Department of Health and Human Services
OFFICE OF MEDICARE HEARINGS AND APPEALS
Kansas City Field Office
Kansas City, MO

Appeal of:	**P. O'CONNOR**	ALJ Appeal No.:	**1-4533825742**
Enrollee:	**P. O'CONNOR**	Medicare Part:	**C**
HICN:	*******2563A**	Before:	**Kim M. Hoffman** U.S. Administrative Law Judge

I. SUMMARY OF DECISION

After carefully considering the evidence and arguments presented, a **FAVORABLE** decision is entered for the enrollee/appellant, P. O'Connor (Enrollee). The Health Plan is required to cover skilled nursing facility (SNF) services beyond April 8, 2016.

II. PROCEDURAL HISTORY

The enrollee is enrolled in a Part C Medicare Advantage Plan sponsored by UnitedHealthcare (Health Plan). The enrollee is appealing the denial of SNF services beyond April 8, 2016. The enrollee requested review by Livanta, a Quality Improvement Organization (QIO). On May 13, 2016, the QIO issued an unfavorable reconsideration decision. (Exh. 1, pp. 1-2).

On May 26, 2016, the Office of Medicare Hearings and Appeals (OMHA) received the enrollee's timely appeal, and the appeal meets the amount in controversy requirements. A telephone hearing was held on August 9, 2016. Paula Warmuth, the enrollee's daughter and attorney, participated on his behalf. Ramiro Pedroza participated on behalf of the Health Plan. Both Ms. Warmuth and Mr. Pedroza provided sworn testimony. Exhibits 1-7 were admitted into the record.[1]

III. ISSUES

Whether the Plan is required to cover skilled nursing facility (SNF) services beyond April 8, 2016?

[1] Ms. Warmuth's letter dated June 30, 2016, was entered into the record as part of Exhibit 7. I found her letter to be argument rather than "new evidence", and she was available at the hearing to respond to any questions.

IV. FINDINGS OF FACT

The enrollee is a 95 year old male. The enrollee's medical history includes dementia, acute kidney injury, urinary tract infection, coronary artery disease, hypothyroidism, myocardial infarction, glaucoma, hyperlipidemia, macular degeneration, blindness, and lower GI bleed. (Exh. 3, pp. 73-74; 77, 79.) He is non-verbal and he requires a PEG tube. (Exh. 1, p. 5; Exh. 2, p. 77.) He was hospitalized in the ICU from February 1 to February 5, 2016, for treatment of MRSA infection and hypernatremia, and then subsequently discharged on February 9, 2016. (Exh. 1, pp. 5-6.) Upon discharge, he was taken to the skilled nursing facility (SNF). Thereafter, he was hospitalized again on February 11 and discharged on February 12. (*Id.*) He returned to the hospital on February 14, 2016, with bright red blood per rectum ((RBPR), and on arrival he was tachycardic. (Exh. 1, p. 6.) He was diagnosed with a MRSA urinary tract infection, and he was admitted for treatment. (Exh. 1, p. 7.) He was discharged to the SNF on February 18, 2016, with a foley catheter, which he had until the end of March 2016. The enrollee requires a PEG tube because of a potential for aspiration, and he requires a two-person mechanical lift for transfers. (Exh. 3, p. 82.) He is treated with a variety of medications, including various eye drops. (Exh. 3, p. 81.)

The documentation in the record shows that his laboratory studies were monitored on a weekly basis from February 22, 2016, through April 30, 2016. (Exh. 3, pp. 1-18.) His hemoglobin level remained low, and his hematocrit remained low. A urinalysis dated March 26, 2016, showed an elevated white blood cell count with a moderate amount of bacteria and a large amount of leukocytes. (Exh. 3, p. 21.) Progress notes show he tolerated his medications and feeding tube, but he was incontinent of bowel and bladder and he required frequent care. (Exh. 3, pp. 102-103.) He remains non-verbal. (Exh. 3, p. 102.) On April 6, 2016, the Health Plan issued a Notice of Medicare Non-Coverage, indicating that the enrollee's SNF services would end effective April 8, 2016. (Exh. 1, pp. 43-44.) The enrollee remained at the SNF for continued care, and was subsequently hospitalized from May 21, 2016, to May 27, 2016. (Hearing CD.) The enrollee appealed, and was seeking coverage of SNF services from April 9, 2016, through May 28, 2016 (or whenever the 100th day is determined to be). (Exh. 4, p. 2; Hearing CD.)

