DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-2061

In the case of	**Claim for**
Commissioner, State of New Jersey Dept. of Human Services (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
National Government Services, Inc. (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision on February 18, 2010. The ALJ denied Medicare coverage for home health skilled nursing services provided to the beneficiary by Ocean County Board of Health from April 17, 2007, through October 13, 2007, as not medically reasonable and necessary.[1] The appellant, a state Medicaid agency, as the beneficiary's subrogee, has asked the Medicare Appeals Council (Council) to review the ALJ's 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 has admitted the appellant's request for review and brief in support of the request into the record as Exhibit (Exh.) MAC-1.

[1] The ALJ determined that a speech therapy evaluation, provided during the same time period, would be covered. The ALJ did not address the issue of liability for the non-covered home health skilled nursing services.

For the reasons and bases set forth below, the Council reverses the ALJ's decision. Medicare coverage is available for the home health skilled nursing services furnished from April 17, 2007, through October 13, 2007.

BACKGROUND AND PROCEDURAL HISTORY

The beneficiary is a male in his forties who has, among other medical conditions, diabetes and spina bifida with hydrocephalus. His medical history includes recurrent urinary tract infections, and anal and rectal abscesses. His bowel and bladder functions are maintained by colostomy and urostomy. He is totally dependent for his care. His mother acts as his primary caregiver. He cannot bear weight and requires maximum assistance to leave his home. At issue in this appeal are skilled nursing visits furnished by Ocean County Board of Health, the provider, from April 17, 2007, through October 13, 2007.

The contractor denied coverage for the nursing services at issue because they did not result in "significant changes in the patient's condition"; nor were there any changes to the plan of care. Exh. 4, at 284. The Qualified Independent Contractor (QIC) determined that the nursing services were not medically reasonable and necessary. Exh. 5, at 308-09. Both the contractor and the QIC found the provider liable for the noncovered costs. Exhs. 4, at 283; 5, at 308.

The ALJ denied coverage of the skilled home health nursing services, in essence, on the basis that, skilled observation and assessment by a nurse are not reasonable and necessary where, as in this case, the beneficiary's "condition" is "chronic" and the problems for which the nursing services were furnished are "a part of a longstanding pattern of [his] condition" for which there has been "no attempt to change the treatment to resolve" the condition. *See* Dec. at 22-23.

DISCUSSION

The Council disagrees with the ALJ's assessment of the evidence. We find that medically reasonable home health skilled nursing visits were provided on an intermittent basis during the dates of service.

The skilled nursing services were needed, first, to observe and assess the beneficiary's wounds, from April 17, through at least the first week of June 2007, and as well, to provide appropriate wound care training. The ALJ stated that "the record lacks documentation of the wound size, depth, nature of drainage and condition and appearance of the surrounding skin." Dec. at 23. This statement does not accurately capture the contents of the records in the file, as they document the beneficiary's open, exudating wound on the coccyx, which the nurses cleaned, irrigated, sterilized, packed, and covered. This activity itself is a skilled nursing service. 42 C.F.R. § 409.33(b)(5) (application of dressings involving prescription medications and aseptic techniques).

Further, in our view, whether or not the beneficiary's immobility or "chronic" condition(s) contributed to or caused the development of the beneficiary's wounds in this case (*see* Dec. at 23) misses the point. The regulations state 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. It must be reasonable within the context of his or her condition. *See* 42 C.F.R. § 409.44(b)(3). Whether skilled nursing services are, or are not, medically reasonable and necessary, is a determination that must be made "solely on the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, *chronic*, terminal, or *expected to last a long time*." *See* 42 C.F.R. § 409.44(b)(3)(iii) (italics supplied); *see also* 42 C.F.R. § 409.32(c) (potential for restoration is not the deciding factor for determining the necessity of skilled services).

Moreover, the ALJ did not consider whether the observation and assessment of the status of the beneficiary's wounds for signs and symptoms of infection or other complications constituted a skilled, and medically necessary, nursing service for this beneficiary. We find that it was, in accordance with 42 C.F.R. section 409.33(a)(2). And, in addition to assessing the status of the beneficiary's wound, the nurses instructed the beneficiary's mother and sister on the beneficiary's wound care regimen. The fact that, during the dates of service, the beneficiary apparently had at least one family member who is familiar with the beneficiary's medical conditions and care needs and routinely acts as the primary caregiver does not necessarily warrant a conclusion that that family member's

caregiver services could effectively substitute those of a skilled nurse who possesses specialized knowledge of, and experience in, how to identify changes or complications in wounds and to assess any need for appropriate wound care intervention or instruction. 42 C.F.R. §§ 409.33(a)(2) and (3), 409.44(b)(1)(iii); *see also* Medicare Benefit Policy Manual (MBPM), CMS Pub. 100-02, Ch. 7, sections 20.2; 40.1.1; 40.1.2.1; 40.1.2.3; 40.1.2.8.

Aside from the medically reasonable and necessary wound care-related skilled nursing services discussed above, the beneficiary also required ongoing skilled level of monitoring and assessment during the dates of service at issue to manage and evaluate his care plan in accordance with the physician's directions. 42 C.F.R. § 409.33(a)(1). Particularly pertinent in this case are the beneficiary's history of urinary tract infections and his bowel/bladder functions managed by colostomy and urostomy. The beneficiary experienced numerous medical complications related to his bowel and bladder functioning throughout the dates of service. He had a recurrence of urinary tract infection around mid-point during the six-month period at issue. He was hospitalized for several days in July 2007 for urosepsis and e.coli infection. He experienced another bout of urinary tract infection two months later. He experienced rectal bleeding more than once during the dates of service, and penile discharge (for which he was given prescription antibiotics). Tissue was found in the urostomy. The nurses noted abscesses in the rectum. The beneficiary developed a fistula near the colostomy site.

During the dates of service at issue, the nurses provided medically reasonable and necessary management and evaluation of the beneficiary's care plan. The beneficiary's underlying conditions and complications related to his conditions required ongoing, intermittent intervention by skilled personnel to promote recovery and medical safety in view of the beneficiary's overall condition. *See* MBPM, Ch. 7, § 40.1.2.2.

DECISION

Based on the foregoing reasons and bases, the Medicare Appeals Council reverses the ALJ's decision. The home health skilled nursing services provided from April 17, 2007, through October 13, 2007, are covered by Medicare, and reimbursement shall be made in accordance with this decision.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

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

Date: December 15, 2010