

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-1292

In the case of

Claim for

State of Vermont

(Appellant)

Hospital Insurance Benefits
(Part A)

(Beneficiary)

(HIC Number)

NHIC

(Contractor)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated May 12, 2010, which concerned home health services furnished to the beneficiary from November 2, 2006, through November 29, 2007. The ALJ determined that the home health services were not covered by Medicare because the services were not skilled. The ALJ further found the beneficiary and the provider each liable for a portion of the non-covered services under section 1879 of the Social Security Act (Act). The appellant has asked the Medicare Appeals Council to review this action.

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 Council enters the timely-filed request for review into the record as Exhibit (Exh.) MAC-1. As set forth below, the Council reverses the ALJ's decision in part and modifies it in part.

BACKGROUND AND PROCEDURAL HISTORY

During the period at issue, the beneficiary was an 85- or 86-year-old female with a principal diagnosis of type II diabetes, uncomplicated. Exh. 4, at 1. She was also diagnosed with other persistent mental disorder (i.e., dementia), abnormality of gait, and hypothyroidism not otherwise specified. *Id.* The beneficiary began receiving home health care in May, 2003. *Id.* The beneficiary's plan of care (POC) called for one skilled nursing visit every other week or as needed to assess diabetic status, knowledge of disease and disease management, nutrition, and skin care; to teach medication use, diabetic management, signs and symptoms to report to medical professionals, nutrition, activity, and skin care; fill the beneficiary's pill-planner, review blood sugar monitoring performed by the beneficiary's caregiver, and provide foot care and skin care as needed. *Id.*

The provider submitted demand bills to the Medicare contractor, which denied Medicare coverage for all dates of service at issue. *See, e.g.,* Exh. 1, at 42-44. The appellant requested redetermination. In separate redeterminations addressing each certification period, the contractor upheld the initial denials. Each redetermination concluded: "There were no skilled needs identified or provided. [The beneficiary's] condition remained stable. *See, e.g.,* Exh. 1, at 2. The redeterminations were equivocal on the issue of liability for the non-covered charges. Several of the redeterminations stated **both** that the beneficiary was liable based on the presence of an Advance Beneficiary Notice (ABN) **and** that the provider was liable because it knew or should have known that the services would not be covered. *See, e.g.,* Exh. 1, at 5-6.

The appellant requested reconsideration by a Qualified Independent Contractor (QIC). The QIC found that the home health services were not covered by Medicare because the nursing visits did not meet Medicare coverage criteria. Exh. 2, at 5. The QIC found that the beneficiary was liable for the cost of the non-covered services furnished during the period January 1 through November 29, 2007. *Id.* at 6. The QIC found the provider liable for the non-covered services furnished during the period November 2 through December 31, 2006. *Id.*

The appellant requested a hearing before an ALJ. The ALJ held a hearing by telephone on April 26, 2010. Dec. at 2. The ALJ issued her decision on May 12, 2010. She concluded that no skilled services were provided during the entire period at issue

and, accordingly, no Medicare coverage was warranted. *Id.* at 12. The ALJ found that the beneficiary was liable for the non-covered services furnished from January 2 through March 1, 2007 and from June 28 through August 1, 2007, based on two ABNs in the record. *Id.* The ALJ found the provider liable for the remaining non-covered services. *Id.*

DISCUSSION

Coverage of Home Health Services

Medicare regulations set forth the conditions that a beneficiary must meet to qualify for coverage of home health services. The beneficiary must: a) be confined to the home; b) be under the care of a physician who establishes a care plan; c) be in need of skilled services; d) be under a qualifying plan of care; and e) receive the required services from, or under arrangement with, a participating home health agency (HHA). 42 C.F.R. § 409.42(a)-(e); see also Act §§ 1861(m) and 1814(a)(2)(C).¹

For the home health services at issue to be covered by Medicare, they must meet the criteria for skilled services under 42 C.F.R. § 409.42(c). As applicable here, skilled nursing services are defined in 42 C.F.R. § 409.42(c)(1) ("Intermittent skilled nursing services that meet the criteria for skilled services and the need for skilled services found in 42 C.F.R. § 409.32. (Also see § 409.33(a) and (b) for a description of examples of skilled nursing and rehabilitative services.")). A skilled service is one "so inherently complex that it can be safely or effectively performed only by, or under the supervision of, professional or technical personnel." 42 C.F.R. § 409.32(a). When the patient has a special medical complication, "a service that is usually nonskilled . . . may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitative personnel." 42 C.F.R. § 409.32(b).

