DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
Commissioner, Connecticut Department of Social Services (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiary)	**** (HIC Number)
Empire Medicare services (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated April 4, 2007. The ALJ decision concerned skilled nursing facility (SNF) services provided by **** for the beneficiary, ****, from February 25, 2006, through March 26, 2006. The ALJ determined the services provided were not covered by Medicare and that the beneficiary remained responsible for the non-covered services. 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 Council considered the record and exceptions set forth in the appellant's request for review and supplementary Memorandum of Law. The appellant's request for review is entered into the record as Exh. MAC-1 and the appellant's Memorandum of Law is entered into the record as Exh. MAC-2.

As set forth below, the Council reverses the ALJ's decision on liability and adopts the finding of Medicare non-coverage.

BACKGROUND AND PROCEDURAL HISTORY

The beneficiary was admitted to **** skilled nursing facility (SNF) on January 17, 2006, after a qualifying hospital stay for treatment of delirium, a urinary tract infection (UTI), and dehydration. Exh. 1 at 1. The beneficiary's hospital discharge diagnoses included: chronic dementia, UTI, dehydration, myocardial infarction, hypercholesterolemia, insulin-dependent diabetes mellitus, hypertension, history of cerebral thrombosis, history of transient ischemic attacks, urethral stricture, and depression. *Id*. The beneficiary received skilled physical and occupational therapies after admission. *Id*. at 47, 35. His physical and occupational therapies were discontinued on February 7, 2006, and February 24, 2006, respectively. *Id*. On February 22, 2006, a notice of non-coverage was initialed by the beneficiary and witnessed by the SNF's social worker stating that the last day of skilled services to qualify the stay for Medicare coverage would be February 24, 2006. Exh. 3 at 2-3.

A demand bill was submitted to the Medicare contractor for SNF services provided from February 25, 2006, through March 26, 2006. The contractor's initial determination and redetermination as well as the Qualified Independent Contractor's (QIC) reconsideration all determined that the services were not covered by Medicare and that the beneficiary was responsible for payment because the provider issued a notice of non-coverage. Exh. 5 at 1-2, Exh. 8 at 4-5.

On behalf of the appellant, Center for Medicare Advocacy (CMA) requested an ALJ hearing which was conducted by teleconference on March 14, 2007. Dec. at 2. A representative of CMA was present at the hearing and although notice of the hearing was sent to the provider, they did not appear. *Id*., *See* Exh. 10 at 1. A Council audit of the hearing established that the appellant's representative stated, "I will be limiting my argument to the fact that the beneficiary's liability should be waived in this case on the grounds that he was not a capable recipient to receive the notice of Medicare non-coverage."

The ALJ addressed the issue of liability in his decision, finding that on February 22, 2006, the beneficiary and "the Beneficiary's Representative" signed the notice of non-coverage and therefore the notice was valid.[1] Dec. at 11. The ALJ concluded the services provided to the beneficiary from February

[1] The notice of non-coverage was initialed by the beneficiary and witnessed by **** the provider's social worker. Exh. 3 at 3.

25, 2006, through March 26, 2006, were not covered by Medicare, and that the beneficiary was responsible for payment of the non-covered services. *Id*.

The appellant filed a timely request for Council review asserting that the ALJ failed to consider that the beneficiary was not a capable recipient of the notice of non-coverage. Exh. MAC-2 at 2.

LEGAL AUTHORITIES

According to section 1879 of the Act, Medicare may limit the liability of a beneficiary or provider (or both) for costs of services not covered under sections 1862(a)(1)(A) or (a)(9). The statute provides that the liability for a non-covered item or service may be limited, when a provider, practitioner, supplier, or beneficiary did not know and could not reasonably have been expected to know that the item or service was not covered by Medicare. 42 C.F.R. § 411.400. A provider may be deemed to have "knowledge" based on its written notice of non-coverage to the beneficiary or its "experience, actual notice, or constructive notice." 42 C.F.R. § 411.406.

