

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-1378

In the case of

Claim for

F.M. for the estate of A.M.
(Appellant)

Medicare Advantage (MA)
(Part C)

**** (deceased)
(Enrollee)

(HIC Number)

Health Insurance Plan of New
York
(MA Organization (MAO)/MA
Plan)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated February 16, 2011. The ALJ determined that the termination of coverage of skilled nursing facility (SNF) services furnished to the enrollee at Carmel Richmond Healthcare and Rehabilitation Center, effective September 3, 2010, was "proper according to Medicare law and policy." Dec. at 10. The ALJ concluded that the MA plan may not be held responsible for the SNF charges incurred from September 3 through 9, 2010. The appellant has asked the Medicare Appeals Council to review the ALJ's decision.¹

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).²

¹ The appellant is the enrollee's son. He represents his mother's estate. ALJ hearing CD.

² The procedures for Medicare Part A and Part B appeals apply to Part C appeals "to the extent that they are appropriate." 42 C.F.R. § 422.608. The Council has determined that, until there is amendment of the regulations governing the MA program or clarification by the Centers for Medicare & Medicaid Services (CMS), application of Part A and Part B appeal procedures, as outlined in 42 C.F.R. part 405, subpart I, is "appropriate" in this case.

The appellant's timely request for review is admitted into the administrative record as Exh. MAC-1. The Council sent the MA plan a copy of the appellant's request. The plan has not filed exceptions to the enrollee's request.

The Council concurs with the ALJ's decision, but modifies the ALJ's decision to set forth additional rationale and bases for concurring with the ALJ's decision.

DISCUSSION

This case concerns the termination of SNF level of care, furnished to the enrollee at Carmel Richmond Healthcare and Rehabilitation Center, beginning September 3, 2010. The basic underlying facts of this case, as summarized in the ALJ's decision, page 2, are not in dispute. The record indicates that the enrollee, 94 years old, was admitted into the SNF on July 22, 2010, following hospitalization for a pelvic fracture. She was determined to have reached her maximum functional potential with physical and occupational therapy). On August 31, 2010, the appellant (the enrollee's son) was notified, by telephone, that because his mother had reached maximum rehabilitative potential and did not require daily skilled level of care, coverage would be terminated ending September 2, 2010. He was informed that the plan would not cover or pay for the SNF charges from September 3, 2010, forward.

The ALJ's decision includes a thorough discussion of the law, regulations, and program guidance governing the coverage requirements for SNF level of care. See Dec. at 4-6, discussing, *inter alia*, 42 C.F.R. sections 409.30 through 409.33 and Medicare Benefit Policy Manual (MBPM), Pub. 100-02, Chapter 8, Section 30. The ALJ also considered the medical documentation and found -

Regulation 42 CFR § 409.31 requires that in order for coverage to be provided for a SNF stay, a Medicare beneficiary must require skilled nursing or/and skilled rehabilitation services on a daily basis. Here, the Enrollee received daily skilled rehabilitation services through at least August 23, 2010, after which time she reached her maximum functional potential. The record is clear that the Enrollee did not require or receive daily skilled rehabilitation at the Provider's facility after September 2, 2010. There are no physician orders to

restart daily therapy. The Enrollee also did not received daily skilled nursing services after September 2, 2010. Despite her need for significant staff assistance, the Enrollee did not have daily skilled nursing needs.

Dec. at 9. The ALJ therefore concluded that the requirements for coverage of SNF services were no longer met after September 2, 2010. *Id.*

The Council has considered the record. We have audited the recording of the ALJ hearing, in its entirety. We note that, during the ALJ proceedings, the appellant raised a concern about the accuracy of IPRO's (the Quality Improvement Organization's) reference to the reason why his mother was admitted to the SNF. More specifically, the appellant indicated that his mother was admitted in July 2010 following hospitalization for a right pelvic fracture,³ and the IPRO's reference to "left hip surgery" was not accurate because the left hip surgery was performed years earlier. ALJ hearing CD; see also Exh. 7 at 154 (appellant's September 10, 2010 written statement in support of the ALJ hearing request). However, the appellant did not dispute the determination that his mother did not require SNF level of care after September 2, 2010; he did not assert that he was not aware of the reason why it was determined she no longer met Medicare's SNF coverage requirements.

Rather, during the ALJ proceedings, the appellant's dispute was on the more specific issue of the timing of the advance notice of Medicare non-coverage. The ALJ's decision accurately captured the appellant's position in this regard -

The Appellant contends that the discharge notice he received did not give the family sufficient time to arrange for all the care and equipment [the enrollee] needed upon her return home. He does not dispute that the Enrollee had reached a plateau in rehabilitation and no longer had daily skilled needs.

Dec. at 9; *reference also* ALJ hearing CD, in which the appellant stated that "they notified me within their rights . . . I understand that . . . [but] we couldn't make the arrangements in time . . . there wasn't enough time to complete everything."

