DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

**DECISION OF MEDICARE APPEALS COUNCIL**
**Docket Number: M-11-1967**

| **In the case of** | **Claim for** |
|---|---|
| Commissioner, Connecticut Department of Social Services (Appellant) | Hospital Insurance Benefits (Part A) |
| **** (Beneficiary) | **** (HIC Number) |
| National Government Services (Contractor) | **** (ALJ Appeal Number) |

The Administrative Law Judge (ALJ) issued a hearing decision dated April 28, 2011, which addressed Medicare coverage for skilled nursing facility (SNF) services furnished to the beneficiary from March 5 to March 8, 2010. The ALJ denied coverage for the SNF services, citing section 1862(a)(1)(A) of the Social Security Act (Act), and found the beneficiary liable for the non-covered services in accordance with section 1879 of the Act. The appellant, the State of Connecticut Department of Social Services, a state Medicaid agency with appeal rights under 42 C.F.R. section 405.908, 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 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 (Form DAB-101), the appointment of representative, and the brief in support of the request, into the administrative record as Exhibit (Exh.) MAC-1, pages 1 through 8.

For the reasons and bases set forth below, the Council reverses the ALJ's decision. Medicare coverage is available for the SNF services furnished to the beneficiary from March 5 to March 8, 2010.

## DISCUSSION

At issue before the Council is Medicare coverage for the SNF services furnished to the beneficiary from March 5 to March 8, 2010. The appellant, Commissioner of the Connecticut Department of Social Services, asks the Council to reverse the ALJ's denial of coverage for the services. The ALJ determined that the services may not be covered as reasonable and necessary services under section 1862(a)(1)(A) of the Act because "[t]here was nothing in the medical record proffered indicating that the services administered amount[ed] to skilled care" and the services furnished were "fairly routine lab work." Dec. at 6. The ALJ found the beneficiary liable for the non-covered charges in accordance with section 1879 of the Act based on a finding that the SNF provided the beneficiary's representative "sufficient notice of non-coverage as early as March 2, 2010, that [the beneficiary's] care would not be covered by Medicare starting March 5, 2010." *Id.* The ALJ's decision was similar to that of the contractor and the Qualified Independent Contractor (QIC), as to both coverage and liability. On redetermination and reconsideration, coverage was denied for lack of evidence of daily skilled services documented in the record for the period from March 5 to March 8, 2010, and because the beneficiary, through his representative, was provided valid advance written notice that coverage would be denied beginning on March 5. *See* Exh. 6 at 2; Exh. 7 at 4-5.

Before the Council, the appellant first indicates that it is disputing the ALJ's decision as to coverage and payment only. The appellant points out that the ALJ erroneously stated in his decision (page 6) that the appellant had "characterized the notice as being insufficient" and that it addressed only the issues of coverage and payment during the ALJ proceedings. Exh. MAC-1 at 5. The appellant urges the Council to reverse the ALJ's decision, allowing for coverage of the services as medically reasonable daily skilled nursing services in the form of both skilled observation and assessment, and case management. *Id.* at 7-8.

A beneficiary must meet various requirements to qualify for the coverage of SNF services. As pertinent herein, Medicare requires that coverage may be allowed only when the service is "skilled" in nature, which means that it is "so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel." 42 C.F.R. § 409.32(a). In addition, the beneficiary must require and receive skilled services (nursing or skilled rehabilitation, or both), on a daily basis. 42 C.F.R. § 409.31(b)(1); *see also* 42 C.F.R. § 409.31(a) (skilled nursing and rehabilitation services are those that are ordered by a physician, require the skills of professional personnel, and are furnished directly by or under the supervision of such personnel). The skilled services must be furnished for a condition for which the beneficiary received inpatient hospital services, or which arose while the beneficiary was receiving care in a SNF for a condition which he or she received inpatient hospital services. 42 C.F.R. § 409.31(b)(2). The skilled services must be ones that, as a practical matter, can only be provided in a SNF, on an inpatient basis. 42 C.F.R. § 409.31(b)(3).

Overall management and evaluation of the care plan may constitute "skilled services" when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. 42 C.F.R. § 409.33(a)(1). Observation and assessment constitute "skilled services" when the skills of a technical or professional person are required to identify and evaluate the patient's needs for modification of treatment or for additional medical procedures until his or her condition is stabilized. *Id.* at § 409.33(a)(2). As the Medicare Benefit Policy Manual (MBPM), Pub. 100-02, makes clear, observation and assessment satisfies this standard "when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation 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." MBPM, Ch. 8, § 30.2.3.2. Similarly, for the management of a care plan, the complexity of the services must "require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety." *Id.* at § 30.2.3.1.

