STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 13, 2017
[redacted]
AGENCY: Niagara
FH #: 7570432Z

In the Matter of the Appeal of

[redacted]

from a determination by the Niagara County Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on September 5, 2017, in Niagara County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Care Agency (Centers Plan for Healthy Living)
Melanie All, Fair Hearing Representative

ISSUE

Was the Agency's determination to deny coverage for nine skilled nursing visits to the Appellant from November 29, 2016 to January 27, 2017 on the grounds that Medicare must first make a determination correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, [redacted], has been enrolled in a Managed Long Term Care Program and has received care and services through a Medicaid Managed Long Term Care Health Plan operated by Centers Plan for Healthy Living. The Appellants' primary insurance is Medicare. The Appellant receives home health aide services in her home and she receives skilled nursing visits one time per week.

2. On November 15, 2016 the Appellant's Physician signed a Home Health Certification and Plan of Care requesting [redacted] Skilled Nursing visits and home health aide services for the Appellant. This Certification lists the Appellant's diagnoses as follows: [redacted].

3. On the November 15, 2016 Home Health Certification and Plan of Care there is a certification box which states "I certify that this patient is confined to his/her home ….". The Appellant's physician did not sign this box on the form.

4. A Registered Nurse from Visiting Nurse Association went to the Appellant's home nine times between November 29, 2016 to January 27, 2017 and provided skilled nursing services to the Appellant.

5. [redacted] submitted a request for payment to the Agency for the nine skilled nursing visits from November 29, 2016 to January 27, 2017.

6. By a Notice dated May 30, 2017 the Agency denied coverage for the nine skilled nursing facility visits from November 29, 2016 to January 27, 2017. The Notice states as follows: "Centers Plan for Healthy Living has determined that coverage for this service will be denied. This action will take effect on 11/29/16. The plan is taking this action because our records show that your primary insurance is through Medicare. This request must first be reviewed by your Medicare provider for a decision before we can take any action. Please contact your Medicare Plan or your Primary Care Physician (PCP) to have your request reviewed. If your primary insurance denies your request because it is not a covered benefit you may submit your request to Centers Plan for Healthy Living …"

7. On July 13, 2017, the Appellant requested this fair hearing regarding the Agency's Denial Notice dated May 30, 2017.

APPLICABLE LAW

Section 365-a of the Social Services Law provides in part:

> 2. "Medical Assistance" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized by this title or the regulations..., which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations...

Section 364.2 of the Social Services Law provides in part, as follows:

The Department of Health shall be responsible for . . .

(b) establishing and maintaining standards for all non-institutional health care and services rendered pursuant to this title, . . .

* * *

Pursuant to regulations at 18 NYCRR 513.0, where prior approval of medical, dental and remedial care, services or supplies is required under the MA program, such prior approval will be granted when the medical, dental and remedial care, services or supplies are shown to be medically necessary to prevent, diagnose, correct or cure a condition of the recipient which: (1) causes acute suffering; (2) endangers life; (3) results in illness or infirmity; (4) interferes with the capacity for normal activity; or (5) threatens to cause a significant handicap. Pursuant to 18 NYCRR 513.6, the determination to grant, modify or deny a request initially must be made by qualified Department of Health professional staff exercising professional judgment based upon objective criteria and the written guidelines of the Department of Health and regulations, and commonly accepted medical practice.

Managed Long Term Care Partial Capitation Contract (Model Contract)
ARTICLE IV
ELIGIBILITY FOR MANAGED LONG TERM CARE
A. Populations Eligible for Enrollment
I. Mandatory Enrollment Counties:
Upon approval of the Department and CMS, counties are designated as mandatory for MLTC (Mandatory). The Contractor will be notified at least sixty (60) days in advance when a county is designated as Mandatory. In these counties, dual eligible individuals (having both Medicare and Medicaid), who are age 21 and older and who are assessed as needing community based long term care services listed in section B (6) of this Article for more than 120 days must enroll in MLTC in order to receive those services. These individuals are defined as MLTC Mandatory Persons.
***
B. Eligibility Requirements
Except as specified in section C of this Article, an Applicant who completes an enrollment agreement shall be eligible to enroll under the terms of this Contract if he/she:
1. meets the age requirements identified in Appendix F;
2. is a resident in the Contractor's service area;
3. is determined eligible for Medicaid by the LDSS or entity designated by the Department;
4. is determined eligible for MLTC by the MLTCP using an eligibility assessment tool designated by the Department;
5. is capable, at the time of enrollment, of returning to or remaining in his/her home and community without jeopardy to his/her health and safety, based upon criteria provided by the Department; and
6. is expected to require at least one (1) of the following services covered by the MLTCP for more than 120 days from the effective date of enrollment:
a. nursing services in the home;
b. therapies in the home;
c. home health aide services;

d. personal care services in the home;
e. adult day health care;
f. private duty nursing; or
g. Consumer Directed Personal Assistance Services
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APPENDIX G
Managed Long Term Care Covered/Non-Covered Services,

