DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-1884

In the case of	**Claim for**
Estate of B.A., by ***, personal representative (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiary)	**** (HIC Number)
Wisconsin Physicians Service (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated July 30, 2010. The ALJ's decision concerned skilled nursing facility (SNF) services furnished to the beneficiary from January 28, 2009, through March 1, 2009. The ALJ determined that the SNF services do not meet Medicare coverage criteria because the beneficiary was not receiving skilled services on a continuous basis, the care was custodial, and the beneficiary was receiving similar care from a hospice provider; therefore, the care was not medically reasonable and necessary under section 1862(a)(1) of the Social Security Act. The ALJ further found that the beneficiary was liable for the cost of the non-covered care pursuant to section 1879 of the Act. The appellant (the beneficiary's son as representative of the beneficiary's estate)[1] has asked the Medicare Appeals Council to review this action. The appellant's timely filed request for review is entered into the administrative 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

[1] While the beneficiary was alive her son had previously had acted as her authorized representative, as that term is defined in 42 C.F.R. § 405.902.

review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c).

The Council has considered the record and exceptions. For the reasons explained below, the Council concludes that the appellant did not know, and could not be expected to know, that the SNF services would not be covered by Medicare. The Council therefore reverses the ALJ's decision as to liability and finds that the provider is liable.

DISCUSSION

The ALJ's decision sets forth the procedural history and applicable legal authorities accurately and in detail. The Council will not repeat that information in full in this action. Briefly, on the dates of service at issue, the beneficiary was an 89-year-old female with a history of multiple myeloma and breast cancer, among other diagnoses. *See* Exh. 1, at 24, 207. The beneficiary was re-admitted to * * * Health & Rehab Center (SNF) on December 11, 2008, following a hospital stay for gastrointestinal bleeding. *Id. See also id.* at 29, 476 (reverse). The beneficiary required and received skilled physical therapy (PT) and occupational therapy (OT) services during December 2008 and January 2009. *See id.* at 257-286. She was discharged from OT on January 19, 2009, and from PT on January 22, 2009. *Id.* at 249.

By telephone on January 21, 2009, the SNF spoke to the appellant "regarding residents LCD [presumably 'last covered day'] as of 1-27-09. Resident will no longer require skilled care - Also discussed what his plans were -." *Id.* at 477. There is no evidence that the SNF issued any written advance beneficiary notice of non-coverage to the beneficiary or the appellant, or that the SNF issued a written termination of services notice as required by 42 C.F.R. § 405.1200. The appellant later signed a hospice election for the beneficiary on January 28, 2009. *Id.* at 581-82. The beneficiary died on March 1, 2009. *Id.* at 548 (reverse).

The SNF billed the appellant for the beneficiary's care for dates of service January 28 through January 31, 2009, and for February 1, 2009 through March 1, 2009. *See* Exh. 2, at 29-32. The appellant disputed that the beneficiary was liable for the charges and asserted that Medicare should cover the charges. *Id.* Thereafter, the SNF submitted claims to the Medicare

contractor. The contractor denied the claims initially and on redetermination. Exh. 3, at 70-85. On further appeal, the Qualified Independent Contractor (QIC) also denied the claims. Exh. 4, at 111-16. Both the redetermination and the reconsideration stated that Medicare would not pay for the SNF services because the beneficiary was receiving Medicare-covered hospice services on the dates of service in question. In both actions, the contractors held the beneficiary, and not the provider, liable for the cost of the non-covered care.

The appellant requested a hearing before an ALJ. The ALJ held a hearing by telephone on July 22, 2010. Representatives of the provider appeared at the hearing. The appellant was unable to be present at the hearing.[2] Dec. at 2. The ALJ issued his decision on July 30, 2010. As noted above, the ALJ concluded that the SNF services are not covered by Medicare and the appellant is liable for the non-covered charges.

The ALJ determined that the SNF services do not meet Medicare coverage criteria because the beneficiary was not receiving skilled services on a continuous basis, the care was custodial, and the beneficiary was receiving similar care from a hospice provider; therefore, the care was not medically reasonable and necessary under section 1862(a)(1) of the Social Security Act. Dec. at 8-9. The Council finds no error in this portion of the ALJ's analysis.

With regard to nursing home residents who elect hospice benefits, the Medicare Benefit Policy Manual (MBPM),[3] CMS Pub. 100-02, provides:

> A Medicare beneficiary who resides in an SNF or NF may elect the hospice benefit if:
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> - The residential care is paid for by the beneficiary; or
> - The beneficiary is eligible for Medicaid and the facility is being reimbursed for the beneficiary's care by Medicaid, and

[2] The Council notes that the appellant does not contend he was prejudiced by not appearing at the hearing. *See* Exh. MAC-1.

[3] CMS manuals may be accessed via the internet at https://www.cms.gov/Manuals/IOM/list.asp (last visited November 29, 2011).

- The hospice and the facility have a written agreement under which the hospice takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual.[4]

MBPM, Ch. 9, § 20.3.

Under this guidance, when a beneficiary elects hospice care, Medicare pays for all nursing care related to the beneficiary's terminal condition by making payment to the hospice provider. Medicare is not obligated to pay any other provider for services furnished to the beneficiary related to the terminal condition. If Medicare were to pay both the hospice provider and the SNF for such services, it would amount to paying twice for the same services.

The appellant does not contend that the SNF care at issue was unrelated to the beneficiary's terminal condition. *See* Exh. MAC-1. Instead, he argues that the services were skilled, and that the beneficiary had not exhausted her Medicare Part A SNF benefits. *Id.* However, even if the SNF had provided skilled nursing care – which the ALJ found did not happen – this would not alter the fact that Medicare paid for all nursing services when it reimbursed the hospice provider. No additional Medicare payment is due with respect to the SNF services.

