



Department of Health and Human Services  
OFFICE OF MEDICARE HEARINGS AND APPEALS  
Midwestern Region  
Cleveland, Ohio

1-380068132  
**RECEIVED**

JUN 17 2009

Center for  
Medicare Advocacy

Appeal of: [REDACTED]	ALJ Appeal No.: 1-380068132
Beneficiary: [REDACTED]	Medicare Part A
HICN: [REDACTED]	Before: Michael D. Bartko U.S. Administrative Law Judge

**AMENDED DECISION**

After carefully considering the evidence and arguments presented in the record, and at the ALJ hearing, a **WHOLLY FAVORABLE** decision is entered for the Appellant, [REDACTED]

It has come to the Court's attention that a typographical error was made when preparing this decision. The original decision indicated the case was covered under part B. The case should indicate the claim is covered under Part A. No other content of the decision has been changed.

**Procedural History**

The Appellant seeks reimbursement for skilled nursing services provided from February 7, 2007, through March 9, 2007. Reimbursement was denied on redetermination on August 13, 2008. (Ex. F) On December 30, 2008, First Coast Service Options, a qualified independent contractor ("QIC") upheld the denial. (Ex. D)

On January 12, 2009, a request for an Administrative Law Judge (ALJ) hearing, pursuant to 42 C.F.R. §405.1014, was timely filed and received by the Office of Medicare Hearings and Appeals (OMHA). (Ex. C) The amount in controversy meets the jurisdictional requirements for an ALJ hearing before the Office of Medicare Hearings and Appeals. (42 C.F.R. §405.1006) A telephonic hearing was held on March 23, 2009. (See audiotape of March 23, 2009, ALJ hearing) Present at the hearing was [REDACTED]

[REDACTED] The witness was sworn and provided sworn testimony at the hearing. [REDACTED]

██████████, an attorney from CMA also made an appearance on behalf the Appellant. See audiotape of March 23, 2009, ALJ hearing) All exhibits and documents presented for consideration were admitted as evidence, and have been considered by the ALJ. The case was decided pursuant to the Administrative Procedure Act (5 U.S.C. §551 et. seq.), Title XVIII of the Social Security Act (Act) and implementing regulations and policy.

### Issues

Do the skilled nursing services provided to the beneficiary from February 7, 2007, through March 9, 2007, meet the coverage criteria for reimbursement by Medicare?

### Findings of Fact

The following facts were established by a preponderance of the evidence:

This case involves inpatient skilled nursing care services provided to the Appellant/beneficiary from February 16, 2007, through March 9, 2007. The QIC denied the services on the grounds that the beneficiary did not have a qualifying three day hospital stay. The QIC argues that the beneficiary was hospitalized on January 5, 2007, through January 9, 2007, but the related SNF care did not occur within 30 days of the hospital stay. (Exhibit D)

The Appellant is 70 years old and suffers from multiple conditions including seizures. (Exhibit E1) The Appellant has a history of migraine headaches, cyclic vomiting, nausea, tardive dyskinesia, epilepsy CAD, hypertension, degenerative joint disease, and anxiety. (Exhibit E1) The Appellant had also reached the point of suicidal ideation. *Id.*

The Appellant has presented medical records that indicate the beneficiary was admitted to the hospital on February 3, 2007, and was not discharged until February 16, 2007. (Exhibit E1) The documented record indicates that the beneficiary was in fact hospitalized as an inpatient on February 3, 2007, through February 16, 2007. (Exhibit E1) Here, the beneficiary was admitted to SNF on February 16, 2007, after a hospitalization for various medical and mental conditions. The beneficiary required skilled nursing for the administration and monitoring of medication with changes. Additionally, the beneficiary displayed behavioral disturbances. (See audiotape of the March 23, 2009, ALJ hearing)

## Legal Framework

### I. ALJ Review Authority

#### A. Jurisdiction:

An individual who, or an organization that, is dissatisfied with the reconsideration of an initial determination is entitled to a hearing before the Secretary of the Department of Health and Human Services (HHS), provided there is a sufficient amount in controversy and a request for hearing is filed in a timely manner. (§1869(b)(1)(A) of the Act)

In implementing this statutory directive, the Secretary has delegated authority to administer the nationwide hearings and appeals system for the Medicare program to OMHA. (See 70 Fed. Reg. 36386, 36387 (June 23, 2005)) The ALJs within OMHA issue the final decisions of the Secretary, except for decisions reviewed by the Medicare Appeals Council. *Id.*

