

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of

Claim for

Vitas Innovative Hospice Care
(Appellant)

Hospital Insurance Benefits
(Part A)

(Beneficiary)

(HIC Number)

Palmetto GBA
(Contractor)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated May 8, 2009, which concerned Medicare coverage for hospice services provided to the beneficiary from September 1, 2007, through September 30, 2007. The ALJ determined that Medicare would not cover the services at issue. The ALJ did not make any determinations with respect to the liability of the parties. 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). As set forth below, the Council reverses the ALJ's decision.

BACKGROUND AND PROCEDURAL HISTORY

This case involves Medicare coverage for hospice services provided to the beneficiary from September 1, 2007, through September 30, 2007. The evidence in the record indicates that the beneficiary's admitting diagnoses to hospice for the recertification period of August 15, 2007, through October 14, 2007, were cerebral degeneration and dementia. Exh. 3 at 224. Medicare denied the claim initially and upon redetermination

because there was insufficient clinical information and other documentation to support the certification of the individual as having a terminal illness with a life expectancy of six or fewer months. *Id.* at 131. Therefore, the contractor found that the thirty days at issue must be denied and that the provider was liable for the non-covered charges. *Id.* at 131-130. On reconsideration, the Qualified Independent Contractor (QIC) found that the hospice's recertification of terminal illness for the period at issue was invalid because the signature of the individual who had signed the certification was illegible. *Id.* at 141. The QIC denied coverage of the hospice services on that basis.

The appellant requested an ALJ hearing, which was held on April 23, 2009. Dec. at 1. In her decision, the ALJ rejected the QIC's conclusions concerning the physician's recertification, finding that the physician signature on the form matched the signature on the initial certification. Dec. at 2. Therefore, the ALJ decided to resolve the case by evaluating whether the beneficiary met the substantive hospice criteria during the period in question.

The ALJ determined that although the beneficiary was unable to provide meaningful communication, was totally dependent on others for her care, and had evidence of weight loss, "these signs and symptoms of dementia are not the more significant signs and symptoms which are more indicative of a 'terminal' diagnosis." *Id.* at 8. Further, the ALJ found that the beneficiary had not exhibited, and the records did not contain evidence of, the "more significant signs and symptoms" of a "terminal" diagnosis such as recent hospitalizations, respiratory infections, skin breakdown, or laboratory results. *Id.* (quoting an unidentified Local Coverage Determination (LCD)).¹ The ALJ concluded that although the beneficiary had signs and symptoms which were evidence of a "general" decline, none of these were true indicia of a "terminal" condition within the requirements of Medicare. *Id.*

In its request for review, the appellant contends that the beneficiary was eligible for hospice services during the month of September 2007, and that other ALJs have issued fully favorable decisions for the other time periods for which the beneficiary was receiving hospice care. Request for Review.

¹ In a section of the decision captioned "CMS Policy," the ALJ quotes portions of an LCD, but does not provide the policy's identification number nor the name of the contractor that issued the LCD. Dec. at 5.

RELEVANT LEGAL AUTHORITY

Section 1812(a)(4) of the Social Security Act (Act) provides that an individual may elect to receive hospice care in lieu of certain other benefits "during up to two periods of 90 days each and an unlimited number of subsequent periods of 60 days each." Section 1814(a)(7) of the Act sets out the certification requirements for payment. See Medicare Benefit Policy Manual (MBPM) (CMS Pub. 100-2), Chap. 9, § 10. Section 1861(dd) of the Act defines what services constitute hospice care to a "terminally ill individual", and states that an individual is considered to be terminally ill if "the individual has a medical prognosis that the individual's life expectancy is 6 months or less." Section 1861(dd)(3)(A) of the Act.

Medicare regulations at part 418 of title 42 of the Code of Federal Regulations (C.F.R.) implement coverage and payment requirements for hospice care. To be eligible to elect hospice care, a Medicare beneficiary must be certified as terminally ill by the medical director or the physician member of the hospice's interdisciplinary group, as well as by the individual's attending physician if the patient has one. 42 C.F.R. §§ 418.20, 418.22. For periods after the initial 90 days, one of the two physicians must re-certify the beneficiary's appropriateness for hospice care. A written plan of care must also be established and followed. 42 C.F.R. § 418.58.