Medicare regulations at 42 C.F.R. § 411.404 set forth the criteria for determining whether a beneficiary knew that services were excluded from coverage as custodial care or as not reasonable and necessary. In determining beneficiary liability, the regulation provides that a beneficiary who receives services that constitute custodial care or that are not reasonable and necessary "is considered to have known that the services were not covered if . . . written notice has been given to the beneficiary, or to someone acting on his or her behalf, that the services were not covered because they did not meet Medicare coverage guidelines." 42 C.F.R. § 411.404(b). The notice may be given by the provider, practitioner, or supplier that furnished the services. 42 C.F.R. § 411.404(c)(3).

Further guidance concerning the criteria for establishing knowledge is found in CMS Ruling 95-1.[2] The Ruling explains that, pursuant to the Act and the regulations, a beneficiary will be considered to have knowledge of non-coverage if he, or the person acting on his behalf, was furnished with a written notice that contains "sufficient information to enable the beneficiary to understand the basis of the denial." *Id*. CMS

[2] By regulation, CMS rulings are binding on ALJs and the Council. 42 C.F.R. §§ 401.108 and 405.1063.

Ruling 95-1 explains that when a beneficiary is provided written notice, there is a "presumption that the [beneficiary] knew, or could reasonably have been expected to know, that Medicare payment for a service or item would be denied." CMS Ruling 95-1-16, *see also* 42 C.F.R. § 411.404.

In addition, the Medicare Claims Processing Manual (MCPM) addresses the issue of defective notice related to capacity of the beneficiary stating, "An [advance beneficiary notice] is not acceptable evidence if [the beneficiary] is incapable of understanding the notice...." CMS Manual System, Pub. 100-04, MCPM, Chapter 30, Section 40.3.1.3. The Manual further clarifies who may qualify as a "capable recipient" of that notice. *Id*. at § 40.3.4.3. Specifically, "[a] comatose person, a confused person (e.g., someone who is experiencing confusion due to senility, dementia, Alzheimer's disease), [or] a legally incompetent person . . . is not able to understand and act on his/her rights, therefore necessitating the presence of an authorized representative for purposes of notice." *Id*. Furthermore, "[i]f the beneficiary was not capable of receiving the notice, the contractor will hold that the beneficiary did not receive proper notice, hold that the beneficiary is not liable, and will hold the notifier liable." *Id*.

DISCUSSION

The Council has carefully considered the ALJ's decision, the record, and the appellant's exceptions. The appellant only contests the ALJ's ruling concerning liability in this case. Exh. MAC-1, MAC-2. Therefore, we adopt without further discussion the ALJ's findings and conclusion that the SNF services at issue were not covered.

The appellant contends that the ALJ erred in holding the beneficiary liable for the costs of the non-covered services. They assert that the beneficiary's liability should be waived, as he was not a "capable recipient" in accordance with the MCPM, Chap. 30, §40.3.4.3. Exh. MAC-2 at 2. Specifically, "[i]n addition to his diagnosis of dementia, the record shows that [the beneficiary] experienced confusion on such a regular basis as to render not legally able to 'understand and act on his rights." Exh. MAC-2 at 6. For the reasons explained below, the Council concludes that the beneficiary did not receive proper notice that the services provided would likely not be covered by Medicare, and finds that the provider is liable for the non-covered services.

The record reflects that the beneficiary did not possess the requisite capacity to qualify as a capable recipient when he signed the notice of non-coverage. Upon admission on January 17, 2006, the beneficiary's physician ordered a wanderguard, a chair pad alarm while in his wheelchair, and a "pressure alarm when in bed related to poor safety awareness [secondary] to Dementia." Exh. 1 at 6, 80. These orders were reauthorized, signed by the physician on February 15, 2006, and in effect for 60 days, during the time the beneficiary signed the notice of non-coverage. *Id*.