This does not end our inquiry, however. The ALJ concluded that the appellant, and not the provider, is liable for the costs of the non-covered care pursuant to section 1879 of the Act. Dec. at 9. The ALJ found that the appellant knew, or had reason to know, that Medicare would not pay for the SNF services.[4] *Id.* On *de novo* review of the record, we conclude that the SNF did not give the required written notice of noncoverage to the appellant.

[4] The ALJ seems to have reached the conclusion that the appellant had actual knowledge that the SNF services would not be covered based on the fact that the representative signed several forms issued by the hospice provider indicating that Medicare's hospice benefit does not cover room and board in a nursing home. *See* Dec. at 9; *see also* Exh. 1, at 686, 613. As discussed below, the Council concludes that the record lacks evidence that the appellant understood that the SNF services furnished to the beneficiary on the dates of service in question were not covered by Medicare, or that he made an informed consumer decision to continue to receive care in the SNF.

The regulations at 42 C.F.R. § 411.404 provide that a beneficiary is considered to have known that services are not covered if the provider that furnished the services gives the beneficiary, or someone acting on her behalf, written notice that the services are not covered because they do not meet Medicare coverage guidelines. Detailed requirements for the timing and content on this written notice, which is called the advance beneficiary notice (ABN), are set forth in the Medicare Claims Processing Manual (MCPM), CMS Pub. 100-04, ch. 29.

The purpose of the ABN is to inform a Medicare beneficiary, before he or she receives specified items or services that otherwise might be paid for, that Medicare certainly or probably will not pay for them on that particular occasion. The ABN, also, allows the beneficiary to make an informed consumer decision whether or not to receive the items or services for which he or she may have to pay out of pocket or through other insurance. In addition, the ABN allows the beneficiary to better participate in his/her own health care treatment decisions by making informed consumer decisions. If the provider, practitioner, or supplier expects payment for the items or services to be denied by Medicare, the provider, practitioner, or supplier must advise the beneficiary before items or services are furnished that, in its opinion, the beneficiary will be personally and fully responsible for payment. To be "personally and fully responsible for payment," means that the beneficiary will be liable to make payment "out-of-pocket," through other insurance coverage. *Id.* at §40.3.

The provider, practitioner, or supplier must issue an ABN each time, and as soon as, it makes the assessment that Medicare payment certainly or probably will not be made. A notification which does not meet the prescribed ABN standards may be ruled defective and may not serve to protect the interests of the notifier (provider, practitioner, or supplier). Any requirement to furnish a notice to a beneficiary is not met by delivery of a defective notice. When, for a particular purpose, an approved standard form exists, it constitutes the proper notice document. *Id.* CMS-approved model Form CMS-10055 is the ABN for use with SNF services.[5]

[5] In addition to giving the beneficiary a written ABN for purposes of limitation on liability under section 1879 of the Act, a SNF must also give a beneficiary a separate notice which explains the right to request an immediate appeal by a Quality Improvement Organization under 42 C.F.R. § 405.1200. There is no evidence that the SNF provided this required notice either.

The Manual further provides that a notice of non-coverage delivered via telephone is not generally sufficient to shift liability from a provider to a beneficiary:

> The contractor will not consider a telephone notice to a beneficiary, or authorized representative, to be sufficient evidence of proper notice for limiting any potential liability, unless the content of the telephone contact can be verified and is not disputed by the beneficiary. If a telephone notice was followed up immediately with a mailed notice or a personal visit at which written notice was delivered in person and the beneficiary signed the written notice accepting responsibility for payment, the contractor will accept the time of the telephone notice as the time of ABN delivery.

MCPM, Ch. 30, § 40.3.4.2.

The SNF documented that it provided notice to the appellant, by telephone, that the beneficiary would no longer require skilled care after January 27, 2009. Exh. 1, at 477. According to the SNF note, the appellant was informed that the beneficiary's last Medicare-covered day would be January 27, 2009. *Id.* The appellant appears to concede that he received a telephone contact from the SNF. Exh. MAC-1. However, it appears that he disputes the content of the telephone notification, or did not understand its import. *Id.* From our reading of the request for review, the Council concludes that the appellant believed at the time of the purported notice, and continues to believe, that the beneficiary was entitled to Medicare coverage for the SNF services furnished on the dates of service in question.

The Council has found no evidence that the SNF followed up the telephone notification with a written notice. The Council therefore finds that the telephone notice was ineffective to put the appellant on notice that Medicare would no longer cover SNF services furnished to the beneficiary after January 27, 2009. Nor was the appellant on notice of the reason(s) Medicare would likely not cover the services. Accordingly, the appellant did not know, and could not reasonably be expected to know, that the SNF services would not be covered by Medicare. The liability of the appellant (the beneficiary's estate) is waived.

By contrast, the regulations provide that a provider, practitioner, or supplier will be considered to have known that items or services are not covered if it informed the beneficiary that the services were not covered or that the beneficiary no longer needed the services. 42 C.F.R. 411.406(d). Here, the SNF documented that it notified the appellant that the services would not be covered. Therefore, the SNF knew that Medicare would not cover the services. The SNF's liability for the non-covered services is not waived.

DECISION

It is the decision of the Medicare Appeals Council that the SNF services furnished to the beneficiary from January 28, 2009, through March 1, 2009, are not covered by Medicare because the beneficiary had elected hospice services during those dates. Neither the beneficiary nor her representative knew, or could reasonably be expected to know, that the SNF services would not be covered by Medicare. The beneficiary's estate is not liable for the cost of the non-covered services. The SNF knew that Medicare would not cover the services. The SNF is liable for the cost of the non-covered services. The ALJ's decision is reversed as to the issue of liability.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/ Susan S. Yim
Administrative Appeals Judge

Date: December 05, 2011