DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
Prestige Home Care Agency (Appellant)	Hospital Insurance Benefits (Part A)
Multiple (see attached) (Beneficiaries)	Multiple (see attached) (HIC Numbers)
Cahaba Government Benefit Administrators, LLC (Contractor)	**** (ALJ Appeal Numbers)

The Administrative Law Judge (ALJ) issued multiple decisions dated December 2 and 4, 2008, concerning Medicare coverage for home health skilled nursing services provided by the appellant to three beneficiaries during the period October 5, 2004, through September 29, 2005. The ALJ determined that the home health skilled nursing services provided to each of the beneficiaries were medically reasonable and necessary, and therefore covered by Medicare. The appellant home health agency has asked the Medicare Appeals Council to review this action.

The Council reviews the ALJ's decisions *de novo*. 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's actions 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 appellant's three requests for review are each entered in their respective record as Exhibit (Exh.) MAC-1. For the reasons set forth below, the Council reverses the ALJ's decisions, finding that the services provided to the three beneficiaries did not meet Medicare coverage requirements.[1]

[1] This decision resolves the requests for review pertaining to beneficiaries B.K., B.N., and F.P. In a separate action, the Council has remanded cases pertaining to two other beneficiaries whose claims were originally combined

Background and Appellant's Contentions

Prestige Home Care Agency, the home health agency, provided home health nursing and personal care services to the three beneficiaries whose services are discussed herein. The intermediary denied coverage of the services. *See, e.g.,* B.K.1 File, Exhs. 1-3.[2] The Commonwealth of Pennsylvania's Department of Public Welfare, acting as subrogee, appealed the denial of Medicare coverage at the redetermination, Qualified Independent Contractor (QIC) reconsideration, and ALJ levels. *Id.* at Exhs. 4, 9, 10.

The ALJ issued three favorable decisions, finding Medicare coverage for the beneficiaries' home health services. *See, e.g.,* B.K.1 File, ALJ Decision, December 4, 2009. The home health agency, which had appeared as a party at the ALJ hearings, filed a timely request for review, asserting that the home health services should not be covered by Medicare for two reasons. *See, e.g.,* B.K.1 File, Exh. MAC-1. First, it contends that each of the beneficiaries had longstanding, chronic illnesses, but did not develop an acute episode or complication requiring skilled nursing during the periods at issue. *Id.* Second, each beneficiary had had many more months of skilled nursing than was necessary to ascertain that an acute episode of their illness(es) was not likely and, therefore, continued observation and assessment were not medically reasonable. *Id.*

The Pennsylvania Department of Public Welfare requested leave from the Medicare Appeals Council to file briefs opposing the home health agency's request for review. The Council granted the request, but noted that the attorney who submitted the request was required to provide a valid appointment of representation consistent with the requirements in 42 C.F.R. § 405.910. The attorney has not filed a brief or an appointment of representative. Therefore, notice of this action has been

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in the same group of cases that were before the ALJ. (Beneficiaries M.J. and A.R.). We are remanding the remaining cases because the recordings of their hearings are inaudible.

[2] Each beneficiary has a separate claims file for each two-month period of service at issue. The evidence in these files will be referred to first by the file itself (such as B.K.1, the file for Beneficiary B.K.'s first two months of service), then by the exhibit number in that file, and, where necessary, by the page number within that exhibit.

limited to the home health agency, the Pennsylvania Department of Public Welfare, and the beneficiaries.

The three beneficiaries whose claims are at issue were all affected by chronic disease and were provided services by the home health agency for a number of months. Each beneficiary's care is evaluated separately below.

APPLICABLE LAW

In order for a beneficiary to qualify for Medicare coverage of home health services, they must be confined to the home, under the care of a physician, in need of skilled services, under a plan of care, and the services must be provided by a participating home health agency. 42 C.F.R. § 409.42. The beneficiary must need "skilled services" in the form of intermittent skilled nursing services, physical therapy services, speech-language pathology services, or occupational therapy services. 42 C.F.R. § 409.42(c). To qualify for Medicare coverage, the intermittent skilled nursing services provided must meet the criteria for skilled services and the need for those services, as described in 42 C.F.R. § 409.32.

