

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Social Security Administration
OFFICE OF HEARINGS AND APPEALS

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DECISION

IN THE CASE OF

Estate of

a _____
(Appellant)

_____ K _____
(Beneficiary)

Aetna Life Insurance
(Intermediary/PRO/HMO/CMP)

CLAIM FOR

Hospital
Insurance Benefits

(HICN)

This case is before the undersigned Administrative Law Judge on an order of remand issued by the Appeals Council on August 12, 1993, directing further proceedings because the prior decision failed to include an evaluation of whether the beneficiary's skilled nursing facility admission met the regulatory exception to the 30-day rule in 42 CFR 409.30(b).

Pursuant to the Council's order, a hearing was scheduled and held before the undersigned Administrative law Judge on May 5, 1994, in Milwaukee, Wisconsin, where representation for the claimant was provided by Victor C. McHenry, a nonattorney representative.

The issue before the undersigned is whether the requirements for coverage of post-hospital skilled nursing facility care have been met.

The statements in the Administrative Law Judge's decision dated September 21, 1992, concerning the pertinent provisions of the Social Security Act, **as** amended, and the pertinent evidentiary facts are incorporated herein by reference except as modified or supplemented below. However, the undersigned does not adopt the inferences and findings in that decision which are not consistent with the conclusions reached herein.

The record shows that the deceased beneficiary had been hospitalized at St. Luke's Medical Center from April 20, 1991 through May 6, 1991. Due to the lack of an available bed at a

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skilled nursing facility, the claimant returned home with care provided from the Visiting Nurse Association Hospice Care. She remained at her home through June 6, 1991 and was admitted to --Nursing Home on June 7, 1991, a period of 32 days following the date of discharge from St. Luke's Hospital.

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On admission tom , the utilization review committee issued a notice advising of non-coverage on the basis that the admission had occurred after the 30th day following the qualifying hospitalization stay. It was on this basis that the Administration denied coverage for the period between June 7 and June 30, 1991 when the claimant was a resident at-) -C1 Nursing Home.

The undersigned finds that the beneficiary needed skilled nursing services when she left the hospital. This is shown by the fact that the family and her attending physician obtained Visiting Nurse Association Hospice Care treatment and by the fact that she was admitted to a skilled nursing facility as soon as was possible following the discharge.

The beneficiary's records and the information provided to the undersigned by the claimant, the beneficiary's daughter-in-law, and the representative, corroborate the plan for skilled nursing admission.

The letter from Dr. m the beneficiary's attending physician, dated April 29, 1994 does not alter this conclusion. The letter is very carefully worded and was addressed to the claimant's representative nearly three years after the facts relating to the deceased's hospitalization and treatments.

While the facts show that the beneficiary may have worsened somewhat following her hospital discharge, the general character and need for treatment did not change, and, therefore, the "exceptionI set forth in Section 42 CFR 409.30(b)(s) is not fulfilled.

When one looks at the rulings of the adjudicators at the intermediary, one senses that reimbursement would have been made without any dispute if skilled nursing placement had been made the very day the hospital discharged the beneficiary or within 30 days thereof. Neither they nor anyone else truly thought that an interregnum of less skilled care was the best idea.for the beneficiary.

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In other words, this case cannot rest on the exception cited above. To do so would be to mischaracterize the facts. Rather, this case remains what it was when last assessed by the undersigned, that is, a case which asks whether the 30 day rule of Section 42 USC Section 1395 X(i)(a) and 42 CFR Section 409.30(b)(a) is one of strict compliance or substantial compliance.

The undersigned finds the answer to be now the same as it was a year ago. That is: substantial compliance and not strict compliance was the intent of Congress. Further, it was and should have been the intent of the drafter of the regulations.

There are several reasons why one can be confident that this was the intent of Congress. First, it fulfills the general plan of the law. (See Havner v Secretary of HHS, 382 F. Supp, 762, 765(EDNY, 1974), and Gartmann v Secretary of HHS, 633 F. Supp. 671, 679 (EDNY, 1986), citing other sources.)

Second, the rules in question are placed in a subordinate, one may say adjective, part of the statute and regulations. The substantive entitlement section does not contain such a limitation as a "3.0-day rule." (See Section 42 USC, Section 1395(a).)

Third, other sections addressing similar situations indicate that substantial compliance with continuity concepts will suffice. E-g= r see 42 USC Section 1395X(v)(1)(G), which deals with a situation the converse of that here, that is, a situation in which one stays longer in the hospital because a skilled nursing home bed is not available. Such provisions should be read in pari materia with the sections directly in point here.

The undersigned finds that the beneficiary did substantially comply with the time rule set forth in the regulations and that substantial compliance is adequate to preserve entitlement in this case. Therefore, the nursing home services should be evaluated by the intermediary to determine if they were skilled and medically well related to the prior hospitalization and thus medically reasonably necessary.

The services appear to the undersigned to pass those substantive tests of coverage; but, initially, the intermediary should decide if this in fact is the case and if the care was medically reasonable and necessary. Therefore, the intermediary is

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considering the claim and to obtain expert consultation from medical doctors before reaching a decision on this matter.

Accordingly, this case is remanded to the intermediary to consider substantive coverage questions other than the time limits or time bars. The intermediary will not deliberate or rule on time bars or time limits because those issues have been decided herein. The time limits have been fulfilled and do not bar coverage.

The intermediary will not address those questions any further: it is ordered not to do so. The intermediary's deliberations will be confined to questions of reasonable medical necessity and the actual level of skill used in rendering service to the deceased.

The undersigned finds that it was abusive and outrageous for the health care finance administration to delay the payment of benefits in this case. It was clear that the beneficiary was intended for a skilled nursing facility. For the intermediary to refuse reimbursement only because the admission occurred two days following the lapsing of the 30-day period is truly an outrageous abuse of authority.

Equally abusive and outrageous was the Appeals Council's decision to perpetuate the delay in reimbursement in this instance. The facts show that this was at most a two-day delay by a family in significant stress who did it's best to comply with the 30-day rule, but a bed was just not available at the time the deceased needed it. One must then ask the rhetorical question: what were they supposed to do in this instance?

Therefore, the undersigned directs that this case be remanded to the intermediary for evaluation of the reasonableness of the services rendered and of the question whether skilled nursing services were in fact provided during the time at issue.

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FINDINGS

After careful consideration of the entire record, the undersigned makes the following findings:

1. The beneficiary underwent a medically necessary inpatient hospital stay which qualified her for post-hospital skilled nursing facility treatment, and she was discharged from the hospital on May 6, 1991.
2. The beneficiary was admitted to a skilled nursing facility, R - Nursing Home, on June 7, 1991, because she needed post-hospital skilled nursing facility care.
3. The admission occurred two days after the 30-day admission requirement of the regulations. The delay in admission was through no fault of the beneficiary or her family.
4. Substantial compliance with the time regulations is adequate to preserve entitlement where attempts were made to comply with time rules.
5. The pre-admission requirements for entitlement to reimbursement for placement in a skilled nursing facility are met, and the carrier is directed to undertake an assessment of the medical necessity and reasonableness of the services provided and to ascertain whether skilled nursing services were given between June 7 and June 30, 1991.

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DECISION

It is the decision of the undersigned Administrative Law Judge that the pre-admission requirements for post-hospital skilled nursing facility care were met and that a decision should be made by the carrier concerning the issue whether reimbursement may be made on the beneficiary's behalf under Part A of Title XVIII of the Social Security Act for the services rendered by the -
-Nursing Home, from June 7 through June 30, 1991.



Patrick Halliaan fl
Administrative Law Judge

SEP 21 1994

Date

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