The records reflect the beneficiary's hospitalization from February 12 to February 17, 2010, for "worsening gross hematuria." His recent medical history included a diagnosis of deep vein thrombosis and the placement of an inferior vena cava filter. Exh. 4 at 3, 6. At the hospital, the beneficiary underwent a cystoscopy and transurethral resection of the prostate (which had a nodular growth that had reoccurred despite two prior transurethral resections), and received three transfusions. *Id.* at 4. The hospital records further indicate, "Because of his severe hematuria and resulting anemia with an initial hematocrit of 29.1 which subsequently fell to hematocrit 23.1 immediately postoperatively, urological intervention was required." *Id*. After the resection, the beneficiary had bloody urine for three days which "gradually quieted," and, on the date of discharge from the hospital, the urine was described as "dark tea color." *Id.* At the time of discharge from the hospital on February 17 (for admission to the SNF) the beneficiary was diagnosed with hematuria secondary to prostate enlargement, recent deep vein thrombosis, chronic renal failure, Parkinson's disease, obstructive sleep apnea, and a history of squamous cell carcinoma. *Id.* at 3.

As of March 2, 2010, a physician indicated that the beneficiary required skilled nursing for one week to monitor for signs of fever, chills, clots, elevated temperature, swallowing problems, and inability to void, and to check the Foley catheter. Exh. 4 at 10. The nurses' notes leading up to March 5, 2010 indicate, among other things, drainage of bloody urine from the Foley catheter. Laboratory tests were ordered. The beneficiary was placed on Ensure five times daily because he was noted to have had a poor appetite. The nurses were to monitor the amount of Ensure ingested. *See id.* at 17-18.[1]

As of March 5, 2010, the first non-covered day, the nurses continued to monitor the beneficiary for signs of hematuria. Laboratory results were abnormal. Exh. 4 at 19. Laboratory tests were ordered to be repeated. *Id.* at 15. The next day, March 6, 2010, the doctor ordered the beneficiary to be hospitalized; the "abnormal" laboratory results were again noted. *Id.* at 15, 19; Exh. 10. The next day, March 7, 2010, nurses documented "bright red" hematuria (Exh. 4 at 20), and a doctor again ordered that laboratory tests be performed (*id.* at 20-21). As of March 8, 2010, the Foley catheter was draining bloody urine. *Id.* at 21. A doctor again indicated that the

[1] As the appellant notes, Medicare covered the SNF services furnished from February 17 to March 4, 2010. Exh. MAC-1 at 6.

beneficiary should be hospitalized, and, on March 8, 2010, he was hospitalized. *Id.*

Having considered the medical evidence, and the above coverage requirements and program guidance, the Council finds the appellant's arguments well-founded. The medical evidence supports coverage for the SNF services furnished from March 5 to March 8, 2010.

The beneficiary required and received daily skilled nursing services in the form of skilled observation and assessment and the management of the beneficiary's care plan. The beneficiary was treated for hematuria in a hospital immediately prior to the admission to the SNF. *See, e.g.*, Exh. 4 at 39. In fact, the hospital records for the period immediately prior to admission to the SNF indicate a doctor's option that, "It is anticipated … that there will be some intermittent hematuria." *Id.* at 4. That is what occurred during the SNF stay at issue. Further, at the SNF, on March 2, 2010, a doctor determined that the beneficiary required skilled nursing for one week to monitor him for various signs and symptoms, including those associated with hematuria. *See id.* at 10. Every day during the three-day period of non-coverage, from March 5 to 8, 2010, the nurses closely monitored the beneficiary daily for possibly abnormal urine changes (e.g., "dark orange" noted one day), and abnormal laboratory results were noted daily. The nurses also closely monitored the beneficiary daily for other indicators of overall decline in condition (e.g., poor appetite) leading up to the re-hospitalization on March 8, 2010, and notified the physician of the "abnormal" laboratory results. *See id.* at 19, 20, 21.

We note that, on March 6, 2010, the second day of the non-covered period, a doctor determined that the beneficiary should be re-hospitalized; the order for hospitalization apparently was not carried out at the request of the beneficiary's son and daughter-in-law. *See* Exh. 4 at 19, 20. But, the doctor, in his medical judgment, determined that the beneficiary should be hospitalized, as evident in a repeated hospitalization order on March 7 and, again, on March 8, 2010. *See id.* at 20 and 21. These orders are unquestionably indicative of a physician's determination that the beneficiary should be furnished hospital level of care, which, in the context of this case, is evidence that tends to support a conclusion that the beneficiary needed, from March 5 to March 8, 2010, a SNF level of care. We disagree that the SNF services at issue were merely "custodial in nature" as the ALJ characterized them. *See* Dec. at 6.

Based on the foregoing, the Council reverses the ALJ's decision. Medicare coverage is available for the SNF services furnished to the beneficiary from March 5 to March 8, 2010.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

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

Date: October 12, 2012