V. LEGAL FRAMEWORK

I. ALJ Review Authority

The Health Plan is subject to appeals procedures set forth under Medicare Part C.

A. Jurisdiction

An enrollee who receives an adverse Medicare Advantage (MA) plan determination, including the MA organization's refusal to provide or pay for services in whole or part, is entitled to a reconsideration by the MA organization, and if not thereafter satisfied, to a subsequent reconsideration to be performed by an Independent Review Entity, in this case a Quality Improvement Organization (QIO). Enrollees dissatisfied with the QIO's reconsideration decision are 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. *See* § 1852(g)(5) of the Act; 42 C.F.R. §§ 422.600-602.

In implementing this statutory directive, the Secretary has delegated her authority to administer the nationwide hearings and appeals system for the Medicare program to the Office of Medicare Hearings and Appeals (OMHA). *See* 70 Fed. Reg. 36386, 36387 (June 23, 2005); *See also* 42 C.F.R. §§ 422.600-602. The ALJs within OMHA issue the final decisions of the Secretary, except for decisions reviewed by the Medicare Appeals Council. *Id.*

Special rules apply to appeals of decisions to terminate coverage for SNF services, including the issuance of a Notice of Non-Coverage to the enrollee, with a description of appeal rights. The enrollee may then seek immediate review from the QIO, and further reconsideration from the QIO if necessary. Thereafter, if not satisfied, the enrollee may seek further review from an ALJ. When an enrollee appeals an MA organization's decision to terminate services, the burden of proof rests with the MA organization to demonstrate that termination of coverage is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage policies. If the QIO reaffirms its decision on reconsideration, the enrollee may appeal the QIO's reconsideration decision to an ALJ.

If the QIO determines on reconsideration that coverage of provider services should terminate on a given date, the enrollee is liable for the costs of continued services after that date, unless the QIO's decision is reversed on appeal. *See* 42 C.F.R. § 422.624-626.

B. Scope of Review

The ALJs within OMHA conduct *de novo* hearings. *See* 70 Fed. Reg. 36386, 36387 (June 23, 2005). In hearing appeals of MA organization determinations under Medicare Part C, the ALJ generally applies the same administrative review and hearing processes that are employed in reviewing cases under Medicare Parts A and B. 42 C.F.R. § 422.562(d). Thereunder, the issues before the ALJ include all issues brought out in the organization determination, organization reconsideration, or QIO reconsideration that were not decided entirely in the enrollee's favor. However, if evidence presented before the hearing causes the ALJ to question a favorable portion of the determination, notice will be sent to the enrollee and it will be considered at the hearing. 42 C.F.R. § 405.1032.

Regarding evidence submitted after the QIO's reconsideration determination, (but not including oral testimony at a hearing or evidence submitted by an unrepresented enrollee), such evidence must be accompanied by a statement explaining why the evidence was not previously submitted. *See* 42 C.F.R. §§ 405.1018(c) and (d). The ALJ may consider such evidence upon determining that good cause exists for the late submission thereof. 42 C.F.R. § 405.1028(a) and (b).

II. Medicare Part C – Medicare Advantage Plan Coverage

Medicare Part C is set forth in section 1851, *et seq.*, of the Social Security Act (the Act). It establishes the Medicare Advantage Program, which permits eligible individuals to receive benefits through enrollment in a private health insurance plan, typically referred to as a Medicare Advantage, or MA plan. *See* §§ 1851(a)(2)(C) and 1859(b)(2) of the Act; 42 C.F.R. §§ 422.1 and 422.4. Medicare regulations at 42 C.F.R. § 422, *et. seq.*, list three basic MA plan types. *See MCM*, ch. 1, § 30.