In the request for review, the appellant takes issue with the ALJ's decision in several respects. The appellant argues that the ALJ erred in relying on the fact that the beneficiary had been receiving home health services since 2003 as evidence that

¹ There is no contention in this case that the beneficiary was not homebound, or that the other technical conditions for Medicare coverage of home health services were not met. The only issues in this case are whether the services at issue were skilled and, if any services remain non-covered by Medicare, the applicability of the limitation on liability provisions of section 1879 of the Act.

the services were no longer skilled. Exh. MAC-1. The appellant also argues that the ALJ erred when she suggested that no skilled care was required because the beneficiary resided with her husband, who was available to provide care. *Id.* The appellant also reiterates the arguments advanced in the memorandum it submitted to the ALJ with regard to specific services it contends were skilled. *Id.*

The Council agrees with the appellant that medically reasonable and necessary home health services that meet coverage criteria are covered by Medicare without regard to when a beneficiary began receiving such services. The Medicare Benefit Policy Manual (MBPM), CMS Pub. 100-02, ch. 7, § 40.1.1, provides:

The determination of whether a patient needs skilled nursing care should be based solely upon the patient's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time. In addition, skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable.

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).

In accordance with the guidance in the regulations and the MBPM, the Council has reviewed the record and finds that the beneficiary required and received intermittent skilled nursing services during several episodes of care. The Council therefore reverses the ALJ's decision with regard to these episodes.

In the first episode, the provider documented that the beneficiary required skilled nursing services beginning on June 3, 2007, to address a stage II pressure ulcer on her sacrum. Exh. 4, at 75 (reverse), 80. Despite the provider's documentation, the ALJ determined that the care was not skilled because "the nurse instructed the Beneficiary's husband on wound care" ² Dec. at 11. The ALJ further stated that "this Beneficiary had longstanding chronic issues with pressure

² The ALJ's observation that the nurse instructed the beneficiary's husband in wound care is contradicted by the medical records, which state, "spouse has poor eyesight and [is] unable to provide washing and dressing that is

ulcers.”³ *Id.* The Council finds that the ALJ erred in concluding that assessment and treatment of the beneficiary’s pressure ulcer was not skilled care.

First of all, the fact that the nurse taught the beneficiary’s spouse or another caregiver wound care techniques does not mean that the services were unskilled. As stated in the MPBM: “A service which, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient’s family, or other caregivers.” MBPM, ch. 7, § 40.1.1. Moreover, the fact that the beneficiary was at risk for skin breakdown weighs in favor of, rather than against, the need for skilled observation and assessment by a nurse when the beneficiary’s caregivers identified wounds when providing care to the beneficiary.

The medical records document that, from June 3, 2007, through June 27, 2007, the provider’s nurses observed and assessed the pressure ulcer on the beneficiary’s sacrum; provided wound care, including cleansing and dressing the wound; and instructed the beneficiary’s caregivers in wound care. See Exh. 4, at 74-97. Therefore, the Council finds that the services provided from June 3, 2007, through June 27, 2007, constituted medically reasonable and necessary intermittent skilled nursing care and are, therefore, covered by Medicare.

Similarly, on August 14, 2007, the beneficiary’s paid caregiver telephoned the provider to report that the beneficiary had raised blisters on her buttocks. Exh. 4, at 124 (reverse). During a visit on August 15, 2007, the provider’s nurse documented:

Eval[uation] of lesion on left buttock. 6-8 fluid filled vesicles on erythematous base, easily undomed without pain, not on dermatomal line, not pressure

needed.” Exh. 4, at 74 (reverse). The records do indicate that the nurse instructed the beneficiary’s paid caregivers in wound care, however. See, e.g., *id.* at 82 (reverse).

³ While the ALJ does not say so explicitly, she appears to be relying on the provision of the MPBM which provides: “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.” MBPM, ch. 7, § 40.1.2.1. The ALJ’s reliance on this provision is misplaced. As discussed below, the provider’s nurses provided wound care to address the beneficiary’s pressure ulcer, as well as other skin breakdown issues.

ulcer. Cleansed with NS [normal saline] and placed strips of iodoform gauze covered with Allevyn adhesive. Call left with MD ans[wering] service. Will need derm[atology] consult if vesicles continue to develop. Instr[ucted] HCA [home care aide] gloves very [important].

Id. at 121. Further, on August 17, 2007, the nurse documented a visit as follows:

PT [Patient] seen today to follow up on redden[ed] blistered area on PTs left buttock. There is a new small area above the original area that has two white blisters. The area was cleaned with NS [normal saline]. Idoform [sic] gauze and [adhesive Allevyn] applied to the area. PCA [personal care aide] was taught how to do the dressing change. Instructed PCA to wear gloves at all times when touching that area or clothing that may have touched that area to prevent spreading. . . . MD was notified of the current status of the wound. . . .

