APPEALS BOARD

**DECISION OF MEDICARE APPEALS COUNCIL**

**In the case of**

Rx Home Care, Inc.  
(Appellant)

\*\*\*\*

(Beneficiary)

Cahaba GBA

(Contractor)

**Claim for**

Hospital Insurance Benefits  
(Part A)

\*\*\*\*

(HIC Number)

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(ALJ Appeal Number)

On May 1, 2009, the Administrative Law Judge (ALJ) issued a fully favorable decision in an appeal filed by the Pennsylvania Department of Public Welfare, a Medicaid state agency as statutory subrogee. The ALJ's decision granted Medicare coverage for home health care services furnished by Rx Home Care (provider) to the beneficiary from October 3, 2005, through September 27, 2006. Dissatisfied with this outcome, the provider has asked the Medicare Appeals Council (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). As set forth below, the Council reverses the ALJ's decision.

**BACKGROUND AND PROCEDURAL HISTORY**

The beneficiary, an individual who was dually eligible for both Medicare and Medicaid benefits, received home health care services from the provider from October 3, 2005, through September 27, 2006. Exhs. 1-6. The Pennsylvania Department of Public Welfare, a Medicaid state agency acting as statutory

subrogee, requested that the provider submit a demand bill to claim Medicare coverage. Exh. 7.

Initially, and upon redetermination, the Medicare contractor denied coverage for the services at issue on the basis that the records submitted did not include a valid physician's order for the frequency of the services provided or for skilled nursing services. Exhs. 1-6.

The Medicaid state agency requested reconsideration of these claims by a Qualified Independent Contractor (QIC). *Id.* The QIC also denied coverage for the periods of service at issue, finding that "insufficient documentation was submitted to substantiate Medicare's coverage criteria. The home health care plans of care/certifications for the dates of service under review did not specify the frequency of the home health care visits to be provided." Exh. 8 at 567. The QIC also determined that the Notice of Non-Coverage (NNC) on file was signed by the beneficiary on March 11, 2003, and did not pertain to the dates of service at issue. *Id.* at 571. Ultimately, the QIC held the provider liable for the non-covered services. *Id.*

The Medicaid state agency then requested a hearing before an ALJ. Exh. 9. By order dated April 1, 2009, the ALJ consolidated several appeals involving the Medicaid state agency into one hearing. Exh. 12. These appeals involved claims arising from several beneficiaries and providers. Hearing CD. The ALJ conducted the consolidated hearing with counsel for the Medicaid state agency participating via teleconference on April 23, 2009. Dec. at 2, Hearing CD. Representatives from another provider, not involved with the present appeal, also participated in the hearing via telephone. Hearing CD. The provider in this case did not participate in the hearing. *Id.* On May 1, 2009, the ALJ issued a fully favorable decision, granting Medicare coverage for all of the home health care services rendered during the periods of service at issue. Dec. at 10-13.

On appeal before the Council, the provider asserts that Medicare coverage is not appropriate for the services at issue because they were not skilled, and thus, do not qualify as reasonable and necessary as contemplated by Medicare's coverage criteria. See Request for Review.

**APPLICABLE LEGAL AUTHORITIES**

For a beneficiary to qualify for Medicare coverage of home health services, he or she must be confined to the home, under the care of a physician, in need of skilled services, under a plan of care, and the services must be provided by a participating home health agency. 42 C.F.R. § 409.42. The beneficiary must need "skilled services" in the form of intermittent skilled nursing services, physical therapy services, speech-language pathology services, or occupational therapy services. 42 C.F.R. § 409.42(c). To qualify for Medicare coverage, the intermittent skilled nursing services provided must meet the criteria for skilled services and the need for those services, as described in 42 C.F.R. § 409.32.

42 C.F.R. § 409.33(a)(2)(i) explains when observation and assessment of the patient's changing condition constitute skilled services: "Observation and assessment 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 her condition is stabilized."

The Medicare Benefits Policy Manual (MBPM) section entitled "Observation and Assessment of the Patient's Condition When Only the Specialized Skills of a Medical Professional Can Determine Patient's Status" provides:

Observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services when the likelihood of change in a patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's treatment regimen is essentially stabilized. When a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, the skilled observation services are still covered for three weeks or so long as there remains a reasonable potential for such a complication or further acute episode.

\* \* \*

However, observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness or injury where these indications are part of a longstanding pattern of the patient's condition, and there is no attempt to change the treatment to resolve them.

CMS Manual System, Pub. 100-02, MBPM, Ch. 7 at § 40.1.2.1.

### DISCUSSION

#### *Medicare Coverage*

The beneficiary began receiving home health care from the provider in June 2001, more than four years before the initial date of service at issue. Exh. 6 at 1; Request for Review. The beneficiary's primary diagnosis was type I diabetes mellitus (without mention of complication and not stated as uncontrolled), and his other diagnoses included hypertension, venous thrombosis, coronary atherosclerosis of unspecified type, glaucoma, and chronic renal failure. Exhs. 1-6.

During the periods of service at issue, a skilled nurse visited the beneficiary approximately once every two weeks to fill a mediplanner with pills and oversee home health aides. *Id.* Concurrently, a home health aide visited the beneficiary five days each week, averaging 30-35 hours a week, to assist with personal care, light housekeeping, and meal preparation. *Id.*

The ALJ granted Medicare coverage for these home health care services, finding them reasonable and necessary for the beneficiary's care because a skilled nurse provided observation and assessment of the beneficiary's overall health, filled his mediplanner with medications, and oversaw home health aides. Dec. at 11-12.