MA organizations are required to disclose the benefits offered under the plan to its enrollees. *See* 42 C.F.R. § 422.111; *MCM*, ch. 3, § 60. This information may also be found in the MA Plan Evidence of Coverage (EOC), which MA plans must provide to enrollees upon enrollment, and on an annual basis. *See MCM*, ch. 3, § 60.7.

A Medicare Advantage plan is reviewed and approved by the Centers for Medicare and Medicaid (CMS) to ensure that Medicare guidelines have been met. 42 C.F.R. § 422.100(f). The plan provides eligible enrollees, at a minimum, basic benefits, which include all Medicare covered Part A and Part B services, except hospice services. MA plans may also include mandatory and/or optional supplementary benefits. *See* 42 C.F.R §§ 422.100(a) and (c); 422.101(a). Services which are not medically reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member, are excluded from coverage under Medicare Part A and Part B. *See* § 1862(1)(A) of the Act; 42 C.F.R. § 411.15(k)(1).

III. Medicare Coverage for Skilled Nursing Facilities

This case involves the termination of SNF benefits. With respect to Medicare coverage of SNF services, section 1812(a)(2)(A) of the Act provides for Medicare Part A coverage of post-hospital extended care services for up to 100 days during a spell of illness. A "spell of illness" is defined in section 1861(a) of the Act as –

> [A] period of consecutive days -
>
> (1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services, inpatient critical access hospital services, or extended care services, and (B) which occurs in a month for which he is entitled to benefits under Part A, and
>
> (2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital or critical access hospital nor an inpatient of a facility described in section 1819 (a) (1) [a skilled nursing facility] or subsection (y)(1) [a religious non-medical health care institution]. [2]

VI. ANALYSIS

The enrollee is requesting that the Health Plan cover SNF services beyond April 8, 2016. The QIO determined that SNF benefits were appropriately terminated effective April 8, 2016. (Exh. 1, pp. 1-2).

Medicare regulations require the Health Plan to pay for medical services or procedures if regular Medicare Part A or Part B would pay for the same services or procedures. 42 C.F.R. § 422.101. Therefore, the Health Plan is required to cover the SNF services that Medicare provides. Section 1812 (a)(2)(A) of the Act provides that Medicare covers up to 100 days of SNF care during a spell of illness. The term "benefit period" means the same thing as the term "spell of illness."

[2] The Evidence of Coverage (EOC) for the Health Plan was not submitted as an exhibit, but since the Health Plan is required to provide, at a minimum, the same benefits as traditional Medicare, I will utilize those standards in deciding this case.

Section 1861(a) defines a benefit period as any period of consecutive days beginning with the first day in which an individual is furnished covered inpatient hospital services after entitlement to Medicare, and which ends with the close of 60 consecutive days after which the individual is neither an inpatient of a hospital or a SNF. The regulation implementing this law is found at 42 C.F.R. § 409.61. There is no limit to the number of benefit periods.

Chapter 8 of the CMS Medicare Benefit Policy Manual (MBPM) (Internet-Only Manual Publ'n 100-2), provides guidance regarding SNF coverage. Pursuant to chapter 8 of the MBPM, care in a SNF is covered if the following four factors are met:

1. The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (*See* §§ 30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;

2. The patient requires these skilled services on a daily basis (*See* § 30.6);

3. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (*See* § 30.7.); and

4. The services must be reasonable and necessary for the treatment of a patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

Additionally, CMS states: "Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation 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." *MBPM*, ch. 8, § 30.2.3.2.

The issue before me is whether the Health Plan is required to pay for SNF care after the termination date of April 8, 2016. At the hearing, Ms. Warmuth argued that her father (the enrollee) remained entitled to SNF services for the full 100 days in the benefit period (which she had initially calculated through May 28, 2016, although that calculation would be impacted by the enrollee's hospital stay from May 21-27, 2016). Mr. Pedroza stated that the Health Plan has decided to cover the enrollee for SNF services for additional days, from May 27 to June 22, 2016, and June 24 to July 11, 2016, which would be 100 days. (This takes into account the enrollee's hospitalization in June 2016.) Mr. Pedroza clarified that it actually would total 105 days, by his calculation. Mr. Pedroza argued that July 11, 2016, would be the last covered day, and that since the Health Plan was willing to cover 100 days during the benefit period/spell of illness, that the issue was moot and the case should be dismissed. Ms. Warmuth argues that the issue is not moot, because if the covered days are April 9 through May 28, 2016 [**or** whatever date is appropriately calculated to be the 100th day, since the enrollee was hospitalized May 21-27], then the enrollee may be entitled to a new benefit period sooner.

