DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
Commissioner, Connecticut Dept. of Social Services. (Appellant)	Medicare Advantage (MA) (Part C)
**** (Enrollee)	**** (HIC Number)
United HealthCare d/b/a Evercare (MA Organization (MAO))	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a favorable decision dated May 28, 2009. The ALJ found that the beneficiary's stay at ****, a Skilled Nursing Facility (SNF), from March 2, 2008, through August 18, 2008, and on August 31, 2008, was covered by Medicare and must be paid for by Evercare, the Medicare Advantage (MA) plan in which the beneficiary was enrolled. The ALJ found that the inpatient stay was covered at the SNF level of care because the enrollee needed and received daily skilled nursing services for care and feeding through a gastrostomy tube. The party requesting review before the ALJ was the Connecticut Department of Social Services, the Medicaid State agency as statutory subrogee (State). The MA plan (plan), Evercare, has requested review of the ALJ decision by the Medicare Appeals Council (Council), arguing that the services at issue did not meet SNF coverage criteria under Medicare.

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, and the expedited determinations and reconsiderations of provider service terminations process found at 42 C.F.R. part 405, subpart J. With respect to Medicare "fee-for-service"

appeals, the subpart I and J procedures pertain primarily to claims subject to the Medicare, Medicaid and SCHIP Benefits Improvement and Protection 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, subparts I and J to this case.[1] The Council reviews this matter *de novo*.

The Council has carefully considered the record which was before the ALJ, the plan's request for review and brief dated July 29, 2009, and the response from the State dated August 14, 2009. The Council enters the plan's request for review and brief into the record as Exhibit MAC-1, and the response from the State of Connecticut as Exhibit MAC-2. The Council has considered the contentions and arguments presented by both the plan and the State, but finds no basis to disturb the ALJ's decision.

A managed care organization offering an MA plan must provide enrollees with "basic benefits," which are all items and services covered by Medicare Part A and Part B available to beneficiaries residing in the plan's service area. 42 C.F.R. § 422.101(a). An MA plan must comply with national coverage determinations (NCDs), local coverage determinations (LCDs), and general coverage guidelines included in original Medicare manuals and instructions. 42 C.F.R. § 422.101(b). By regulation, NCDs are also binding on ALJs and the Medicare Appeals Council. 42 C.F.R. § 405.1060.

The State asserts that the enrollee required skilled nursing care during the period at issue because he required and received enteral feeding comprising over 26 percent of his daily calorie requirement and over 501 milliliters of fluid per day, which is defined as a skilled nursing service under 42 C.F.R. § 409.33(b)(2). The record supports the State's argument. The record indicates that the beneficiary has been receiving all of his nutrition since 2007 through a gastostomy tube (g-tube). During the period at issue the beneficiary received 85 cc/hour of Jevity formula to be administered daily via G-tube from 2:00

[1] 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).

p.m. through 10:00 a.m. Exh. 5, at 74. This equals approximately 1700 cc of fluid per day (85cc x 20 hours), and was the enrollee's only source of nutrition. The enrollee also received all medications via the g-tube. This is a covered skilled nursing service as defined in the regulations at 42 C.F.R. § 409.33(b)(2).

The plan urges the Council not to give effect to this regulation because g-tube feedings may be administered by personnel other than registered nurses. However, the regulations define the service of enteral feeding comprising over 26 percent of daily calorie requirements and over 501 milliliters of fluid per day as a skilled nursing service that may be furnished directly by, or under the supervision of skilled technical or professional personnel such as registered nurses and licensed practical nurses. 42 C.F.R. §§ 409.31(a), 404.33(a). A certified nursing assistant may perform this task daily under the general supervision of skilled personnel, subject to each SNF's protocol for such services. There is no evidence suggesting that the SNF did not provide supervision.

DECISION

It is the decision of the Medicare Appeals Council that the plan is responsible for the charges for covered SNF services to the enrollee from August 2-18, 2008, and on August 31, 2008.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: November 16, 2009