However, before the Council, the appellant-provider contends that Medicare coverage is not appropriate for the services at issue because they were not reasonable and necessary as contemplated by the regulations. Request for Review. Specifically, the appellant-provider asserts that there were no physician orders for skilled services during the periods in question and that skilled "observation and assessment" services cannot occur for over a 50-week period. *Id.* We agree.

After reviewing the medical evidence contained in the administrative record, the Council finds that the beneficiary did not receive or require skilled care during the periods of service at issue. The beneficiary did not receive any skilled rehabilitation therapy during the period of service at issue. Thus, for the home health care services to qualify for Medicare coverage, the beneficiary must have received and required intermittent skilled nursing care. However, the plans of care on file reveal physician's orders for the skilled nurse to "visit Q 2 weeks to pour mediplanner." *Id.* Pouring medications into a pill planner is not a skilled service as it not "so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel." 42 C.F.R. § 409.32(a). The record does not contain physician's orders for skilled care at the level contemplated by the regulations. Exhs. 1-6.

Further, the evidence of record does not support the ALJ's conclusion that the visiting nurse provided observation and assessment services. Dec. at 11-12. The plans of care do not contain physician's orders for observation and assessment and the nursing notes do not reveal any significant changes in the beneficiary's status or condition. Given the above, there was no anticipated likelihood of complications or an acute episode that would have required observation and assessment by a skilled nurse. 42 C.F.R. § 409.33(a)(2)(i); MBPM, Ch. 7 at § 4.1.2.1.

For the foregoing reasons, the Council concludes that the skilled nursing services provided to the beneficiary during the periods of service at issue were not medically reasonable and necessary pursuant to section 1862(a)(1) of the Social Security Act (Act), and therefore, are not covered by Medicare. The home health aide services are not covered when a beneficiary does not also require skilled care. 42 C.F.R. § 409.45(a). Therefore, Medicare does not cover the dependent home health aide services at issue. The ALJ's decision is reversed.

#### *Liability*

As the Council determined that Medicare does not cover the services at issue because they were not medically reasonable and necessary under section 1862(a)(1) of the Act, we must next apply the limitation on liability provisions of section 1879.

Section 1879 of the Act provides that a beneficiary or provider may be liable for the cost of an item or service that is not

"reasonable and necessary" based upon prior knowledge of non-coverage. Act at § 1879(a); 42 C.F.R. §§ 411.400, 411.404, 411.406; Medicare Claims Processing Manual (MCPM), Ch. 30, §40. A beneficiary is deemed to have knowledge of non-coverage if the provider furnishes written notice to the beneficiary explaining why it believes that Medicare will not cover the item or service. 42 C.F.R. § 411.404(b). A provider is deemed to have knowledge of non-coverage, in part, when it informs the beneficiary before furnishing the item or service that it is not covered. 42 C.F.R. § 411.406(d)(1). A provider also has actual or constructive knowledge of non-coverage based upon "[i]ts receipt of CMS notices, including manual issuances, bulletins, or other written guides or directives from [Medicare contractors]" and "[i]ts knowledge of what are considered acceptable standards of practice by the local medical community." 42 C.F.R. § 411.406(e)(1),(3).

The Council finds that the appellant-provider in this case knew or had reason to know that Medicare would not cover the home health services during the period at issue, pursuant to 42 C.F.R. § 411.406(e)(1),(3). Therefore, the appellant-provider will be liable for the non-covered items unless it provided valid notice to the beneficiary in writing that the services likely would not be covered by Medicare.

The record contains a signed Notice of Non-Coverage Home Health Advance Beneficiary Notice (HHABN) dated March 11, 2003. Exh. 7 at 550. The HHABN indicated that the service at issue, skilled nursing visits to prepare and pour the medication organizer, does "not meet the requirements for coverage under Medicare" because "skilled services are not part-time or intermittent," "services are not skilled," and the visits were "authorized by & billed through county services [Medicaid]." *Id.* Thus, the notice informed the beneficiary in writing that the services at issue likely would not be covered by Medicare - more than two years prior to the start of the period of service at issue.

The Medicare Claims Processing Manual explains when a provider must reissue a HHABN as follows:

A single HHABN covering an extended course of treatment is acceptable [to limit liability] provided the HHABN identifies all items and services for which the HHA believes Medicare will not pay. If, as the extended course of treatment progresses, additional items or services are to be furnished for which the

HHA believes Medicare will not pay, the HHA must separately notify the patient in writing (i.e., give the beneficiary another HHABN) that Medicare is not likely to pay for the additional items or services and obtain the beneficiary's signature on the HHABN. One year is the limit for use of a single HHABN for an extended course of treatment; if the course of treatment extends beyond one year, a new HHABN is required for the remainder of the course of treatment.

MCPM, Ch. 30 at § 60.6.1 (version effective Oct. 01, 2003). As the date of the HHABN on file is more than two years prior to initial date of service at issue, the Council finds that the March 2003, HHABN provided insufficient notice to the beneficiary that Medicare would likely not cover the periods of service at issue. As explained above, "if the course of treatment extends beyond one year, a new HHABN is required for the remainder of the course of treatment." *Id.* As such, the provider is liable for the non-covered services.

#### DECISION

It is the decision of the Medicare Appeals Council that Medicare does not cover the home health care services furnished to the beneficiary from October 3, 2005, through September 27, 2006, and that the provider is liable for the non-covered costs.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson  
Administrative Appeals Judge

/s/ M. Susan Wiley  
Administrative Appeals Judge

Date: November 3, 2009