42 C.F.R. § 409.33(a)(2)(i) explains when observation and assessment of the patient's changing condition constitute skilled services: "Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment or for additional medical procedures until his or her condition is stabilized."

CMS Pub. 100-02, Medicare Benefits Policy Manual (MBPM), Chapter 7, Section 40.1.2.1. (Observation and Assessment of the Patient's Condition When Only the Specialized Skills of a Medical Professional Can Determine Patient's Status) provides:

> Observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services when the likelihood of change in a patient's condition requires skilled nursing 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. When a patient was admitted to home health care for skilled observation because there was a reasonable potential of a

> complication or further acute episode, but did not develop a further acute episode or complication, the skilled observation services are still covered for three weeks or so long as there remains a reasonable potential for such a complication or further acute episode.
> * * *
> However, 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.

ANALYSIS

Beneficiary B.K.
(Dates of service from October 5, 2004, through June 1, 2005; and from August 1, 2005, though September 29, 2005)

Beneficiary B.K. started care with the home health agency on June 15, 2003, approximately sixteen months before the dates of service at issue here. B.K.1 File, Exh. MAC-1. Her primary diagnosis was hypertension, and her other diagnoses were coronary atherosclerosis, cardiac dysrhythmia, polyarthritis, constipation, and urinary tract infection. B.K.1 File, Exh. 13 at 57 (Home Health Certification and Plan of Care). During the ten months at issue, the beneficiary's physician signed certifications that she required, and should receive, skilled nursing services one to two times a month (for observation and assessment, and teaching medications) and personal care services five to seven times a week for the first eight months. *See, e.g.,* B.K.1 File, Exh. 13; B.K.5 File, Exh. 13.

The contractor and QIC both denied Medicare coverage of the skilled nursing services because there were no significant changes in the beneficiary's condition, medications, or treatment plan during the dates of service under review. *See, e.g.,* B.K. 1 File, Exhs. 3, 9. Although the contractor and QIC acknowledged that the medical documentation did show longstanding problems, along with chronic signs and symptoms (such as edema and dizziness), they determined it was not reasonable or medically necessary to provide ongoing monthly skilled nursing assessment when there were no acute changes in the beneficiary's condition or treatment. *Id.* Both the contractor and the QIC found the home health agency liable for

the costs of the noncovered care. *Id.* The ALJ granted Medicare coverage for the skilled nursing, stating that the beneficiary needed observation and assessment at the start of care, and that it was reasonable to expect that she would need it thereafter. Dec. at 4-5.

After reviewing the medical evidence, the Council determines that Beneficiary B.K. did not require skilled nursing services for observation and assessment during the dates of service reviewed here. As the contractor and the QIC noted, her condition was stable and chronic; her vital signs (including pulse, respiration, and blood pressure) did not fluctuate significantly; and her dizziness and edema were ongoing symptoms of her chronic hypertension. *See, e.g.,* B.K.1 File, Exh. 13; B.K.2 File, Exh. 12; B.K.4 File; Exh. 13. She appears to have had only two medication changes during this period, and they were uneventful. *See* B.K.1 File, Exh. 13; B.K.4 File, Exh. 13. Given the above, there was no realistic likelihood of complications or an acute episode that would have required observation and assessment by a skilled nurse. 42 C.F.R. § 409.33(a)(2)(i); CMS Pub. 100-02, MBPM, Chapter 7, Section 4.1.2.1. We also find that the ALJ erred in stating that the beneficiary had a "need for instruction in ostomy care." *Id.* at 4. All of the records in Beneficiary B.K.'s files state that she did not have an ostomy. *See, e.g.,* B.K.1 File, Exh. 13 at 59; B.K.2 File – Exh. 12 at 50.