Mr. Pedroza's testimony implies that it does not matter if the enrollee was entitled to SNF services from April 9, 2016, forward, and he contends that a retroactive adjustment would be

inappropriate. Ms. Warmuth argues that her father (the enrollee) was entitled to SNF coverage on April 9, 2016, going forward, and she requests that I find accordingly.

I conclude from Mr. Pedroza's testimony that the Health Plan has determined that it is not necessary to review the enrollee's entitlement to SNF services from April 9, 2016, to May 28, 2016 (or whatever would be the 100th day), because the Health Plan is deciding to cover the SNF services from May 27, through July 11, 2016 (taking into account the enrollee's hospitalization in June). Technically, Mr. Pedroza may be correct that if the Health Plan is willing to cover 100 days during the benefit period, then it should not matter which days are covered. However, the issue presented to me in this appeal is the enrollee's entitlement to SNF services from April 9, 2016, forward. I find, based upon the medical documentation and the testimony and argument of Ms. Warmuth, that the enrollee was entitled to SNF coverage on April 9, 2016, and each day thereafter, until he received the full 100 days of SNF benefits for the benefit period. (This would exclude the time he spent in the hospital in May of 2016.) While it ultimately may make no difference, since Mr. Pedroza is correct that the enrollee is only entitled to 100 days of SNF coverage in a given benefit period, I must address the issue before me and that issue involves the enrollee's entitlement to SNF services after the date of termination on April 8, 2016.

I note that when SNF services are terminated, it is the Health Plan's burden to show that the termination was proper. In this case, the Health Plan has not met that burden of proof. The services were terminated based upon a finding that the enrollee's needs required long term care, and that skilled nursing services were no longer required. (Exh. 1, pp. 26-27 – Explanation of Non-coverage) If I understood Mr. Pedroza's testimony, he indicated that the Health Plan did not review the medical records for the period of April 9, 2016, to May 20, 2016. (Hearing CD.) The enrollee was hospitalized from May 21- 27, 2016, and then returned to the SNF, at which point Mr. Pedroza has indicated the Health Plan will cover the SNF services from May 27 – July 11, 2016, excluding the enrollee's hospitalization in June.

Ms. Warmuth stated that when the enrollee became a private pay patient on April 9, 2016, they were checking his blood on a regular basis, and she noted blood work on April 9, 11, 13, 16, 18, 21, 23, 25, 27, and 30. (Hearing CD; Exh. 3, pp. 1-7.) She explained his various medical issues, and she provided her opinion that her father (the enrollee) continued to require daily skilled nursing services from April 9, 2016, and continuing, until such time as the 100 days of SNF coverage were exhausted. I agree and I therefore find that SNF services were improperly terminated on April 8, 2016. The enrollee's care was beyond routine custodial care, and although the nursing services may not have substantially improved his condition, it does appear that they did slow or minimize his deterioration. Accordingly, the Health Plan must cover SNF services as of April 9, 2016, and that coverage shall continue until the 100 days of SNF coverage are exhausted for the benefit period. This does not include any periods during which the enrollee was hospitalized, and I will leave it to the Health Plan to make the appropriate calculations, in accordance with this decision.

VII. CONCLUSIONS OF LAW

I find that the Health Plan is required to cover SNF services beyond April 8, 2016. I find that the Health Plan shall cover SNF services from April 9, 2016, and continuing thereafter, until the 100 days of SNF coverage for the benefit period are exhausted.

VIII. ORDER

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

SO ORDERED.

Dated: AUG 2 3 2016

Kim M. Hoffman
U.S. Administrative Law Judge