

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DEPARTMENTAL APPEALS BOARD

ORDER OF MEDICARE APPEALS COUNCIL  
REMANDING CASE TO ADMINISTRATIVE LAW JUDGE  
Docket Number: M-12-108

In the case of

Claim for

Nizhoni Health Systems  
\_\_\_\_\_  
(Appellant)

Hospital Insurance Benefits  
(Part A)  
\_\_\_\_\_

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\_\_\_\_\_  
(Beneficiary)

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\_\_\_\_\_  
(HIC Number)

NHIC

\_\_\_\_\_  
(Contractor)

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(ALJ Appeal Number)

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The Administrative Law Judge (ALJ) issued a decision dated August 3, 2011, which concerned Medicare coverage for home health skilled nursing services furnished by Nizhoni Health Systems to the beneficiary from October 1, 2007, through December 7, 2007. The ALJ determined that the home health skilled nursing services were covered by Medicare. The appellant provider (Nizhoni) has asked the Medicare Appeals Council to review this action.<sup>1</sup>

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.

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<sup>1</sup> The Council refers to the party that filed the request for Council review by name (Nizhoni) because the appeals below were filed by the Massachusetts Executive Office of Health and Human Services' Third Party Appeals Unit (MassHealth). Pursuant to 42 C.F.R. § 405.908, when a beneficiary is a Medicare/Medicaid dual eligible, a Medicaid State agency may be a party to the Medicare claims appeal process when it has made payment for the services, or it may be liable for the services.

42 C.F.R. § 405.1112(c). The Council has entered Nizhoni's request for review into the record as Exhibit (Exh.) MAC-1.<sup>2</sup>

As explained below, the Council finds that there are procedural errors and omissions in this case at the ALJ level. Therefore, the Council vacates the ALJ's decision and remands this case to an ALJ for further proceedings, including a *de novo* hearing and decision. See 42 C.F.R. §§ 405.1108(a), 405.1128(a). The Council has also noted that the discussion of the law and facts in the ALJ's decision (now vacated) was incomplete and erroneous in some respects. Therefore, the Council has summarized these errors and omissions below, so they can be avoided on remand.

#### Contentions in Nizhoni's Request for Review

In its request for review, Nizhoni states that the Irvine branch of the Office of Medicare Hearings and Appeals (Irvine OMHA) did not send Nizhoni a copy of the ALJ decision. Exh. MAC-1. Instead, Nizhoni obtained the decision from a paralegal at MassHealth, on September 28, 2011, approximately two months after the decision was mailed. *Id.* (including a copy of the e-mail from a paralegal at MassHealth forwarding the decision); see also Notice of Decision, dated August 3, 2011, at 3, showing copies were sent to MassHealth, the QIC, and a contractor, but not to Nizhoni. Nevertheless, Nizhoni filed a timely request for Council review on October 4, 2011.

Nizhoni contends that the ALJ erred in finding Medicare coverage for the home health services that Nizhoni provided to the beneficiary, because the beneficiary was not homebound. Exh. MAC-1. Nizhoni also contends that the home health services it provided do not meet Medicare criteria because there was no intermittency in care and care was needed for an indefinite period of time with no predictable endpoint. *Id.* Nizhoni provided a copy of its request for review to the appellant

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<sup>2</sup> Nizhoni's request for review also has ninety-one pages of medical documents attached. It would appear that at least some of these medical documents are already part of the record. Nizhoni has not asserted that it has good cause for submitting this evidence for the first time at the Council level. See 42 C.F.R. § 405.1122(c) (requiring such a good cause showing). Therefore, the Council is excluding these duplicates from the record, but they are marked for identification purposes as Exh. MAC-2 (Excluded). If some of the documents are different from those already in the record, on remand Nizhoni may ask the ALJ to make those documents part of the record by complying with the applicable parts of 42 C.F.R. § 405.1018 (requiring a good cause showing to submit additional documentary evidence at the ALJ level).

below, MassHealth. *Id.* However, MassHealth has not filed a response with the Council.

### Introduction

As mentioned above, in the course of reviewing the record and the request for review, the Council has noted that there were procedural errors and omissions in the adjudication and documentation of this case at the ALJ hearing level. These problems are described below, in the Factual History and Procedural Background section, and the Discussion section. As a result of these errors and omissions, it appears that Nizhoni was not afforded due process and an opportunity for a hearing at the ALJ level. Therefore, the Council vacates the ALJ's decision and remands the case for a *de novo* ALJ hearing and decision. In this *de novo* hearing and decision, the ALJ should also address the substantive issues that Nizhoni has raised, and any other substantive issues that must be addressed to decide the case fully.

