

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-1925

In the case of

Commissioner, Connecticut
Department of Social Services

(Appellant)

(Beneficiary)

National Government Services

(Contractor)

Claim for

Hospital Insurance Benefits
(Part A)

(HIC Number)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated April 21, 2011, which concerned Medicare coverage for services provided to the beneficiary in a skilled nursing facility (SNF) from September 19, 2011, through October 31, 2009. The ALJ found that these services did not constitute daily skilled care, and therefore, were not covered by Medicare. The ALJ then found the beneficiary liable for the non-covered services. The appellant, the State of Connecticut Department of Social Services, a state Medicaid agency as statutory subrogee, 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 appellant in the request for review, unless the appellant is an unrepresented beneficiary. *Id.* § 405.1112(c). The Council admits the appellant's request for review and supporting brief into the administrative record as Exhibit (Exh.) MAC-1.

Neither the appellant nor the provider in this case disputes that the services at issue are not covered by Medicare.

Therefore, the Council adopts the ALJ's finding of non-coverage without further discussion. However, as set forth below, the Council finds that the beneficiary is not liable for the non-covered services at issue and therefore reverses the ALJ's decision on liability. The Council finds the provider liable for the non-covered services.

BACKGROUND AND PROCEDURAL HISTORY

The beneficiary began receiving skilled nursing services from a SNF in August 2009 following a qualifying three-day hospital stay. See Exh. 2 at 10. After several weeks of furnishing Medicare-covered SNF level services, the provider prepared a written notice of non-coverage (NONC) to advise the beneficiary that Medicare "probably will not pay" for services rendered beginning September 19, 2009, and that the beneficiary could appeal this determination. On September 14, 2009, the provider delivered the NONC to the beneficiary's authorized representative, who signed¹ and dated the NONC on September 16, 2009. There was no additional written notice in the record detailing the basis for the non-coverage in follow-up to the signed notice of non-coverage.

The appellant sought Medicare coverage for the services provided to the beneficiary from September 19, 2009, to October 31, 2009. See Exh. 3 at 4-5. Initially and at the redetermination level, the Medicare contractor denied coverage for the services on the ground that they were not reasonable and necessary. *Id.* at 1-2. The contractor also found the provider liable for the services. *Id.* The appellant requested a reconsideration by a Qualified Independent Contractor (QIC). See Exh. 4 at 9-10. The QIC agreed with the contractor's conclusions that Medicare did not cover the services and that the provider was liable for the non-covered services. See *id.* at 2-4.

The appellant subsequently filed a request for an ALJ hearing, disputing only the beneficiary's liability for the services. Exh. 5 at 1-4. During the hearing, the appellant argued that the NONC was insufficient because it did not identify the specific non-covered services and did not explain why such

¹ In his decision, the ALJ stated that the beneficiary signed the NONC; however, it was the beneficiary's authorized representative (wife) who signed it. See Dec. at 4.

services would not be covered. Testimony of M.A., CD Recording of ALJ Hearing, March 22, 2011.

The ALJ reversed the QIC's reconsideration on liability and found the beneficiary liable for the non-covered services. Dec. at 5. The ALJ reasoned that the NONC included an explanation of the reasons that Medicare would not cover the services, the potential liability of the beneficiary, and the beneficiary's appeal rights. *Id.* The ALJ also found that a handwritten notation² on the NONC indicated that the beneficiary received in-person delivery of the notice. *Id.* Accordingly, the ALJ concluded that the beneficiary received actual notice of non-coverage. See Dec. at 5. Before the Council, the appellant contests whether the NONC provided sufficient notice of non-coverage to the beneficiary.

APPLICABLE LEGAL AUTHORITIES

Medicare may limit a beneficiary's liability for non-covered services if certain conditions are met. See Social Security Act, § 1879(a). Medicare regulations provide that a beneficiary is not liable if he receives services that are not medically reasonable and necessary, and if he did not know and could not reasonably have been expected to know that the services were not covered by Medicare. See *id.* § 1879(a)(2); see also 42 C.F.R. § 411.400.

The Medicare regulation at 42 C.F.R. § 411.404 sets forth the criteria for determining whether a beneficiary knew that services were not covered. According to the regulation, a beneficiary is considered to have known that the services were not covered if written notice has been given to the beneficiary, or to someone acting on his behalf, and if the notice was given by the provider. 42 C.F.R. §§ 411.404(b) and (c)(3).