The amount in controversy meets the jurisdictional requirements for a hearing before OMHA. (42 C.F.R. § 405.1006(b)) The request for a hearing is timely if filed within sixty (60) days after receipt of a QIC reconsideration decision. (See 42 C.F.R. §405.1014)

#### B. Scope of Review

The issues before the ALJ include all the issues brought out in the initial determination, redetermination, or reconsideration that were not decided entirely in a party's favor. (For purposes of this provision, the term "party" does not include a representative of CMS or one of its contractors that may be participating in the hearing.) However, if evidence presented before the hearing causes the ALJ to question a favorable portion of the determination, he or she notifies the parties before the hearing and may consider it an issue at the hearing." See 42 C.F.R. § 405.1032(a).

#### C. Standard of Review

The Office of Medicare Hearings and Appeals conducts "de novo" reviews of cases. "The [OMHA] directs four field offices staffed with Administrative Law Judges who conduct "de novo" hearings . . ." (70 Fed. Reg. 36386 (June 23, 2005) See also *In the case of Atlantic Anesthesia Associates, P.C. M.A.C.* (June 17, 2004) ("An ALJ qualified and appointed pursuant to the Administrative Procedure Act acts as an independent finder of fact in conducting a hearing pursuant to § 1869 of the Act. This requires de novo consideration of the facts and law.")).

## II. Principles of Law

### A. *Social Security Act and Code of Federal Regulations*

Part B of Title XVIII of the Act governs the Supplemental Medical Insurance Program and provides coverage for medical services and supplies furnished by physicians or by others in connection with physicians' services and other specific health related items and services. Individuals participate voluntarily in the Medicare Part B program and pay a monthly premium.

Coverage of medical and other health services is qualified by Title XVIII §§1862(a). Title XVIII §1862(a) of the Act limits Medicare payments to items or services that are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member," notwithstanding any other provision of Title XVIII of the Act. (42 C.F.R. §411.15(k)(1)) Section 1833(e) of the Act requires a claim for payment under Medicare Part B to be supported by sufficient information and documentation. (*See also* 42 C.F.R. §424.5(a)(6))

The services provided to the Beneficiary herein are physical therapy services, covered under Part B, but were provided in a Part A of Title XVIII of the Act (Part A) facility. The services were correctly billed on form CMS-1450, UB92, for payment through a Part A intermediary by the Appellant.

Skilled service requirements for inpatients are found in 42 C.F.R. §409.44. Therefore, the occupational therapy services must, "(i)...be considered under accepted standards of medical practice to be a specific, safe, and effective treatment for the beneficiary's condition; (ii)...be of such a level of complexity and sophistication or the condition of the beneficiary must be such that the services required can safely and effectively be performed only by a qualified occupational therapist or by a qualified occupational therapy assistant under the supervision of a qualified occupational therapist..., (iii)...be an expectation that the beneficiary's condition will improve materially in a reasonable (and generally predictable) period of time based on the physician's assessment of the beneficiary's restoration potential and unique medical condition...; and (iv) the amount, frequency, and duration of the services must be reasonable. (42 C.F.R. §409.44(c)(2))

Section 1879(a) of the Act provides that if the services provided are deemed to be not reasonable and necessary for the diagnosis and treatment of an illness or injury or to improve the functioning of a malformed body member or are deemed to be custodial, payment under Part A and Part B may still be made if both the Beneficiary and the Provider of the services did not know, nor reasonably should have been expected to know, that the services would not be reimbursable by Medicare. If no payment may be made under this section, the Beneficiary's liability for the charges incurred may be waived if the Beneficiary did not know, nor reasonably should have been expected to know, that the services would not be reimbursable by Medicare. (§1879(b))

### B. CMS Manuals

An ALJ is not bound by manuals, program memoranda and other issuances created by CMS; however, an ALJ must accord substantial deference to them as valid interpretive rules that clarify the application of statutory and regulatory requirements. In *Shalala v. Guernsey Memorial Hospital*, 514 U.S. 87 (1995), the United States Supreme Court concluded that an agency manual section was a valid interpretive rule and also found that it was reasonable for the agency to follow it. (*Id.* at 102)

"In determining whether to grant reimbursement in this case we begin with the axiom that 'the congressional policy underlying the federal social security legislation requires the courts to interpret the Act liberally, and any doubts should be resolved in favor of coverage.'" *Herbst v. Finch*, 473 F.2d 771, 775 (2d Cir., 1972); *accord, Gold v. Secretary*, 463 F.2d 38 (2d Cir., 1972); *Rasmussen v. Gardier*, 374 F.2d 589 (10<sup>th</sup> Cir., 1967); *Sowell v. Richardson*, 319 F.Supp. 689 (D.C.S.C., 1970); *Lord v. Richardson*, 356 F.Supp. 232 (S.D. Ind., 1972). "The Act should be construed to effectuate its overriding purpose even if the words used leave room for a contrary interpretation." *Haberman v. Finch*, 418 F.2d 664 (2d Cir., 1969).

### Analysis

The instant appeal is from a party dissatisfied with the decision of the QIC to affirm the initial determination and redetermination. The request for hearing was timely filed and there is a sufficient amount in controversy. The appeal is therefore properly before the undersigned ALJ in the OMHA Midwestern Field Office.

Appellant argues that she did complete a prior three day inpatient hospital stay prior to the admission to the SNF. Appellant further contends that the beneficiary's medical condition required skilled services, as she required monitoring for her unstable and unsafe behavior and related medical conditions that required medication adjustments and monitoring of the beneficiaries reactions to the changes in medications. The QIC denied the services on the grounds that the beneficiary did not have a qualifying three day hospital stay. The QIC argues that the beneficiary was hospitalized on January 5, 2007, through January 9, 2007, but the related SNF care did not occur within 30 days of the hospital stay. (Exhibit D) The QIC found the beneficiary liable on the grounds the denial of services was a technical denial and therefore the beneficiary remained liable.

Overall management and evaluation of a plan of care is considered a skilled service when a patient's physical or mental condition requires skilled personnel to meet the patient's needs, promote recovery, and ensure safety. (42 C.F.R. § 409.33(a)(1)) Additionally, pursuant to 42 C.F.R. § 409.33(a)(2), observation and assessment of the patient's changing condition is considered skilled when technical or professional personnel are required identify and evaluate the patient's need for modification of treatment or for additional medical procedures until his or her condition is stabilized. On the other hand, personal care services, such as administration of routine oral medication,

assistance with ADLs, general skin care, and routine care of the incontinent patient, generally do not require skilled services, unless there are medical complications involved, as specified in 42 C.F.R. § 409.32(b). (42 C.F.R. § 409.33(d))

In order to be skilled, the services provided to the beneficiary must be so inherently complex they could be performed safely and effectively only by professional or technical personnel, or under the supervision of such. Observation and assessment is a skilled service only when it requires a professional person to identify and evaluate the patient's need for treatment or medical procedures. In addition, management of a patient's care plan may be skilled if the patient's condition requires involvement of professional personnel.

Here, the beneficiary was admitted to SNF on February 16, 2007, after a hospitalization for various medical and mental conditions. The beneficiary required skilled nursing for the administration and monitoring of medication with changes. Additionally, the beneficiary displayed behavioral disturbances. (See audiotape of the March 23, 2009, ALJ hearing) There was sufficient evidence in the record to indicate the beneficiary's medical condition, physical and mental, was so complex and unstable as to require skilled services.

The Appellant has presented medical records that indicate the beneficiary was admitted to the hospital on February 3, 2007, and was not discharged until February 16, 2007. (Exhibit E1) The documented record indicates that the beneficiary was in fact hospitalized as an inpatient on February 3, 2007, through February 16, 2007. In light of the foregoing, the undersigned ALJ finds that the Appellant required and received acute inpatient hospital services from February 3, 2007 through February 16, 2007, and therefore had a three day qualifying hospital admission prior to her admission to the SNF on February 16, 2007.

Therefore, the services warranted Medicare coverage. Accordingly, payment may be made for the services under the Medicare rules.

Conclusions of Law

The Appellant has satisfied the applicable coverage criteria for reimbursement under Part A, Title XVIII of the Act for the skilled nursing services provided to the beneficiary from February 16, 2007, through March 9, 2007. The Appellant has provided sufficient documentation required by § 1833(e) of the Act. Therefore, as a matter of law, the services are included under §1862(a)(1) of the Act.

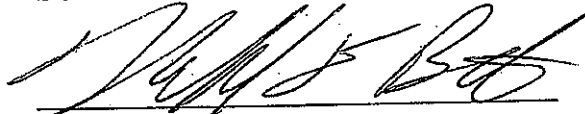
Order

The Medicare Contractor is **DIRECTED** to process this claim in accordance with this decision.

**SO ORDERED.**

Dated: \_\_\_\_\_

4/9/09



**Michael D. Bartko**  
U.S. Administrative Law Judge

Enclosures: Form OMHA-156, *List of Exhibits*