### Factual Background and Procedural History

The beneficiary, sixty-one years old at the dates of service, was diagnosed with hypertension, schizophrenia, and diabetes mellitus II. Exh. 1 at 98-99. He was living in a group home where food and meals were provided. *Id.* at 104. He had been receiving home health services for the past fourteen months. See *id.* at 2. At the start of his home health services (fourteen months earlier), he signed a Home Health Advance Beneficiary Notice (HHABN) acknowledging that Nizhoni did not expect that Medicare would pay for his skilled nursing visits because he was not homebound. Exh. 2, page following 68, electronically imaged as page number 121. On the HHABN, the beneficiary also indicated that he was choosing to receive the services and have the bill for their costs sent "to his other insurance, but not Medicare." *Id.*

The Home Health Certification and Plan of Care for the episode from October 9, 2007, through December 7, 2007 contained orders for five to seven skilled nursing visits each week, with three additional visits as needed for any acute condition changes. Exh. 1 at 7. The skilled nurses visited the beneficiary daily throughout this period. *Id.* at 110-69. According to the Plan of Care, the skilled nurses were to check vital signs; check for signs and symptoms of decompensation; assess lung sounds as needed; check for pedal edema as needed; perform or supervise

fingerstick blood glucose as needed and every morning; assess mood, mental status, safety, medication side effects and efficacy; and call the physician if the beneficiary's systolic blood pressure was greater than 170, diastolic blood pressure was greater than 110, or blood sugar was greater than 400. *Id.* at 4. The skilled nurses also were to teach disease process, medicals and compliance, home safety, signs and symptoms of decompensation, coping skills, nutrition, and diet. *Id.* As noted above, the beneficiary had been receiving similar home health services for fourteen months before these dates of service. According to the administrative record, the beneficiary continued receiving daily skilled nursing visits, for similar services, for another ten months after the dates of service at issue here. Exh. 1 at 170-532; Exh. 2 at 65-68.

After Nizhoni submitted demand bills for the home health services it had provided to the beneficiary, the Medicare contractor denied coverage initially. Exh. 2 at 3, 69 (referring to the submission of demand bills). MassHealth requested a redetermination. Exh. 2 at 72. The redetermination affirmed the denial of coverage and held the provider liable for the costs. *Id.* at 69-71. MassHealth then requested reconsideration by the Qualified Independent Contractor (QIC). *Id.* at 24-25. The QIC denied coverage for the dates of service at issue here on the grounds that the documentation did not support that the beneficiary was homebound. Exh. 2 at 17-20 (both sides of pages). The QIC also held the HHABN invalid, and held the provider liable for the costs. *Id.*

MassHealth next requested an ALJ hearing, in this and twenty-six other cases, and sent a copy of its request to Nizhoni. Exh. 2 at 11, 13-16. The ALJ sent a notice of hearing to MassHealth, the QIC, and the contractor, but not to Nizhoni. Exh. 2 at 1-5. The ALJ held a consolidated hearing on these cases on July 22, 2011. CD Recording of ALJ Hearing, July 22, 2011 (ALJ Hearing), from 7:07 to 10:02 a.m. Nizhoni did not participate, having not received notice. Nor did any other providers participate.

On August 3, 2011, the ALJ issued a favorable decision for MassHealth, finding the beneficiary homebound, and determining that the skilled nursing visits were covered by Medicare. Dec. at 1-4, 10-11. The ALJ addressed the notice of her decision to MassHealth, but she did not provide a copy of either the notice or the decision to Nizhoni. See Notice of Decision, dated August 3, 2011, electronically imaged page numbers 011-015 (showing copies sent to the QIC and the contractor, but not to

Nizhoni). As explained above, the documentation submitted by Nizhoni shows that it obtained a copy of this decision (and other decisions that the Irvine OMHA office had failed to send it) on September 28, 2011. See Exh. MAC-1 (including attached e-mail from MassHealth paralegal P.B. forwarding copies of ALJ decisions). Six days later, on October 4, 2011, Nizhoni filed this appeal.

## DISCUSSION

### Procedural Errors and Omissions

As the provider of the home health services at issue, Nizhoni was a party to the proceedings at the ALJ level, even if it had not been the party that requested a redetermination, reconsideration, and ALJ hearing. 42 C.F.R. §§ 405.902, 405.906(a)-(b). Therefore, the ALJ should have notified Nizhoni of the proceedings at the ALJ level, and provided it with an opportunity to participate. See *id.* at § 405.1020(c) (requiring the ALJ to send notice of the hearing to all parties that filed an appeal or participated in the reconsideration, and any party who was found liable for the services at issue subsequent to the initial determination). In this case, Nizhoni was found liable at the redetermination and reconsideration levels.

However, the ALJ did not notify Nizhoni of the hearing or otherwise offer it an opportunity to participate, thus depriving it of due process at the ALJ level. Accordingly, the Council vacates the ALJ's decision and remands the case for a *de novo* ALJ hearing and decision. See 42 C.F.R. §§ 405.1108, 405.1128(a).

### Substantive Issues for ALJ Consideration

As noted above, the Council vacates the ALJ's decision based on procedural error. The Council will now address the major substantive issues for the ALJ's consideration on remand.