The requisite written notice must include an Expedited Determination (ED) generic notice (Form CMS-10123) when covered services are being terminated. See Expedited Determination Process for Original Medicare, Questions and Answers (Q&As), Group 5, Q&A 3 and Q&A 4. This notice alerts a beneficiary of an appeal right, in particular, the right to obtain an immediate review by a Quality Improvement Organization (QIO) of the decision to terminate skilled services. *Id.* Group 5, Q&A 2.

² The following note appears below the representative's signature on the NONC: "informed in person on 9/14/09." Exh. 7 at 3.

The ED generic notice by itself, however, provides insufficient notice in a situation where all Medicare-covered services are ending, but the provider intends to deliver non-covered care. See Expedited Determination Process for Original Medicare, Q&As, Group 5, Q&A 4. Under these circumstances, CMS policy requires providers to issue *both* an ED generic notice and a Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN). *Id.* Group 5, Q&A 4.

A SNF ABN must cite the particular services for which payment will be or is likely to be denied and must also cite the notifier's reasons for believing Medicare payment will be or is likely to be denied. Medicare Claims Processing Manual (MCPM) (IOM Pub. 100-04), ch. 30, § 40.3.1.2. The purpose of a SNF ABN is to inform a Medicare beneficiary, before he receives services that under other circumstances might be covered, that Medicare certainly or probably will not cover the services in this situation and why. *Id.* § 40.3. A SNF ABN allows the beneficiary to make an informed consumer decision about whether to receive the services for which he may have to pay out of pocket or through other insurance. See *id.* Applying these guidelines, the Council reviews the appellant's contentions and the notice in this case.

DISCUSSION

The appellant contests the validity of the NONC as an ABN for two reasons. First, the appellant contends that the NONC is insufficient as an ABN because it does not specify what services Medicare would not cover and does not explain why Medicare would deny such services. See *id.* Second, the appellant argues that there was insufficient documentation of the in-person notice of non-coverage provided to the beneficiary to constitute valid delivery. See *id.*

The Council agrees with the appellant that the NONC was insufficient to qualify as an ABN. The NONC in this case was an ED generic notice that alerted the beneficiary of the date when coverage would end and explained the beneficiary's right to obtain a QIO review. See Exh. 7 at 2-3. This NONC was the only written notice provided to the beneficiary for the relevant dates of service, and the record lacks evidence that the beneficiary received a complementary SNF ABN, in accordance with the manual provisions.

As noted above, the ED generic notice cannot serve as an advance beneficiary notice, for purposes of shifting liability from the provider to the beneficiary, where, as here, all Medicare-covered services are ending, but the provider intends to deliver non-covered care. See Expedited Determination Process for Original Medicare, Q&As, Group 5, Q&A 4.

Under these circumstances, Medicare guidelines expressly state that a SNF ABN must be provided to a beneficiary in addition to an ED generic notice because an ED generic notice, like the one in this case, does not specify the particular type of services that would not be covered by Medicare. See *id.* Group 5, Q&A 2, Q&A 4. The NONC also does not explain why Medicare coverage of SNF services would end. See *id.* Group 5, Q&A 2. Without this information, a beneficiary cannot make an informed consumer decision about whether to receive the non-covered services.

Moreover, the documentation of the in-person notice is inadequate to determine the content of the notice, who gave notice, or to whom it was given. The notice is annotated "informed in person on 9/14/09." However, the notice does not indicate who was informed in person (the beneficiary or her responsible party) and is not signed by an authorized representative of the SNF. The documentation does not indicate that the recipient of any oral notice received the complete information required in a valid written notice. It does not indicate whether the provider explained why Medicare will not cover the services or whether the provider even identified the particular non-covered services for the beneficiary.

Based upon the facts and Medicare guidance, the Council concludes that the SNF did not effect valid delivery of an ABN. Accordingly, the beneficiary is not liable for the non-covered services for the period at issue. The Council holds that the provider, in issuing the NONC, knew that the services would not be covered. Therefore, the provider is liable for the non-covered charges.

DECISION

Because the appellant limits its request for review to the issue of liability, the Council adopts the ALJ's conclusion that the

nursing services at issue were not covered by Medicare. However, the Council reverses the ALJ's findings and conclusions on liability. The Council holds the provider liable for the non-covered services provided to the beneficiary from September 19, 2009, through October 31, 2009.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: November 21, 2011