Id. at 126. Nurses continued to assess and treat the area through the visit on August 30, 2007. *See id.* at 121-136. By the visit on September 5, 2007, the provider's nurse documented that the beneficiary's left buttock wound had healed completely. *Id.* at 139. Accordingly, the Council finds that the services provided from August 15, 2007, through August 30, 2007, constituted medically reasonable and necessary intermittent skilled nursing care and are, therefore, covered by Medicare.

Finally, the beneficiary again developed skin integrity issues on October 25, 2007. During the visit on that date, the provider's nurse documented that the beneficiary had small open areas on her right foot. *Id.* at 159 (face and reverse). The nurse again provided assessment and treatment for the foot wounds on October 29, 2007. *Id.* at 163. By the visit on November 5, 2007, the nurse documented that the wounds on the beneficiary's foot had healed. *Id.* at 166 (reverse). Accordingly, the Council finds that the services provided from October 25, 2007, through October 29, 2007, constituted medically reasonable and necessary intermittent skilled nursing care and are, therefore, covered by Medicare.

With regard to the remaining dates of service not specifically addressed above, the Council agrees with the ALJ's conclusion

that the care provided was not skilled and, therefore, is not reasonable and necessary and is not covered by Medicare.

Liability for Non-Covered Services

Because we have concluded that certain of the services at issue are not reasonable and necessary, we must consider whether the liability of the beneficiary or the provider may be limited pursuant to section 1879 of the Act. Section 1879 of the Act provides that a beneficiary or supplier may be liable for the cost of an item or service that is not "reasonable and necessary" based upon prior knowledge of non-coverage. Section 1879(a) of the Act; 42 C.F.R. §§ 411.400, 411.404 and 411.406. A beneficiary is deemed to have knowledge of non-coverage if the supplier provides a notice to the beneficiary explaining why it believes that Medicare will not cover the item or service. 42 C.F.R. § 411.404(b).

The ALJ concluded that the beneficiary was liable for the non-covered services furnished from January 2 through March 1, 2007 and from June 28 through August 1, 2007. Dec. at 12. The ALJ apparently based this conclusion on the two ABNs that are in the record as Exh. 6. The ABNs in Exh. 6 are nearly illegible. Nevertheless, it is possible to discern that the ABNs state that skilled nursing visits would likely not be covered by Medicare because the services were not skilled. Exh. 6, at 2, 3. The beneficiary's representative (her spouse) signed one ABN on January 1, 2007, and the other on June 27, 2007. *Id.*

The ALJ erred in limiting the effect of the ABNs to January 2 through March 1, 2007, and June 28 through August 1, 2007. The Medicare Claims Processing Manual (MCPM) provides that once a beneficiary receives a valid ABN, the beneficiary is considered to have knowledge of Medicare non-coverage for the same or similar services furnished during the next twelve months.

A notice that a beneficiary received within the twelve months before the claims denial at issue may be considered as evidence of prior knowledge with respect to such same or similar service or item that is denied payment by Medicare for the same reason in both the earlier and the later cases.

MCPM, CMS Pub. 100-4, ch. 30, § 40.2.2. See also *id.* at § 40.3.1.3 (A previously furnished ABN is acceptable evidence of notice for current items or services if the previous ABN cites

similar or reasonably comparable items or services for which denial is expected on the same basis in both the earlier and the later cases). In accordance with the quoted MCPM provisions, the Council finds that, effective with the ABN signed by the beneficiary's representative on January 1, 2007, the beneficiary, and not the provider, is liable for the cost of any non-covered services she received from January 2, 2007, through November 29, 2007. With regard to the non-covered services furnished from November 2, 2006, through January 1, 2007, the Council agrees with the ALJ's finding that the provider is liable based on its presumed knowledge of published Medicare coverage authorities. 42 C.F.R. § 411.406(e).

DECISION

The Council has considered the record and the exceptions and has concluded that the beneficiary received Medicare-covered intermittent skilled nursing care from June 3, 2007 through June 27, 2007; from August 15, 2007 through August 30, 2007; and from October 25, 2007, through October 29, 2007. Accordingly, the ALJ's decision is reversed as to these dates of service. The beneficiary's representative signed an ABN on January 1, 2007. Therefore, the beneficiary is liable for the non-covered services furnished from January 2 through November 29, 2007. The provider is liable for the non-covered services furnished from November 2, 2006 through January 1, 2007. The ALJ's findings on liability are modified accordingly.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

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

Date: November 16, 2010