The first issue is whether the beneficiary was confined to the home. The ALJ erred in determining that the beneficiary was confined to the home solely on the basis that the beneficiary's physician had "certified in the Home Health Certification and Plan of Care . . . that the beneficiary was confined to the home." Dec. at 2. This determination overlooks the fact that in the same Home Health Certification and Plan of Care the physician signed, the following words also appear: "HOMEBOUND

STATUS: PATIENT IS NOT HOMEBOUND, NOT CONFINED TO PLACE OF RESIDENCE, SERVICES MEDICALLY NECESSARY, ALTERNATIVE MORE COSTLY." Exh. 1 at 6-8 (capitalization in original). There is no other evidence in the current record that the beneficiary was confined to the home. In the Council's view, the above-quoted language taken from the Home Health Certification and Plan of Care document, viewed within the context of the remainder of the current record that does not otherwise indicate the beneficiary was confined to the home, calls into question the finding that the beneficiary was homebound.

The Council further notes that virtually all of the daily skilled nursing notes have boxes checked which read, "Homebound: No. Not confined to place of residence, care medically necessary, alternative more costly. Non-Homebound reason: Able to leave home independently." Exh. 1 at 112-69. Five of the daily skilled nursing notes have handwritten entries that when the nurse arrived between 6:30 and 7:25 a.m., the beneficiary was asleep in bed, fully dressed with his shoes on. See Exh. 1 at 117, 131, 138, 151, and 152.<sup>3</sup> In addition, as the QIC pointed out, the records show that the beneficiary was awake, alert, oriented and ambulated without an assistive device. Exh. 2 at 18 (reverse side). The provider-submitted Outcome and Assessment Information Sets (OASIS) and skilled nursing visit notes that stated the beneficiary was not homebound and was able to leave home independently. *Id.*

Given this evidence in the administrative record, the Council does not agree with the ALJ's finding that the beneficiary was confined to the home (homebound), within the meaning of the statute and regulations. See section 1814(a)(2)(C) of the Social Security Act (Act); 42 C.F.R. § 409.42. If no further evidence on the homebound issue is adduced on remand, this case will not need to proceed further, because the beneficiary's homebound status, as defined by the Act, the regulations, and the policy manuals, is a predicate to Medicare coverage for home health services. However, if the remand is not resolved on this basis, the following points are also worth noting.

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<sup>3</sup> In fact, nurse G.D. recorded these facts in his notes all five of the days when he was assigned to visit the beneficiary. Nurse M.F., who was assigned to visit the beneficiary on most of the other days, never recorded this type of information.

Second, the ALJ's decision did not address the following two related issues, which the ALJ shall address, if appropriate, on readjudication.

- a) Whether the beneficiary was in need of intermittent skilled services, and therefore qualified for home health services on that basis?
- b) Whether the provision of home health services to the beneficiary met the part-time or intermittent care requirements of the Act?

See Act, § 1861(m); 42 C.F.R. §§ 409.44(b)(2), 409.42(c)(1); and Pub. 100-2, Medicare Benefit Policy Manual (MBPM), Chapter 7, Sections 30.4, 40.1, 40.1.3.

In the Council's view, the current administrative record does not support a finding that the beneficiary was in need of intermittent skilled services. Rather, it shows that he received care *daily* for a total of two years, from August 2006 through September 2007. Again, as with the issue of homebound status, unless these facts are substantially different on remand, the claim by MassHealth for Medicare coverage will not proceed further.

Third, if this issue must be reached, the Council notes a substantial question, both legally and factually, as to whether the services that Nizhoni furnished to the beneficiary were in fact *skilled* nursing services. The Plan of Care and daily nursing notes record the beneficiary's need for and receipt of medication management (including prepouring medications and storing unused medications in a lock box); "supervising" the beneficiary's fingerstick blood glucose tests; and highly repetitive teaching of subjects such as medication compliance, diabetic diet compliance, and personal hygiene. See Exh. 1 at 112-69. None of these activities constitute skilled nursing. See 42 C.F.R. §§ 409.44, 409.32, and 409.33(a), (b), and (d). Absent substantially different evidence on remand, it is doubtful that the services the nurses were providing to the beneficiary on the dates of service qualify for Medicare reimbursement as *skilled* nursing care.

REMAND INSTRUCTIONS

For the foregoing reasons, the Council hereby orders that on remand:

- a) The ALJ will offer all of the parties, including Nizhoni and MassHealth, the opportunity for a *de novo* hearing;
- b) If any of the parties declines to participate in the *de novo* hearing, that declination will be documented, in writing, in the administrative record; and
- c) After the hearing, the ALJ will issue a new decision.

The ALJ may take further action not inconsistent with this order. 42 C.F.R. § 405.1126(b).

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim  
Administrative Appeals Judge

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

Date: June 01, 2012