The social worker's initial evaluation conducted on January 17, 2006, approximately one month prior to the date at issue, determined that the beneficiary was confused, frequently forgetful, and oriented to person only, not oriented to place or time. Exh. 1 at 91. Nevertheless, the social worker who witnessed the beneficiary's signature on the notice of non-coverage did not document the event in her progress notes or make an entry regarding the beneficiary's momentary ability to comprehend and act on the notice of non-coverage.

The Medicare 30 day assessment Minimum Data Set (MDS), which was completed just seven days prior to the date the beneficiary signed the notice of non-coverage, denotes severe cognitive deficits. Exh. 1 at 84. The beneficiary was only oriented to staff names or faces; he was not able to normally recall the current season, location of his room, or that he was in a nursing home. The beneficiary possessed indicators of delirium, periodic disordered thinking or awareness. His cognitive skills for daily decision-making regarding simple tasks of daily life were labeled as "severely impaired." *Id*. Furthermore, the beneficiary's cognitive status, skills, or abilities had "deteriorated" when compared to his status about 30 days prior. *Id*.

On February 7, 2006, the beneficiary's physical therapist discharged him from therapy because, "[p]lateau of benefits from skilled PT interventions reached at current mental level [secondary to] dementia." Exh. 1 at 47. On February 21, 2006, the beneficiary's occupational therapist noted that he continued to demonstrate decreased cognition and fluctuating alertness. *Id*. at 40. On February 24, 2006, two days after the beneficiary signed the notice of non-coverage, the occupational therapist discharged the beneficiary from treatment because his

"cogn[itive] status and limited mobility limit[ed] further progress." *Id*. at 41.

On February 22, 2006, date the beneficiary signed the notice, the nurses noted that the beneficiary had, "usual confusion." Exh. 1 at 22.

The beneficiary's psychiatrist conducted a follow-up psychiatric consultation on March 10, 2006, less than four weeks after the beneficiary signed the notice of non-coverage. The psychiatrist determined the beneficiary possessed "Dementia, continuous, intrusive" and found it to be "severe." Exh. 1 at 58. The psychiatrist also stated the beneficiary's psychiatric medication dosage should not be reduced due to the beneficiary's delusions. The psychiatrist determined that the beneficiary had impaired memory, concentration, attention, and orientation. Again, the beneficiary was documented to be oriented only to person and not to place or time. *Id*.

The record shows that the beneficiary had an authorized representative that would qualify as a capable recipient of the notice of non-coverage. The hospital transfer report states that the beneficiary's daughter, S.H., is the responsible person. Exh. 1 at 3. The social service initial assessment and each progress note also mention the involvement of the beneficiary's daughter. *Id*. at 93. Finally, the MDS states that the beneficiary's family member is responsible. *Id*. at 84, 91.

The MCPM explains that a "confused person (e.g., someone who is experiencing confusion due to senility, dementia, Alzheimer's Disease) . . . is not able to understand and act on his/her rights," and therefore an authorized representative must be provided the notice of non-coverage under such circumstances. MCPM, Chapter 30, Section 40.3.4.3. The presumption that the beneficiary had knowledge, indicated by CMS Ruling 95-1, is rebutted by the overwhelming evidence that the beneficiary was not able to understand and act on his rights and as such not a capable recipient of the notice of non-coverage. Therefore, the notice requirements of section 1879 and Ruling 95-1 were not met by the notice of non-coverage of record. Having no other evidence that the beneficiary knew or should have known that the services would not be covered, the Council finds that the beneficiary's liability is waived.

The Council finds that the provider, in issuing the notice of non-coverage, knew that the services were not covered. MCPM, Pub. 100-04, Chap. 30, § 40.1. Therefore, the provider is liable for the non-covered charges.

DECISION

It is the decision of the Medicare Appeals Council that the beneficiary's liability is waived under section 1879 of the Act. The provider is liable for the non-covered charges.

MEDICARE APPEALS COUNCIL

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Constance B. Tobias
Chair, Departmental Appeals Board

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Mary C. Peltzer
Appeals Officer

Date: January 11, 2008