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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

OCT 11 2001

Departmental Appeals Board
Medicare Operations Division
Room 633-F, HHH Building
200 Independence Avenue, S.W.
Washington, DC 20201

064-26-7483A, HIC Number

Lillian Lipsitz
108 Hickory Hill Rd.
Apt. G
Williamsville, NY 14221

NOTICE OF FINAL DECISION OF MEDICARE APPEALS COUNCIL

What This Notice Means

No response has been received to the notice of proposed decision previously issued in this case. Therefore, the decision has been entered as final. The right to court review described below applies to both the beneficiary and the managed care organization.' If you have any questions, you may contact the Health Care Financing Administration regional office or the local Medicare contractor.

Your Right to Court Review

The right to court review is provided for in cases arising under title XVIII of the Social Security Act if the amount in controversy is \$1,000 or more (section 1869(b) of the Act (42 U.S.C. 1395ff(b)), or section 1876(c)(S)(B) of the Act if an HMO is involved (42 U.S.C. 1395mm(c)(5)(B))). The right to court review is provided for in cases arising under title XI of the Act where the amount in controversy is \$2,000 or more (section 1155 of the Act (42 U.S.C. 1320c-4)). If you desire a court review of the decision and the amount in controversy requirement is met, you may commence a civil action by filing a complaint in the United States District Court for the judicial district in which you reside, or have your principal place of business, within sixty (60) days from the date of the receipt of this letter. It will be presumed that this letter is received within five (5) days after the date shown above unless a reasonable showing to the contrary is made.

If you cannot file your complaint within 60 days, you may ask the Medicare Appeals Council to extend the time in which you may begin a civil action. However, the Council will only extend the time if you provide a good reason for not meeting the deadline. Your reason(s) must be set forth clearly in your request.

If a civil action is commenced, the complaint should name the Secretary of Health and Human Services as the defendant and should include the HIC number and/or docket number, if any, shown at the top of this notice. The Secretary must be served by sending a copy of the summons and complaint by registered or certified mail to the General Counsel, Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. In addition, you must serve the United States Attorney for the district in which you file your complaint and the Attorney General of the United States. (See rules 4(c) and (i) of the Federal Rules of Civil Procedure and 45 CFR 4.1.)

Enclosure

cc:

William Berry, Legal Services
Melissa Deboth, Independent Health

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of
Estate of
Edward Lipsitz

(Appellant)

Claim for

MCO Benefits

Edward Lipsitz
(Beneficiary)

064-26-7483A
(HICN)

Independent Health
(Carrier/Intermediary/PRO/HMO)

The Administrative Law Judge issued a decision on October 27, 1999. The appellant has asked the Medicare Appeals council to review that decision. The Medicare Appeals Council grants the request for review because there is an error of law (20 CFR 404.967 and 404.970, by reference of 42 CFR 422.608).

The Council has considered the record that was before the Administrative Law Judge. The Council adopts the Administrative Law Judge's conclusion that the inpatient hospital stay was covered from May 10, 1999 to May 12, 1999, and his finding that from May 13, 1999 to May 19, 1999, the beneficiary did not need acute care necessitating an inpatient hospital stay, but rather needed and received skilled nursing care that could be provided in a skilled nursing facility. The Council does not adopt the Administrative Law Judge's conclusion that the care provided from May 13 to May 19, 1999 is not covered.

The beneficiary was properly admitted to Millard Fillmore Hospital from the emergency room on May 10, 1999 (Ex. 11, pp. 30-32) by a participating physician with the managed care organization (MCO) (Ex. 8, p. 17).¹ On May 11, the beneficiary's wife signed the MCO's Acute Admission Denial, effective May 12.²

¹ The MCO has not challenged the beneficiary's contentions that Dr. Cieslak was a contracted physician.

² Although the notice purported to be effective on May 12, the managed care organization erred in not disclosing in the notice (Ex. 4, pp. 11-17) the procedure for appealing to a Peer

On May 12, 1999, he was transferred to an alternate level of care in another facility within the Millard Fillmore Health System (Ex. 11, pp. 27-29, 66). The beneficiary was discharged to a skilled nursing facility (SNF) on May 19, 1999.

At the Administrative Law Judge hearing, the MCO asserted that the beneficiary would have been transferred to a SNF at the time the beneficiary's wife signed the Admission Denial, but she refused placement. The Council does not find any support for this contention in the record.³ The beneficiary's wife denied at the hearing that she was offered or refused SNF placement before May 19, 1999. The record does indicate that she preferred one SNF over others, but the beneficiary and his wife accepted placement in another SNF on May 19, and the beneficiary was subsequently transferred to the one they preferred. Moreover, the record corroborates the assertion in the request for review that there were no available SNF beds until May 19. The social workers' notes indicate that there were no available SNF beds on May 13, 1999, and the beneficiary was not screened by potential SNFs for placement until after May 17, 1999 (Ex. 11, p. 19). The beneficiary was screened by the SNF where he was ultimately placed on the same day he was discharged (Ex. 11, p. 20). The attending physician's report corroborates the social workers' statements: "Attempts were made to place the patient from the emergency room, but apparently little assistance was provided by Independent Health in making these arrangements." (Ex. 11, p. 13.)

Section 1861(v)(1)(G)(i) of the Social Security Act provides that a Medicare covered level of inpatient hospital care includes situations in which a hospital provides inpatient services that would constitute post-hospital extended care services if provided by a skilled nursing facility, and that such services are medically necessary but not otherwise available to a beneficiary. After reviewing the record, the Medicare Appeals Council finds

Review Organization (PRO), as required by Medicare regulations at 42 CFR 422.620 and 422.622 and pursuant to the MCO's contract with the beneficiary (Ex. 10, p. 31). If the beneficiary had appealed to the PRO, the beneficiary would not have been liable for the care until the day after the PRO notified the beneficiary of its decision if it was unfavorable.

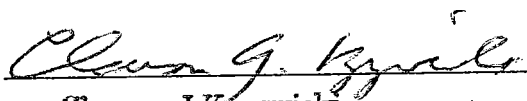
³ The MCO cited Ex. 11, p. 7 for support of its contention, but that document was part of a case analysis prepared by the Center for Health Dispute Resolution (CHDR) (see Ex. 3), not by an attending physician.

that there were no available SNF beds for the beneficiary from May 13 to May 19, 1999, and, as stated above, we adopt the Administrative Law Judge's conclusion that the beneficiary needed and received skilled nursing care that could be provided in a skilled nursing facility. Therefore, the beneficiary's inpatient services from May 13 to May 19, 1999 are covered under section 1861(v)(1)(G)(i) of the Social Security Act.

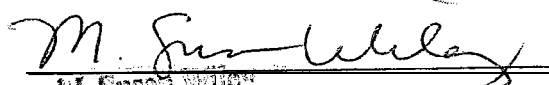
DECISION

It is the decision of the Medicare Appeals Council that the beneficiary's inpatient hospital stay from May 10, 1999 to May 19, 1999 is covered by Medicare.

MEDICARE APPEALS COUNCIL



Clausen J Krzywicki
Administrative Appeals Judge



M. Susan Wiley
Administrative Appeals Judge

Date: OCT 11 2001