

Medicare claimants brought action for injunction against procedures for determining eligibility for coverage of skilled physical therapy. The District Court, Jose A. Cabranes, J., held that fiscal intermediary's practice of routinely denying certain categories of physical therapy claims to be provided at skilled nursing facilities violated due process.

(8) Constitutional Law 278.7(3)

92k278.7(3) Most Cited Cases

Fiscal intermediaries practice of routinely denying Medicare claims for skilled physical therapy on basis of informal presumptions or rules of thumb violated due process.

U.S.C.A. Const.Amend. 5; Social Security Act 1814(a)(2)(C), 1816(a), as amended, 42 U.S.C.A. 1395f(a)(2)(C), 1395(a).

(10) Health 477

(Formerly 356Ak241.91, 356Ak241.90)

Claimants of Medicare benefits for skilled physical therapy whose claims were denied on basis of improper presumptions were entitled to order declaring the procedure unlawful and to reconsideration of individual claims but were not entitled to presumption of Medicare coverage whenever treating physician prescribed program of daily physical therapy.

I. FINDINGS OF FACT

A. DESCRIPTION OF THE PLAINTIFF CLASS

3. The Typical class member is afflicted with multiple disabilities that may complicate and prolong his rehabilitation. Tr. 50, 283, 311-312, 316, See 43 C.F.R. 409.33(a)(1) (recognizing that patients with multiple disabilities often require more extensive nursing or rehabilitation services than do patients with a single disability).

D. THE EFFECTS ON PLAINTIFFS OF DENIALS OF BENEFITS

18. Patients who are denied Medicare coverage are responsible for paying for their own physical therapy through insurance, personal savings or contribution from family members. Tr. 50, 56, 164, 211. In such circumstances many patients forgo medically necessary physical therapy because they or their families believe that they cannot afford to pay for such therapy themselves. Tr. 8, 21, 26-27, 43-44, 49-50, 56-57.

E. DEFENDANTS COVERAGE DETERMINATION PROCESS

21. The SNF is responsible as an initial matter for determining whether a newly admitted patient is to receive Medicare coverage. Tr. 13, 144, 4; HIM-13 at 3439.1. If the SNF decides that the services to be received by the patient are covered by Medicare, but the intermediary later reverses the SNF's decision, the SNF must absorb the cost of any such services if it "knew or could be expected to know, that payment for such services...could not be made" under Part A of Medicare, 42 U.S.C. 1395pp(b), Tr. 64.
22. A SNF that grants a claim FOR Medicare coverage is required to provide the Intermediary with extensive documentation of the patient's medical condition, the services rendered to the patient, and the extent of the patient's recovery. Tr. 212-213. The intermediary may decide on the basis of this information to reverse the SNF's initial award of coverage to the patient. Tr. 147-148. The SNF may then be liable for the cost of any services erroneously rendered to the patient.

23. However, when the SNF denies a claim for Medicare coverage, the SNF is not required to provide the intermediary with any information concerning the patient's condition (aside from his admitting diagnosis) or the treatment that have been ordered by the physician or rendered by the SNF. The SNF is required to provide additional documentation to the intermediary only if the patient seeks reconsideration of the SNF's denial of benefits. Accordingly, an SNF's denials of coverage are rarely, if ever, questioned by the intermediary unless the patient has requested reconsideration. Tr. 29, 147, 329.
24. The Secretary of HEW formerly provided a coverage determination procedure sometimes called a "presumption of non-liability" whereby the SNF was presumed not to have known or to have had reason to know that the services provided to a patient were not covered under Medicare. The SNF was entitled to this "presumption of non-liability" only if it met a "denial rate criterion" established by the Secretary. HIM-13 3433.
25. Because SNF's were more likely to lose their "presumption of non-liability" by erroneously granting coverage than by erroneously denying coverage, see Findings of Fact 22-24, supra, some SNF's tended to decide "questionable" claims by "erring always on the side of denying, rather than "1242 allowing" coverage in order to preserve their "presumption of non-liability". Tr. 148-149, 328.

II. CONCLUSIONS OF LAW

A. JURISDICTION SATISFIED – Plaintiffs proved that all remedies were exhausted

B. MERITS SATISFIED – Plaintiffs proved that their FIFTH AMENDMENT RIGHTS TO DUE PROCESS were violated and the regulatory requirements for the reviewers to not be arbitrary and capricious in their denials were not met

C. RELIEF – Plaintiffs are entitled to relief. Accordingly, an order shall enter declare Accordingly, an order shall enter declaring unlawful the intermediaries' unlawful practices of denying claims for physical therapy benefits, enjoining the future use of such practices and instructing the Secretary properly to supervise determination of physical therapy coverage made by his intermediaries. Members of the Plaintiff class whose claims were denied based on practices of the intermediaries that have been found to be unsupported by applicable regulations, see Section IIB(1), supra, and who have not prevailed on appeal, are entitle. To reconsideration of their claims.

D. JUDGMENT – Retroactive Relief to the Plaintiff Class

- i. The defendant will give written notice to all living members of the plaintiff class of their right to request that their claims for Medicare Skilled Nursing Facility benefits be re-determined.
- ii. In addition to the personalized notice, the defendants will publish a generalized notice to the plaintiff class of the judgment that: "The US District Court in Fox v Bowen, Civil Action No. H 78- 541 (JAC) has determined that the Secretary of Health Education & Welfare and his agents have acted illegally between October 1978 and April 1986 by arbitrarily denying Medicare skilled nursing facility benefits to patients receiving daily physical therapy treatments.

E. JUDGMENT - Prospective Relief to Skilled Nursing Facilities

- i. The defendant will give written notice to all skilled nursing providers of the plaintiff class of their right to request that their claims for Medicare Skilled Nursing Facility benefits be re-determined.

1. The defendant will not employ arbitrary presumptions or rules of thumb in order to deny coverage; such presumptions include the defendant's practice of denying skilled nursing facility coverage;
 2. To patients requiring maintenance therapy;
 3. For non-weight bearing therapy administered to fracture patients;
 4. For passive "range of motion" activities;
 5. For patients who can ambulate 50 feet with supervision;
 6. For amputees who have not been fitted with prostheses;
 7. For those patients who require daily skilled physical therapy for a period in excess of two weeks.
- ii. The court shall appoint a special master to assist in administering and evaluating the relief provided by this judgment. The Special master shall have the following duties:
1. Conduct a seminar for all intermediary and provider personnel in Connecticut. At the seminar, the special master will explain the rulings of the court, including the requirement that all members of the plaintiff class receive an individualized assessment of their entitlement to skilled nursing facility benefits.
 2. After the special master has collected the claims reconsideration information, the special master will submit a formal written report to the court.
 3. After receipt of the special master's written report, the court will schedule an evidentiary hearing at which the special master will be available for examination, if requested by either or both of the parties or by the court. After such hearing, the court may issue such further orders as are appropriate or necessary in the circumstances.

THE RESULT OF THE *FOX V BOWEN* COURT ORDER WAS A COMPLETE REVISION OF THE SKILLED CARE COVERAGE REVIEW GUIDELINES BY THE DEPARTMENT OF HEALTH EDUCATION AND WELFARE FOR THE INTERMEDIARIES ACROSS THE COUNTRY.

REVISION OF MEDICARE SKILLED NURSING MANUAL – Transmittal No: 262 Issued by the Department of Health and Human Services (HEW) Date: December 1987

Section 214, Covered Level of Care – General – This section has been revised in its entirety for greater clarity and in order to help ensure that the guidelines are implemented in a uniform and consistent manner.

Section 280.9, Custodial care – This section has been revised to delete outdated and extraneous material and to provide clear examples of types of care that are considered custodial.

SKILLED NURSING FACILITY CARE PURPOSE AND INTENT OF THE NEW GUIDELINE

The custodial care section of the manual has not been revised in 20 years. The SNF level of care section has not been revised for 12 years.

Beneficiaries, providers and courts have grown increasingly displeased with what are perceived as inappropriate denials of SNF coverage.

We have revised and expanded the manual guidelines to present more clearly the requirements for coverage. The purpose is to make it easier to identify covered care and ensure that claims are approved when the requirements for coverage are met.

The SNF level of care guidelines and custodial care guidelines has been totally rewritten. The new description of custodial care eliminates outdated references to rehabilitation services. The new description of a covered level of SNF care presents a more detailed explanation of the 3 elements that must be met; skilled services on a daily basis that as a practical matter must be furnished in a SNF.

APPROACH TO LEVEL OF CARE REVIEW

The guidelines are in a chapter entitled COVERAGE OF SERVICES. Remember that you are reviewing for coverage. Look for evidence that services are covered, to approve the claim. If you can't find the evidence, then denial is appropriate. Do not approach a claim assuming it is non-covered and looking only for evidence to us in denying it.

When you use screens to focus your medical review efforts, they should be coverage screens. Cases that screened out cannot be arbitrarily denied on level of care grounds just because they did not pass the screen. They must be developed and reviewed in more detail. In short, you can use medical review screens to approve claims without in-depth individual review, but not to deny them. Any rule of thumb that would declare the level of care requirements not met and deny a claim on the basis of elements such as the patient's condition, restoration potential, ability to walk, or degree of stability without individual review of all pertinent facts to see if coverage could be justified is unacceptable. A medical denial decision should be based on a detailed and thorough factual analysis of the patient's total condition and needs.

A custodial care denial would be based on section 1862 (a)(3) of the law.

A level of care denial would be based on section 1862 (a)(1)(A) of the law.

THEREIN TRANSMITTAL 262 WAS PRECEDED WITH A PREAMBLE TO ALL MEDICARE INTERMEDIARIES EXPLAINING IN DETAIL THE INTENT, PURPOSE AND APPLICATION OF THE NEW GUIDELINES.

The guidelines for regulatory rules 3132, 3132.1, 3231.2, 3132.3, 3132.4, 3132.5, 3102.10A, 3101.9 were all rewritten and issued in transmittal 262. Section 3132.1.B, page 3-56.14, makes three statements on the issue of qualifications for therapy:

- 1) While a patient's condition is a factor in deciding if skilled services are needed, it should never be the sole factor in deciding that a service is not skilled.
- 2) The deciding factor in determining if rehabilitation services are skilled is whether the skills of a therapist are needed, not the patient's potential for recovery.
- 3) A usually non-skilled service can, because of complications, require the skills of a therapist.

Reading all of these sections in context leads to a logical conclusion: If you determine that there is not a reasonable expectation of improvement in a patient's condition, you still do not know, conclusively that skilled therapy is not needed. There may be a need for skilled services to establish a maintenance program. Or a special medical complication might require skilled services to perform exercises or treatments that normally are considered non-skilled.

THE REST OF TRANSMITTAL 262 DEALS WITH THE SKILLED NURSING COMPONENT OF RESTORATIVE CARE IN A SNF. IT IMPLORES THE REVIEWERS TO BASE THEIR REVIEW ON THE SUBSTANCE OF EACH CASE AND DISALLOWS THE USE OF RULES OF THUMB OR ARBITRARY SCREENING CRITERIA WITHOUT FACTUAL PROOF OF THE LACK OF MEDICAL NECESSITY AND NEED FOR SKILLED SERVICES.

UNFORTUNATELY, HEW AND ITS INTERMEDIARIES DID NO SEMINARS FOR THE PROVIDERS IN THE REST OF THE COUNTRY AND HAS NEVER REALLY FOLLOWED THE 262 GUIDELINES AS PROMULGATED BY *FOX V BOWEN*. CLAIMS REVIEW IS STILL ARBITRARY AND CAPRICIOUS USING SCREENS FOR SELECTING CLAIMS FOR REVIEW AND THEN DENIAL.

THIS VERY ACT HAS REDUCED THE 100 DAY COVERAGE PERIOD PER SPELL OF ILLNESS, THAT THE MEDICARE BENEFICIARIES ARE ENTITLED TO, FROM AVERAGE COVERAGE PERIODS OF 34 DAYS BEFORE PPS TO 22 DAYS CURRENTLY. IN TIMES PAST (1980'S) THE AVERAGES WERE AT LEAST IN THE 40 TO 50'S.

THIS MEANS THAT THE TYPICAL SNF PATIENT IS ONLY RECEIVING AT BEST 20% OF THE COVERAGE THAT THEY HAVE PAID FOR! AND THE PROVIDERS OF THE SKILLED SERVICES ARE NOT BEING PAID TO RESTORE PATIENTS, MERELY WAREHOUSE THEM UNTIL THEY RUN OUT OF MONEY AND GO ON MEDICAID.