DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-12-257

In the case of	**Claim for**
All Valley Home Health (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiary)	**** (HIC Number)
Palmetto GBA (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated September 26, 2011, which concerned home health services provided to the beneficiary from May 20, 2010, through July 18, 2010. The ALJ denied coverage after finding the record lacked evidence and did not substantiate "the beneficiary's homebound condition." The ALJ further determined that the appellant was liable for the non-covered services. The appellant has asked the Medicare Appeals Council (Council) to review this action. The Council enters the appellant's request for review into the record as exhibit (Exh.) MAC-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).

For the reasons set forth below, the Council reverses the ALJ's decision. Medicare coverage is available for the services at issue.

BACKGROUND

Initially and upon redetermination, the Medicare contractor denied coverage for home health services provided to the beneficiary from May 20, 2010, through July 18, 2010. Exh. 1 at 16-18. The contractor found the provider liable for the non-covered charges. *Id.* The appellant requested reconsideration by a Qualified Independent Contractor (QIC). *Id.* at 13-15. The QIC issued an unfavorable reconsideration and also found the provider liable for the costs of the non-covered charges. Exh. *Id.* at 5-6. The appellant timely requested a hearing before an ALJ. *Id*. at 1-4. Subsequent to the hearing, held on July 26, 2011, the ALJ issued a decision denying coverage. ALJ Decision (Dec.). Specifically, the ALJ found "there are no progress notes or additional medical records substantiating the beneficiary's home bound condition". *Id.* at 9. The appellant contests the ALJ decision to the Council.

DISCUSSION

Having reviewed the administrative record and considered the appellant's contentions, the Council reverses the ALJ's decision. The Council disagrees with the ALJ's assessment of the evidence on the issue of the beneficiary's homebound status. The Council also finds that the services provided during the dates of service were skilled in nature.

A. Coverage Determination

The beneficiary began receiving home health services on September 22, 2009. Exh. 2 at 6. The dates of service at issue are for the re-certification period of May 20, 2010, through July 18, 2010. *Id.* The beneficiary had a primary diagnosis of diabetes mellitus. *Id.* Secondary diagnoses included history of stroke, high blood cholesterol and hypertension. *Id.*

1. Homebound Status

Contrary to the ALJ decision, the Council finds the record supports the conclusion that the beneficiary was homebound during the dates of service at issue. One condition for coverage of home health services is that the beneficiary must be "confined to the home or in an institution that is not a hospital, SNF or nursing home . . . ." 42 C.F.R. § 409.42(a). Section 1814(a) of the Social Security Act (Act) provides as follows:

[A]n individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home," the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual.

See also Section 1835(a) of the Act; Medicare Benefit Policy Manual (MBPM), CMS Pub. 100-02, Ch. 7, § 30.1.1.

In this case, the treating physician noted the beneficiary's homebound status in the home health plan of care re-certification for the dates of service at issue. Exh. 2 at 6-7. The re-certification further noted that the beneficiary was unable to leave the home without taxing efforts. *Id.* Additionally, the re-certification documented the beneficiary had functional limitations which included poor vision, poor manual dexterity, unstable and weak gait, poor hearing, impaired tactile sensation, dyspnea with moderate exertion, left side paralysis and limited range of motion, and incontinence. *Id.* The re-certification also noted the beneficiary received assistance daily from an attendant. *Id.* Moreover, the record demonstrated that the beneficiary required the use of an assistive device, namely, a cane or walker, to leave the home. *Id.*

In the case at hand, absences from the home, though infrequent, included adult day care and doctor visits. *Id.* at 7. Policy guidance published by CMS explains how homebound status is affected by absences from the home:

> If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are

> attributable to the need to receive health care treatment.[1]

MBPM, Ch. 7, § 30.1.1.

In accordance with the guidance quoted above, neither attendance at adult day care nor going to doctor's appointments disqualifies a beneficiary from being considered homebound.

Contrary to the ALJ's assessment of the documentation contained in the record, the record indeed contains six separate skilled nursing assessment notes from the dates of service at issue which document the beneficiary's functional abilities, respiratory issues and dependence on assistance devices. Exh. 2 at 19, 22, 27, 29, 32, 34. On the assessments, the nurse indicated the beneficiary experienced moderate shortness of breath on exertion, had poor manual dexterity, and was ambulatory only with assistive devices. *Id.*

All of the above considerations, taken together, sufficiently support a conclusion that the beneficiary was homebound during the period at issue.