³ The ALJ expressly noted that the enrollee was admitted to the SNF in July 2010, following hospitalization for a right pelvic fracture. Dec. at 1, finding of fact no. 1.

The appellant explained that his mother was blind in her right eye, had macular degeneration in her left eye, and was "practically deaf." He explained that much advance preparation (make his home handicapped-accessible; secure a home health aide; obtain a hospital bed) was needed in anticipation of his mother's return to his house, and that he wanted to fulfill his mother's request that she be allowed to die at her son's home. But two days' advance notice of termination, particularly around the Labor Day weekend, just did not afford the family enough time to make all necessary arrangements. ALJ hearing CD.

In his request for Council review, the appellant does not raise any contention concerning the ALJ's findings of fact or conclusions of law pertaining to the decision to terminate SNF level of care. The Council has considered the medical documentation that was of record before the ALJ (Exh. 1) and we find no reason to alter the ALJ's determination that, as of September 2, 2010, the enrollee was not shown to have required or received daily rehabilitation or nursing skills so as to continue to qualify for coverage of SNF level of care after September 2, 2010. We concur with the ALJ's assessment of the evidence in this regard.

We do, however, supplement the ALJ's discussion on the validity of the notice of termination of coverage furnished to the appellant, to fully respond to the appellant's contention before the Council, which is somewhat different from the contention raised before the ALJ. As noted, during the ALJ proceedings, the appellant argued more generally that two days' advance notice was not sufficient. However, in his request for review, the appellant refers to subsection D (headed "Notice and Liability") of Section II (headed "Principles of Law") of the ALJ's decision, and asserts that he should not be held responsible for the SNF charges incurred from September 3 to 9, 2010, because he was not given written notice of termination. He received only a telephone notice. Exh. MAC-1.

The ALJ's decision included the regulations in 42 C.F.R. § 422.624, in their entirety, as well as a discussion of section 90.5, Chapter 13, of the Medicare Managed Care Manual (MMCM), Pub. 100-16. Dec. at 6-9. The ALJ noted that the appellant was furnished a notice of Medicare non-coverage, dated August 31, 2010, informing the appellant that SNF coverage will end September 2, 2010, because the enrollee no longer required daily skilled services, and that he may be held responsible for SNF charges incurred as of September 3, 2010. The ALJ also

acknowledged that this notice indicated that the notice was given by telephone. Dec. at 2 (finding of fact 3), 9 (analysis). The ALJ did not otherwise discuss in further detail the validity of the telephone notice given two days before the date of termination. See *id.* at 9-10 (analysis). He concluded that the appellant was provided "proper" advance notice of termination. *Id.* at 10.

The question before us is the validity of the telephone notice. The MMCM, Chapter 13, Section 60.1.3 (Notice Delivery to Representatives), provides:

NOTE: This section applies to a representative receiving written notification of organization determinations or service terminations. Signature requirements discussed below do not apply to organization determination notices.

The CMS requires that notification of changes in coverage for an enrollee who is not competent be made to a representative of the enrollee. Notification to the representative may be problematic because that person may not be available in person to acknowledge receipt of the required notification. Medicare health plans are required to develop procedures to use when the enrollee is incapable of receiving or incompetent to receive the notice, and the Medicare health plan cannot obtain the signature of the enrollee's representative through direct personal contact.

Regardless of the competency of an enrollee, if the Medicare health plan is unable to personally deliver a notice of non-coverage to a representative, then the Medicare health plan must telephone the representative to advise him or her when the enrollee's services will no longer be covered. The Medicare health plan must identify itself to the representative and provide a contact number for questions about the plan. It must describe the purpose of the call which is to inform the representative about the right to file an appeal. The information provided must at a minimum, include the following:

- The date services end, and when the enrollee's liability begins;

- How to get a copy of a detailed notice describing why the enrollee's services are not being provided;
- A description of the particular appeal right being discussed (e.g., QIO vs expedited);
- When (by what time/date) the appeal must be filed to take advantage of the particular appeal right;
- The entity required to receive the appeal, including any applicable name, address, telephone number, fax number or other method of communication the entity requires in order to receive the appeal in a timely fashion;
- Provide at least one telephone number of an advocacy organization, or 1-800-MEDICARE that can provide additional assistance to the representative in further explaining and filing the appeal; and
- Additional documentation that confirms whether the representative, in the writer's opinion, understood the information provided.

The date the Medicare health plan conveys this information to the representative, whether in writing or by telephone, is the date of receipt of the notice.

Confirm the telephone contact by written notice mailed on that same date. Place a dated copy of the notice in the enrollee's medical file, and document the telephone contact with the member's representative (as listed above) on either the notice itself, or in a separate entry in the enrollee's file or attachment to the notice. The documentation will indicate that the staff person told the representative the date the enrollee's financial liability begins, the enrollee's appeal rights, and how and when to initiate an appeal. Also include the name, organization and contact number of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.

