DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-325

In the case of	**Claim for**
Landmark Home Health Care (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiary)	**** (HIC Number)
Cahaba Government Benefit Administrators, LLC (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated September 15, 2010, concerning Medicare coverage for home health skilled nursing services the appellant furnished to the beneficiary from November 21, 2008, through December 15, 2008. The ALJ denied coverage for the services, and found the appellant liable for the non-covered costs. 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 appellant's request for review and accompanying letter is hereby made a part of the record as Exhibit (Exh.) MAC-1.

In its request for review, the appellant raises three main contentions. First, the appellant asserts that the ALJ erred in not recognizing that both the beneficiary's increased oxygen needs and his increased Coumadin monitoring were changes in his condition and medical care warranting skilled nursing. Exh. MAC-1 at 1-2; *see* 42 C.F.R. § 409.33(a)(2). Second, the

appellant submits that the ALJ erred in finding that the beneficiary did not require skilled care, by relying in part on the chronic nature of the beneficiary's medical problems. Exh. MAC-1 at 1; *cf.* 42 C.F.R. § 409.44(b)(3)(iii) (whether skilled care is reasonable and necessary depends 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). Third, the appellant explains that the skilled nursing at issue here started after the beneficiary experienced an episode of cyanosis, because of a reasonable potential for complications or a further acute episode. Therefore, the appellant contends that, based upon section 40.1.2.1 of chapter 7 of the Medicare Benefit Policy Manual (MBPM) (CMS Pub. 100-2), the skilled observation services the beneficiary received are covered for three weeks or for as long as a reasonable potential exists for such a complication or further acute episode. Exh. MAC-1 at 3-4.[1]

The Council has reviewed the record and the appellant's contentions. For the reasons set forth below, the Council reverses the ALJ's decision, and determines that Medicare covers the skilled nursing services the appellant provided to the beneficiary from November 21, 2008, through December 15, 2008.

Factual and Procedural Background

The beneficiary, age 91 during the dates of service, was diagnosed with:

- respiratory distress (which had led to an episode of cyanosis diagnosed in the emergency room three days earlier);
- orthostatic hypotension;
- atrial fibrillation; and
- congestive heart failure.

Exh. 4 at 9. The beneficiary's cardiac history included coronary artery disease with five coronary artery bypass grafts, two cardiac stents, and a pacemaker. *Id.* He was also on long

[1] Overall, the care at issue in this case comprised three and one-half weeks, which included eight skilled nursing visits. Exh. 1 at 21.

term Coumadin therapy (for his multiple cardiac diseases, devices, and problems). *Id.* At one point his blood oxygen saturation level was measured at 84 percent, on room air. *Id.* at 20. The beneficiary's physician prescribed an increase in oxygen from three liters per minute on an as needed basis to five liters per minute continuously, following his emergency room visit for cyanosis and recognition of his low blood oxygen saturation levels. Exh. 2 at 32; Exh. 4 at 9.

In the plan of care for home health services, the beneficiary's physician ordered skilled nursing care once in the initial week and then twice a week for four weeks, to assess his therapeutic response or adverse response to the prescribed Coumadin dosages (via blood draws and lab work), and to assess his cardio-pulmonary status (including obtaining his pulse oximetry responses), *inter alia.* Exh. 4 at 1-2. The beneficiary needed nurses to monitor the Coumadin medication, because it affected the prothrombin time and related INR (International Normalized Ratio), which reflected his blood clotting times (both internally and externally). Exh. 4 at 1.

During their home health visits, the nurses obtained blood samples for the prothrombin and INR analyses, and based on this data, his physician modified the Coumadin dosages twice. *See* Exh. 4 at 1-6. Pursuant to the plan of care, the nurses also did regular cardiovascular and pulmonary checks, including checks for oxygen saturation as needed. *See, e.g., id.* at 17. In addition, the nurses monitored his pressure ulcers, instructed the beneficiary and his caregivers in the reasons for and use of the increased oxygen supply, safety measures (for recognizing low oxygen levels, using oxygen safely, and avoiding falls), and the effects and risks of blood thinning medication. *Id.* at 8-15, 18, 20-21, 27, 29.[2]

The contractor denied coverage for the home health skilled nursing visits. Exh. 1 at 21. On redetermination, the contractor again denied coverage on the ground that the beneficiary was not experiencing "acute significant changes in his condition, medication, or treatment plan," and held the home health agency liable for the non-covered charges. Exh. 1 at 2-

[2] In addition, both the beneficiary's spouse and his caregiver asked about the possibility of his transfer to hospice care. Exh. 4 at 9, 17. The home health representative discussed this with them and the beneficiary. *Id.* at 17-18. The beneficiary was transferred to hospice care on December 16, 2008. *Id.* at 35.

5.[3] On reconsideration, the Qualified Independent Contractor (QIC) agreed with the contractor's redetermination, denying coverage. Exh. 2 at 2-5.

On September 5, 2010, the ALJ issued a decision denying coverage. Dec. at 10-11. First, the ALJ reasoned that the beneficiary had received prior home health services, but the appellant had not provided those records. *Id.* at 10-11. Second, the ALJ concluded that the beneficiary did not require skilled observation and assessment because "the evidence does not include any orders for changes to the beneficiary's plan of care, or any changes to his medication." *Id.* at 11.

However, the ALJ's reasons for denying coverage are incorrect, and the record in this case supports coverage for the home health skilled nursing services the beneficiary received. Therefore, as set forth below, the Council reverses the ALJ, and finds Medicare coverage for the home health skilled nursing services from November 21, 2008, through December 15, 2008.

