DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-1623

In the case of	**Claim for**
K.B. (Appellant)	Medicare Advantage (MA) (Part C)
**** (Enrollee/Beneficiary)	**** (HIC Number)
Sterling Life Insurance Company/Sterling Option II (MA Organization (MAO)/ MA Plan)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated March 30, 2011. The ALJ determined that the MA plan[1] is not required to provide coverage for any of the home health aide services provided to the beneficiary on the dates of service at issue, which are from September 17, 2009, through September 29, 2009; from October 1, 2009, through October 29, 2009; from November 3, 2009, through November 24, 2009; and on December 15, 2009; January 5, 2010; and January 12, 2010. The appellant enrollee has asked the Medicare Appeals Council (Council) to review the ALJ's decision.

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). The request for Council review is admitted into the record as Exh. MAC-1.

[1] Sterling Option II is a private fee for service (PFFS) MA plan.

The Council has carefully considered the administrative record and the request for review. For the reasons and bases set forth below, the Council adopts the ALJ's decision.

LEGAL PRINCIPLES

The regulation codified at 42 C.F.R. § 422.608 states that "[t]he regulations under part 405 of this chapter regarding MAC review apply to matters addressed by this subpart to the extent that they are appropriate." The regulations "under part 405" include the appeals process found at 42 C.F.R. part 405, subpart I. With respect to Medicare "fee-for-service" appeals, the subpart I procedures pertain primarily to claims subject to the Medicare, Medicaid and SCHIP Benefits Act of 2000 (BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). 70 Fed. Reg. 11420, 11421-11426 (Mar. 8, 2005). The Council has determined, until there is amendment of 42 C.F.R. part 422 or clarification by the Centers for Medicare & Medicaid Services (CMS), it is "appropriate" to apply, with certain exceptions, the legal provisions and principles codified in 42 C.F.R. part 405, subpart I to this case.[2]

A MAO offering a MA plan must provide enrollees with "basic benefits," which are all items and services covered by Medicare Parts A and B available to enrollees residing in the plan's service area. 42 C.F.R. § 422.101(a). A MA plan must comply with national coverage determinations, local coverage determinations, and general coverage guidelines included in original Medicare manuals and instructions. 42 C.F.R. § 422.101(b). The plan must inform the enrollee of applicable conditions and limitations, premiums and cost-sharing (such as copayments, deductibles, and coinsurance) and any other conditions associated with the receipt or use of benefits. 42 C.F.R. § 422.111(b)(2).

[2] As noted by CMS, "the provisions that are dependent upon qualified independent contractors would not apply since an independent review entity conducts reconsiderations for MA appeals." 70 Fed. Reg. 4676 (January 28, 2005).

DISCUSSION

The enrollee seeks Medicare coverage for home health aide services provided from September 17, 2009, through September 29, 2009; from October 1, 2009, through October 29, 2009; from November 3, 2009, through November 24, 2009; and on December 15, 2009; January 5, 2010; and January 12, 2010. Both the MAO and Maximus each issued two decisions, with each decision governing some of the dates of service at issue. Exh. A, at Exh. 8, Exh. 6, Exh. 5; Exh. B, at Exh. 8, Exh. 6, Exh. 5. The MAO denied coverage for all the home health aide services at issue, finding that custodial care was provided. Exh. A, at Exh. 6; Exh. B, at Exh. 6. On further review, Maximus, in a decision that governed the dates of service of September 17, 2009, through September 29, 2009, from October 1, 2009, through October 29, 2009, and from November 3, 2009, through November 24, 2009, determined that the plan's coverage denial was correct because the enrollee had received custodial care, and did not receive skilled services. Exh. B, Exh. 8. In a separate decision, that governed the dates of service of December 15, 2009, January 5, 2010, and January 12, 2010, Maximus also denied coverage concluding that the enrollee was not receiving a qualifying skilled service and that the provider of the services at issue was not Medicare certified. Exh. A, Exh. 8.

The ALJ also denied Medicare coverage for these services. Dec. at 9-11. The ALJ provided four reasons for denying coverage. *Id*. at 10-11. First, the ALJ stated that the provider cannot receive Medicare reimbursement because it does not have a National Provider Identifier (NPI). *Id*. at 10. Second, the ALJ determined that the services were custodial, and therefore not covered by Medicare. *Id*. Third, the ALJ found that the plan does not provide coverage beyond Medicare's home health service requirements; so the custodial services at issue would still be non-covered services. *Id*. Finally, the ALJ addressed both the enrollee's statement and the provider's statement that the plan had informed them both that the services would be covered. *Id*. at 10-11. The ALJ concluded that "because the MAO never told the Appellant or [the provider] that it would cover the services at issue, coverage of the services remains denied." *Id*.

The enrollee's request for review argues that the ALJ "did not address the fact that I was promised coverage for a home health aid by [the plan's] customer service representatives on multiple occasions." Exh. MAC-1.

The Council has carefully considered the record and the appellant's request for review, but finds no basis to change the ALJ's decision. The Council concurs with all four of the ALJ's denial reasons. Dec. at 9-11. The ALJ correctly determined that the provider could not receive Medicare reimbursement because it did not have an NPI. *Id*. at 10. Further, at the ALJ hearing, the provider's representative testified that it did not have a license for Medicare. Hearing CD. The ALJ also correctly determined that the services were custodial. Dec. at 10. Both the 2009 and 2010 Evidence of Coverage (EOC) indicate that custodial care is not covered under either the plan or Medicare, unless a covered skilled service is provided as well. EOC, at 94-95 (2009); EOC, at 56 (2010). The record does not indicate that the enrollee received any skilled services from the provider. Instead, the record shows that the enrollee's care consisted of services such as, ordinary housework, body care, bathing, etc. Exh. A, Exh. 1; Exh. B, Exh. 1. The ALJ indicated that the plan did not cover home health services beyond what Medicare covers. Dec. at 10. The Council has reviewed the applicable 2009 and 2010 EOCs and finds that the plan does not provide home health coverage beyond original Medicare. *See* EOC (2009 & 2010).

The enrollee's contentions before the Council all relate to the ALJ's fourth reason for denial. *See* Exh. MAC-1; Dec. at 10-11. Contrary to the enrollee's contentions, the ALJ did respond to the enrollee's argument that coverage for the services at issue had been promised by the plan's customer service representatives. *See* Exh. MAC-1; Dec. at 10-11. The ALJ determined that the plan had not informed either the enrollee or the provider that the services would be covered. Dec. at 11. The Council concurs with the ALJ's determination. The ALJ noted that neither the enrollee nor the provider had received written confirmation of coverage. *Id*. at 10. The plan has provided numerous, detailed telephone summaries. The Council's review of those summaries does not provide any indication that coverage was promised. Instead, it appears that the enrollee and the provider misunderstood the communications with the plan's customer service representatives. At the same time, however, the enrollee has repeatedly acknowledged that she was advised that she had to receive services from Medicare participating provider, and the provider knew well that they did not participate in Medicare. As such, the Council finds that the plan did not promise coverage to either the enrollee or the provider.

Therefore, the Council concludes that there is no basis for changing the ALJ's decision. The Council therefore adopts the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: September 9, 2011