When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date received. Place a copy of the notice in the enrollee's medical file, and document the attempted telephone contact to the members'

representative. The documentation will include: the name, organization and contact number of the staff person initiating the contact, the name of the representative you attempted to contact, the date and time of the attempted call, and the telephone number called. When the return receipt is returned by the post office with no indication of a refusal date, then the enrollee's liability starts on the second working day after the Medicare health plan's mailing date. The form instructions accompanying a denial notice may also contain pertinent information regarding delivery to enrollees or their representatives. Plans and providers will consider such instructions as manual guidance.

NOTE: References to Medicare health plans also apply to delegated entities, as applicable[.]

We find no merit in the contention that telephone notice as provided for in the MMCM is invalid because the regulations require a signed and dated written notice. The regulations in section 422.624 and the MMCM should be considered *in pari materia*. The regulations and the MMCM are not contradictory. The MMCM provisions are a valid exercise of the Secretary's authority to issue sub-regulatory interpretive rules.

In promulgating 42 C.F.R. § 422.624, CMS emphasized that it had chosen a practical approach that would be easy to administer. 68 Fed. Reg. 16652 (Apr. 4, 2003). Thus, the final rule recognized that requiring notice more than two days in advance of termination of services was often not practical, particularly in institutional settings. *Id.* at 16665. At the same time, consumer testing indicated that Medicare beneficiaries prefer to receive relevant information timed according to when they need to act. *Id.* at 16657. CMS also recognized that, although all enrollees need to be made aware of their appeal rights on a timely basis, only a small proportion is likely to object to the termination of their services. Thus, it is in the best interests of all parties that the notice delivery process be as streamlined and simple to administer as possible. *Id.* at 16656.

At the same time, CMS was cognizant of the need to accomplish notification in the most cost-effective and least burdensome manner. *Id.* at 16657. This is consistent with repeated admonition in the preamble that CMS sought "to balance two conflicting responsibilities--the need to ensure that an M+C

[Medicare + Choice] enrollee has an opportunity to a meaningful appeal without undue financial exposure with the obligation not to impose inappropriate financial burdens on M+C organizations." *Id.* at 16665; see also 16657 ("we have attempted to arrive at policies that balance the rights and responsibilities of all the involved parties").

As applicable in this case, 42 C.F.R. § 422.624(c) contemplates hand delivery of a written notice to a capable enrollee who is an inpatient of the SNF (or to a representative who is present at the SNF). It does not address the situation where the enrollee might not be capable of receiving personal delivery. The MMCM, chapter 13, section 60.1.3, expressly addresses situations where an enrollee is incapable of receiving personal delivery, and the responsible party is unavailable to receive personal delivery of a written notice. In these situations, the manual provides detailed instructions for the delivery of valid notice by telephone, which must be followed up with mailing of a written notice. The date of a valid telephone contact is considered the date of notice.

Moreover, CMS has acknowledged that 42 C.F.R. § 422.624 was consistent with similar notice requirements in Original (fee-for-service) Medicare such as those set forth in CMS Program Memoranda A-99-52 and A-99-54 for home health agency advance notices. 68 Fed. Reg. 16652, 16658 (Apr. 4, 2003). Original Medicare has had comparable longstanding manual provisions regarding telephone notice to a representative. The current manual guidance on delivery of notice in Original Medicare appears in Medicare Claims Processing Manual, Pub. 100-04, chapter 30, sections 40.3.4 through 40.3.5.

In sum, we conclude that MAOs are not required to apply literally the signature and date requirements of 42 C.F.R. § 422.624 when in-person delivery of written notice is impracticable. To do so would effectively require more than two days advance notice, when notice must be mailed to an authorized representative. This could impair the ability of providers, or MAOs, to make timely and appropriate level of care decisions, a result that benefits neither the enrollee nor the MAO. Actual notice, as conveyed telephonically and documented in prescribed detail as set forth in the MMCM, sufficiently protects the appeal rights of enrollees. The CMS manuals provide valid sub-regulatory interpretive guidance when an enrollee is incapable, and the authorized representative is not available in person to sign the notice.

The notice of non-coverage in this case met all requirements for delivery of a valid telephone notice as stated in MMCM, chapter 13, section 60.1.3. The appellant does not dispute that he received actual notice, by telephone, two days in advance, that SNF coverage will be terminated and why coverage will be terminated. There is no dispute that he was aware of his appeal rights, as he exercised those rights. There is no question that he knew the plan will not cover the SNF charges incurred as of September 3, 2010.

DECISION

The Council adopts the ALJ's determination that the MA plan may not be held responsible for the charges incurred for SNF services furnished to the enrollee at Carmel Richmond Healthcare and Rehabilitation Center from September 3, 2010, through September 9, 2010.

The Council modifies 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: October 6, 2011