Discussion

The Council has reviewed the record in this case, and determined that the beneficiary received reasonable and necessary skilled nursing care for changes in his condition, treatment, and medication that required skilled observation and assessment. A general principle governing reasonable and necessary skilled nursing care is that a patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. *See* MBPM, CMS Pub. 100-02, Ch. 7, § 40. However, a patient's overall medical condition *is* a valid factor in deciding whether skilled services are needed. *Id*.

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[3] There is no language in the Medicare regulations requiring that the patient be experiencing "*acute* significant changes" in his condition, medication, or treatment plan. *Cf.* Exh. 1 at 3 (language of QIC Reconsideration). The Medicare regulations provide for coverage of skilled nursing for "observation and assessment of the patient's changing condition" 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." 42 C.F.R. § 409.33(a)(2)(i). This beneficiary had experienced and was experiencing the types of changes in his condition, medication, and treatment plan that warranted skilled nursing. These included his episode of cyanosis, his physician's decision to sharply increase his oxygen, and his changing prothrombin and INR values, which required adjustments in his Coumadin dosages to be stabilized within safe ranges, *inter alia.*

As noted above, the decision of the beneficiary's physician to order home health skilled nursing services for three and one half weeks was prompted by an emergency room diagnosis of cyanosis. Exh. 4 at 1-2, 9. This emergency was a serious medical event for the beneficiary, given his cardiac and pulmonary co-morbidities. As a result, his physician increased his oxygen from three liters per minute as needed to five liters per minute continuously. *Id.*; Exh. 2 at 32. The combination of the beneficiary's condition, age, medical history and limited mobility created a very reasonable potential for serious complications or a change in condition that could require skilled nursing care.[4] In the days and weeks that followed, his physician and nurses also monitored the effect of his Coumadin dosage on his prothrombin time and INR, which were in the high range on November 26, 2008, and well above the safe range on December 11, 2008. Exh. 4 at 5, 4. Therefore, on December 4, 2008, and again on December 12, 2008, the physician issued orders changing the beneficiary's Coumadin dosage. *Id.* at 3.

In the ways described in the factual background above, the home health nurses provided skilled observation and assessment of the beneficiary's cardiovascular and pulmonary status, after the increase in his oxygen needs, and during the adjustment of his Coumadin dosage. *See* Exh. 4 at 1-35. Given the beneficiary's multiple cardiac problems, previous cardiac surgeries, and use of cardiac devices, achieving a stabilized, therapeutic prothrombin time and INR was critical to his recovery and stabilization. *See id.* at 9, 3-5.

In addition, the nurses provided patient and caregiver education at a skilled level, including instructions on why the beneficiary was using increased oxygen, how to manage it, and how to recognize signs of low blood oxygen levels; information about the role Coumadin played preventing clots, given his medical history, the risks of his prothrombin time and INR values being too low or too high, and the importance of frequent communication with the nurses and physician about those levels. *See, e.g., id.* at 15, 18, 20-21. The nurses also responded to an inquiry about hospice care, discussed hospice care with the beneficiary and his caregivers, and helped to arrange for hospice care. *Id*. at 17, 18, 35. As noted above, all of this

[4] "Information from the patient's medical history may support whether there is a reasonable potential for a future complication or acute episode and therefore may justify the need for continued skilled observation and assessment beyond the 3-week period." *See* MBPM, Ch. 7, section 40.1.2.1.

was done within three and one-half weeks, in a total of eight nursing visits.

To summarize, the foregoing constituted skilled nursing care; the beneficiary clearly needed it; and it was provided pursuant to a valid Home Health Certification and Plan of Care. *See* Exh. 4 at 1-2.

The ALJ erred in denying coverage for these home health skilled nursing visits. The ALJ based her denial in part on the fact that the appellant did not provide the records of prior home health services the beneficiary received. Dec. at 12. However, neither the contractor nor the QIC had requested prior home health records from the Appellant, and the regulations do not require that such records be included with the current claim. Moreover, the ALJ did not ask the appellant for the records of prior home health services, either before or during the hearing. *See* Exh. 3 at 26-30 (Notice of Hearing); CD Recording of ALJ Hearing, September 9, 2010. The ALJ also erred in concluding that the medical notes in the record do not demonstrate that the nursing visits involved skilled services. *Id.* at 13. This is incorrect, for the reasons explained in the foregoing paragraphs. The nurses did provide skilled services as defined by the Medicare regulations.

In addition, as the appellant contends, the Medicare Benefit Policy Manual provides an additional basis for covering the three and one half weeks of home health skilled nursing care in this case. Medicare coverage for this care is premised on the Medicare Benefit Policy Manual section which provides that skilled observation nursing services which a beneficiary began receiving because there was a reasonable potential of a complication or further acute episode (here, possibly another episode of cyanosis) are still covered, even if there is not another acute episode, for three weeks or for so long as a reasonable potential exists for such a complication or further episode. CMS Pub. 100-02, MBPM, Chapter 7, Section 40.1.2.1.

The Council does not need to reach the issue of liability for any non-covered services, because there are no non-covered services in this episode of eight home health skilled nursing visits.

DECISION

The Medicare Appeals Council reverses the ALJ's decision, and finds Medicare coverage for the home health skilled nursing services the appellant provided to the beneficiary from November 21, 2008, through December 15, 2008.

MEDICARE APPEALS COUNCIL

/s/ Stanley I. Osborne, Jr.
Administrative Appeals Judge

/s/ Susan S. Yim
Administrative Appeals Judge

Date: August 9, 2011