DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

ACTION OF MEDICARE APPEALS COUNCIL
ON REQUEST FOR REVIEW
Docket Number: M-12-1140

In the case of	**Claim for**
L.R. o/b/o A.R. (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiary)	**** (HIC Number)
IPRO (QIO) (Contractor)	**** (ALJ Appeal Number)

INTRODUCTION

The Administrative Law Judge (ALJ) issued an unfavorable decision, dated January 18, 2012, concerning the decision of the provider skilled nursing facility (SNF) to terminate skilled services for the beneficiary on October 5, 2011. The ALJ determined that the SNF's decision was appropriate, as the beneficiary no longer required skilled care. The beneficiary, through her representative (daughter), has asked the Medicare Appeals Council (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 did not send a copy of the request for review to the provider, although the provider is a party to the appeal. Failure to copy all parties on a request for review tolls the Council's adjudication deadline until all parties "receive notice of the request for [Council] review." 42 C.F.R.

§ 405.1106(a). On June 25, 2012, the Council sent the provider (via facsimile) a copy of the request for review. The Council has received no response from the provider.

The Council admits the appellant's request for review and subsequent interim correspondence into the record as Exhibits (Exhs.) MAC-1 through MAC-4, respectively. As set forth below, the Council adopts the ALJ's decision.

BACKGROUND

The ALJ found that the 87 year old beneficiary was first admitted to the SNF on August 25, 2011, following inpatient hospitalization from August 16, 2011, through August 25, 2011, for a "seizure-type episode." Dec. at 2. The beneficiary was then sent to the hospital emergency room on August 28, 2011, for chest pain, was released, and was re-admitted to the SNF on August 30, 2011. *Id.* Following readmission, the beneficiary received physical therapy (PT), occupational therapy (OT), and nursing services. *Id.* The SNF discharged the beneficiary from both PT and OT on September 30, 2011, and issued a "Notice of Medicare Non-Coverage" (NNC), which stated that Medicare coverage of SNF services would end on October 5, 2011, as "there [was] no continuing evidence of medical necessity for the skills of a professional nurse or a therapist to safely and effectively carry out the plan of care." *Id.* at 1-2, *citing* Exh. 1. A SNF representative documented in the NNC that she notified the beneficiary's daughter by telephone on October 3, 2011, of the termination of skilled services and of the beneficiary's appeal rights. Exh. 1, at 1, 3. The Quality Improvement Organization (QIO) and the Qualified Independent Contractor (QIC) affirmed the provider's decision on appeal. Dec. at 1-2.

The ALJ stated that the provider terminated skilled care based on a lack of evidence that the skills of a professional nurse or therapist were required. Dec. at 5. The ALJ also reviewed the beneficiary's medical condition, on initial admission to the SNF, subsequent hospitalization, and readmission, and determined that "[i]t is clear that no skilled services were ordered or received after October 5, 2011, and thus there are no services" for which the ALJ could order reimbursement. *Id.* at 5-6.[1] The ALJ then found the beneficiary liable for any non-covered charges, based on "actual knowledge" of non-coverage. *Id.* at 6.

[1] The ALJ found that she lacked jurisdiction to order the resumption of therapy. *Id.*

DISCUSSION

In her request for review, the appellant refers the Council to the "2nd full paragraph" on page six of the ALJ's decision, then asserts that "rehabilitative services were 'medically reasonable and necessary' . . . ." Exh. MAC-1, at 1. The appellant also argues that she "did not have prior knowledge that Medicare payment for services would be denied before 90 or 100 days." *Id.* The appellant states that "rehabilitative services should have been continued" and that, although some of the beneficiary's chronic conditions did not improve, others did. *Id.* The appellant concludes by asking that the Council review the ALJ's decision in light of the decision in *Jimmo v. Sebelius,* Civil No. 5:11-CV-17 (D. Vt. October 25, 2011). *Id.*

The Council is unclear on the appellant's reference to the second full paragraph on page six of the ALJ's decision, as that paragraph concerns limitation on liability under section 1879 of the Social Security Act (Act), not medical necessity under section 1862 of the Act. The Council construes the appellant's contention, however, as being that the services provided were "reasonable and necessary" under section 1862 and that the beneficiary continued to require skilled care as of and beyond the cut-off date of October 5, 2011.

As the ALJ pointed out, the record indicates that the provider discharged the beneficiary from skilled PT and OT on September 30, 2011, a month after readmission to the SNF, because the beneficiary had inconsistent vital signs, low blood pressure, and dizziness while standing. Dec. at 6. The beneficiary could at that time transfer with moderate assistance, ambulate with a rolling walker for fifteen feet with minimum to moderate assistance, could "complete four minutes of activity tolerance exercises," and had shown "some improvements in activities of daily living." *Id.* The Council agrees with the ALJ that the record does not establish that the beneficiary qualified for care after October 5, 2011, that was both medically reasonable as well as necessary, within Medicare's coverage criteria.[2]

The appellant's reliance on the *Jimmo v. Sebelius* litigation is also unavailing. On January 24, 2013, the United States District Court for the District of Vermont approved a settlement agreement in that case, in which the plaintiffs alleged that the Centers for Medicare & Medicaid Services (CMS) wrongly applied an "improvement standard" in making skilled care determinations

[2] The fact that the beneficiary did not use the entire 100 day SNF "spell of illness" benefit is irrelevant in determining coverage.

for home health, SNF, and outpatient rehabilitation services. In a Fact Sheet on the litigation,[3] CMS stated that it had denied establishing an improper "rule of thumb" improvement standard and that the Court had not ruled on the plaintiffs' arguments. CMS also stated that, while expectation of improvement was one factor for consideration in determining skilled care, "Medicare policy has long recognized that there may also be specific instances where no improvement is expected but *skilled* care is, nevertheless, required in order to prevent or slow deterioration and maintain a beneficiary at the maximum practicable level of function." Emphasis supplied; *see* 42 C.F.R. § 409.32(c). CMS summarized that "coverage depends not on the beneficiary's restoration potential, but on *whether skilled care is required*, along with the underlying reasonableness and necessity of the services themselves." Emphasis supplied. CMS pointed out a party's responsibility to provide "sufficient documentation to substantiate clearly that skilled care is required, that it is in fact provided, and that the services themselves are reasonable and necessary . . . ." CMS noted that the Settlement Agreement also specified: "**Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage**." Bold in original. Instead, CMS stated that the Settlement Agreement required that CMS clarify existing policies for consistent and appropriate coverage determinations. *See, generally,* "*Jimmo v. Sebelius* Settlement Agreement Fact Sheet," Attachment.

The *Jimmo v. Sebelius* Settlement Agreement Fact Sheet is not itself authority, but it concisely restates the governing coverage standards as relevant to this case in light of the appellant's contention referring to the settlement. A Medicare beneficiary must, in part, require the skills of professional or technical personnel for rehabilitation therapy services to meet coverage requirements. *See, e.g.,* 42 C.F.R. §§ 409.31(a)(2), 409.32, 409.33. In this case, the Council agrees with the ALJ that the beneficiary did not require skilled services after October 5, 2011.

As the beneficiary does not dispute the documented telephone contact by the provider on the NNC, the Council upholds the ALJ's finding that the beneficiary is liable for any non-covered charges after October 5, 2011.

[3] The Council includes the CMS Fact Sheet as an attachment to this decision.

CONCLUSION

The Council has considered the record and exceptions. The Council concludes that the appellant's exceptions present no basis for changing the ALJ's action. The Council therefore adopts the ALJ decision.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

Date: February 21, 2014