For the foregoing reasons, the Council concludes that the skilled nursing services provided by the appellant to Beneficiary B.K. during the dates of service listed above were not medically reasonable and necessary, and therefore not covered by Medicare. Also, pursuant to 42 C.F.R. § 409.45(a), home health aide services are not covered when a beneficiary does not need skilled care. Therefore, the personal care services, which were provided to Beneficiary B.K. during the first eight months of the ten months at issue here, are also not covered by Medicare. The ALJ's decision concerning this beneficiary is reversed. The appellant home health agency is liable for the costs of the non-covered services; the beneficiary is not liable.

Beneficiary B.N.
(Dates of service from October 27, 2004, through February 23, 2005)

B.N. started care with the home health agency on June 29, 2004, approximately four months before the dates of service at issue. B.N.1 File, Exh. MAC-1. Her primary diagnosis was hypertension; other diagnoses were coronary atherosclerosis, malignant neoplasm of the skin, hyperlipidemia, joint disease, and polyarthritis. B.N.1 File, Exh. 13 at 58 (Home Health Certification and Plan of Care). During the four months at issue the certification and plan of care called for skilled nursing services one to two times a month (for observation and assessment, and teaching medications and signs and symptoms of cardiac complications), and personal care services three to five times a week. B.N.1 File, Exh. 13 at 58; B.N.2 File, Exh. 13 at 67.

The contractor and the QIC both denied Medicare coverage for the skilled nursing services, finding that there had been no significant changes in the beneficiary's condition, medications, or treatment plan during the dates of service under review. *See* B.N.1 File, Exhs. 3, 9; B.N.2 File, Exhs. 3, 9. Although the contractor and QIC acknowledged that the medical documentation did show longstanding problems with chronic signs and symptoms, they determined it was not reasonable or medically necessary to provide ongoing monthly skilled nursing assessment when there were no acute changes in the beneficiary's condition or treatment. *Id.* Both the contractor and the QIC found the home health agency liable for the costs of the noncovered care. *Id.*

The ALJ, however, found the skilled nursing services covered, stating that the beneficiary had needed observation and assessment at the start of care, and then it was reasonable to expect that she would need it thereafter. Dec. at 4-5.

After a review of the medical evidence, the Council has determined that the beneficiary did not require skilled nursing services for observation and assessment during the dates of service reviewed here. The beneficiary's condition was stable and chronic; there were no significant changes in her medical condition. *See* B.N.1 File, Exhs. 3, 9, and 13 at 52-53; B.N.2 File, Exh. 13 at 62. Moreover, during this period, there was no evidence that the beneficiary was likely to have complications or an acute episode. Therefore, she did not require observation and assessment by a skilled nurse. 42 C.F.R. § 409.33(a)(2)(i);

CMS Pub. 100-02, MBPM, Chapter 7, Section 4.1.2.1. Moreover, the Council notes that although the ALJ found that the beneficiary had a "need for instruction in ostomy care," B.N.'S medical record indicates that she did not have an ostomy. *See* B.N.1 File, Exh. 13 at 56; B.N.2 File, Exh. 13 at 64.

For these reasons, the Council finds that the nursing services provided to the beneficiary B.N. during the period at issue were not reasonable and necessary, and therefore not covered by Medicare. Therefore, the home health services, as dependent services, are not covered either. 42 C.F.R. § 409.45(a). Accordingly, the ALJ's decision concerning this beneficiary is reversed. The appellant home health agency is liable for the costs of the noncovered services.

Beneficiary F.P.
(Dates of service from September 14, 2004, through November 12, 2004; and from November 13, 2004, through January 11, 2005)

The beneficiary started care with the home health agency on May 17, 2004, approximately four months before the dates of service at issue. F.P.1 File, Exh. MAC-1. Her primary diagnosis was hypertension, and, additionally, coronary atherosclerosis, cellulitus of her leg, asthma, polyarthritis, a duodenal ulcer, and obesity. F.P.1 File, Exh. 13 at 59-60. During the four months in question the beneficiary's physician certified that she needed skilled nursing services one to two times a month (for observation and assessment of her cardiovascular status) as well as teaching the patient and her caregiver the signs and symptoms of her cardiac condition. She also received personal care services three to five times a week. *Id., see also* F.P.2 File, Exh. 13 at 56-57.