2. Skilled Services

In addition to being homebound, Medicare requires that covered home health services must include "skilled services" in the form of intermittent skilled nursing services, physical therapy services, speech-language pathology services, or occupational therapy services. 42 C.F.R. § 409.42(c). To qualify for Medicare coverage, the intermittent skilled nursing services provided must meet the criteria and need for skilled services found in 42 C.F.R. § 409.32. Observation and assessment constitutes skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment or for additional medical procedures until the patient's condition is stabilized. 42 C.F.R. § 409.33(a)(2). Patient education services constitute skilled services when the skills of a professional are required to teach self-maintenance. 42 C.F.R. § 409.33(a)(3).

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[1] Absences attributable to the need to receive health care treatment include, but are not limited to:

- Attendance at adult day centers to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy.

After considering the appellant’s contentions, the Council finds the services provided were skilled in nature and also reasonable and necessary. The MBPM, Ch. 7, § 40.1.2.1 provides:

> Observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services where the likelihood of change in a patient’s condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's treatment regimen is essentially stabilized. Where a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, the skilled observation services are still covered for *three* weeks or so long as there remains a reasonable potential for such a complication or further acute episode.
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> Information from the patient's medical history may support the likelihood of a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond the 3-week period. Moreover, such indications as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment. Where these indications are such that it is likely that skilled observation and assessment by a licensed nurse will result in changes to the treatment of the patient, then the services would be covered. There are cases where patients who are stable continue to require skilled observation and assessment...
>
> However, observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness or injury where these indications are part of a longstanding pattern of the patient's condition and there is no attempt to change the treatment to resolve them.

In the instant case, the beneficiary’s physician ordered home health services for skilled assessment and observation, as well

as teaching and instruction.[2] Exh. 2 at 6-7. The record indicates that immediately prior to the dates of service the beneficiary's condition necessitated medication changes: Trilipix (for cholesterol) and Actos (to stabilize blood sugar) due to unstable blood sugars, ranging from 88-303. *Id.* at 41-42. Therefore, the skilled services were ordered to monitor the beneficiary's blood sugar and blood pressure for complications with medication changes. *Reference* Hearing CD at 11:19:29-11:45. Additionally, the doctor ordered teaching and instruction by the skilled nurse so the beneficiary could learn to manage the new medication regime, form an understanding of long term diabetic complications, and for the implementation of an 1800 calorie diet. Exh. 2 at 6-7; *reference* hearing CD at 11:21:21-11:21:36.

The Council notes that for a service to be considered reasonable and necessary, the service must be consistent with the nature and severity of the beneficiary's condition, his or her medical needs, and accepted standards of medical and nursing practice. *See* 42 C.F.R. § 409.44(b)(3). The Council is persuaded by the appellant's argument that the skilled monitoring was appropriate due to the beneficiary's diabetes, history of stroke, unstable blood sugars, and hypertension. As noted by the appellant, the Trilipix dosage had the potential to affect the beneficiary's blood sugar, which would have required adjustments to the dosage and necessitated monitoring of any potential affects to the beneficiary.

Additionally, policy guidance published by CMS provides that "teaching the preparation and maintenance of a therapeutic diet require the skills of a license nurse. *See* MBPM, Ch. 7, § 40.1.2.3. Therefore, the Council finds the orders for teachings were appropriate so that the beneficiary could eventually manage her diabetic diet and medication changes without nurse supervision, but more importantly be able to look out for irregularities and report any complications to the doctor.[3]

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[2] The record indicates that nine visits were conducted over the dates of service at issue. Exh. 1 at 21, *reference* hearing CD at 11:23:08-11:23:21.
[3] Although the beneficiary received assistance from an attendant with activities of daily life (ADLs) and instrumental activities of daily life (IADLs), the plan of care notes the beneficiary lived alone. Exh. 2 at 41.

DECISION

Based on the foregoing reasons and bases, the Council reverses the ALJ's decision. The home health services provided from May 20, 2010, through July 18, 2010, are covered by Medicare, and reimbursement shall be made in accordance with this decision.

MEDICARE APPEALS COUNCIL

/s/ Stanley I. Osborne, Jr.
Administrative Appeals Judge

/s/ Susan S. Yim
Administrative Appeals Judge

Date: March 19, 2012