In order to implement hospice and other coverage provisions, local and regional Medicare contractors issue local coverage determinations (LCDs). LCDs are not binding on ALJs or the Council; however, if an ALJ or the Council declines to follow a local policy in a certain case, the ALJ or Council must explain why. 42 C.F.R. § 405.1062. In this case, Palmetto GBA has issued a relevant LCD: LCD L16343: Hospice - Alzheimer's Disease & Related Disorders, which sets forth criteria for determining Medicare coverage of hospice care. In the LCD, Palmetto GBA has provided medical criteria that support a terminal prognosis for beneficiaries with Alzheimer's disease and related disorders. The criteria are quoted verbatim in Appendix A of this decision.

DISCUSSION

New Evidence Submitted with the Appellant's Request for Review

The appellant submitted evidence with its request for review. On July 13, 2009, the Council informed the appellant that it had not indicated whether any of the additional documentation submitted with its request for review was new evidence. The Council advised the appellant that if it submitted any new evidence with its request for review, it must show good cause for submitting the documentation at this late stage in the appeal proceedings. See 42 C.F.R. §§ 405.966(a)(2), 405.1018, 405.1122(c). The appellant responded, explaining the status of the evidence it had submitted to the Council. The Council has determined that many of the documents appended to the request for review duplicate the ALJ's exhibits, and, therefore, require no evaluation of good cause. Rather, they are excluded as duplicative.

The following documents, which are procedural in nature, do not require a good cause evaluation, as they do not constitute "new evidence." They have been entered into the record as follows: the appellant's request for review (Exh. MAC-1); the accompanying letter (Exh. MAC-2); a copy of a fully favorable hearing decision dated April 29, 2009, (Exh. MAC-3); a copy of the cover letter sent to the beneficiary's son (Exh. MAC-4); the Fed Ex shipment receipt for notification to the beneficiary's son (Exh. MAC-5); and the Fed Ex shipment receipt for notification to the ALJ (Exh. MAC-6).

Medicare Coverage for the Hospice Services at Issue

The Council disagrees with the ALJ's assessment of the evidence in this case and finds that the beneficiary qualified for hospice services during the period September 1, 2007, through September 30, 2007.

As noted above, the appellant contends that the beneficiary met hospice coverage criteria during the month of September 2007, and that other ALJs have issued fully favorable decisions for other periods during which the beneficiary received hospice care. Exh. MAC-2. The fact that other ALJs have issued fully favorable decisions for other time periods for which the beneficiary was receiving hospice care does not by itself resolve the coverage issue for the period of service before us, as hearing decisions are not precedential.

We find, however, that the ALJ erred in applying LCD L13653, Hospice - Determining Terminal Status. Dec. at 5-8. The contractor who issued that LCD was Cahaba GBA, LLC - Midwest. LCD L13653. The contractor in this case is Palmetto GBA. Exh. 3 at 131. Further, the LCD referenced in the hearing decision does not include Illinois as a Primary Geographic Jurisdiction. LCD L13653. The Council finds that the LCD quoted above, LCD L16343, Hospice - Alzheimer's Disease & Related Disorders, is the applicable LCD for this case.

Although the beneficiary was not diagnosed with Alzheimer's disease, the beneficiary was diagnosed with end-stage cerebral degeneration and dementia. Exh. 3 at 224. The LCD generally allows hospice coverage for a beneficiary with Alzheimer's disease who has a Reisburg Functional Assessment Staging (FAST) Scale score greater than or equal to seven with specific co-morbid or secondary conditions. LCD L16343. The Council finds that the LCD provides guidelines that are pertinent to resolving coverage in this case. The beneficiary's FAST score during the dates of service at issue ranged from a 7c to 7d, which meets the LCD's requirements. Exh. 3 at 535, 442-459. Moreover, with the exception of self-feeding, the beneficiary was totally dependent in all activities of daily living (ADLs), was incontinent of bladder and bowel, was non-ambulatory, essentially non-verbal, and suffered from leg contractures. *Id.* She had hypertension and complications involving severe cellulitis of the left leg. *Id.*

The Council finds that the beneficiary's condition satisfied the conditions set forth in the applicable LCD, L16343. Therefore, the hospice services provided to the beneficiary from September 1, 2007, through September 30, 2007, meet Medicare coverage requirements. Because the services are covered, it is not necessary to address the liability provisions in section 1879 of the Act.

DECISION

It is the decision of the Medicare Appeals Council that the beneficiary required and received covered hospice services from September 1, 2007, through September 30, 2007. Accordingly, the hearing decision is reversed. The intermediary shall make appropriate payment to the provider consistent with this decision.

MEDICARE APPEALS COUNCIL

/s/ M. Susan Wiley
Administrative Appeals Judge

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: November 9, 2009