The contractor denied Medicare coverage on redetermination on the ground that it was not reasonable or medically necessary to provide monthly skilled nursing visits to assess longstanding medical problems when there had been no acute changes in the beneficiary's condition or treatment. F.P.1 File, Exh. 3 at 15; F.P.2 File, Exh. 3 at 15. The contractor found the home health agency liable for the noncovered services. *Id.*

On reconsideration, the Qualified Independent Contractor (QIC) found that the documentation provided was inadequate and that the beneficiary's care had not met Medicare coverage criteria.

F.P.1 File, Exh. 9 at 31.[3] Although the beneficiary had reported "heart palpitations," the record did not indicate that the home health agency had thoroughly assessed the cause of the palpitations. *Id.; see also* F.P.2 File, Exh. 13 at 51-52. The beneficiary was also noted to have lower extremity edema, but it was not quantified or further assessed. *Id.* The beneficiary was also noted to have wheezing in her lungs, but there was no record whether she was compliant in her nebulizer/inhaler treatments. *Id.* Lastly, the QIC noted that there had been no changes in the beneficiary's medications or plan of care; in addition, no skilled teaching was documented. *Id.* The QIC concluded that the home health agency was responsible for the noncovered costs. F.P.1 File, Exh. 9 at 31-32*; see also* F.P.2 File, Exh. 9 at 31-32.

The ALJ concluded that the beneficiary needed and received skilled nursing care in the form of observation and assessment, and that she "needed instruction in ostomy care." Dec. at 4-5. According to her medical records, the beneficiary did not have an ostomy. F.P.1 File, Exh. 13 at 57; F.P.2 File, Exh. 13 at 54. Moreover, the ALJ's finding that the beneficiary required and received skilled observation and assessment is not supported by the evidence. In that regard, the Council notes that although the ALJ listed the beneficiary's medical conditions and treatments in the decision's Findings of Fact, the hearing decision does not note any specific medical conditions and/or medical care that the ALJ considered to be skilled, either singly or in combination (other than the reference to ostomy care), that demonstrated that the care the home health agency provided was skilled. Dec. at 4-5.

After reviewing the limited medical evidence, the Council has determined that Beneficiary F.P. did not require skilled nursing services for observation and assessment during the dates of service reviewed here, and that the services that were documented were not skilled, for the reasons given by the QIC. The beneficiary's condition appears to have been stable and chronic; skilled nursing for observation and assessment was not required. 42 C.F.R. § 409.33(a)(2)(i); CMS Pub. 100-02§, MBPM, Chapter 7, Section 4.1.2.1. Moreover, there is no evidence that the signs and symptoms that were recorded in the nurses' notes

[3] The QIC denied coverage for the second two months of skilled nursing care on the ground that the physician's signature on the Home Health Certification and Plan of Care was not dated. F.P.2 File, Exh. 9 at 31. However, the Home Health Certification and Plan of Care document in the record contains a dated signature. *Id.*, Exh. 13 at 57.

prompted further investigation, a consultation with the physician, additional teaching about medications, or other steps to treat the beneficiary. *See* F.P.1 File, Exh. 13 at 54, 55; F.P.2 File, Exh. 13 at 51, 52.

Accordingly, the Council concludes that the nursing services provided by the appellant to F.P. during the dates of service listed above were not medically reasonable and necessary, and therefore not covered by Medicare. The home health nursing and dependent services are therefore not covered by Medicare. 42 C.F.R. § 409.45(a). The ALJ's decision pertaining to this beneficiary is reversed. The appellant home health agency is liable for the costs of the noncovered services.

DECISION

The Council finds that the home health services provided to beneficiaries B.K., B.N., and F.P. were not medically reasonable and necessary and are not covered by Medicare. Therefore, the three hearing decisions are reversed. The home health agency is liable for the noncovered costs of the services it provided to the three beneficiaries.

MEDICARE APPEALS COUNCIL

/s/ M. Susan Wiley
Administrative Appeals Judge

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: November 2, 2009