Services When Provided, Would Be Covered by the Capitation Services Provided as Medically Necessary:

Social and Environmental Supports
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Home Care
a. Nursing
b. Home Health Aide
c. Physical Therapy (PT)
d. Occupational Therapy (OT)
e. Speech Pathology (SP)
f. Medical Social Services
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Personal Care
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Medicare Benefit Policy Manual, Chapter 15, section 60.4.1: For a patient to be eligible to receive covered home health services, the law requires that a physician certify in all cases that the patient is confined to his/her home.

DISCUSSION

The Agency's determination to deny coverage for nine skilled nursing visits to the Appellant from November 29, 2016 to January 27, 2017 on the grounds that Medicare must first make a determination was not correct.

The Agency representative maintained at the hearing that coverage for the nine skilled nursing visits to the Appellant from November 29, 2016 to January 27, 2017 was denied by the Agency because Medicare must be billed for the services first since Medicare is the Appellant's primary insurance. The Agency representative asserted that if Medicare denied coverage for the nine visits then the Agency would make a determination as to eligibility under the Appellant's Medicaid Managed Care Long Term Plan.

The Appellant's Attorney acknowledged at the hearing that the Appellant's primary insurance is through Medicare. However, she stated that Medicare does not cover home health visits, including skilled nursing visits, unless the patient's physician certifies that the Appellant is

"confined to home". She stated that the Appellant's physician did not certify on any documentation that the Appellant was confined to her home. She presented the November 15, 2016 Home Health Certification and Plan of Care signed by the Appellant's physician and the Appellant's physician did not sign the box which states "I certify that this patient is confined to his/her home". The Appellant's Attorney stated that the Appellant is not confined to her home as she often goes out and is physically able to go out at any time.

The Appellant's Attorney stated that [redacted], the provider of the skilled nursing services, cannot bill Medicare for the visits because they were non-covered services under Medicare because the Appellant was not "confined to home". She explained that [redacted] indicated that they would not bill Medicare for these services because there was no certification from the Appellant's physician that she was confined to the home. The Appellant's Attorney asserted that [redacted] would be engaging in fraudulent billing if they billed Medicare for services that they knew were not a covered service.

The Agency representative at the hearing did not dispute in any manner that the Appellant was not "confined to home" and she did not dispute that the skilled nursing visits to the Appellant would not be covered by Medicare. Rather, the Agency's representative stated that visits had to be billed to Medicare first even if there was no coverage.

In general, a Medicaid Managed Long Term Care Plan can require a member to submit medical bills to Medicare first if Medicare is the primary insurance. However, in this case the Medicaid Managed Long Term Care Plan cannot require that Medicare be billed first when it is clear that Medicare does not provide coverage for skilled nursing visits when a patient is not "confined to home". As outlined above the Medicare regulations and the Medicare Benefit Policy Manual state that home health services, including skilled nursing visits, will only be covered when the patient is certified by his or her physician to be "confined to home". In this case the Appellant's physician has not certified the Appellant to be "confined to home" and therefore the skilled nursing visits are not covered under Medicare. It is not reasonable to require the services to be billed to Medicare first when Medicare does not provide coverage for said services.

Accordingly, the Agency's determination cannot be sustained.

DECISION AND ORDER

The Agency's determination to deny coverage for nine skilled nursing visits to the Appellant from November 29, 2016 to January 27, 2017 on the grounds that Medicare must first make a termination was not correct and is reversed.

1. The Agency is directed to not deny coverage for the nine skilled nursing visits from November 29, 2016 to January 27, 2017 because Medicare has not been billed first.

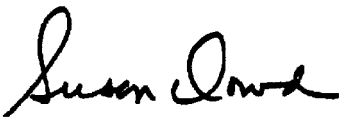
As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

FH# 7570432Z

DATED: Albany, New York
09/26/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee