

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of

Quality Home Health
Services, Inc.

(Appellant)

(Beneficiary)

TrustSolutions, LLC (PSC)

(Contractor)

Claim for

Hospital Insurance Benefits
(Part A)

(HIC Number)

(ALJ Appeal Number)

INTRODUCTION

The Administrative Law Judge (ALJ) issued sixty-eight individual decisions, dated from July 30, 2008, through October 1, 2008, which concerned overpayments for home health services provided to the sixty-four beneficiaries on dates of service listed on the attachment. These cases primarily involved two categories: (1) daily skilled nursing visits to provide insulin injections for diabetic patients; and (2) skilled nursing, rehabilitation, and social services. The ALJ determined in all cases that the services provided were not medically necessary and thus not covered by Medicare. In some cases, the ALJ then determined that the appellant was liable for noncovered services and for the overpayment amount. The appellant has asked the Medicare Appeals Council to review these actions.

The Council reviews the ALJ's decisions *de novo*. 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's actions to the exceptions raised by the party in the requests for review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c). As set forth below, the Council adopts the ALJ's decisions in part, and reverses the ALJ decisions in the remaining instances.

BACKGROUND

This appeal arises from a statistical sample of home health services provided during review period June 11, 2003, through August 31, 2005. Ex. 6, at 1.¹ Program Safeguard Contractor TrustSolutions, LLC, determined that the sample cases at issue should not have been covered and extrapolated an overpayment amount of \$2,224,313. *Id.* The appellant does not challenge the validity of the statistical sample or the extrapolation methodology in its requests for review or memorandum brief.² The Council therefore does not consider these subjects on appeal.

The ALJ issued a Notice of Hearing, dated June 12, 2008, (Notice) for claims involving 91 beneficiaries. Ex. 22. The Notice scheduled the hearing for July 14-17, July 21-24, and July 28-29, 2008. Ex. 22, at 1. The hearing recording indicates that the hearing was conducted on July 14 (beneficiaries 1-20), July 15 (beneficiaries 21-69), and July 16 (beneficiaries 70-91). MAC Master File I. As noted, the ALJ found that the home health services were not medically reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act (Act) and, in some cases, that the appellant was liable for non-covered services under section 1879 of the Act and not entitled to waiver of overpayment under section 1870 of the Act. The appellant filed individual requests for review for sixty-eight ALJ decisions, involving the sixty-four beneficiaries listed on the attachment.³

¹ Citations to the ALJ decision and administrative record herein shall be to the decision and record for lead beneficiary G.A. (ALJ Appeal 1-275714543), unless otherwise indicated.

² The appellant did assert below that some of the disputed services, even if not properly covered, did not result in actual overpayments because the same amount of payment would have been made for that period of service under the prospective payment system even omitting the questioned units of service. The appellant did not develop this argument on appeal or contend that this fact would not be adequately addressed by the methodology used for extrapolation to the appellant's total claims which presumably were also made under the same payment system. We also note that the claims for beneficiaries J.G. (ALJ Appeal 1-275934469) and W.P. (ALJ Appeal 1-275926794) involve dates of service outside the review period for the statistical sample. The Medicare contractor noted in its redetermination decisions that these claims were not a part of the statistical sample. Ex. 3, at 1 (beneficiary J.G.); Ex. 4, at 1 (beneficiary W.P.).

³ The attachment to the memorandum brief names two additional beneficiaries (M.K. and W.C.) as involved in this appeal. As the appellant provided the Council with no requests for review or ALJ decisions for these beneficiaries, the Council does not consider those claims in this review.

APPLICABLE LEGAL STANDARDS

Standard of review

As these cases arise from QIC reconsideration decisions, the Council applies Medicare appeals regulations in Title 42 C.F.R., part 405, subpart I. Interim final rule with comment period, 70 Fed. Reg. 11420, 11425 (Mar. 8, 2005). Under these regulations, both the ALJ and the Council conduct *de novo* review of appealed claims. 42 C.F.R. §§ 405.1000(d), 405.1046(a), 405.1110(c).

Home Health Services

In order for Medicare to cover and pay for home health services furnished to a beneficiary, there are two basic requirements: (1) the beneficiary must be qualified, *i.e.*, eligible to receive home health services; and (2) the services must be covered home health services. In pertinent part, in order to qualify for home health services, a beneficiary must be confined to his or her home and must need skilled nursing care on an intermittent basis or physical, occupational, or speech therapy services. See sections 1814(a)(2)(C) and 1861(m) of the Social Security Act (Act); 42 C.F.R. § 409.42;⁴ Medicare Benefit Policy Manual (MBPM)(Pub. 100-02) Ch. 7, § 30.⁵ The beneficiary may not qualify based solely on a need for skilled nursing care unless the nursing care meets the definition of "intermittent" or the beneficiary is also receiving another qualifying service, *i.e.*, rehabilitative therapy. After the beneficiary qualifies for home health services, she may receive coverage for part-time or intermittent home health services, such as skilled nursing or home health aide services.

The term "intermittent," for purposes of section 1814(a)(2)(C) of the Act (and section 1835(a)(2)(A) of the Act) is defined as:

⁴ Once an individual qualifies for coverage of home health services under section 1814(a)(2)(C) of the Act, *e.g.*, because of a need for intermittent skilled nursing care, the individual may have part-time or intermittent skilled nursing and home health aide services covered by Medicare under section 1861(m) of the Act. Individuals who do not qualify for coverage under section 1814(a)(2)(C) of the Act may not receive Medicare payment for any of the services described in section 1861(m) of the Act.

⁵ Services by home health aides, social services, and occupational therapy are examples of dependent services that are not covered in the absence of a qualifying home health service. See MBPM Ch. 7, §§ 50.2, 30.4, 50.3. The need for skilled care must be determined by evaluation before covered services are provided. MBPM Ch. 7, §§ 30.2.10, 40.1.1.

Skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

Section 1861(m)(7)(B) of the Act. The Centers for Medicare & Medicaid Services (CMS) has clarified the definition of "intermittent" skilled nursing care requirement in relation to diabetic patients. Specifically, CMS states that an exception to the intermittent requirement is "daily skilled nursing services for diabetics unable to administer their insulin (when there is no able and willing caregiver)." MBPM Ch. 7, § 40.1.3. CMS notes that insulin is typically self-injected by the beneficiary or injected by a member of the beneficiary's family. *Id.* § 40.1.2. However, the injection of insulin can be considered a reasonable and necessary skilled services "where a patient is either *physically or mentally unable to self-inject* and there is no other person who is able and willing to inject the patient." *Id.* § 40.1.2.4 (emphasis supplied).

Whether nursing services qualify as "skilled" care depends upon whether the services require the skills of a licensed nurse, considering the complexity of the service, the beneficiary's condition, and accepted standards of medical and nursing practice. 42 C.F.R. § 409.44(b), *cross-referencing* 42 C.F.R. §§ 409.32, 409.33(a), 409.33(b); *see also* MBPM Ch. 7, § 40. To be considered a "skilled" nursing or rehabilitation service, the service "must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel." 42 C.F.R. § 409.32(a). Examples of skilled nursing services include the overall management and evaluation of a care plan, the observation and assessment of a patient's changing condition, and patient education services. 42 C.F.R. § 409.33(a). Skilled rehabilitation services include assessment of rehabilitation needs, therapeutic exercises or activities, gait evaluation and training, range of motion exercises, and certain maintenance therapy. 42 C.F.R. § 409.33(b).

"Personal care" services do not require the skills of qualified technical or professional personnel and are not covered by Medicare. 42 C.F.R. § 409.33(d). Personal care services include administration of routine oral medications, routine services to maintain satisfactory functioning of indwelling bladder catheters, and assistance in dressing, eating, and going to the toilet. *Id.* Personal care services also include

"[g]eneral supervision of exercises which have been taught to the patient; including the actual carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function Similarly, repetitious exercises to improve gait, maintain strength, or endurance . . . and assistive walking do not constitute skilled rehabilitation services." 42 C.F.R. § 409.33(d)(13).

Limitation on Liability, Overpayment Waiver

An item or service may meet Medicare coverage criteria, but nonetheless be excluded from coverage as not reasonable and necessary in a specific case when it is "not reasonable and necessary for the diagnosis or treatment of illness or injury" or constitutes "custodial care." Sections 1862(a)(1)(A) and 1861(a)(9) of the Act. Section 1879 of the Act provides, in pertinent part, that a beneficiary or supplier may be held liable for items or services that are not covered under sections 1862(a)(1) or 1862(a)(9) when they knew or could reasonably have been expected to know of the noncoverage. Section 1879(c) of the Act; Medicare Claims Processing Manual (MCPM)(Pub. 100-03) Ch. 30, §§ 30.1, 30.2. A beneficiary is deemed to have knowledge of noncoverage based upon prior written notice or evidence of actual knowledge. CMS Ruling 95-1.IV.A, *citing* 42 C.F.R. § 411.404; MCPM Ch. 30, §§ 40.2, 40.3. A provider or supplier is presumed to have knowledge of noncoverage, in part, based upon "general notices to the medical community of Medicare payment denial of services and items under all or certain circumstances. (Our notices include, but are not limited to, manual instructions, bulletins, [contractor] written guides, and directives)" CMS Ruling 95-1.IV.B.2, *citing* 42 C.F.R. § 411.406; MCPM Ch. 30, § 40.1.

DISCUSSION

In its appeal of these ALJ Decisions, the appellant argues that the reasons offered for denial of services at the contractor and ALJ fail to conform to applicable standards in statute, regulation and CMS policies. MAC-2, at 1. The appellant also contends that the ALJ regularly deferred to statements by the QIC, to the point of quoting them directly as his rationale for decisions, without discussing any of the evidence presented by the appellant in the individual cases. *Id.* at 2-3. According to the appellant, the decisions do not show any independent review of the medical records relating to the individual beneficiaries.

A determination regarding Medicare coverage of home health services is to be based "upon objective clinical evidence regarding the patient's individual need for care." 42 C.F.R. § 409.44(a). The ALJ decisions reviewed here vary but are, in some cases, very brief and conclusory or rely merely on generalized statements without reference to applicable Medicare regulations and Manual provisions. We also agree with the appellant that some of the ALJ decisions fail to demonstrate a careful review of the underlying evidence. The appellant overstates this objection in his claim that the ALJ merely cut and pasted the content of QIC determinations. It is evident that in many of the cases appealed here the ALJ cited to and relied on evidence in the record that was not mentioned in QIC reconsiderations. *See, e.g.,* ALJ decisions and QIC reconsiderations for beneficiaries J.C. and M.M.

We need not, however, evaluate whether the ALJ adequately reviewed the individual medical records in each case here, because, as noted, the Council conducts a full *de novo* review of the issues on appeal. In that context, the Council has itself reviewed the recorded hearings, and considered the exhibits including the individual medical records and the beneficiary-specific statements submitted below by the appellant.

Because of the number of beneficiaries, the large volume of material, and overlapping issues, we do not in this decision discuss every relevant document related to every service provided to every beneficiary at issue. Even where we do not discuss each item in detail, we have reviewed the clinical records and case files in reaching our conclusions.

Below we group our discussion around four major bases for which payment was denied in the cases at issue: (1) failure to

document homebound status; (2) failure to show that a diabetic beneficiary needed skilled nursing (SN) visits to measure blood sugar and inject insulin; (3) failure to show other SN services were reasonable and necessary; and (4) failure to show that a beneficiary required skilled physical therapy (PT) services. We identify those cases where a correct resolution of those issues alters the outcome for particular beneficiaries (identified by initials).

Next, we identify cases in which the ALJ decisions provided sufficient analysis and rested on adequate evidence in the record or in which no substantive issue was identified by the appellant. In those cases, we adopt the ALJ decisions without further detailed discussion.

Finally, we discuss cases that present idiosyncratic questions of medical necessity or documentation not disposed of under the bases already discussed. In some cases, the medical documentation is incomplete, lacking important components to establish the presence of medical or factual elements on which the appellant relies to establish the beneficiary's need for or entitlement to the services for which payment is claimed. In other cases, the information provided about a beneficiary's needs or condition in the physician's certifications, Outcome and Assessment System Information Set (OASIS) reports, and the assessments, notes and progress reports of nurses or therapists are confusing, mutually inconsistent, or even in direct conflict. Where less than perfect or identical descriptions nevertheless suffice to make reasonably clear why a skilled service was required to appropriately treat a medical need, we have indicated that. Where the records before us cannot be reconciled or are too incomplete to support a conclusion, we note that ultimately the appellant is responsible for creating, collecting, maintaining and providing documentation adequate to establish that the services provided are covered by Medicare. In those cases where such documentation is not in the record, the claims cannot be covered and we have identified those situations below as well.

We then discuss questions of waiver of liability and the relevant overpayment provisions.

Finally we include a chart summarizing the effects of our decision on all pending claims.

1. Homebound status

In 22 decisions, the ALJ denied services in whole or in part based on his conclusion that the beneficiary was not homebound. As noted above, one prerequisite for coverage of home health services is that the beneficiary must be "confined to the home or in an institution that is not a hospital, SNF or nursing home" as those terms are defined by statute. 42 C.F.R. § 409.42(a). Section 1814(a) of the Act provides that, for purposes of eligibility for home health services, an individual --

shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home," the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program . . . shall not disqualify an individual from being considered to be "confined to his home." Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration.

See also Section 1835(a) of the Act. Thus, an individual who leaves home on a regular basis for nonmedical purposes would not satisfy the homebound criteria despite using an assistive device such as a cane. On the other hand, an individual who cannot safely leave home alone is not disqualified because a caregiver can sometimes drive her to medical visits or to church.

CMS further explained how homebound status is affected by absences from the home as follows:

It is expected that in most instances, absences from the home that occur will be for the purpose of receiving health

care treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

MBPM, Ch. 7, § 30.1.1.

The appellant proposed that the homebound status of the beneficiaries at issue should be gauged based on methods developed in a study project which used a literature review and expert panel analysis to develop algorithms and medical record review tools.⁶ The study does not purport to create new standards to govern coverage under Medicare but rather to provide approaches to improve the utility of OASIS data for contractors and providers. ALJ Decision in 1-275714543 (G.A.) at 12. While the goals of increasing consistency and improving the percentage of correct classifications for which the authors aim may be admirable, the study itself is clearly preliminary with a view to "substantial work" remaining and "more research" being needed. *Id.* The appellant offered no evidence that the algorithms or tools were widely accepted or even in actual use in the relevant medical community. We agree with the ALJ that the cases before him, and now before us, must be decided under the currently applicable legal standards without reliance on the tentative research approach presented in the study. We turn next to how the ALJ applied those legal standards to the evidence in these cases.

The ALJ did not question that each of the beneficiaries here had been certified by a physician as in need of home health services. He nevertheless found that each failed to meet the Medicare definition of being homebound. See, e.g., ALJ Decision in 1-275714543 (G.A.) at 11. Although he referred to the definitions of "confined to home" discussed above, the ALJ's application of those definitions did not begin with the question of whether each beneficiary required the assistance of another person or a supportive device to leave home or had another medically contraindicating condition. Nor did the ALJ in most cases focus on how often the beneficiary left home, with what level of difficulty or for what purposes.

⁶ See ALJ Decision in 1-275714543 (G.A.) at 12 n.1. for full citation and contractual information on this study.

Turning to the factors which the ALJ did discuss in determining that beneficiaries were not homebound, we find that, in many cases, the ALJ appears to have given decisive weight to aspects of the beneficiaries' condition that do not necessarily evidence that they were able to leave home safely at all or without considerable and taxing effort. For example, the ALJ relied on findings in OASIS reports that a beneficiary was independent with some or all basic activities of daily living (ADLs), without acknowledging that an ability to eat, dress, toilet, or bathe oneself is not equivalent to the ability to leave the house safely and without considerable effort. See, e.g., ALJ Decisions in 1-275755220 (Z.A.) at 11 and in 1-275742123 (I.A.) at 11. Nor does the ability to independently transfer from bed to chair or on to and off of a toilet imply sufficient independent mobility outside the home. Similarly, the ALJ focused on findings that beneficiaries' vital signs were within normal range on an OASIS or a skilled nursing visit as evidence that those beneficiaries were not homebound. *Id.* Nothing in the applicable definitions requires that a beneficiary have abnormal vital signs in order to be considered homebound.⁷

We have therefore reviewed the records for all of the beneficiaries for whom the ALJ made an unfavorable homebound finding. We consider what reason was given for the claim of homebound status and whether the medical records support or contradict that claim.

G.A. (ALJ 1-275714543 and 1-275893175) - This beneficiary's diagnoses included diabetic management, heart disease and hypertension. The record is not consistent about whether the beneficiary uses a supportive device, although some notes reference a cane. Case file for ALJ Number 1-275714543, Ex. 17. The appellant contends that the cumulative effect of several factors demonstrate inability to leave home without taxing effort. Appellant's Patient Exhibit Files (Patient Ex.) 1 of Volume (Vol.) 1, at 2. The OASIS documents shortness of breath (SOB, or dyspnea) with moderate exertion. Case file for ALJ Number 1-275714543, Ex. 14, at 10. Moderate exertion includes such activities as dressing, using the toilet, or walking less

⁷ This is not to say that these factors can never be relevant. If the asserted basis for home confinement is inconsistent with independence in ADLs or stability in vital signs, such findings may undercut the asserted basis. The ALJ, however, appears to have recited these findings as conflicting with homebound status without regard to the reason(s) for which the appellant asserted that the beneficiary was homebound. Furthermore, unstable vital signs or lab values may be relevant to justifying a need for skilled services for monitoring or observation. MBPM, Ch. 7, § 40.1.2.1.

than 20 feet. *Id.* The OASIS further documents that she is unable to go shopping without assistance, though she is able to do light housekeeping, meal preparation and laundry. *Id.* at 13. The nursing assessments report problems with balance or unsteady gait, "fatigues easily," forgetful/confused with fair memory, and "unsafe to leave home w/o assist." Case file for ALJ Number 1-275714543, Ex. 15, at 1 et seq. The ALJ did not address any of this evidence, apart from noting her shortness of breath without comment. He pointed to the documentation that the beneficiary lived alone (though receiving assistance from family and neighbors), was independent with basic ADLs, could ambulate and perform transfers, had vital signs and glucose readings "within normal limits," could ride in a vehicle (driven by someone else) or in a bus (if accompanied by someone else), and wore glasses for her visual impairment.⁸ These observations do not contradict the clinical findings that the beneficiary could not safely leave home without assistance. We therefore reject the ALJ's conclusion that the "evidence compels a conclusion that the beneficiary did not meet the medicare's [sic] criteria for being homebound." ALJ Decision in 1-275714543 at 12. A review of the file in the second case for this beneficiary does not materially change this conclusion for that time period. Case File for ALJ Number 1-275893175 *passim*.

I.A. (ALJ 1-275742123) - The appellant asserts that the beneficiary was homebound due to shortness of breath with minimal activity and fatigue, citing the OASIS and nursing notes. Patient Ex. 4, of Vol. 1, at 1. The appellant does not assert that any assistive device was needed for mobility. *Id.* at 2. The Follow-up OASIS in the record does not support the appellant's assertions. The beneficiary is cited as showing signs of dyspnea only on walking more than 20 feet or climbing stairs, whereas minimal activity would mean SOB even from eating or talking. Case File for ALJ Number 1-275742123, Ex. 11, at 5. Functional limitations to endurance and ambulation are noted on the OASIS, but the nature of the limitation is not indicated and nothing is entered in the box for homebound status. *Id.* at 3. Most of the nursing notes show no negative findings in the musculoskeletal area, although a scattering note weakness, balance or gait issues. Case File for ALJ Number 1-275742123, Ex. 14 *passim*. In the section for homebound status, none of the

⁸ It is not clear on what the ALJ based his conclusion that the beneficiary had glasses that corrected her vision. The OASIS calls for an assessment of vision "with corrective lenses if the patient usually wears them." Case file for ALJ Number 1-275714543, Ex. 14, at 4. That assessment for this beneficiary stated that she still had partially impaired vision and specifically cited "blurred vision." *Id.*

notes checked the boxes for SOB on exertion. In each case, the only items checked were "fatigues easily" and "other," with the word "ambulatory" written in. *Id.* The clinical information in the record does not provide support for finding that this beneficiary was confined to his home. We therefore adopt the ALJ's conclusion that no services were covered because the beneficiary did not qualify as homebound.

Z.A. (ALJ 1-275755220) - The appellant asserts that the beneficiary is SOB "upon exertion," according to OASIS, requires use of an asthma inhaler and that nursing notes on some visits document SOB and/or pain requiring medication. Patient Ex. 5, of Vol. 1, at 1. The OASIS indicator on dyspnea is marked "never, patient is not short of breath," although asthma is one of the diagnoses, which may indicate that the inhaler successfully addresses any respiratory needs. Case File for ALJ Number 1-275755220, Ex. 12, at 6. The OASIS shows intermittent aching back pain, at an acceptable level at that assessment. *Id.* at 2. Of the more than 100 nursing notes in the record, the vast majority indicate that the patient denies any pain, with fewer than a dozen reporting pain, mostly at 2 or 3 on a 10-point scale. *Id.*, Ex. 13, at 1-120. Only 30 notes, all from between January 31, 2005 and February 15, 2005, identify "SOB on exertion" as relevant to homebound status, and none of those check the box under respiratory findings for "Dyspnea/SOB." *Id.* Under homebound status, the notes all indicates "uses assistive device" and "fatigues easily," but nothing in the clinical record makes clear what assistive device the beneficiary uses and how her fatigue affected her inability to leave home. *Id.*

The Act requires that a beneficiary have a "normal inability" to leave home without considerable and taxing effort. Occasional episodes of pain or SOB do not establish that such symptoms incapacitate the beneficiary on a regular basis from leaving home, where the clinical record shows that the symptoms are absent most of the time. We therefore adopt the ALJ's conclusion that no services were covered because the beneficiary did not qualify as homebound.

J.A. (ALJ 1-275754422) - The appellant contends that the beneficiary was homebound because a cast after surgery for an arm fracture made it very difficult for her to use her walker which she needed for "safety and balance" due to functional limitations in weakness, endurance, and ambulation. Patient Ex. 6, of Vol. 1, at 1-2. The ALJ noted that she needed assistance for dressing and grooming but was otherwise independent with ADLs, and found that the OASIS at start of care showed no

assistive device while the discharge OASIS showed a need for a single-point cane which the beneficiary refused to use. ALJ Decision in 1-275754422, at 10, citing Exs. 12 and 13. He concluded that "the documentation in the nursing notes, physical therapy notes, and discharge assessment do not support that the beneficiary was homebound as it is noted in the OASIS, that she was unable to safely leave home unassisted," and then pointed out that she missed two PT appointments when the therapist recorded being "unable to locate the patient." *Id.* at 10; see Ex. 11.

These cryptic comments by the ALJ appear to imply that the OASIS assessment must be false if the patient was not at home on two occasions in two months, but that assumption is ill-founded since the beneficiary may have left home with assistance or with considerable effort or have been away from home for one of the purposes which do not interrupt homebound status. The SOC OASIS, however, plainly undercuts the assertions that the beneficiary needed use of her arm to leave home because she was dependent on a walker, since it states that she is able to "independently walk on even and uneven surfaces and climb stairs . . . (i.e., needs no human assistance or assistive device)." Case File in 1-275754422, Ex. 12, at 3. Nor does the SOC OASIS provide any other basis to suggest the beneficiary was homebound and indeed the box for "homebound" is not checked, despite the checkmark, noted by the ALJ, in the box "unable to safely leave home unassisted." *Id.* at 9. None of the nursing notes have a check in the box for unsafe to leave home without assistance and only three check use of assistive device, although they note fatigue or unsteady gait on many of them. Case File in 1-275754422, Ex. 14 *passim*. The discharge OASIS states that she requests a device to walk alone or requests assistance to negotiate stairs or uneven surfaces, but contains the handwritten note that the patient "refuses to use her walker." Case File in 1-275754422, Ex. 13, at 7. (The ALJ apparently derived his reference to a cane from the PT discharge summary. Case File in 1-275754422, Ex. 15.) The same OASIS also states, however, that the patient is "no longer home bound," which indicates that not using the walker was not a sufficient obstacle to her ability to leave home. *Id.* at 10. We conclude that the documentation is inconsistent and insufficient to establish that the beneficiary was actually homebound as a result of her arm injury. We therefore adopt the ALJ's conclusion that no services were covered because the beneficiary did not qualify as homebound.

S.C. (ALJ 1-275886089 and 1-27589716) - The appellant argues that this beneficiary was rendered homebound as a result of his psychiatric condition. Patient Exs. 15 and 16, of Vol. 1, at 1-2. The appellant cites MPBM, Chapter 7, section 30.1.1, which provides as an example of a beneficiary considered confined to home a "patient with a psychiatric illness that is manifested in part by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations." The appellant asserts that the beneficiary was very forgetful, mentally unstable, delusional and hallucinating, according to physician visit notes, and was taking multiple psychotropic medications, and consequently could not safely navigate alone outside his home. Patient Exs. 15 and 16, of Vol. 1, at 1-2. The ALJ noted the diagnosis of schizophrenia, but stated that he had no "behavioral problems or depression," resided in "a board and care facility," had no respiratory or cardiac problems, had normal vital signs, and "was alert and oriented." ALJ Decision in 1-275886089, at 11-12. The ALJ stated that the beneficiary required "the use of a device or another person's assistance to walk," but was "independent in grooming, dressing the lower body, toileting and transferring." *Id.* at 12. The ALJ then concluded that the beneficiary was not homebound. *Id.*

The physician certification indicates that the beneficiary was forgetful and suffered from anxiety as well as impaired vision resulting from diabetic retinopathy, in addition to diagnoses of schizophrenia and seizure disorder and the start of care worksheet also noted safety issues resulting from the retinopathy and unsteady gait. Case File in 1-275886089, Ex. 10, at 1, and Ex. 9, at 1. The beneficiary had been discharged from a psychiatric hospital with indications of "guarded" expectations for present and future ability to manage care and placed in care of a psychiatrist while at the boarding care facility. Case File in 1-275886089, Ex. 18. The SOC OASIS indicates a pre-existing condition of impaired decision-making and states that the beneficiary requires assistance from the paid staff several times during day and night with such functions as meals, housekeeping, shopping, laundry, and socialization. Case File in 1-275886089, Ex. 19, at 1-4. His cognitive functioning is assessed as "requires assistance and some direction in specific situations (e.g. on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility" (level 2 on a 0-4 scale of difficulty); he is confused "in new or complex situations only;" and he is alert but anxious daily. *Id.* at 11. He does not, however, demonstrate delusional or other behavioral

problems or depressive mood. *Id.* The nursing notes all indicate that he could not safely leave home without assistance but vary in the details checked as to the reason(s), checking visual, physical (unsteady gait and fatigue), mental/emotional and/or "activity restricted by MD." Case File in 1-275886089, Ex. 20 *passim*. The social work assessment indicates that the beneficiary is 41 years old and having difficulty adjusting to his illness, that he needs "to remain safe in a facility that provides for ADL's," and is dependent for medical management. Case File in 1-275886089, Ex. 21, at 1. His psychiatric evaluation at the hospital (5 days before his start of care) shows paranoid delusions, hearing voices, and impaired judgment. Case File in 1-275886089, Ex. 24.

We conclude that documentation is sufficient to establish that the beneficiary could not safely navigate outside of the controlled setting without supervision or considerable effort and risk. We reverse the ALJ and conclude that the beneficiary was homebound.

L.C. (ALJ 1-275874107) - The appellant contends that all clinical notes demonstrate that the beneficiary had an unstable gait, fatigued easily and was unsafe to leave home without assistance. Patient Ex. 18, of Vol. 1, at 1. The recertification OASIS has no indication of any reason that the beneficiary is homebound where that information is called for. Case File in 1-275874107, Ex. 11, at 11. The SOC OASIS which would have been for an earlier period is not in the record. Her diagnoses include poorly controlled diabetes and heart disease. *Id.* at 1. The recertification OASIS states that she is able to walk independently on any surface and climb stairs without an assistive device or personal assistance, and the only use of an assistive device is for bathing or showering. *Id.* at 8.

The nursing notes do consistently indicate homebound status based on unsteady gait, use of assistive device, fatigues easily and unable to leave home safely without assistance. Case File in 1-275874107, Ex. 13 *passim*. They also consistent reflect musculoskeletal findings of weakness, balance and unsteady gait and mental findings of some confusion or forgetfulness. *Id.* The social services assessment indicates that the patient has independent mobility and does not reflect difficulty in leaving home. Case File in 1-275874107, Ex. 14, at 2. All the documentation focuses primarily on the reasons that the patient cannot manage her diabetes independently and her lack of a willing and able caregiver to assist with that.

The clinical record is in conflict about whether the beneficiary needed any assistance in ambulating and whether she was unable to safely leave home. Given the direct conflict in the clinical records, we cannot find that the appellant has documented that the beneficiary was homebound and we therefore adopt the ALJ's unfavorable conclusion.

V.G. (ALJ 1-275779188) - The appellant asserts that the beneficiary was chair/bed bound, with congestive heart failure and edema, SOB with minimal exertion, and weighing nearly 300 pounds. Patient Ex. 22, of Vol. 1, at 1. The ALJ found the documentation "confusing and conflicting." ALJ Decision in 1-275779188, at 12. As the ALJ pointed out, the SOC OASIS section on homebound reason is not filled out. Case File in 1-275779188, Ex. 9, at 15. The same OASIS, however, indicates that she has diagnoses of gout, arthropathy, uncontrolled diabetes and congestive heart failure post heart catheterization; requires a supportive device or assistance to walk alone or climb stairs, that she has swollen and painful joints, is morbidly obese, has pitting edema of her lower legs, needs some assistance with multiple ADLs, and has dyspnea with minimal exertion and limited endurance. *Id.* at 2-12. She is noted to need a walker. *Id.* at 14. The plan of care noted the multiple diagnoses, functional limitations in endurance and dyspnea on minimal exertion but does not mention use of a walker. Case File in 1-275779188, Ex. 10, at 1. Progress notes indicate that she is largely chair or bed bound with feet elevated due to edema but uses wheelchair/walker for ambulation. Case File in 1-275779188, Ex. 14, at 2. Nursing notes regularly indicate homebound status due to "unsteady gait, requires assistance" and unsafe to leave to home without assistance, and note musculoskeletal problems with balance, gait swelling or joint stiffness/rigidity, continuing edema, and high risk of falls. Case File in 1-275779188, Ex. 15 *passim*. Some of the notes also indicate a loss of range of motion, shortness of breath, or that the beneficiary is chairbound or using an assistive device. *See, e.g., id.* at 4, 11, 45, 95. The social services discharge note shows the beneficiary as needing assistance for ADLs and mobility and using a walker/cane. Case File in 1-275779188, Ex. 16, at 2.

In this case, the documentation is consistent in portraying an individual dependent on assistance for any mobility, and seriously limited by dyspnea, edema, morbid obesity and joint problems. While the OASIS writer failed to indicate the reason for homebound status, the reasons are made clear in the same document and are consistent with the clinical findings of

multiple professionals. We therefore reverse the ALJ's finding that this beneficiary was not homebound.

L.K. (ALJ 1-275792244) - The appellant agrees that the patient was inappropriate for home health services and asserts that the claims were only for assessment visits at which that determination was made. Patient Ex. 37, of Vol. 1, at 1. Under Medicare rules, an initial evaluation "is considered an administrative cost of the agency and is not chargeable as a visit since at this point the patient has not been accepted for care," although if "the patient is determined suitable for home health care by the agency, and is also furnished the first skilled service as ordered under the physician's plan of care, the visit would become the first billable visit in the 60-day episode." MBPM, Ch. 7 § 70.2.C. Since the nursing and PT initial evaluations found the patient unsuitable, the visits cannot be covered regardless of whether the beneficiary was homebound. We therefore do not reach the ALJ's discussion about homebound status but modify the decision to reject coverage for the reason stated.

E.K. (ALJ 1-275800087) - The appellant states that the nursing notes document that the beneficiary uses an assistive device and needs the assistance of another person to leave the home due to an unsteady gait. Patient Ex. 39, of Vol. 1, at 1. The ALJ found that the beneficiary did use a walker but pointed out that the social worker documented that the beneficiary "attended community activities regularly," which he found inconsistent with homebound status. ALJ Decision in 1-275800087, at 12.

The OASIS supports the beneficiary's need for a walker to ambulate alone and identifies as additional homebound reasons residual weakness and inability to leave home safely. Case File in 1-275800087, Ex. 9, at 8, 11. Nursing notes document unsteady gait without assistance and unsafe to leave home without assistance, as well as the need for assistive device, as reasons for homebound status. Case File in 1-275800087, Ex. 15. The PT assessment recorded multiple falls in preceding weeks, gait abnormality, multiple balance deficits, and atrophy and muscle wasting. Case File in 1-275800087, Ex. 18. Records indicate on discharge from PT the beneficiary could use her walker to ambulate within her mobile home without fall risk. Case File in 1-275800087, Ex. 17, at 1. The social work note cited by the ALJ further states that the beneficiary will "continue attending community senior group for socialization and support" and notes her strong support from neighbors, but also states that "slow mobility hinders pt ability to leave home" and

identifies her gait abnormality and need for assistance with ADLs and mobility. Case File in 1-275800087, Ex. 21, at 1.

Section 1814(a) of the Act provides that "regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program . . . shall not disqualify an individual from being considered to be 'confined to his home.'" In this case, the social work note is somewhat ambiguous in referring to community activities and a community senior group for socialization and support, but can be read as referring only to absences to participate a day program of the kind contemplated by the statute. The rest of the clinical records appear to support that the beneficiary cannot safely leave home alone without considerable and taxing effort. We therefore reverse the ALJ's conclusion that the beneficiary is not homebound.

M.K. (ALJ 1-239060895) - The appellant asserts the beneficiary should be considered homebound due to SOB with ambulation of more than 20 feet and use of a cane and grab bars. Patient Ex. 40, of Vol. 1, at 1. The ALJ noted discrepancies in the OASIS and nursing notes about the beneficiary's vision problems and hand dexterity limitations, but found that "they do indicate that the beneficiary had unsteady gait and that she requires assistance." ALJ Decision in 1-275876204, at 12. He then concluded that the "evidence compels a conclusion the beneficiary did not meet the medicare's [sic] criteria for being homebound." *Id.* at 13. The ALJ's conclusion does not follow from his own findings.

The OASIS indicates that the beneficiary has partially impaired vision even with glasses, needs caregiver assistance with several times during the day and night, is in pain daily though not constantly at level of 7-8 on a scale of 0-10 in her back and lower extremities made worse with movement or ambulation, is SOB when walking more than 20 feet, has limited endurance, and uses a cane. Case File in 1-275876204, Ex. 10, at 2-13. The OASIS assessed the beneficiary as unable to leave home safe unassisted and homebound due to poor endurance. *Id.* at 15. The box on ambulation, however, was checked as able to independently walk on all surfaces. *Id.* at 12. The plan of care also notes functional limitations on endurance and use of a cane and grab bars and the pain in her back and lower extremities. Case File in 1-275876204, Ex. 11, at 1-2. The nursing notes consistently identify the reasons for homebound status as use of assistive device, inability to leave home safely without assistance, fatigue, and unsteady gait/requires assistance and find problems

with weakness, balance and gait. Case File in 1-275876204, Ex. 15 *passim*. Pain at various levels is reported on many but not all visits. *Id.* Any discrepancies relating to vision and hand dexterity may be relevant to the beneficiary's ability to self-inject insulin but do not form a basis for rejecting the clinical evidence that this beneficiary is homebound. We therefore reverse the ALJ's conclusion on this issue.

K.K. (ALJ 1-275925394) - The appellant's statement is mislabeled as to name and number but addresses the facts relating to this beneficiary asserting that homebound status is established by his SOB with moderate exertion and use of a front-wheeled walker. Patient Ex. 43, of Vol. 1, at 1. The ALJ stated that the documentation did not support the claim that he was homebound due to a need for assistance to ambulate because the OASIS shows him able to ambulate without assistance. ALJ Decision in 1-275925394, at 12. The recertification OASIS actually item on ability to ambulate states that the patient requires use of a device or assistance to walk and "requires assistance to ambulate" is checked as homebound reason. Case File in 1-275925394, Ex. 10, at 8, 11. The OASIS also documents dyspnea and SOB with moderate exertion such as dressing or walking less than 20 feet. *Id.* at 6. Nursing notes consistently document homebound status based on use of an assistive device, unsteady gait/requires assistance, fatigues easily and unable to leave home without assistance and findings of problems with balance, gait and weakness, as well as confusion and forgetfulness at times. Case File in 1-275925394, Ex. 11 *passim*. The social services note shows that K.K. lives in a senior building with his wife and "seldom leaves home." Case File in 1-275925394, Ex. 12, at 1. We reverse the ALJ's conclusion that this beneficiary was not homebound.

C.M. (ALJ 1-275918690) - The appellant asserts that the beneficiary is homebound due to SOB on moderate exertion and use of a walker to ambulate (as well as need for a bedside commode to address difficulty getting to the bathroom). Patient Ex. 46, of Vol. 1, at 1. The ALJ suggested that there "was no indication that she had any cardiac or respiratory problems, no significant signs of functional limitations" and she was "able to perform" her basic ADLs. ALJ Decision in 1-275918690, at 11. At the same time, the ALJ stated that "the therapy assessments indicated that the beneficiary required more assistance for mobility and task completion than did the nursing assessment" and that the OASIS "documents shortness of breath when walking more than 20 feet and climbing stairs," although he implied this

was inconsistent with a notation that respiratory status is within normal limits. *Id.*

Contrary to the ALJ's statements, the OASIS documents cardiac problems, with diagnoses including angina that was not well-controlled and severe generalized weakness. Case File in 1-275918690, Ex. 9, at 2. Also contrary to the ALJ's statements, the OASIS documents functional limitations in endurance and ambulation and states that the beneficiary is homebound due to residual weakness. *Id.* at 4. The beneficiary is also documented as having musculoskeletal problems with knees, having decreased mobility and endurance, and suffering daily (though not constant) pain at level 4, having cardiovascular symptoms of chest pain and fatiguing easily, and having SOB on walking more than 20 feet. *Id.* at 4-6. The ALJ is incorrect that the findings conflict on respiratory status as SOB/dyspnea is noted in a different part of the respiratory status while the section in which WNL or within normal limits is marked asks about cough, sputum, cyanosis, breath sounds, etc. *Id.* at 7. The OASIS also indicates the need for an assistive device or assistance to walk or climb stairs, that she is unable to go shopping even with assistance, and that she uses a walker and bedside commode. *Id.* at 10-12. Nursing notes consistently document homebound status due to unsteady gait/requires assistance and uses assistive device and fatigues easily; they also document findings relating to unsteady gait, balance and weakness. Case File in 1-275918690, Ex. 14 *passim*. We conclude that the clinical record supports that the beneficiary was homebound. The ALJ gave no other reason for denying coverage of the services provided, which included 16 SN visits, 5 PT visits, 5 OT visits, and 1 social work visit over two months. We therefore reverse the ALJ Decision.

F.M. (ALJ 1-275896363 and 1-275919375) - The appellant asserts that the beneficiary is homebound due to SOB on moderate exertion and use of a wheelchair, walker, or cane as needed. Patient Exs. 48 and 49, of Vol. 1, at 1. The ALJ noted that the beneficiary was diagnosed with schizophrenia and resided in an assisted living facility and used a cane. ALJ Decisions in 1-275896363 and 1-275919375, at 11. However, the ALJ found that he had no behavioral problems or depression, no "respiratory or cardiac problems that limited his functional ability," and had normal vital signs and independence with basic ADLs except bathing. *Id.* at 11-12. The ALJ concluded that he was not homebound. *Id.*

Besides schizophrenia and uncontrolled diabetes, the beneficiary's diagnoses include congestive heart failure and chronic obstructive pulmonary disease (COPD), both rated as "controlled with difficulty, affecting daily functioning," so it is difficult to see how the ALJ could have found otherwise. Case File in 1-275919375, Ex. 9, at 1. Functional limitations are noted with hearing, endurance, ambulation and dyspnea. *Id.* at 8. His respiratory status on the OASIS indicates SOB with moderate exertion. *Id.* at 6. Homebound reasons checked were residual weakness, unable to safely leave home unassisted, dependent on adaptive devices, and medical restrictions. *Id.* at 11. He is on psychotropic medication and not observed to demonstrate any listed behaviors at least once a week, although forgetfulness was noted. *Id.* at 7, 12. His plan of care is consistent with the OASIS, noting forgetfulness and use of assistive devices (cane, walker, wheelchair) with functional limitations in hearing, endurance, ambulation and dyspnea with minimal exertion. Case File in 1-275919375, Ex. 10, at 1. The nursing notes and other clinical records further support the beneficiary's homebound status and undercut the ALJ's findings. We therefore reverse his conclusion on homebound status.

N.M. (ALJ 1-275918843 and 1-275896205) - The appellant asserts that the beneficiary is homebound due to SOB on moderate exertion and use of a cane. Patient Exs. 4 and 5, of Vol. 2, at 1. The ALJ finds no documentation of residual weakness and use of assistive device which were given as reasons for homebound status. ALJ Decision in 1-275918843, at 12. The OASIS documents homebound reasons as residual weakness, requires assistance, unable to leave home safely unattended, and dependent on adaptive device. Case File in 1-275918843, Ex. 10, at 15. The beneficiary is noted as needing care several times during each day with all ADLs, suffering intractable pain in lower back and legs, SOB with moderate exertion, and requiring the use of a cane to walk. *Id.* at 4, 5, 10, 12, and 13. She is unable to go shopping even with assistance. *Id.* at 13. Nursing notes consistently document SOB on exertion, fatigues easily and uses assistive device and report problems with balance, gait, weakness, and forgetfulness or confusion. Case File in 1-275918843, Ex. 15 *passim*. We do not find that the fact that the OASIS does not note forgetfulness or confusion undercuts the documentation of weakness, SOB, and dependency that demonstrate homebound status here. We therefore reverse the ALJ's conclusion on homebound status as to the beneficiary in both cases.

A.N. (ALJ 1-276174700) - The appellant asserts that the OASIS report shows the beneficiary is SOB with moderate exertion due to heart disease and has daily, though not constant, pain interfering with activity, and that the clinical record corroborates that she cannot safely leave home without assistance. Patient Ex. 8, of Vol. 2, at 1. The ALJ found that the beneficiary's OASIS established that she was independent with mobility and all basic ADLs and did not need an assistive device of ambulation. ALJ Decision in 1-276174700, at 11. The recertification OASIS does show pain and SOB as asserted. Case File in 1-276174700, Ex. 13, at 2, 6. The OASIS does not, however, show a need for assistive devices or other assistance with mobility or give any reason that the beneficiary would be homebound. The nursing notes state that the beneficiary is homebound for SOB on exertion, use of assistive device, and unsafe to leave home without assistance, but the findings report no pain and no negative findings for cardiovascular, respiratory, musculoskeletal or neurosensory systems, apart from visual impairment which is not stated as relevant to homebound status. Case File in 1-276174700, Ex. 14 *passim*. No assistive device is identified, however. The social services note indicates that the beneficiary is independent with mobility although receiving assistance with ADLs but states that homebound status is based on "impaired mobility hinders pt.'s ability to safely leave home," with no reference to SOB or any assistive device.

Given the inconsistencies in the clinical records, we adopt the ALJ's conclusion that the appellant failed to establish that this beneficiary was homebound.

O.O. (ALJ 1-275863810) - The appellant asserts that the beneficiary is homebound due to SOB on minimal to moderate exertion, pain interfering with activity, and use of assistive device for ambulation because of unsteady gait. Patient Ex. 11, of Vol. 2, at 1. The ALJ recognized that the OASIS indicated SOB on moderate exertion and use of a device to ambulate and bathe; that the plan of care showed that the beneficiary used a cane, walker and wheelchair for mobility; and that nursing notes showed periods of forgetfulness, weakness and joint stiffness. ALJ Decision in 1-275863810, at 10, and exhibits cited therein. He nevertheless concluded that she has not been shown to need considerable and taxing effort to leave home, after noting that she was able to dress, toilet and transfer herself and was alert and oriented to person, place and time. *Id.* at 10-11. The evidence cited by the ALJ does not support his conclusion.

In addition to the findings noted by the ALJ, the OASIS report shows intermittent pain rated from 0-3 and made worse by movement and ambulation and notes homebound status due to residual weakness, dependency on adaptive devices and inability to safely leave home unassisted. Case File in 1-275863810, Ex. 13, at 2, 11. The plan of care also shows functional limitations in endurance, ambulation and dyspnea with minimal exertion. Case File in 1-275863810, Ex. 9, at 1. The nursing notes also note homebound status due to unsteady gait and need for assistive device. Case File in 1-275863810, Ex. 15 *passim*. The days on which pain is noted, however, show it as controlled by medication. *Id.* The appellant adequately documented the beneficiary's homebound status and the ALJ Decision on this issue is therefore reversed.

A.T. (ALJ 1-275913609) - The appellant asserts that the OASIS and clinical notes show the patient to be SOB on minimal exertion, which it contends is sufficient to show practical inability to leave home and is not negated by independence on ADLs. Patient Ex. 24, of Vol. 2. at 1. The ALJ noted that the OASIS showed the beneficiary SOB on moderate exertion but stated that there was "no documentation to support this" and treated the absence of negative respiratory findings on nursing notes as conflicting. ALJ Decision in 1-275913609 at 11. He stated that the beneficiary had diagnoses of depression and dementia as well as diabetes, that he walked with a cane, and that he was sometimes forgetful, but also that he was alert and oriented and independent with ADLs. *Id.* The ALJ is correct that the recertification OASIS assessed the beneficiary as SOB on moderate rather than minimal exertion, i.e. when dressing or walking less than 20 feet rather than when merely eating or talking. Case File in 1-275913609, Ex. 13, at 6. The OASIS gives the only reason for homebound status as "unable to safely leave home unassisted." *Id.* at 11. Intermittent pain is noted in back and extremities but at a level (0-3) that the patient indicated was acceptable. *Id.* at 3. The OASIS does not identify any mental or behavioral issues, but does document use of a cane. *Id.* at 7-8. The plan of care on the other hand has no entry for use of any assistive device nor any mental status notes other than the diagnoses, but does show dyspnea with minimal exertion. Case File in 1-275913609, Ex. 9, at 1. The nursing notes record no episodes of pain; none of them show SOB on exertion as a reason for homebound status or make any other respiratory findings. Case File in 1-275913609, Ex. 14 *passim*. They do consistently record the beneficiary as homebound because he is unsafe to leave home without assistance and fatigues easily, and note weakness and forgetfulness. *Id.* None of them

indicate use of any assistive device. *Id.* The social service visit says that the beneficiary is independent with mobility but also says that impaired mobility hinders his ability to safely leave home.

In this case, the clinical findings are inconsistent and in some respects conflicting. While the records assert that the beneficiary cannot leave home safely, it is unclear whether the beneficiary uses a cane or other device, whether his physical status is such that he would be SOB as a result of the exertion needed to exit the home, or whether his mental status creates some lack of safety. Given the inconsistencies in the clinical records, we adopt the ALJ's conclusion that the appellant failed to establish that this beneficiary was homebound.

A.V. (ALJ Decision in 1-275855364) - The appellant relies only on the assertion that the beneficiary was SOB after walking 20 feet or more and notes that fatigue is "not uncommon for a patient with diabetes and certainly not uncommon for a patient with a urinary tract infection." Patient Ex. 30, of Vol. 2, at 1. The ALJ found the documentation "confusing and conflicting," with the OASIS showing SOB on moderate exertion but independence with ambulation. ALJ Decision in 1-275855364, at 11-12. We agree with the ALJ that the clinical record provides little support for a homebound finding. The OASIS shows the beneficiary needing assistance from a caregiver only once or twice a week, pain free, and capable of independence with shopping, housekeeping, laundry and all ADLS. Case File in 1-275855364, Ex. 11, at 4-5, 12, 14. At the same time, the OASIS records functional limitations with endurance and SOB on exertion. *Id.* at 9, 12. The reason for homebound status is given as "unable to safely leave home unassisted" and other, "diabetic teaching." *Id.* at 15. Nursing notes make no findings as to SOB or musculoskeletal weakness, pain, or any other issues, but state homebound status based on "unsafe to leave home" without assistance and "fatigues easily." Case File in 1-275855364, Ex. 16 *passim*. She had recently been released from the hospital after a urinary tract infection, but there was no documentation suggesting that this resulted in greater difficulty leaving home. Case File in 1-275855364, Ex. 19. None of the documents shows any requirement for use of an assistive device or other reason for personal assistance for mobility. Given the inconsistencies in the clinical records, we adopt the ALJ's conclusion that the appellant failed to establish that this beneficiary was homebound.

R.W. (ALJ 1-275736766) - The appellant argues that the absence of home health services might have forced this beneficiary to move from an assisted living facility to a skilled nursing facility (SNF). Patient Ex. 32, of Vol. 2, at 1. The beneficiary had a primary diagnosis of knee weakness and pain. Case File in 1-275736766, Ex. 9, at 2. The SOC OASIS documents that the beneficiary could not do any laundry and needed someone to do all shopping and errands or prepare meals and that she needed an assistive device to walk, specifically a walker and grab bars. *Id.* at 10-12. Her functional limitations are noted as hearing (deaf in one ear with moderate difficulty understanding simple instructions) and poor vision, with a secondary diagnosis of macular degeneration and the reason for homebound status is given as "unable to safely leave home unassisted." *Id.* at 4. She required assistance from paid caregivers at her board and care facility several times during the day and night. *Id.* at 4. She had knee pain at level 3 and decreased ambulatory endurance. *Id.* at 5. Her plan of care records use of cane and walker and limitations resulting from problems with ambulation and endurance as well as hearing and vision impairments. Case File in 1-275736766, Ex. 11, at 1. The nursing and PT notes are consistent with these clinical findings and support homebound status. The ALJ Decision on this issue is therefore reversed.

None of the services received by any of the beneficiaries whose homebound status we have found not to be adequately documented may be covered. We therefore do not discuss those beneficiaries' cases further. We turn next to whether coverage is properly provided for the specific services claimed for beneficiaries whose homebound status either was not questioned or has been upheld by us.

2. Insulin injection

For many of these beneficiaries, home health services were primarily to assist them with diabetic management. In most of those cases, the issue presented is whether the appellant adequately documented why the beneficiary or caregiver could not perform blood sugar testing and insulin injection or could not be trained to do so. CMS's manual discusses in some detail the criteria regarding home health care for homebound diabetics.

Generally, Medicare considers that a licensed nurse is required for injection of medications and covers those services when reasonable and necessary to treat a disease. MBPM, Ch. 7, § 40.1.2.4 A. Insulin, however, "is customarily self-injected

by patients or is injected by their families. However, where a patient is either physically or mentally unable to self-inject insulin and there is no other person who is able and willing to inject the patient, the injections would be considered a reasonable and necessary skilled nursing service." MBPM, Ch. 7, § 40.1.2.4 A.2. The following example is offered:

A patient who requires an injection of insulin once per day for treatment of diabetes mellitus, also has multiple sclerosis with loss of muscle control in the arms and hands, occasional tremors, and vision loss that causes inability to fill syringes or self-inject insulin. If there weren't an able and willing caregiver to inject her insulin, skilled nursing care would be reasonable and necessary for the injection of the insulin.

Id. Skilled nursing visits to teach patients or caregivers how to manage a treatment regimen are reasonable and necessary "where the teaching or training is appropriate to the patient's functional loss, illness, or injury." MBPM, Ch. 7, § 40.1.2.3. If it becomes apparent that the training is unsuccessful after a reasonable period of time, the reason for failure should be documented and the attempt ended. *Id.* Teaching diabetic management is addressed as an example of reasonable and necessary skilled nursing care, as follows:

A physician has ordered skilled nursing visits for injections of insulin and teaching of self-administration and self-management of the medication regimen for a patient with diabetes mellitus. Insulin has been shown to be a safe and effective treatment for diabetes mellitus, and therefore, the skilled nursing visits for the injections and the teaching of self-administration and management of the treatment regimen would be reasonable and necessary.

MBPM, Ch. 7 § 40.1.1; see also MBPM, Ch. 7 § 40.1.2.3 (skilled nurses are needed to teach "the self-administration of injectable medications" and to teach "a newly diagnosed diabetic or caregiver all aspects of diabetes management, including how to prepare and to administer insulin injections, to prepare and follow a diabetic diet, to observe foot-care precautions, and to observe for and understand signs of hyperglycemia and hypoglycemia).

In some cases, the ALJ based his unfavorable decision on the necessity for skilled nurses to test blood sugar and provide insulin injections, in whole or in part, on the failure of

appellant to prove that no willing or able caregiver could be found to provide the injections. This was error. The MPBM contains a presumption that there is no able and willing caregiver or other person in the home to provide the services rendered by the home health agency unless the patient or family indicates otherwise, or objects, or the home health agency has firsthand knowledge to the contrary. MBPM, Ch. 7, § 20.2.⁹ CMS has made clear furthermore that there "is no requirement that the patient, family or other caregiver be taught to provide a service if they cannot or choose not to provide the care." MBPM, Ch. 7 § 40.1.2.3. In addition, in instances where a beneficiary resided in an assisted living facility or a board and care facility, the ALJ suggested at times that the appellant should have shown why the staff of that facility could not have been trained to provide diabetic care, including injections. Medicare covers home health services to individuals residing in such facilities, which are not primarily for treatment and care of sick or disabled persons or skilled nursing or rehabilitation services, unless the home health services being provided are required by state law to be provided by the facility. The record contains no basis to conclude in any of the cases at issue that the skilled nursing or PT services at issue for these beneficiaries were required by state law to be provided by their facilities.¹⁰ Where these considerations were the sole reason that the ALJ denied coverage for skilled nursing visits, we reverse without further comment. We also ignore without further comment ALJ findings on this point inconsistent with our discussion of the law when we address other reasons which the ALJ for denying coverage of diabetic management visits.

⁹ This section provides in full as follows:

Where the Medicare criteria for coverage of home health services are met, patients are entitled by law to coverage of reasonable and necessary home health services. Therefore, a patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services. However, where a family member or other person is or will be providing services that adequately meet the patient's needs, it would not be reasonable and necessary for HHA personnel to furnish such services. Ordinarily it can be presumed that there is no able and willing person in the home to provide the services being rendered by the HHA unless the patient or family indicates otherwise and objects to the provision of the services by the HHA, or unless the HHA has first hand knowledge to the contrary.

¹⁰ The appellant argues that state law actually bars staff of these facilities from giving insulin injections. See, e.g., Patient Exs. 48 and 49, of Vol. 1, at 1. We make no findings on this point as it is not necessary to our decision.

Another error found in a number of the ALJ decisions is the assumption that a beneficiary identified in an OASIS as having "partially impaired" vision, but also noted to wear glasses, is likely to have sufficiently corrected vision to be able to prepare and administer insulin injections. This assumption ignores the definition on the OASIS form of "partially impaired" vision defined as meaning that beneficiary, using any corrective lenses normally worn, "cannot see medication labels or newsprint, but can see obstacles to path, and the surrounding layout, can see fingers at arm's length." See, e.g., Case File in 1-275925394, Ex. 10, at 2. Given this definition, it is reasonable to assume that a beneficiary with such limited sight even with correction might have significant difficulty with measuring dosage and performing injections.¹¹ We note briefly those cases where impaired vision supports inability to self-inject.

We next discuss the individual cases in which the ALJ concluded the appellant failed to document why skilled nursing was needed for diabetic management teaching and/or blood sugar monitoring and insulin injection.

G.A. (ALJ 1-275714543 and 1-275893175 discussed above regarding homebound status) received 120 SN visits during the dates of services at issue in 1-275714543 and 121 SN visits during the dates of service at issue in 1-275893175. The ALJ stated without further discussion that no documentation evidenced inability to self-inject. ALJ Decision in 1-275714543, at 12. The OASIS documents that G.A. had partially impaired vision and blurred vision. Case file for ALJ Number in 1-275714543, Ex. 14, at 4. The OASIS notes that a skilled nurse performs the blood sugar and assesses the beneficiary as able to take oral medication independently but unable to "take injectable medications unless administered by someone else." *Id.* at 5, 14. The nursing notes regularly record that the beneficiary was able to verbalize understanding but unable to demonstrate the procedure himself. Case file for ALJ Number in 1-275714543, Ex. 15 *passim*. A social services note records that G.A. was not able or willing to administer insulin nor was his family caregiver. Case file for ALJ Number in 1-275714543, Ex. 18.

¹¹ The ALJ also at times treated as contradictory nursing notes in such cases in which the box under neurosensory symptoms for "visual impairment" is not checked. See, e.g., Case File in 1-275876204, Ex. 15, at 1. The nursing notes forms in the record do not include a definition of visual impairment. It is therefore possible that the nurses filling them out assumed that the entry should be made only for full rather than partial visual limitations. For that reason, the absence of a check in that box cannot be taken as a contradiction of a finding of partial visual impairment in an OASIS.

Similar documentation is in the case file for 1-275893175. We conclude that the SN and dependent visits are covered.

S.C. (ALJ 1-275897916 and 1-275886089 discussed above regarding homebound status) received 176 SN visits during the dates of services at issue in 1-275897916 and 177 SN visits during the dates of services at issue in 1-275886089. The ALJ gave no analysis for denying coverage for skilled nursing for diabetic management, discussing only homebound status. The documentation regarding the visual impairment and mental and psychiatric limitations of this beneficiary was cited above. The clinical record is replete with notes supporting his inability to manage self-medication due to poor vision, tactile and coordination deficits due to diabetic neuropathy, cognitive issues and psychological problems. We conclude that the SN and dependent visits are covered.

V.G. (ALJ 1-275779188 discussed above regarding homebound status) received 120 SN visits during the dates of services at issue. The ALJ commented that it "is documented that the beneficiary was alert and oriented times three [i.e., aware of person, place and time], never confused or anxious, and could recall directions independently, but was unable to give herself insulin twice daily." ALJ Decision in 1-275779188, at 12. Later, however, the ALJ stated that there was "no documentation justifying that the beneficiary was unable to self inject insulin." *Id.* at 13. In addition to the clinical information regarding her condition discussed above, the SOC OASIS indicates that diabetic management represented a new diagnosis or treatment regimen for the beneficiary within the preceding two weeks. Case File in 1-275779188, Ex. 9, at 1. She is noted to have arthritis and gout, swollen joints, and joint pain worsened with movement. *Id.* at 2, 5, 12. She is noted to have weak hand grip and stiff fingers. *Id.* at 11. She has partially impaired and blurred vision. *Id.* at 4. The OASIS assesses her as unable "to give injectable medications unless administered by someone else." *Id.* at 13. A multi-disciplinary care conference documents that she is "unable to understand glucometer instructions & unable to draw insulin 2° to rigidity of finger joints related to arthritis." Case File in 1-275779188, Ex. 13; see also Ex. 14. We conclude that the SN and dependent visits are covered.

C.H. (ALJ 1-275913193) received 86 SN visits during the period at issue. The ALJ pointed to contradictions in the clinical record as to whether the beneficiary could monitor his blood sugar and administer his insulin himself. ALJ Decision in 1-

275913193, at 11. Physician orders dated December 20, 2004 state that on admission to home health the patient is able to self-test and self-inject but needed teaching on disease process with an initial duration of 14 daily visits for that purpose. Case File in 1-275913193, Ex. 10, at 3; see also SOC OASIS, Ex. 12, at 2 ("pt. is able to self insulin injection [with] minimal assistance at this time."). Progress Notes on January 18, 2005 expressly note that patient can "demonstrate and perform" self-monitoring and self-injection. Case File in 1-275913193, Ex. 14, at 1. Yet, nursing notes consistently record that the patient is "mentally unable to self manage" diabetic treatment. Case File in 1-275913193, Ex. 15 *passim*. The appellant explains the discrepancy as resulting from the doctor having introduced C.H. to the use of an "insulin pen" while Medicare coverage was only available for insulin injections which C.H. proved unable to manage safely as shown by frequent blood sugar readings above 150 in the nursing notes. Patient Ex. 29, in Vol. 1, at 1-2. Given the directly conflicting information in the record, we cannot find that the appellant adequately documented that 86 SN visits were reasonable and necessary and we therefore adopt the ALJ decision.

E.K. (ALJ 1-275800087 discussed above regarding homebound status) received 120 SN visits during the dates of services at issue. The ALJ gave no reason to deny coverage of the SN visits apart from his finding, which we have reversed, that the beneficiary was not homebound. OASIS indicates that the beneficiary had partially impaired vision, and other documentation confirms that poor vision and motor skills caused inability to self-inject. Case File in 1-275800087, Ex. 9, at 2; Ex. 13, at 1; Ex. 15 *passim*, and Ex. 21, at 1. We conclude that the SN and dependent visits are covered. This beneficiary also received 12 PT visits. The ALJ gave no additional reason for denying the PT visits, which addressed gait abnormality, atrophy, muscle weakening, and high risk for falls after multiple loss of balance episodes. Case File in 1-275800087, Ex. 18 *passim*. We therefore reverse the ALJ Decision in its entirety.

M.K. (ALJ 1-275876204 discussed above regarding homebound status) received 120 SN visits during the dates of services at issue. The ALJ stated that documentation did not explain why the beneficiary could not learn to self-inject and did not show clinical or physical reason. ALJ Decision in 1-275876204, at 12. The OASIS indicates that the beneficiary had partially impaired vision was unable to self-administer administer insulin. Case File in 1-275876204, Ex. 10, at 2, 4, 14.

Progress notes show continued dependence on SN for insulin preparation and injection due to poor vision and hand dexterity, and continuing unstable blood sugar. Case File in 1-275876204, Ex. 13, at 1-2; see also Ex. 14. A social work evaluation also records that neither the patient nor the caregiver is willing or able to administer insulin but that the patient is trying to locate a willing caregiver. Case File in 1-275876204, Ex. 16, at 1.

The ALJ suggested that the nursing notes were inconsistent with the OASIS because they do not note the vision and hand dexterity problems, but only unsteady gait and need for assistance. ALJ Decision in 1-275876204, at 12. The box for "vision impairment" on the nursing notes form does not have an option for partial impairment, so the absence of a check in that box on the nursing notes forms does not necessarily indicate that the beneficiary did not have the vision problems noted on the more detailed OASIS. No indicator is included on the form to note degree of hand dexterity. We conclude that the SN visits are covered.

K.K. (ALJ 1-275925394 discussed above regarding homebound status) received 121 SN visits and 1 social work visit during the dates of services at issue. OASIS shows partially impaired vision. Case File in 1-275925394, Ex. 10, at 2. The patient is described as not speaking English, "unable to follow glucometer instructions," despite use of an interpreter. *Id.* at 12. We conclude that the SN and dependent visits are covered.

F.M. (ALJ 1-275896363 and 1-275919375 discussed above regarding homebound status) received 120 SN visits during the dates of services at issue in 1-275896363 and 120 SN visits during the dates of services at issue in 1-275919375, plus 2 visits from social workers. The reasons mentioned in some of the nursing notes for F.M.'s not performing self-injection and glucose monitoring is related to "lack of exposure," "deficient knowledge", instability of blood sugar level, or "inability to prepare and administer insulin." See, e.g., Case File in 1-275896363, Ex. 11, at 1, 6, 9, and 11. None of the documents in the record makes clear why the beneficiary is unable to learn to self-inject, whether efforts were made to teach him, and, if so, why they failed. We agree with the ALJ that the documentation is inadequate and therefore the SN visits and dependent services are not covered.

N.M. (ALJ 1-275918843 and 1-275895726 discussed above regarding homebound status) received 121 SN visits involving insulin injection during the dates of service at issue in 1-275918843

and 120 visits during the dates of service at issue in 1-275895726. The ALJ notes that the beneficiary is documented as uncomfortable with performing insulin injections but finds no "clinical reason" or "physical limitation" preventing her from doing so. ALJ Decision in 1-275918843, at 12. The OASIS indicates that the beneficiary has "partially impaired" vision as defined above. Case File in 1-275918843, Ex. 10, at 4. She is unable to use even a special telephone with large numbers. *Id.* at 13. The OASIS specifically assesses her as "[u]nable to take medication unless administered by someone else" and "[u]nable to take injectable medications unless administered by someone else." *Id.* at 14. The nursing notes repeatedly document that the beneficiary was "[u]nable to demonstrate procedure," and needed continuous interventions and instructions. Case File in 1-275918843, Ex. 15 *passim*. We find adequate documentation of the beneficiary's physical inability to self-inject. We conclude that the SN and dependent visits are covered.

O.O. (ALJ 1-275863810 discussed above regarding homebound status) received 121 SN visits involving insulin injection during the dates of service at issue. The ALJ made no finding or comment about O.O.'s ability to self-inject. The clinical findings discussed in relation to her homebound status demonstrate several obstacles to self-injection. The record indicates that efforts were made, with interpreters, to teach the beneficiary to self-manage her diabetes. Case File in 1-275863810, Ex. 13, at 2, and Ex. 12, at 3. Progress notes record that the beneficiary has "episodes of memory deficit," difficulty following her plan of care, and unstable blood sugar, all of which necessitate continuous teaching and SN assistance with blood sugar and injections. Case File in 1-275863810, Ex. 12, at 1-2. We conclude that the SN and dependent visits are covered.

N.S. (ALJ 1-275930840) received 58 SN visits for administration of insulin and 1 dependent SW visit during the time at issue. The basis for denial by the ALJ was that SN administered the insulin incorrectly. ALJ Decision in 1-275930840, at 11. Physician orders on the plan of care were for 20 units every morning and 10 units every afternoon. Case File in 1-275930840, Ex. 9, at 1-2. Nursing notes reflect that this order was reversed throughout the period at issue. Case File in 1-275930840, Ex. 12, at 65-120. The ALJ is also correct that two nursing notes show an alteration in the amount administered with no initials or explanation of error. Case File in 1-275930840, Ex. 12, at 93, 95. We therefore reject the appellant's argument

that the medical record substantiates the prescribed dosage being given at the correct time to the correct patient. *Cf.* Patient Ex. 20, in Vol. 2, at 1. We adopt the ALJ decision and the services remain denied.

J.T. (ALJ 1-275775031) was denied coverage for 7 SN visits relating to insulin administration, 10 PT visits, and 13 HHA visits. ALJ Decision in 1-275775031, at 11. His principal diagnosis was uncontrolled diabetes, but he also suffered from renal failure, stroke with hemiplegia, and abnormal gait. Case File in 1-275775031, Ex. 9, at 1. The ALJ did not question whether the beneficiary could self-inject but found that "as of December 8, 2004, the beneficiary's primary caregiver, his wife, had been competently instructed in insulin administration, diabetic management, and she was knowledgeable about when to call the physician . . ." ALJ Decision in 1-275775031, at 11. He further concluded that no change occurred in the beneficiary's condition in the remaining period and therefore that the SN services were not reasonable and necessary. *Id.* The medical record does not support the ALJ's conclusions.

This was a recertification from a prior period in which the beneficiary was receiving SN visits twice daily for blood sugar checks and insulin injection." Case File in 1-275775031, Ex. 10, at 1. The visits continued at that level until December 5, 2004 and the contractor concluded that those visits were reasonable and necessary. Case File in 1-275775031, Ex. 7, at 1. While some training did occur before December 8, 2004, the nurse was still teaching the patient and his wife the proper low sugar, low sodium diet on December 7 and 21, 2004, the correct disposal of syringes and needles on December 8, 2004, appropriate safety measures on December 12, 2004, and the signs and symptoms of hyper- and hypoglycemia on December 18 and 28, 2004 and January 8 and 12, 2005. The ALJ does not identify any basis on this record to conclude that all necessary teaching was completed by December 8, 2004 or that the wife had demonstrated all the relevant competency by that date. Furthermore, the beneficiary required the SN to inject insulin based on his blood sugar reading on 4 of 7 visits at issue, suggesting that he and his wife were not yet competently managing his diabetes without assistance. Also, a new medication (Cipro) was introduced on December 21, 2006. We conclude that the additional SN visits were reasonable and necessary based on the clinical evidence. Home health aide visits are covered because the SN visits were a qualifying service.

The documentation regarding PT is more problematic. There is no PT evaluation in the record, and the clinical notes and discharge form are largely illegible. Case File in 1-275775031, Exs. 14 and 15. It is impossible to determine whether the recertification visits were needed to instruct in a HEP or whether the patient was expected to or did receive substantial rehabilitative benefits. The PT visits therefore remain denied.

S.T. (ALJ 1-275867562) received 120 SN visits and 1 SW visit. The ALJ noted that the reason given for inability to self-inject is "forgetfulness related to old age and poor vision," which the OASIS indicates that the beneficiary has "normal vision" and "no memory deficits or problems with her memory." ALJ Decision in 1-275867562, at 11. The ALJ concludes that the "documentation and oral testimony provide no explanation of these inconsistencies," and therefore that the "written record including the physician's orders for home health and oral testimony of the appellant" do not show that the home health services were reasonable and necessary. *Id.*

The recertification OASIS contains the entries cited by the ALJ, identifies no functional limitations, and states only that the "patient not comfortable in doing self-injection of insulin." Case File in 1-275867562, Ex. 9, at 2, 7, 8, 12. The nursing notes all check the item for "forgetful" and that the patient "needs continuous instructions." Case File in 1-275867562, Ex. 16 *passim*. The record is not sufficient to establish that the patient was unable, mentally or physically, to self-inject, as opposed to simply unwilling to learn. The manual provisions quoted earlier make clear that a caregiver may decline to undertake injections if unable or unwilling to do so, a beneficiary is entitled to coverage for insulin injections only if unable to self-inject.

We therefore adopt the ALJ decision.

3. Other skilled nursing services¹²

¹² For beneficiaries for whom PT services were at issue along with SN services, we have included our discussion of the PT services in this section for simplicity. More information on the standards governing coverage of PT services is given in the next section of this decision which addresses beneficiaries for whom PT services were the primary home health services. Also, where other home health services (such as social worker visits or home health aides) were denied only because the primary qualifying services was denied, where we reverse the denial of the primary qualifying service, we also reverse the denial of the dependent service without further discussion.

In the following cases, the ALJ denied SN services (and sometimes other home health services as well) on the grounds that they were not reasonable and necessary. Generally, the need for a skilled nurse to provide a service may be evaluated based on the "inherent complexity of the service, the condition of the patient and accepted standards of medical and nursing practice." MBPM, Ch. 7, § 40.1.1. In reviewing these questions, CMS has provided guidance that -

The determination of whether the services are reasonable and necessary should be made in consideration that a physician has determined that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the patient when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

MBPM, Ch. 7, § 40.1.1.

Overall, we find that the ALJ failed to conduct the kind of individualized inquiry called for by the applicable regulations and manual provisions. In most cases, the ALJ recited stock phrases to explain his denials without providing any analysis of why they applied to the specific situation under review. The few details which he mentions are frequently drawn verbatim from the decisions issued in the prior levels of appeals without citation to the exhibits before him or explanation of why contrary evidence was discounted. It has, therefore, been necessary for us to conduct a detailed review and analysis in most cases to determine if the clinical record before documents that the services ordered were reasonable and necessary in light of the patient's individual condition and history.

In addition, the phrases recited by the ALJ often misstate the applicable standards for when skilled services are reasonable and necessary. For example, the ALJ repeatedly recites that there was "no change in the beneficiary's overall condition, functional status, or plan of care" during the relevant period, or that the services were merely "general assessments, ongoing observation, and repetitive teaching to a medically stable patient." ALJ Decision in 1-275-934577, at 11. This distorts the applicable guidance on when skilled nursing is needed to assess and monitor a patient for possible changes. CMS explains the standards as follows:

Observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services when the likelihood of change in a patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's treatment regimen is essentially stabilized. Where a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, the skilled observation services are still covered for three weeks or so long as there remains a reasonable potential for such a complication or further acute episode. Information from the patient's medical history may support the likelihood of a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond 3-week period. Moreover, such indications as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment. . . . However, observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness or injury where these indications are part of a longstanding pattern of the patient's condition, and there is no attempt to change the treatment to resolve them.

MBPM, Ch. 7, § 40.1.2.1.

M.B. (ALJ 1-275929512) - The beneficiary received 7 SN visits during the period at issue which the ALJ denied as not reasonable and necessary. ALJ Decision in 1-275929512, at 11. The beneficiary suffered from psychosis and diabetes and lived in an assisted living facility. *Id.* Her physician ordered weekly SN visits to observe and assess her with emphasis on diabetic and metabolic status and to teach her disease management. *Id.* The ALJ concluded that notes showing that paid help was taught to "give orange juice and food" and call physician for blood sugar below 70 demonstrated that "a caregiver in the facility" was checking blood sugar results and could administer insulin. *Id.*

Guidance on when observation and assessment require skilled nursing services is provided in the CMS Manual as follows:

Observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services when the likelihood of change in a patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's treatment regimen is essentially stabilized. . . . Information from the patient's medical history may support the likelihood of a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond 3-week period. Moreover, such indications as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment. Where these indications are such that it is likely that skilled observation and assessment by a licensed nurse will result in changes to the treatment of the patient, then the services would be covered. There are cases where patients who are stable continue to require skilled observation and assessment. . . . However, observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness or injury where these indications are part of a longstanding pattern of the patient's condition, and there is no attempt to change the treatment to resolve them.

The SOC OASIS indicates that the patient's blood sugar is still fluctuating and that medications were being adjusted. Case File in 1-275929512, Ex. 11, at 12. However, the appellant submitted only 5 notes from SN visits; only two of those show any blood sugar measurement, both within normal limits; none show any change in medication. The appellant pointed to the beneficiary's use of Coumadin as new and calling for additional monitoring, but the clinical records do not show when this medication was introduced nor that this medication was a focus of monitoring. Patient Ex. 11, in Vol. 1, at 1.

We conclude that the appellant failed to document that the services provided were reasonable and necessary and we therefore adopt the ALJ Decision.

C.D. (ALJ 1-275763682) - This beneficiary received 10 SN visits, 3 PT visits, and 1 OT visit during the period at issue. The ALJ concluded that SN services were not reasonable and necessary because only "generalized observations, ongoing assessments, and repetitive teaching" were provided and his vital signs,

treatment plans, and medical condition did not change during the period. ALJ Decision in 1-275763682, at 10.

The OASIS documents that the beneficiary experienced a medical change within the two weeks preceding SOC related to asthma and respiratory insufficiency;¹³ had other diagnoses of COPD, muscle weakness, and painful joints due to osteoarthritis; suffered from edema, SOB, generalized weakness, and back pains; and had recurrent bronchitis or bronchial asthma. Case File in 1-275763682, Ex. 15 *passim*. The plan of care called for SN to assess breath sounds and signs of respiratory issues and teach disease management of asthma, as well as monitoring and teaching related to osteoarthritis and all organ systems. Case File in 1-275763682, Ex. 9, at 1. Education was to include use of hand nebulizer, signs and symptoms to report to doctor or treat as emergency, proper breathing and coughing techniques, etc. *Id.* Nursing notes frequently note rales/rhonch/wheezes confirming asthma not yet well-controlled and record skilled observations and assessments focusing on cardiovascular and respiratory systems, and instruction on disease process. Case File in 1-275763682, Ex. 14 *passim*. SN services were reasonable and necessary to assess, monitor and teach the beneficiary to adjust to new diagnoses and medication regime. The appellant argues that PT discharged the patient after 3 visits because the focus was on establishing a home exercise program (HEP) to ensure the patient could improve strength, gait and endurance. Patient Ex. 20, at 1. Establishment of an appropriate HEP was a skilled service and 3 visits were reasonable to evaluate, develop and teach the HEP. We therefore reverse the ALJ Decision.

S.G. (ALJ 1-275-934577) - This beneficiary received 8 SN visits, 5 PT visits, and 1 OT visit during the period at issue. The ALJ concluded that SN services were not reasonable and necessary because there was "no change in the beneficiary's overall condition, functional status, or plan of care" during the relevant period, and "no documentation of a reasonable potential" for "a medical complication," and because the SN was merely "general assessments, ongoing observation, and repetitive teaching to a medically stable patient." ALJ Decision in 1-275-934577, at 11.

¹³ The OT evaluation reported that the beneficiary had reduced independence in self-care and reduced functional endurance and mobility. Case File in 1-275763682, Ex. 18. No OT services were ultimately provided due to refusal by patient, but the initial evaluation corroborates a recent deterioration in condition leading to the need for HH services.

The appellant concedes that "not all of the [SN] visits were unique and individually beneficial to the patient," and asks for payment of the initial assessment visit and 3-4 additional visits. Patient Ex. 24, in Vol. 1, at 1. On this basis, we uphold the ALJ's denial of 4 SN visits as not reasonable and necessary. The appellant argues as to the other visits that the beneficiary was in end stage renal disease (ESRD) of which she died during the home health episode and that these visits were needed "for the establishment of the baseline medical condition." *Id.*

Plainly, the ALJ's description of S.G. as a "medically stable patient" is incompatible with the clinical documentation. Her ESRD was rated at severity 3 (defined as "symptoms poorly controlled; patient needs frequent adjustment in treatment and close monitoring"), along with an exacerbation of osteoarthritis at 2-3 and osteoporosis and anemia at level 2 ("symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring"). Case File in 1-275-934577, Ex. 16, at 2. The SOC OASIS also documented a need to rule out pneumonia relating to breathing issues. *Id.* She had depression attributed to her "deteriorating condition," had weakness in upper and lower extremities, and was described as "very frail." *Id.* at 9, 14. The nursing notes document monitoring and observation for signs and symptoms of worsening disease, tracking of oxygen saturation, and teaching of the patient and caregiver related to managing the disease process, medications, diet, and safe lifting and movement around the home. Ex. 17 *passim*. The plan of care called for assessment of renal status, edema, urine, pain levels and causes, to monitor hydration and dietary instructions, and to instruct on possible complications to report to the doctor, with an expectation of a "fair" potential to prevent further exacerbation. Case File in 1-275-934577, Ex. 9. Four SN visits in a month to accomplish these goals are reasonable and necessary.

The ALJ denied the PT visits because the beneficiary's prior level of functioning (PLOF) was independent with a walker and the evidence "does not demonstrate that the beneficiary experienced a significant change from his [sic] usual physical functional ability that would warrant the services of a therapist." ALJ Decision in 1-275-934577, at 11. S.G. had daily pain in both hips and knees at level 3 triggered by ambulation. Case File in 1-275-934577, Ex. 16, at 4; *see also* Ex. 18, at 1. She had swollen and painful joints, decreased range of motion, and shuffling gait. *Id.* at 10. The initial PT evaluation does show her prior level of functioning as

independent with a walker, but also records declining functional ability by SOC, multiple gait deviations, and use of moderate assistance for transfers, sitting and ambulation of 15 feet and minimal assistance on bed mobility. Case File in 1-275-934577, Ex. 18, at 1. She was not expected to be able to return to her pre-illness functional level, but the goal was to minimize the effects and progression of her illness. *Id.* at 2. The 5 PT visits record work on achieving independence in bed mobility and increasing stability in her walker, with some improvement reported by the last visit. Case File in 1-275-934577, Ex. 19 *passim*. The appellant indicates that the course of therapy was interrupted by the patient's hospitalization and death from her underlying illness. Patient Ex. 24, in Vol. 1, at 1. The clinical evidence supports coverage of the PT visits at issue.

E.G. (ALJ 1-275933192) - This beneficiary received 9 SN visits, 6 PT visits, and 6 OT visits during the period at issue. The appellant argues that she needed to maintain a certain level of functionality to remain in her assisted living facility and avoid transfer to a more expensive SNF. Patient Ex. 26, in Vol. 1, at 1. The ALJ correctly notes that the appellant does not explain and the record does not support why the beneficiary required SN services for the onset of a urinary tract infection which is given as the reason for home health. ALJ Decision in 1-275933192, at 11; Case File in 1-275933192, Ex. 11, at 2. The SN visits remain denied.

The ALJ also found no documentation of a change in functional ability from baseline at the time of initial PT and OT evaluations. Decision in 1-275933192, at 11. The SOC OASIS shows onset or exacerbation as of July 20, 2004 of gait abnormality, muscle weakness and backache at level 3 severity, with physical therapy listed as primary diagnosis. Case File in 1-275933192, Ex. 11, at 2. The August 11, 2004 PT/OT discharge summary states that the patient presented with functional decline in ADLs and mobility with general weakness and impaired balance and details "good progress" in reducing the level of dependence on multiple ADLs. Case File in 1-275933192, Ex. 12, at 1. The PT evaluation noted reduced strength in lower extremities, impaired balance, fear of falling, unsteady gait and the need of assistance for transfers as problems and set goals of minimal assistance with transfers, increased bed mobility and increased ambulation. Case File in 1-275933192, Ex. 13, at 1. The PT and OT visit reports show work on those goals with some improvements hampered by pain and cognitive issues. Case File in 1-275933192, Exs. 14, 16 *passim*. The clinical record adequately indicates that the onset of the

infection was accompanied by an exacerbation of pain and decrease in functional abilities and that the PT and OT services were reasonable and necessary to address these developments.

D.H. (ALJ Decision in 1-275912945) - Eleven SN visits and 12 PT visits were provided to D.H. during the six weeks at issue, all of which the ALJ denied as not reasonable and necessary on the grounds that no significant changes in "overall condition, functional status, or plan of care" occurred during that period, no "reasonable potential for the beneficiary to have a medical complication" was documented, and the PT record does not show a significant decline at SOC or change in function by discharge. ALJ Decision in 1-275912945, at 11. The appellant argues that the beneficiary not only had a Foley catheter but had had a spinal fusion 30 days before services began, and developed complications during services including need for an enema and new antibiotic therapy. Patient Ex. 30, in Vol. 1, at 1-2.

The plan of care documents the spinal fusion, as well as emphysema, anemia, and prostate enlargement with urinary retention, and orders SN instruction on "serious complications, sequelae and risk/aggravating factors and appropriate measures to prevent recurrence." Case File in 1-275912945, Ex. 9, at 1; see also Ex. 14, at 1-2, 10. Generally, CMS considers "SN services provided at a frequency appropriate to the type of catheter in use" and that, "[a]bsent complications, Foley catheters generally require skilled care once approximately every 30 days." MBPM, Ch. 7, § 40.1.2.7. At a minimum, therefore, two SN visits were reasonable and necessary for management of the beneficiary's Foley catheter. Three added SN visits responded to complications/new developments including re-insertion of the catheter and orders for new medicines for nursing reports of fecal impaction and urinary infection symptoms. Case File in 1-275912945, Ex. 10, at 5-6, 8. Therefore, 5 SN visits are reasonable and necessary, while the need for 6 additional visits was not adequately documented. The PT evaluation showed functional limitations in range of motion, strength graded at 3 on a scale of 5, multiple gait deviations, assistance needed to walk 15 feet, and assistance needed for dressing, bathing, bed mobility, transfers, and meal preparation. Case File in 1-275912945, Ex. 18, at 1. The discharge OASIS reported patient now able to ambulate with walker with only supervision and with extended range of motion in upper and lower extremities. Case File in 1-275912945, Ex. 15, at 10. His strength had improved to a 4+; he had become moderately independent with transfers and bed mobility; his balance was improved and his fall risk reduced. Case File in 1-

275912945, Ex. 16, at 1. The clinical record does not support the ALJ's finding of no significant functional changes triggering or resulting from PT services. The PT services are reasonable and necessary.

W.K. (ALJ 1-275791460) - This beneficiary received 12 SN visits, 1 PT visit, and 5 Home Health Aide (HHA) visits during the period at issue. The ALJ concluded that SN services were not reasonable and necessary because they were only "general assessments, ongoing observations, and repetitive teaching to a medically stable patient" with no reasonable potential for a medical complication, "particularly in relation to his COPD or diabetes mellitus." ALJ Decision in 1-275791460, at 11. The SOC OASIS shows COPD and diabetes well controlled on current therapy, despite the appellant's argument that the beneficiary had an exacerbation of COPD which might lead to pneumonia in the winter months. Compare Case File in 1-275791460, Ex. 13, at 2 with Patient Ex. at 36, in Vol. 1, at 1. The nursing notes do not evidence what skilled services were required or provided; no documentation is included for any PT visit; and HHA visits are denied because they are dependent. We adopt the ALJ decision.

K.K. (ALJ 1-275906203) - The beneficiary received only one SN visit, The ALJ found that this initial evaluation visit for an assessment for home health services "is considered an administrative expense because at this point the patient has not been accepted for care." ALJ Decision in 1-275906203, at 10. The initial assessment visit occurred on January 14, 2005, four days after the patient's release from the hospital, and documented that he was cognitively impaired (with history of memory loss requiring supervision, impaired decision-making, and disruptive behavior) and his caregiver (at a board and care facility) was not able to manage his antibiotic treatment for recent urinary infection and care of a Stage 2 pressure sore on his coccyx. Case File in 1-275906203, Ex. 11, at 1-2, 6. Wound care was provided on that visit and he was assessed as appropriate for SN visits. *Id.* at 8, 16. A plan of care was developed and physician's orders issued, but apparently not further implemented. The patient was documented on January 17, 2005 as having died at the facility. Case File in 1-275906203, Ex. 12; Ex. 13: Ex. 9, at 1.

While an initial evaluation that finds the beneficiary unsuitable for home health care is not reimbursable, the rule is different for the situation here. If "the patient is determined suitable for home health care by the agency, and is also furnished the first skilled service as ordered under the

physician's plan of care, the visit would become the first billable visit in the 60-day episode." MBPM, Ch. 7 § 70.2.C. The fact that the beneficiary's death precluded the delivery of additional services would not alter the coverage for the first billable visit. We reverse the ALJ decision denying coverage for this reason.

M.M. (ALJ Decision in 1-275691855) - This beneficiary received 9 SN visits,¹⁴ 5 PT visits, and 1 OT visit over two months after she was discharged home with 22 surgical staples. She had a total knee replacement on June 30, 2004, spent 10 days in a SNF, returned to the hospital for revision of the arthroplasty on July 14, 2004, and then returned to the SNF until July 25, 2004. ALJ Decision in 1-275691855, at 9. The ALJ found that the OASIS "documented that wound care was not done," that the beneficiary was recovering from surgery "at a normal pace," and that SN services after the first four nursing visits did result in any changes to the patient's plan of care or her condition and functioning, and were unnecessary since the beneficiary was not discharged directly from the hospital but had had two SNF stays. *Id.* at 10. He further concluded that the PT and OT services were not necessary because she received 17 "units" of PT and 18 of OT between her two SNF stays. *Id.* at 9-10.

The appellant argues that the staples were removed on her first home care visit and that wound care and observation thereafter was necessary and in fact resulted in observation of a warm reddened condition beginning necessitating a report to the physician and a follow-up doctor's visit. Patient Ex. 50, in Vol. 1, at 1. In addition, the appellant argues that aggressive PT was unlikely to have been possible during the SNF stays since the patient still had staples in her knee then and that the home environment presented different obstacles that required OT evaluation and PT skills to address. *Id.* at 1-2.

The SOC OASIS indicates that the primary reason for home health is to monitor the wound site for infection and assess the patient's safety and functional status in her environment. Case File in 1-275691855, Ex. 11, at 2. While wound care was indeed not performed on that visit, the nurse recorded assessing incision site for infection and bleeding and evaluating skin integrity and other functional systems. *Id.* at 8, 15. In any

¹⁴ The QIC and the ALJ indicated that four SN visits were covered as reasonable and necessary to assess and observe the surgical wound healing, but 9 visits after August 4, 2004 were not. ALJ Decision in 1-275691855, at 10; Case File in 1-275691855, Ex. 7, at 2. Thus, 9 SN visits are issue before us.

case, it is not clear why the ALJ mentioned the notation that wound care was not performed, since he did not disagree with the QIC's conclusion that this visit was reasonable and necessary. The staples were indeed removed on the first SN visit two days later. Case File in 1-275691855, Ex. 19, at 1. The SOC OASIS and nursing notes record high risk for infection and bleeding due to the knee surgery having required revision and to the limited mobility of the 80-year old beneficiary and alteration in the patient's comfort level due to post-operative pain as necessitating nursing interventions. Case File in 1-275691855, Ex. 11, at 2, 5; Ex. 19 *passim*. The ALJ's assertion that the SN visits after August 4, 2004 resulted in no change in the resident's plan of care appears to ignore the clinical evidence that a SN visit on September 11, 2004 resulted in identification of changes in the wound (warm to touch and discolored) leading to a report to and visit with an orthopedic doctor and a different wound care treatment. Case File in 1-275691855, Ex. 19, at 10, 11. The QIC complained of inconsistencies in the nursing notes, pointing for example to checking "no negative findings" in the area for integumentary/skin findings on 9 notes. Case File in 1-275691855, Ex. 7, at 2. This comment overlooks the handwritten comment each day on the precise status and condition of the knee wound. Case File in 1-275691855, Ex. 19 *passim*. It is most reasonable to read these notations as indicating no additional problems with skin integrity other than the surgical wound being followed. We conclude that the additional 9 SN visits were reasonable and necessary.

A multi-disciplinary care conference on July 26, 2004 noted a need for PT due to decreases in transfer ability (requiring stand-by assist), gait, range of motion in the knee involved (0-10 degrees), and dynamic balance. Case File in 1-275691855, Ex. 18, at 1. The PT evaluation that date had noted unsteady, antalgic gait, pain and edema in the left leg, use of a walker and standby assistance to ambulate 20 feet (with PLOF of independent ambulation with quad cane), and limited range of motion in knee and dynamic balance rated fair. Case File in 1-275691855, Ex. 24, at 1. Goals were to teach a HEP, to increase range of motion in knee to 50 degrees, to improve dynamic balance to fair+, and to improve gait and reach 100 feet with walker in hallway. *Id.* The intervening visits record therapeutic exercises focusing on flexing and extending left knee and improving gait to increase balance and safety, gentle range of motion exercises and teaching of HEP.¹⁵ PT was

¹⁵ The ALJ apparently discounted the PT evaluation of the beneficiary's start of care need for standby assistance in bed mobility, transferring and moving from sitting to standing position on the grounds that the OT evaluation

discontinued on August 17, 2004 when the beneficiary refused further PT because of bleeding at the incision site. Case File in 1-275691855, Ex. 22, at 1. A progress note on August 28, 2004 indicates that, at that time, the beneficiary had no pain, her incision site was intact without bleeding or drainage, and she was able to ambulate independently using a quad cane for balance and safety. Case File in 1-275691855, Ex. 17, at 1. This reflects a significant improvement over the need for a walker and standby assist to walk 20 feet.

Any PT provided prior to the revision surgery is not relevant since the second operation implies a significant change in her condition. Nothing in the record documents the number or nature of the "units" of PT provided in the SNF immediately after the beneficiary's discharge from her second surgery. We cannot conclude that any such services would have met the needs of the beneficiary post-removal of the staples and in a home environment. The clinical record indicates that 5 PT visits were beneficial and needed to establish and train in an effective HEP. We therefore reverse the ALJ as to the PT visits.

The OT visit on August 2, 2004 not only involved evaluation of the patient's needs in the assisted living facility environment but also teaching the patient and caregiver "how to turn properly, how to safely climb stairs while practicing knee precaution" and performing range of motion, transfer, and mobility training. Case File in 1-275691855, Ex. 20, at 1; Ex. 21. The OT confirmed that the beneficiary had learned and was continuing a HEP. *Id.* Prior OT visits in the SNF do not appear duplicative since the environment was different (and unlikely, for example, to have included stairs or throw rug as hazards) and the beneficiary still had staples in her knees when the prior visits took place so her condition was also likely significantly different. A single skilled visit to assess these changes and provide instruction to allow her to adapt to her changed environment and condition safely does not appear

"independent in her ADLs." ALJ Decision in 1-275691855, at 10. In fact, the OT progress note does not show the beneficiary as independent in all ADLs, but as needing supervision in some areas. Case File in 1-275691855, Ex. 21. She is indeed shown as independent in bed mobility and bed to chair transfers but needing supervision and assistive devices for tub/shower transfers and dressing her lower body. *Id.* The OT does not rate her on sitting to standing. *Id.* Given that the OT evaluation took place a week after the PT evaluation, noted the beneficiary's need for and benefit from the HEP being taught by the PT, and involved a different discipline with somewhat different focus, we do not find that the OT notes contradict the PT evaluation.

unreasonable. We therefore reverse the ALJ as to the OT services.

P.M. (ALJ 1-275896205) - This beneficiary received 9 SN visits, 5 PT visits, 5 OT visits, and 1 SW visit, in addition to 7 SN visits which were allowed on redetermination. The ALJ denied the 9 SN visits after January 12, 2004 on the grounds that the nursing notes did not document continued skilled wound assessment because the status or appearance of the beneficiary's foot wound was not described. ALJ Decision in 1-275896205, at 11. He also opined that the beneficiary was medically stable with "no likelihood of potential instability" justifying skilled nursing. *Id.* As to the PT and OT services, the ALJ stated that no change in functional ability was documented to warrant skilled therapy. *Id.* He also asserted that "the social worker visits is also denied for medicare coverage" due to "no documentation supporting the necessity for social worker evaluation. *Id.* The appellant argued that the PT and OT provided to this 73-year old wheelchair and bed bound patient were necessary to enable her to assist in his own transfers and bed mobility in order to remain in her home living situation. Patient Ex. 6, in Vol. 2, at 1-2.

This beneficiary had multiple diagnosis including gangrene of one toe resulting in amputation, severe peripheral vascular disease, peripheral neuropathy, ESRD, and dementia and dependent for all ADLs. Case File in 1-275896205, Ex. 11, at 2, 6-7, 9. She was noted with a potential to develop infections. *Id.* at 13. The ALJ's description of this patient as having no likelihood of potential instability post-amputation is not supported by the record. Indeed, the redetermination found that it was "reasonable and necessary for the skilled nurse to go into the home post acute care to monitor the wound," but then states, with no further explanation, that "the RN reviewer has determined that only 7 skilled nurse visits were reasonable and necessary and that 9 should be denied." Case File in 1-275896205, Ex. 7, at 1.

The nursing notes reflect treatment of the amputation site giving way to monitoring of the skin integrity with specific notation of the wound site continuing through the January 30, 2004 visit, while the focus of the later visits is on assessing the patient's problems with weakness, muscle cramping and numbness and on training the patient/caregiver on managing medications, nutrition and hydration, signs of infection, prevention of pressure sores, and safety. Case File in 1-275896205, Ex. 12 *passim*. The physician plan of care appears to

contemplate that nurse wound care would be necessary for up to three weeks and that training of the patient/family in protecting skin and extremities and managing the disease processes would require four to six weeks. Case File in 1-275896205, Ex. 9, at 1-2. This is consistent with the nursing notes. There is no clear cutoff between the 7 allowed visits and the 9 denied visits. We conclude that the SN visits were reasonable and necessary.

The PT initiated training in a HEP program with a view to improving bed mobility and balance on December 30, 2003, after an evaluation performed December 24, 2003. Case File in 1-275896205, Ex. 13; Ex. 15, at 1. She was able to use a walker with maximum assistance and it was hoped that she could build up to ambulating with it in the home with supervision. *Id.* Some improvement was recorded in moving bed mobility from minimal assistance to supervised or "contact guard" level assistance and transfer ability from moderate to minimal assistance. *Id.* However, the patient was noted to be "very tired most sessions" with little participation and to have reached a plateau, so the therapy was discontinued on January 7, 2004. Case File in 1-275896205, Ex. 15, at 4; see also Ex. 14. The OT evaluation took place on December 27, 2004 and noted a plan to focus on bed mobility, bed to wheelchair transfers and range of motion training. Case File in 1-275896205, Ex. 17, at 2. The following visits record performing gentle range of motion movements while seated, as well as teaching caregivers techniques for energy conservation, and safe assists, with the final visit on January 9, 2004. Case File in 1-275896205, Ex. 17 passim. There does not appear to be documentation of what changes occurred as a result of the OT services.

The physician ordered a social work evaluation on December 23, 2003. Case File in 1-275896205, Ex. 10, at 2. The social work assessment determined that the beneficiary had strong family support and awareness of available community resources and included "supportive counseling and education" to the patient and family to assist with her "healthy coping skills and positive attitude" and a review of safety issues. Case File in 1-275896205, Ex. 20, at 1-2.

We conclude that the PT services were reasonably expected to yield improvements and did result in some benefit despite the beneficiary's fatigue and weakness limiting their success. Therefore, the PT visits were reasonable and necessary. The record does not contain as clear a documentation of what added benefit was expected from or gained from the OT services. The

appellant indicates that they differ little with PT "more of a physically restorative nature than maintenance/increase of functionality" compared to OT. Patient Ex. 6, in Vol. 2, at 2. We conclude that the appellant has not shown that the OT visits were reasonable and necessary. Given the complete dependence of P.M. on her caregivers, it was reasonable to order a social work evaluation to ensure that her situation and resources would support healing of her wound and adequate management of her complex disease state. Therefore, the single SW visit was reasonable and necessary.

In sum, we modify the ALJ decision to continue to deny the 5 OT visits but to cover the other services.

S.M. (ALJ 1-275701705) - At issue were 13 SN visits, 8 PT visits, and 4 OT visits to a beneficiary recently discharged from several months at a SNF where she had been treated for septic shock and acute renal failure. ALJ Decision in 1-275701705, at 11; Case File in 1-275701705, Ex. 12, at 2. She had diagnoses of fibromyalgia, general body weakness, arthritis and chronic diarrhea, all rated as controlled with difficulty and needing ongoing monitoring. Case File in 1-275701705, Ex. 12, at 2, 8. The chronic diarrhea was noted as requiring a changed treatment regimen and new requirements were noted for a low sodium, low fat diet with no gluten or milk products. *Id.* The ALJ acknowledged that the beneficiary "suffered from joint aches and diarrhea," but stated that there was "no change in the beneficiary's overall condition, functional status, or plan of care during the coverage period at issue," that she did not have nausea, vomiting, or fluid intake problems, that there was "no documentation of a reasonable potential for the beneficiary to have a medical complication," and that the SN services were "general assessments, ongoing observations, and repetitive teaching to a medically stable patient." ALJ Decision in 1-275701705, at 11.

A case conference stated that the SN was to "monitor weight and hydration status due to reported episodes of diarrhea, monitor bilateral pedal edema, give instructions to alleviate condition, monitor and instruct dietary compliance, evaluate safety concerns - patient is weak and having trouble in ambulation and transfers," and give "instructions on medications and disease management." Case File in 1-275701705, Ex. 11. The beneficiary had lost more than 10 pounds in the prior 3 months. Case File in 1-275701705, Ex. 12, at 8. The nursing assessment documented high risk for falls, pain and alteration in comfort, and the potential for electrolyte imbalance as concerns, which conflicts

with the ALJ's assertion that there was no potential for medical complications. The redetermination noted that only three nursing notes reported diarrhea without recording details of episodes and that "minor diarrhea episodes do not warrant the skills of a nurse." Case File in 1-275701705, Ex. 7, at 1. This characterization trivializes the clinical record. The nursing notes focus on managing fluid volume risks related to her diarrhea and use of diuretics and "compromised regulatory mechanisms in hemodynamic and renal systems," as well as monitoring changes in vision, giving medication and monitoring reaction, and encouraging measures to avoid edema. Case File in 1-275701705, Ex. 14, at 1, and *passim*. We conclude that the SN visits were reasonable and necessary given the beneficiary's total condition.

Comparing the SOC and Discharge OASIS documents improvements in the beneficiary's independence level on 5 of 7 basic ADLs, undercutting the ALJ's finding of no change in functional status. Compare Case File in 1-275701705, Ex. 12, at 9-10, with Case File in 1-275701705, Ex. 13, at 9-10 and at 14 (documenting improved functional statute and independence as outcomes). The ALJ asserted that the PT and OT focused on areas which could be provided through non-professionals after initial instruction. ALJ Decision in 1-275701705, at 11. The PT evaluation and notes included development of and training in a HEP, which in itself justifies several visits. Case File in 1-275701705, Exs. 16 and 17. PT progress notes also documented different skills and interventions at each visit with plans for the following visits covering not only strength, endurance and ambulatory distance, transfer and gait training, dynamic balance, safety, energy conservation techniques, and fall recovery techniques. Case File in 1-275701705, Ex. 17 *passim*.

The OT noted patient's decline in ADLs secondary to the septic shock and recorded exercises to increase independence and instruction to improve safety in the home environment. Case File in 1-275701705, Exs. 19 and 20. Neither the OT notes nor the appellant's discussion of the case make evident what value the OT added to PT services which appeared to cover the same ground.

We conclude that the PT services were reasonable and necessary but that the appellant has not established that the OT services provided in addition were reasonable and necessary.

R.O. (ALJ 1-276192175) - The beneficiary received 9 SN visits and 14 PT visits. Regarding the need for SN, the ALJ recites

the same reasoning quoted in the case of the beneficiary above (and in numerous other cases). ALJ Decision in 1-276192175, at 11. The beneficiary had diagnoses on referral of abnormality of gait, hemiplegia affecting dominant limbs, stroke with speech deficits, COPD, and chronic anxiety. *Id.*; Case File in 1-276192175, Ex. 15, at 1. He had daily knee pain, had weak and uneven grip, showed ankle edema (+3), was chairfast, was SOB with minimal exertion, had intermittent constipation and needed a special diet, and needed assistance for bathing and transferring at the recertification assessment. Case File in 1-276192175, Ex. 16, at 5-8. Nursing notes indicate concern about fall risk due to unsteady gait with cane, suggesting that R.O. did leave his wheelchair at times. Case File in 1-276192175, Ex. 14, at 1. The appellant points out that nurses twice initiated doctor's appointments when they observed worsening of the edema in the patient's right leg. Patient Ex. 9, in Vol. 2, at 2; Case File in 1-276192175, Ex. 14, at 3, 5. The edema was noted to have resolved by SN visit on January 22, 2005. Case File in 1-276192175, Ex. 14, at 9. On other visits, nurses provided instruction on low sodium diet, safety measures such as loose socks and elevation to deal with poor circulation, instruction on exercises to increase strength, and trained patient and caregiver on medications, side effects and reportable signs and symptoms of disease. *Id. passim.* On February 1, 2005, the patient called 911 and was seen in the emergency because of chest pains. Case File in 1-276192175, Ex. 16, at 10. He was discharged from home health on February 5, 2005. Case File in 1-276192175, Ex. 16. The clinical record does show reasonable potential for medical complications and the need for and benefit from skilled monitoring of the beneficiary's condition, especially related to his edema and COPD. The SN services were reasonable and necessary.

The ALJ cited a discrepancy in the documentation on the PT services in that the PT indicated that the beneficiary achieved "maximum rehabilitation possible" while the discharge OASIS showed "no change in the functional status after physical therapy and therefore, had already reached the maximum rehabilitation potential." ALJ Decision in 1-276192175, at 11. The discharge OASIS shows the beneficiary's level of ADL independence unchanged. Compare Case File in 1-276192175, Ex. 15, at 8 with Case File in 1-276192175, Ex. 16, at 6. The PT notes indicate mostly exercise to improve gait and balance, and increase endurance and ambulatory distance. Case File in 1-276192175, Ex. 21 *passim.* Although instruction on fall risk prevention and safety education were also noted, the clinical records do not explain why a HEP was not taught or could not

suffice especially since the PT reports that the beneficiary was "able to follow instructions well." *Id.*; Ex. 22, at 1.

We thus modify the ALJ decision to cover the SN visits but deny the PT visits.

F.O. (ALJ 1-275929776) - The beneficiary received 8 SN visits, 5 PT visits, and 5 OT visits. The ALJ found that F.O. had a prior home health admission for the same diagnosis of COPD and concluded that the diagnosis was not new and that no exacerbation was documented "that would require re-education," along with reciting again the same comments on the SN services mentioned in prior cases. ALJ Decision in 1-275929776, at 11. The ALJ denied the PT services as not requiring skilled level tasks beyond a HEP. *Id.* at 11-12.

The SOC OASIS primary diagnosis is COPD with exacerbation, along with muscle weakness, atrial fibrillation, hypertension and urinary incontinence. Case File in 1-275929776, Ex. 15, at 2. The physician also recorded exacerbation of the beneficiary's COPD on her plan of care. Case File in 1-275929776, Ex. 10, at 1. She uses a cane, walker or wheelchair as able and has SOB with minimal exertion. *Id.* at 8. The SN goal was for patient within 1-3 weeks to demonstrate ability to conserve energy, tolerate ADLs at maximum potential, and manage her COPD. On discharge, her respiratory status had improved to SOB only when walking more than 20 feet or climbing stairs and her independence increased in all basic ADLs, except that she still required use of an assistive device for ambulation. Nursing notes show repeated findings of dry coughing and dyspnea and training on use of oxygen and nebulizer and managing energy conservation. Case File in 1-275929776, Ex. 17 *passim*. The ALJ does not cite any basis for disregarding the clinical evidence of an exacerbation or for concluding that the beneficiary had received education during her prior home health services that would cover her current medical condition and needs. For example, the plan of care indicates a need to train on continuous use of oxygen via nasal cannula whereas it is unclear if the beneficiary previously needed oxygen. Case File in 1-275929776, Ex. 10, at 1. We cannot conclude that the SN visits were unnecessary or excessive.

The PT plan of care called for emphasis on "proper pacing," energy conservation, and decreasing SOB and fall risk. Case File in 1-275929776, Ex. 21, at 1. In addition to increasing ambulation distance, the PT introduced stair training on the second visit and the use of an ankle weight for strengthening on

the third visit. Case File in 1-275929776, Ex. 22, at 1-3. By the fourth visit, the therapist recorded increase leg strength to 4 or 4+ from 3+ on a scale of 5 and improved standing balance, and stated that the patient was able to follow instructions correctly. *Id.* at 4. The fifth and final visit reflected discharge as now able to ambulate with walker and oxygen and independent in all functional aspects. *Id.* at 5. The PT discharge summary indicates that the abnormal gait was completely resolved, that the patient was now able to manage oxygen treatment safely and was not in acute respiratory distress, and that she had been "reinstructed" on reportable side effects of her medication and importance of keeping doctors' appointments. Case File in 1-275929776, Ex. 18, at 1. The beneficiary still needed a walker (though not a wheelchair) but no longer needed standby assistance and could ambulate on uneven surfaces. Case File in 1-275929776, Ex. 20, at 1. Five PT visits to teach HEP and achieve the noted improvements in gait, mobility and functionality is not unreasonable.

We reverse the ALJ decision.

A.P. (ALJ 1-275927083) - The services at issue are 11 SN visits, 1 PT visit, and 10 OT visits which the ALJ denied for reasons virtually identical to those recited in the previous cases. ALJ Decision in 1-275927083. The ALJ questioned the beneficiary's primary diagnosis of COPD with exacerbation because of the absence of evidence of a hospital stay or doctor's visit prior to her home health admission. *Id.* The appellant contends that the doctor had "started the patient on Antibiotic therapy . . . and a hand held nebulizer treatment and asks the agency to train the patient in the use of the machine and care of the equipment." Patient Ex. 12, in Vol. 2, at 1.

The beneficiary's diagnoses on the SOC OASIS include COPD with acute exacerbation, osteoarthritis of spine, neck pain, and generalized weakness. Case File in 1-275927083, Ex. 10, at 2. The beneficiary is noted to have severe SOB, partially impaired vision, and daily pain and stiffness in the neck. *Id.* at 4, 5 A.P. required assistance in bathing, minimal assistance in transferring, and use of a cane to ambulate. *Id.* at 9-10. The beneficiary was assessed as able to take oral and inhalant medications independently. *Id.* at 11-12. The prescription cited by the appellant does not establish that the nebulizer was new or that training in its use was required. Case File in 1-275927083, Ex. 12, at 1.

It was reasonable to obtain a consult from PT in light of the neck pain, osteoarthritis and weakness. The PT concluded no services were required and deferred to the OT. Case File in 1-275927083, Ex. 12, at 3. OT services were recommended with a goal of increasing range of motion and reducing pain and of educating the patient to conserve energy during ADLs to reduce SOB. Case File in 1-275927083, Ex. 15, at 1. The OT progress notes record gradual reduction in pain levels and increased activity tolerance with therapeutic exercises and increasing independence with training and cuing in breathing techniques, work simplification and energy conservation. Case File in 1-275927083, Ex. 21 *passim*. The fourth visit notes that the patient reports not doing the HEP consistently and observes that the patient's use of accessory neck muscles for breathe may be causing the pain. *Id.* at 3. On the succeeding visits, the patient reported doing the HEP and then feeling better, but the OT noted a continuing need to cue proper breathing and working to move the patient from exercise in sitting to standing position. *Id.* at 3-8. The patient was then discharged from OT as having met goals and having review HEP and skills taught for ADLs, stretches, energy conservation, pacing and breathing. *Id.* at 9. The difficulty in achieving compliance with the HEP indicates that this 88-year old beneficiary may well have needed more skilled visits to master the skills than another patient might have. We therefore cannot conclude that the OT services were unreasonable or excessive.

We reverse the ALJ decision.

D.P. (ALJ 1-275926971) - The ALJ denied coverage for 9 SN visits and 8 PT visits after October 27, 2004. ALJ Decision in 1-275926971, at 11. (4 PT visits were covered at the redetermination level. Case file in 1-275926971, Ex. 4, at 2.) In addition to reciting that no significant change was shown during the coverage period and that the services were merely "general assessments, ongoing observations, and repetitive teaching to a medically stable patient," the ALJ also found that the SN visit notes failed to document assessment or care of the beneficiary's decubitus ulcer. *Id.*

The SOC OASIS states that D.P. had just been discharged from the hospital but omits any information on her in-patient stay and fails to identify any diagnoses. Case File in 1-275926971, Ex. 10, at 1-2. It also states that the beneficiary (who has a below-knee amputation) does *not* have a stasis or pressure ulcer, although it notes skin lesions including excoriated buttocks and leg rashes. *Id.* at 6, 8. D.P. is totally dependent for

toileting, transferring and bathing, and is chairfast and unable to ambulate. *Id.* at 12. The goals for home health are stated as educating the caregiver on infection control and blood sugar monitoring (although diabetes is not noted on the OASIS, the diagnosis appears on the plan of care).¹⁶ *Id.* at 16. The plan of care identifies diagnoses including muscle weakness, decubitis ulcer on buttock, and uncontrolled diabetes, and calls for NS to perform and teach proper wound care, diabetes management, and safety. Case File in 1-275926971, Ex. 12, at 1-2. As the ALJ correctly observed, the SN notes contain no reference to wound care and in fact every SN note records no negative skin findings (with no checks in items for rash, decubitis/wound, or poor skin care). The documentation is inadequate to justify the SN visits as reasonable or necessary.

The ALJ found that the 78 units of PT and 75 units of OT were provided at the SNF and "reasonable time was allowed for the establishment of a safe and effective maintenance program," so further skilled PT was not necessary. ALJ Decision in 1-275926971, at 11. The physician prescribed PT because the beneficiary was "very deconditioned with mild DOE upon light exertion & unsteadiness in sitting. Requires maximum assist for transfers to w/c <-> bed <-> toilet." Case File in 1-275926971, Ex. 16, at 1. The PT evaluation at SOC noted pain (level 6 of 10) and reduced mobility in both shoulders and hands with strength rated at 2 of 5, low threshold for fatigue, fair sitting balance, and need for maximum assists for transfers and most bed mobility. Case File in 1-275926971, Ex. 19. The remaining PT notes stress that the beneficiary is "self-limiting," needing a lot of reassurance and cues, but also that she made steady improvements in sitting balance and activity tolerance. Case File in 1-275926971, Ex. 20 *passim*. The therapist moved from bed mobility and transfer skills, to training the beneficiary and caregivers on independent range of motion exercises and a home exercise program. *Id.* The discharge summary on November 13, 2004 states that the beneficiary has achieved independence in bed mobility and minimal assist with wheelchair/bed transfers, now has good sitting balance, and is able to continue an independent HEP. Case File in 1-275926971, Ex. 21.

The record does not indicate what D.P.'s condition was on entry to the SNF (or hospital), how long her stay was, or what the goals were of the PT/OT services provided to her as an in-patient. Although the redetermination suggests that the

¹⁶ The beneficiary and caregiver refused use of insulin shots. Case File in 1-275926971, Ex. 14, at 2.

services had restored her to the "ability to perform cares as before," this assumption was based on the SOC OASIS rating prior and current level of functioning as the same, but ignores the fact that the prior level of functioning in the OASIS is defined as 14 days before the start of care. Case File in 1-275926971, Ex. 7, at 2. Hence, all that can be concluded is that her ADL functioning did not change significantly during her last two weeks in the SNF.

While some patients might have been able to master the HEP program and achieve the progress in other goals more quickly, the PT documented the high anxiety, variable motivation and need for extra encouragement for this beneficiary. We cannot say that 9 PT were excessive or unreasonable for the goals accomplished.

We modify the ALJ decision to deny coverage for the SN visits but provide coverage for the PT visits.

W.P. (ALJ 1-275926794) - The ALJ denied coverage for 6 SN and 6 PT visits. ALJ Decision in 1-275926794, at 11-12. The 89-year old beneficiary had spent two and ½ months in a SNF after an acute care hospital admission for heart failure and reportedly received 137 units of PT and 156 of OT at the SNF. Case File in 1-275926794, Ex. 8, at 1. (At the redetermination level, 4 SN and 4 PT visits were covered as reasonable to teach about disease process and establish a HEP. Case File in 1-275926794, Ex. 4, at 2-3.) He was now in a board and care facility. Besides reciting the general denials of SN services, the ALJ commented that the SN notes show unsteady gait and weakness but only show one episode of wheezing. ALJ Decision in 1-275926794, at 11.

The SOC OASIS records diagnoses during in-patient stay of congestive heart failure and muscle wasting, and additional diagnoses include dementia, coronary artery disease and esophageal reflux. Case File in 1-275926794, Ex. 15, at 2. He had a sore on his right ankle (not identified as a pressure ulcer). *Id.* at 6. He was noted to have coarse diminished breath sounds (rhonchi) but not to be SOB, to have issues with forgetfulness, anxiety and confusion in new situations, and to have limitations in hearing, endurance and ambulation. *Id.* at 8, 10, 11. His ADL levels had improved over the preceding two weeks but he continued to need assistance to bathe and transfer and to be unable to perform household tasks at all. *Id.* at 11-12. He required a walker or wheelchair for ambulation. *Id.* at 12-13. He was assessed with a high fall risk. *Id.* at 15-16.

The plan of care called for SN to "perform skilled assessments," teach the patient and caregiver about congestive heart failure, monitor for edema, lung sounds, SOD and dizziness, report changes in blood pressure, and instruct on medications, diet, home safety, and reportable signs and symptoms. Case File in 1-275926794, Ex. 9, at 1. The SN reported wheezing on January 5, 2007 (the first post-OASIS visit), as the ALJ noted, and instructed the patient and new caregiver on coughing and deep breathing, as well as on hydration, on taking blood pressure and pulse before taking medications, and on when to hold the medication. Case File in 1-275926794, Ex. 17, at 1. The second visit involved a change in medication, instruction to patient and caregiver on diet, and information on signs and symptoms to report to physician as possible decline in status. *Id.* at 2. On the third visit, the patient had pain in the bladder and the nurse obtained a doctor's order for urinalysis and instructed the caregiver on obtaining a mid-stream sample. *Id.* at 3. On the following visit, the nurse addressed continuing edema in both legs and instructed the caregiver on elevating the legs, weighing frequently for water retention, and watching for side effects of diuretic prescribed. *Id.* at 4-5. The remaining notes do not show any changes in treatment, condition, or new instruction or training, but rather continued assessment and monitoring and reinforcement of the topics already addressed. *Id.* at 6-8. This record undercuts the ALJ's assertion that the beneficiary was stable and did not need skilled monitoring or assessment. While no significant changes were noted in the last three visits, we cannot say that three visits was an unreasonable period in which to ensure that the patient was now stable enough to no longer need skilled care. We therefore concluded that the SN visits are covered.

PT evaluation reported moderate assist required for bed activities, bathing, and transfers, strength deficits (3/5) in all extremities, poor balance in standing and ambulating, a staggering gait, intermittent pain in legs, and knees tending to buckle due to fatigue. Case File in 1-275926794, Exs. 20, 21. The treatment goals were to increase strength, endurance, mobility/gait and range of motion and to make the patient aware of body mechanics and safety to reduce fall risk. *Id.* The discharge summary reported that the therapist had developed and supervised a HEP, and had focused on training in body mechanics, functional transfers, gait and safety. Case File in 1-275926794, Ex. 19. The patient was reported to have increased strength to 4/5 in all extremities, to have improved to standby assist in bed mobility and transfers, and to have better gait on

even surfaces. *Id.* The services thus included but went beyond improving strength, activities tolerance and distance ambulated. It is true, as the ALJ noted, that these 6 PT visits were provided on top of services in the SNF and 4 allowed visits for purposes of teaching a HEP. The record does not include any information about what the nature of the prior services were or what the condition of the beneficiary was before and after receiving them. It is therefore not possible to conclude that the 6 visits at issue were excessive given the clinical documentation of the beneficiary's continued high risk and assessed need and capacity for improved balance, strength, and independence in a safe home setting.

We therefore reverse the ALJ decision.

P.R. (ALJ 1-275926627) received 12 SN visits and 1 SW visit which were denied by the ALJ who recited that no significant changes occurred during the period (although he acknowledged the patient complained of leg pain at times), and that the SN was for observation and assessment of a "medically stable" patient. ALJ Decision in 1-275926627, at 11. He also pointed to conflicts in the documentation in that onset of congestive heart failure (CHF) was noted on his plan of care as April 6, 2005, which was actually the date of his SOC OASIS.¹⁷ *Id.*; Case File in 1-275926627, Exs. 8, 11. This error appears harmless as the SOC OASIS clearly documents that the patient was released April 4, 2006 from a SNF where he was under treatment for CHF and atrial fibrillation, but also notes a change in treatment regimen for the CHF within the preceding two weeks. Case File in 1-275926627, Ex. 11, at 1. The patient's diagnoses also included chronic renal failure, osteoarthritis, and peptic ulcer with two hospital admissions since December 2004. *Id.* at 2. The beneficiary had intractable pain on a daily basis ranging from 3-8/10, was noted to have pitting edema and weakness of his right leg, skin abrasions to his knee, dry cough, and abnormal breath sounds. *Id.* at 5-6, 9, 11. He had reported weight loss of 30 pounds since December 2004 and was assessed at moderate nutritional risk. *Id.* at 10. He was independent with his ADLs, but needed reminders or assistance to take his medications. *Id.* at 12-14. The goals of home health were to monitor and teach disease management, provide training on medications, diet and

¹⁷ The other "conflict" identified by the ALJ is that the entry in the SOC OASIS for "living arrangements" indicates a board and care or boarding facility while the entry for "patient lives with" is checked as "lives alone." Case file in 1-275926627, Ex. 11, at 3-4. The most reasonable reading is that the patient likely lives in a single room in a boarding facility. In any case, the ALJ identifies no reason why confusion over this point would undercut the validity of the clinical findings.

safety, resolve the edema, and to prevent other complications, *Id.* at 2, 16. A multidisciplinary care conference reviewed these facts and highlighted the patient's need for "close monitoring in preparing, taking multiple medications" and observation and monitoring to prevent complications. Case File in 1-275926627, Ex. 14. Progress notes showed patient condition as stabilized on May 10, 2005 and discharge from SN about three weeks later on June 4, 2005. Case File in 1-275926627, Exs. 12, at 1, and 13.¹⁸ The services are consistent with the guidance in the MBPM regarding skilled observation and assessment of a patient with potential for complications and are therefore reasonable and necessary. The ALJ decision is reversed.

N.R. (ALJ 1-275702267) - The beneficiary received 15 SN visits, which the ALJ denied as not reasonable necessary, and 1 OT visit, 8 Home Health Aide (HHA) visits, and 1 SW visit, which were denied because no qualifying service was covered. ALJ Decision in 1-275702267, at 11. The ALJ found no evidence of significant change in the beneficiary's "overall condition, functional status, or plan of care," but also noted that the SOC OASIS showed a stage 2 pressure ulcer while the discharge OASIS should no skin lesion or open wound present. *Id.* He stated that the record contained "only 2 wound assessment sheets" and that treatment by cleansing with normal saline did not require skilled nursing and could have been done by the beneficiary's daughter who was also able to take blood glucose readings and report them as needed. *Id.*

The SOC OASIS shows that the beneficiary was released the day before from a SNF where he was treated for sepsis and hypoglycemia. His primary diagnosis for home health was a stage 2 decubitus ulcer on his coccyx noted as poorly controlled, with additional diagnoses including ESRD, diabetes, and general weakness (for which treatment also needed frequent adjustment and dose monitoring). Case File in 1-275702267, Ex. 13, at 2, 5. The ulcer was recorded as not healing at the time of SOC. *Id.* at 6. He had a history of having his toes amputated and had bowel and bladder incontinence and limited endurance and ambulation capacity. *Id.* at 4, 5. The plan of care for the ulcer was not merely to cleanse it with normal saline, but also to apply duoderm twice weekly and change PRN for soilage and peeling. *Id.* at 6. He was depressed and lethargic and his ADL had declined in the preceding two weeks to total dependency in

¹⁸ Notes from those visits indicate, as the appellant argues, that the SN were working closely with the patient's physician regarding medications ordered for the patient but not obtained due to coverage issues. Case File in 1-275926627, Ex. 15, at 8-9.

dressing, transferring and bed mobility, and toileting, and to increased need for assistance in other areas. *Id.* at 9-10. He had declined for able to walk with an assistive device to being chairfast and unable to even operate the wheelchair. *Id.* at 10. He needed a hospital bed and moved with a Hoyer life. *Id.* at 12. He was also noted to be at some nutritional risk and to need a special diet. *Id.* at 8.

The beneficiary at start of care was thus suffering from a coccyx pressure ulcer which was not healing and not responding to treatment so far, and was plainly at high risk for further skin breakdown and infection given his incontinence, nutritional risk, dependency, and very limited mobility. *Id.* at 13. The weekly wound assessment form filled out nine days later (December 23, 2003) shows that ulcer had reduced in size and was now rated at stage 1. Case File in 1-275702267, Ex. 15, at 1. On the form completed one week later, the wound had healed. *Id.* at 2. During the intervening SN visits, nursing notes show that the wound was monitored and assessed regularly until it healed, which was noted by January 1, 2004. It is thus clear that the patient's condition in fact changed substantially during at least the period of the first 8 SN visits and that skilled treatment of the wound was reasonable, necessary, and effective. The remaining visits, however, focus on training the caregiver on disease, diet, turning to reduce the risk of future sores developing, and what developments would warrant calling the physician. Nothing in the record explains why 7 more visits were required to impart this information to the caregiver.

We therefore modify the ALJ decision to cover 8 SN visits and deny coverage for 7 SN visits. The OT, SW and 6 HHA visits occurred within the same time frame and would therefore be covered; 2 HHA visits occurred when no qualifying home health services were covered and are therefore denied.

J.S. (ALJ 1-275927337) - The ALJ denied coverage for 13 SN visits and 14 PT visits. ALJ Decision in 1-275927337, at 11-12. The ALJ noted normal findings on the SOC OASIS as to respiration, blood sugar readings, chest pain or edema, noted some forgetfulness, and noted that the beneficiary catheterized himself for urine retention due to prostate cancer. *Id.* at 11. The ALJ concluded that no significant changes occurred, no reasonable potential existed for complications, and the SN services were general assessments, ongoing observations, and repetitive teaching to a medically stable patient. *Id.*

The SOC OASIS actually shows change in treatment regimen for uncontrolled diabetes within prior 14 days. Case File in 1-275927337, Ex. 10, at 1. The primary reasons given the need for SN were to check fasting blood sugars, to assess and monitor the beneficiary's condition and safety in his assisted living facility, and to instruct the patient on disease process and medications. *Id.* at 2-3; see also Case File in 1-275927337, Ex. 11 (plan of care. When the SN found the blood sugar readings were normal over several visits, the frequency of visits was reduced to once a week from three times a week as of October 19, 2004. Case File in 1-275927337, Ex. 12, at 1, 4, 8. It was reasonable and necessary to provide skilled nursing to ensure that the beneficiary safely adapted to a changed regime for managing his diabetes. The nursing notes also reflect concern for potential urinary tract infection in light of the catheterization and instruction on use of a diuretic medication on October 25, 2004 and November 5, 2004. Thereafter, the instructions appear repetitive reviews of disease process, medications and precautions with no indication of why the patient and caregivers were not able to learn effectively. We therefore conclude that 6 SN visits were reasonable and necessary while the appellant has not established that 7 additional SN visits were coverable.

As to PT, the ALJ opined that the documentation does not show a change from the beneficiary's "usual physical functional ability" because the PLOF was the same as the CLOF in the SOC OASIS and the PT evaluation showed the PLOF as ambulating with standby assistance and walker and "assistance with" ADLs which was the same as at SOC. ALJ Decision in 1-275927337, at 11-12.

The SOC OASIS rates functional level at the time of assessment and at 14 days prior to that date. At both points in time, the beneficiary is rated as needing an assistive device (walker) or human supervision or assistance to ambulate, and as needing assistance to dress and bathe and minimal assistance to transfer and groom himself. Case File in 1-275927337, Ex. 10, at 12. He is noted to have poor conditioning, limited endurance and SOB with moderate exertion. *Id.* at 10, 12. His primary diagnosis is gait abnormality with a history of right hip replacement and hypothyroidism. *Id.* at 2. The plan of care called for PT to establish a HEP, provide skilled training on transfers and gait, perform therapeutic exercises to improve strength, range of motion, balance and coordination, and to educate on energy conservation and safety awareness. Case File in 1-275927337, Ex. 11, at 1. The PT evaluation does not rate prior ADLs individually but states PLOF (at undefined time) was a need for

assistance with ADLs and in-home mobility. Case File in 1-275927337, Ex. 21, at 1. The CLOF is moderate to maximal assist for bed mobility and transfers, a more dependent rating than the CLOF in the OASIS. *Id.* at 2. Neither the PT evaluation nor the SOC OASIS clarifies the onset of gait problems (or the date of hip surgery). The PT evaluation also notes a history and elevated risk of falls. *Id.* The PT clinical notes show instruction in a HEP program and improvements in strength, balance and gait, and lowered fall risk by discharge, but provide little information about skilled interventions and repeated refer to merely continuing program. Case File in 1-275927337, Ex. 19 *passim*; Ex. 18.

The change in diabetic management was a reasonable basis to assess the beneficiary's PT and the history of fall and hip replacement justify PT assessment to determine if the potential for further complications could be expected to be reduced. The appellant has not demonstrated the need for so many PT visits beyond those needed to assess his needs and capacity for rehabilitation and teach and monitor a HEP for him to increase strength and mobility. We therefore conclude that 4 PT visits should be covered but that 10 PT visits are not reasonable and necessary.

D.S. (ALJ 1-275933004) - The beneficiary was discharged to home health from an 18-day SNF stay during which she received rehabilitation after hip replacement including 45 units of PT and 40 of OT, and was also treated for hypertension and chronic renal failure. ALJ Decision in 1-275933004, at 11; Case File in 1-275933004, Ex. 7, at 1; Ex. 18, at 1. The primary reasons listed for home health was abnormal gait. Case File in 1-275933004, Ex. 18, at 2.

Over the next two months, she was provided with 9 SN visits, 6 PT visits, 4 OT visits, and 1 SW visit. (At the QIC, coverage was authorized for the initial PT and OT evaluation visits but continued to be denied for 5 PT and 3 OT visits. Case File in 1-275933004, Ex. 7, at 2.) In addition to the usual recitation on the lack of need for SN, the ALJ stated (without record citation) that on discharge from the SNF, "her medical condition was noted to be stable and there was no indication that her physician planned to recommend home skilled nursing services." *Id.* The appellant argues that the beneficiary was receiving dialysis and lived in an apartment with stairs and a slanted walkway she needed to negotiate in order to reach dialysis treatments. Patient Ex. 19, at 1-2.

The SOC OASIS dated May 10, 2004 reports that the beneficiary suffered from pain in her hip rising to level 5/10 made worse by movement and ambulation and requiring breakthrough medication, and swollen, painful joints. Case File in 1-275933004, Ex. 18, at 5, 12. She has skin integrity issues, including bruises, scaling skin, incision scar, fistulas, poor turgor and edema. *Id.* She is assessed at high risk of nutritional deficit, with weakness in her lower extremities. *Id.* at 10-11. Her independence with ADLs had improved over the prior two weeks, but she still required assistance for bathing and used a walker or wheelchair to ambulate. *Id.* at 12-13. The plan of care signed by her physician called for SN to assess and monitor all body systems with emphasis on, inter alia, pain, functional mobility, nutrition/hydration status, safety and self-care and to train the patient and caregiver on hypertension, infection control, hip precautions, nutritional needs, complications and side effects, and safe use of pain medications. Case File in 1-275933004, Ex. 9, at 1; see also Ex. 10, at 1 (physician order for admission to home health). The documentation thus does not support an inference that the beneficiary was medically stable with no reasonable potential for complications on her release from the SNF nor that home health services were not contemplated and approved by a physician.¹⁹

The nursing notes identify the problem as "limited mobility related to surgical procedure/discomfort," while consistently reporting that D.S. denied any pain during each visit. Case File in 1-275933004, Ex. 14 *passim*. Each note reports instruction on safe ambulation, good nutrition and/or medication management and each states that she verbalizes understanding and none identify a need for continuous instructions or an inability to demonstrate relevant procedures. *Id.* A progress note on June 11, 2004 stated that the beneficiary was independent with her ADLs, denied any pain or discomfort, used an assistive device to walk for "feeling of safety," and was "able to demonstrate body mechanics use and good body alignment." Case File in 1-275933004, Ex. 12. While it was reasonable and necessary to provide skilled monitoring and assessment while instructing the beneficiary about nutritional and fall risk and

¹⁹ The ALJ may have relied on a communications note dated May 13, 2004 stating that the "patient initiated contact" on May 11, 2004 and "requested to be seen on 5/13/04" secondary to dialysis treatment. Case File in 1-275933004, Ex. 25, at 1. Since the SOC OASIS was already completed on May 10, 2004, we do not read this note as implying that the patient generated the initial contact with the home health agency. Even if she did, we see nothing in the applicable law that would make it improper to provide services on the initiative of a patient so long as the physician ordered those services after determining that they were necessary for her condition.

disease and medication management on her first return home since hip surgery, nothing in the records indicates why that need continued after June 11, 2004. We conclude that the 5 SN visits prior to that date are covered but the 4 additional SN visits are not.

The PT discharge summary indicates that the patient presented originally with a functional decline in ADLs and mobility related to her hip repair and by discharge was independent with all ADLs and independently mobile with a quad cane for stairs. Case File in 1-275933004, Ex. 24. The PT evaluation showed the beneficiary as independent with all ADLs except unable to self-bathe, using a walker and needing moderate to maximum assist on stairs and some assistance on uneven surfaces. Case File in 1-275933004, Ex. 20. The PT clinical notes consistently focus on improving the beneficiary's ability to negotiate steps safely without assistance. Case File in 1-275933004, Ex. 22. By May 25, the patient was reporting no pain, was able to negotiate the stairs without help and ambulating outdoors using a quad cane, and was ambulating indoors without an assistive device. *Id.* at 4. On the two remaining visits, the PT reported instruction in fall recovery, added exercises to the HEP to reduce forward fall risk, completed training for gait on uneven surfaces, and then discharged her with a continuing HEP. The PT visits were not excessive to return the beneficiary to independence and safety in her home environment. The environment and activity challenges in the home setting with the need to ambulate in reaching dialysis treatments were substantially different from those in the SNF, so the receipt of PT in that setting does not make these services unnecessary. We reach the same conclusion as to the 4 OT visits and the SW evaluation.

We therefore modify the ALJ decision to cover 5 SN visits, 6 PT visits, 4 OT visits and 1 SW visit, but deny 4 SN visits.

D.T. (ALJ 1-275698591) - The ALJ denied 9 SN visits, 6 PT visit, and 6 OT visits noting no significant changes or potential for complications with the usual comment that skilled level of nursing was not needed. ALJ Decision in 1-275698591, at 11. The appellant argued that the beneficiary came home from the hospital with a "T-tube" which required skilled monitoring of drainage. Patient Ex. 26, in Vol. 2, at 1-2. Further, the appellant contended that she was in a hospital bed with difficulty in swallowing, SOB with minimal exertion, and dependent on a wheelchair for mobility, whereas previously she had been able to ambulate without an assistive device. *Id.* at 1.

The SOC OASIS documents her hospital release and gives as the primary reason for home health "to monitor medical acute condition from recent hospitalization." Case File in 1-275698591, Ex. 14, at 1-2. She has some anxiety and confusion in new situations and requires prompting. *Id.* at 11. The SOC OASIS contains many blanks and omissions and its evaluation of her ADLs is inconsistent with the appellant's arguments and more consistent with the ALJ's description. *Id.* at 12-13. There is no record of the presence of a T-tube. She is recorded as using a walker not a wheelchair and as never being SOB. *Id.* at 12, 15. No current diagnosis is recorded nor the reason for the hospitalization.²⁰ *Id.* The discharge OASIS records her as SOB with minimal exertion, but with no cognitive issues except confusion in new situations and now independent on all ADLs and needing no assistive device with ambulation. We find the documentation inadequate to demonstrate the reasons for and nature of the SN services and therefore uphold the ALJ's denial of these services.

As to PT and OT, the ALJ stated that no significant change was documented warranting skilled services and that the beneficiary was already functioning at a high level on both PLOF and CLOF on the SOC OASIS "with the exception of her ability to bathe, do laundry, shop, and drive." ALJ Decision in 1-275698591, at 11. The clinical records support that the beneficiary was initially dependent on a walker and presented a fall risk with dizziness and deficits in balance and gait, but that by the time of discharge she was able to ambulate safely without an assistive device. This is a significant change. We therefore find the PT and OT visits were reasonable and necessary.

D.T. (ALJ 1-275749641) This beneficiary was denied coverage for 3 SN visits, 14 PT visits, and 6 OT visits.

The records shows that D.T. was admitted to hospital on December 15, 2004 for "further management of ascending cholangitis," pneumonia post-surgery for T-tube placement, and in need of total parenteral nutrition management and discharged December 31, 2004. Case File in 1-275749641, Ex. 18, at 1; Ex. 16, at 1. Physician orders dated December 31, 2004 at SOC show diagnoses including cholangitis with klebsiella yeast infection; anemia; hypertension; benign prostate hypertrophy; pneumonia (resolved);

²⁰ The plan of care provides a number of diagnoses including physical and occupational therapy (which, as the ALJ notes, are not medical conditions), functional decline, muscle weakness, hypertension, and anemia. Case File in 1-275698591, Ex. 9, at 1.

and line sepsis (resolved). Case File in 1-275749641, Ex. 12, at 1. The doctor ordered wound care for the T-tube with weekly SN visits and a PT evaluation. *Id.* at 1, 3. A multi-disciplinary care conference on admission described the beneficiary as weak, needing assistance with all ADLs and a two-person assist to ambulate, and having difficulty swallowing requiring a mechanically soft diet. Case File in 1-275749641, Ex. 13, at 1. SOC OASIS reports that the primary reason for home health was to provide follow-up care to monitor health condition and PT treatment to address muscle weakness and abnormal gait. Case File in 1-275749641, Ex. 16, at 2. The beneficiary was also documented with intractable pain at level 4, SOB on moderate exertion, with compromised cognitive functioning and depression, weakness in upper and lower extremities and hand grasp, using a walker or wheelchair, and currently (and two weeks previously) in need of moderate to complete assistance with all basic ADLs. *Id. passim.*

The ALJ agreed with the prior reviewers that SN services were reasonable only until two visits after the removal of the T-tube (January 19, 2005) and concluded that thereafter the beneficiary was stable. ALJ Decision in 1-275749641, at 11. The last 3 SN visits record the healing of the wound left after removal of the T-tube, which was reported healed on the last visit after which the beneficiary was discharged from SN services. The ALJ does not explain his conclusion that the risk of infection in the wound was eliminated prior to its healing. We find no basis in the clinical record to conclude that the last 3 SN visits were excessive and therefore reverse the denial of coverage.

The ALJ's denial of PT services was primarily based on his erroneous treatment of the PLOF shown on the SOC OASIS as the measure of the patient's "usual baseline status," when instead it is merely a report of the status two weeks before the assessment was performed (at which point this beneficiary was in the hospital). ALJ Decision in 1-275749641, at 11-12. The OT and PT evaluations report the baseline level of functioning as independent with all ADLs and not needing an assistive device to ambulate. Case File in 1-275749641, Ex. 21, at 1 and Ex. 25, at 1. By the close of therapy, the beneficiary had regained independence in ADLs and the caregiver was trained to assist in a continuing HEP to improve mobility. Case File in 1-275749641, Ex. 26, at 6. The ALJ gave no independent reason to deny the dependent OT visits.

We therefore reverse the ALJ decision.

S.S. (ALJ 1-275930712) - The ALJ denied 10 SN visits and 10 PT visits. ALJ Decision in 1-275930712, at 11. In addition to reciting the same grounds repeated in other cases, the ALJ commented that the referral intake record noted "severe hypertension" but the beneficiary's blood pressure was within normal limits on the SOC OASIS and throughout the SN notes. *Id.* The ALJ's assertion that the beneficiary had "severe hypertension" on an intake sheet appears to be based on misreading a case conference note dated November 10, 2003 which reads as follows: "Admitted a case of an 84 yo female with severe conjunctivitis, htn, and residual weakness. Admitted to hospital due to a fall probably related to syncopal episode as diagnosed." Case File in 1-275930712, Ex. 11, at 2. What was noted as severe was her eye condition, which is consistent with the level 10 pain from which she was noted to be suffering on the SOC OASIS and was monitored on the nursing visits. Case File in 1-275930712, Exs. 12 and 21.

S.S. had recently been released from the SNF to which she was sent after release from her hospital stay. Case File in 1-275930712, Ex. 12, at 2; see also Exs. 10 and 20. The beneficiary's primary diagnosis was atrial fibrillation, along with syncope, hypertension and dementia. *Id.*; see also Case File in 1-275930712, Ex. 9, at 2. The physician ordered SN to assess cardiopulmonary status for signs and symptoms of atrial fibrillation and hypertension, to identify precipitating or predisposing factors in onset of syncope episodes and eye pain, to assess compliance with diet, hydration, medication and safety measures, and to instruct the patient and caregivers on the various disease processes and measures to respond to them. Case File in 1-275930712, Ex. 9, at 2. In addition, nurses were to check vital signs and report if the patient's blood pressure was greater than 140/90 or lower than 90/60. *Id.* At SOC on November 4, 2003, the beneficiary was taking medication for pain at level 10 in the left periorbital eye area. Case File in 1-275930712, Ex. 12, at 5. She had an irregular heartbeat, fatigued easily, required assistance in bathing and transferring and needed an assistive device for ambulation. *Id.* at 6, 9. It is thus evident that, while the beneficiary suffered from hypertension, it was not the primary or only reason for which SN was required. The primary reason was to determine what was triggering syncope with attendant fall risks and try to stabilize her cardiac condition and restore her functional strength to prevent further falls. By the discharge date of December 31, 2003, she was no longer homebound, was no longer in pain, had improved mental function, was independent with all basic ADLs, no longer needed any assistive device to ambulate 4,

5, 8-10. We find nothing in the record to undercut the physician's professional assessment that the beneficiary required SN services to recover from the severe eye problem, monitor her heart condition and ensure her safety in adjusting to the home setting.

The ALJ also noted that the beneficiary received "units of PT and 12 units of OT at the SNF from October 27, 2003 to October 30, 2003." ALJ Decision in 1-275930712, at 11. Apparently, the ALJ drew this information from the original reviewer who states that 12 units of PT were received in the SNF. Case File in 1-275930712, Ex. 7, at 2. This raises a question about the meaning of the repeated references to "units" of therapy, since it is difficult to imagine this beneficiary receiving 24 therapeutic visits in 3 days. The PT notes show problems with fatigue, SOB and head pain, gradual introduction of new exercises for HEP, improvement in balance and safety, and gradual improvement in independence in transferring. Case File in 1-275930712, Ex. 14. The clinical notes do not support the ALJ's conclusion that the beneficiary had not suffered any decline prior to SOC or that PT was provided merely to increase strength or distance walked. The PT notes document that it was necessary to increase the program and train on the HEP slowly because the patient's limitations. Case File in 1-275930712, Ex. 14, at 6-8. The record supports that the PT services were reasonable and necessary to address the beneficiary's medical conditions.

We therefore reverse the ALJ decision.

M.V. (ALJ 1-275756951) - The ALJ denied 6 SN visits, rejecting the appellant's argument that this 99-year old beneficiary had a significant decline in condition demonstrated by 4 hospital admissions in the preceding three months and needed skilled monitoring and caregiver education. ALJ Decision in 1-275756951, at 10. The ALJ noted that the beneficiary had been allowed 13 SN visits after release from a previous hospital admission. *Id.* The ALJ concluded that the beneficiary and her family received sufficient instruction then on the disease process, diet and safety and the current services were "general monitoring of a medically compromised but medically stable beneficiary." *Id.* at 11.

The recertification OASIS notes the repeated hospitalizations; records a primary diagnosis of thoracic spinal compression, with hypertension and dementia; notes SOB on walking more than 20 feet, memory deficit and impaired decision-making in a

beneficiary who is forgetful and disoriented; and rates ALJ levels at minimal to maximum assist. Case File in 1-275756951, Ex. 13 *passim*. She needs hospital bed, bedside commode, and wheelchair or walker for mobility. *Id.* at 7. No changes are identified from the previous period assessment (during which the 13 visits were allowed). *Id.*

The appellant argues that, far from being stable, the patient was in final decline and "actively dying," and weekly SN visits were necessary to coordinate care for complications, monitor skin integrity, and educate the family on her care. Patient Ex. 29. The beneficiary left home health to enter hospice care. Case File in 1-275756951, Ex. 10, at 3; Ex. 11.

The patient is incontinent of bowel and bladder and nursing notes do reflect monitoring of skin integrity to forestall the risk of pressure sores. Case File in 1-275756951, Ex. 14 *passim*. The notes record provision of education but also note needs for continuing intervention and instruction. *Id.*

The documentation indicates that continuing weekly SN visits to the beneficiary was reasonable and necessary to forestall further hospitalizations and maintain her skin integrity, given her fragile condition. We reverse the ALJ Decision.

W.W. (ALJ 1-275741690) - The beneficiary received 7 SN, 12 PT, 1 SW. Within the two weeks preceding SOC, the beneficiary suffered a stroke with altered mental status and daily headaches and has a history of diabetes and cardiac problems. Case File in 1-275741690, Ex. 16, at 2, 5. The SOC OASIS records mental problems including hallucinations, agitation, forgetfulness, sleeplessness, impaired decision-making and paranoia. *Id.* at 11. He is at high nutritional risk having had a 30-pound recent weight change. *Id.* at 10. He has swollen and painful knees, poor conditioning and weakness. *Id.* at 11-12. His PLOF was independent with all basic ADLs, while he now needed assistive devices (cane) or minimal assist for dressing, bathing and ambulating. *Id.* at 12-13, 15. He is assessed as unable to take medication unless administered by someone else. *Id.* at 14. The home health services were discontinued when the patient was admitted to the hospital for a possible stroke. Case File in 1-275741690, Ex. 11, at 8.

The ALJ does not find that SN services were unnecessary or unreasonable for this beneficiary's condition, but instead concludes that the nursing notes do not document performance of the measures called for in the plan of care. ALJ Decision in 1-

275741690, at 11. Specifically, he notes two blood pressure readings at a level which called for notifying the physician but no documentation of physician contact. *Id.* He points to the plan of care called for instruction by SN on breathing exercise, infection control and drug regimen, with several new medications, and states that only one notation is made for administration of one drug and no notes show the required instruction in breathing and infection. *Id.*

There is evidence in the record that the nurse contacted the physician on several occasions, but not about the high blood pressure readings despite awareness of the risk of hypertension. Compare Case File in 1-275741690, Ex. 12, at 3-4, Ex. 18, at 3 with Case File in 1-275741690, Ex. 18, at 1-2. A nurse does advise the patient/caregiver to call a nurse or doctor for any blood pressure reading above 150/90. Case File in 1-275741690, Ex. 18, at 5. Further, while there is evidence of instruction on safety in ambulation and reduction of stress, none of the notes document the other interventions called for on the plan of care.

We conclude that the ALJ properly denied the coverage of the SN services after the initial assessment as not providing the skilled level of services planned for. We therefore cover the initial visit and deny coverage of the remaining 6 SN visit.

The ALJ denied coverage of the PT services on the grounds that the beneficiary did not have "good rehabilitation potential" and the therapy was merely "general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation." ALJ Decision in 1-275741690, at 11. The PT notes certainly make clear that the patient had considerable difficulty with motivation and focus, and the PT therapist records seeking input from his supervisor on dealing with the patient. Case File in 1-275741690, Ex. 19 *passim*. However, the notes also record that, with considerable encouragement, the patient was able to successfully improve his static and dynamic balance, functional endurance, and strength, to learn fall recovery skills, and to reduce the level of assistance needed for his basic ADLs and move from a walker to a single point cane. *Id.* The notes show that the caregiver was trained to encourage a HEP and in safety precautions. *Id.* Given the impact these improvements have in reducing fall risk and regaining functionality, we cannot say that the therapist's assessment in the PT evaluation of "good" rehabilitation potential was erroneous from the point of view of the time the assessment was made. Case File in 1-275741690, Ex. 20, at 1.

We therefore reverse the ALJ on this service and cover the PT visits. The SW visit is also covered since a qualifying service is covered.

4. Physical therapy as only/primary service

Physical therapy services are covered "if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist" and if "reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury." MBPM, Ch. 7, § 40.2.1. Generally, there must be a reasonable expectation of material improvement or a need for skilled services to establish a maintenance program and the nature, amount, duration and frequency of the services must be consistent with the patient's medical needs. *Id.*

M.A. (ALJ 1-275897659) - The ALJ denied coverage for 4 PT visits and 1 OT visit during the 60-day period beginning October 6, 2003. ALJ Decision in 1-275897659, at 10. The ALJ found that the record shows a primary diagnosis of diabetes and additional diagnoses of neurogenic bladder, neuropathy, severe osteoarthritis, hypertension and hypothyroidism, and a gait disturbance with an onset date of October 2003. *Id.* at 9. The beneficiary was discharged from a SNF where she was placed after a hospital stay (the third in one summer) with findings of progressive weakness, especially in her legs, and repeated falls. Case File in 1-275897659, Ex. 25, at 1. The SOC OASIS documents pain at level 3 in her knees and legs, limited range of motion, decreased mobility, a pressure sore on the left buttock, fatigue, edema in both legs, SOB with moderate exertion, and the need for moderate to total assists on basic ADLs. Case File in 1-275897659, Ex. 13, at 5-13. She was chairfast and unable to wheel herself. *Id.* at 10. SN visits were already covered and, at the prior levels of review, some PT visits were found reasonable and necessary but the last 4, after October 24, 2003, remained denied. Case File in 1-275897659, Exs. 4, 7. The reasons the ALJ gave for denial were that the PLOF and CLOF in the OASIS were identical, that by October 24, 2003 the beneficiary could transfer with standby assistance and ambulate with a walker for 20 feet with "contact guard assistance and only one rest break," and that the beneficiary received 19 "units" of PT in the SNF and 8 covered units at home which should have been sufficient for a HEP to be conducted

without a skilled therapist. ALJ Decision in 1-275897659, at 10.

The first reason results from the ALJ's consistently overlooking that the SOC OASIS defines PLOF as the patient's functioning 14 days before the SOC. This beneficiary was institutionalized on that date recovering from weakness and falls. The PT evaluation describes her prior level as capable of ambulating household distances with standby assists, so that the patient clearly lost ground in the current episode. Case File in 1-275897659, Ex. 23, at 1. The PT assessed her potential as good for partial return to her former level with some ongoing assists for ambulation. *Id.* The ALJ does not explain why he considers the level of functioning he describes on October 24, 2003 as adequate to render the additional visits excessive. In the remaining visits, the patient is documented as achieving further improvement in becoming independent in bed mobility, needing only supervision in transferring from bed to wheelchair, standby assist in gait training exercises with the walker, and independently able to continue in a HEP. Case File in 1-275897659, Ex. 22. Finally, the record does not document what PT services were received in the SNF. A level of functioning sufficient to permit the beneficiary to be discharged from institutional care does not necessarily imply that no further skilled services are required. We conclude that the clinical record does not support the denial of the PT services.

The OT visit was not covered because the patient refused the evaluation. Case File in 1-275897659, Ex. 21.

J.B. (ALJ 1-275924093) - This beneficiary received 2 SN visits and 4 OT visits during the period at issue, but the primary service was PT with 7 visits. The record establishes that J.B. was a blind diabetic living with a family member who administered his insulin. Case File in 1-275924093, Ex. 14. He received dialysis three times a week due to renal failure. *Id.* The diagnosis leading to the services at issue was abnormality of gait, accompanied by muscle weakness and complaints of back pain. *Id.* at 1, 5. The ALJ denied coverage for all visits on the grounds that the SN was merely for "general assessments, ongoing observations, and repetitive teaching to a medically stable patient" and the PT on the grounds that the need for PT or OT skilled services was not documented with no proof that his SOC functioning was less than his usual baseline. ALJ Decision in 1-275924093, at 11.²¹

²¹ The ALJ describes this baseline as "being independent with his activities of daily living and functional mobility." ALJ Decision in 1-275924093, at

The appellant argues that the fact that the prior and current levels of functioning are the same on the OASIS is an artefact of the form which requires that the "prior" column report the "patient's condition 14 days prior" to the SOC date. Case File in 1-275924093, Ex. 14, at 12. Patient Ex. 9, in Vol. 1, at 2. The appellant points to the therapists' evaluation and notes, which indicate that the scapular pain and mobility problems resulted from a fall on the stairs. *Id.*; see Case File in 1-275924093, Exs. 20-21. None of the documents makes clear exactly when the fall occurred.

Skilled PT services to address abnormal gait are discussed in the CMS Manual as follows:

Gait evaluation and training furnished a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality require the skills of a qualified physical therapist and constitute skilled physical therapy and are considered reasonable and necessary if they can be expected to improve materially the patient's ability to walk. Gait evaluation and training which is furnished to a patient whose ability to walk has been impaired by a condition other than a neurological, muscular, or skeletal abnormality would nevertheless be covered where physical therapy is reasonable and necessary to restore the lost function.

MBPM, Ch. 7, § 40.2.2. The physical therapist identified the gait deviations as forward flexed trunk, uneven cadence, and uneven stride. Case File in 1-275924093, Ex. 18, at 1. The plan of care called for the patient to reach expected rehabilitation potential for gait, balance and transfer training, to reduce pain, and to increase mobility, coordination and strength to be reflected in ADLs within 4-5 weeks. Case File in 1-275924093, Ex. 9. The PT discharge OASIS shows J.B. as now independent with grooming, bathing, dressing, transferring, ambulation, and laundry, clearly a substantial functional improvement from the SOC OASIS. Case File in 1-275924093, Ex. 15, at 7.

11. In fact, the OASIS assessment shows the beneficiary's prior and current level of function at SOC as requiring some to considerable assistance on all ADLs except eating, toileting, and using the telephone. Case file in 1-275924093, Ex. 14, at 12-14.

The appellant has adequately documented that the skilled services were reasonable and necessary. We reverse the ALJ Decision.

J.C. (ALJ 1-275934711) - The beneficiary received 6 PT visits, 6 OT visits, 7 HHA visits during the period at issue. The ALJ denied coverage as not reasonable and necessary. ALJ Decision in 1-275934711, at 11. He stated that the PT mainly focused on strength, endurance and distance which could have been developed in a home exercise program (HEP) without skilled services after instruction, and the beneficiary had already received PT during two months in a SNF after release from the hospital where she received treatment for a fractured femur. *Id.* He also noted that the PT notes and evaluation identify different hips as the problem. *Id.*

The plan of care called for the PT to establish a HEP, to strengthen extremities, and to provide transfer and gait training with the goals of ambulating safely with walker and performing ADLs with minimal assistance. Case File in 1-275934711, Ex. 9, at 1; see also Ex. 11, at 1. The physician's order indicate that the beneficiary presented near the SOC with a functional decline in ADLs and general weakness and impaired balance. Case File in 1-275934711, Ex. 10, at 4. The SOC OASIS documented intermittent pain in the right hip and leg and her need for assistance from someone else to dress, bathe, transfer, and toilet. Case File in 1-275934711, Ex. 12. The discharge OASIS shows the pain in right hip reduced to a low level once in a while and independence achieved in dressing, transferring and toileting. The ALJ is correct that the PT evaluation notes pain in the left hip, but it also notes problems in gait, balance and ability to transfer. Case File in 1-275934711, Ex. 14. While the progress notes do show work on improving strength, endurance and distance ambulated and development and training in a HEP, they also document training in bed mobility, transfer from bed to chair and sitting to standing, and gait improvement. Case File in 1-275934711, Ex. 15.

The physician's order indicates that J.C.'s functioning in gait and self-care had declined and the PT records indicate that the limited visits provided appropriate skilled services in gait and transfer training and education for a continuing HEP to meet the other identified needs. The record documents that the PT services were expected to and did result in a material improvement in the beneficiary's mobility and ADLs. The appellant has adequately documented that the skilled services were reasonable and necessary. We reverse the ALJ Decision.

J.G. (ALJ 1-275934469) - The beneficiary received 5 PT visits during the period at issue. The ALJ denied coverage as not reasonable and necessary. ALJ Decision in 1-275934469, at 11. The ALJ rejected the appellant's argument that the beneficiary needed the additional PT visits because he responded slowly due to advanced age (89 years old). *Id.*; *cf.* Patient Ex. 23, in Vol. I, at 1-2. The ALJ stated (without citing any evidence) that "by January 16, 2007, the documentation demonstrates that sufficient therapy was provided as of that point and the beneficiary demonstrated increased strength in both his legs," so that a HEP could have been used for him to continue to build strength and endurance. ALJ Decision in 1-275934469, at 11.

J.G. had a history of falls, had been released from a SNF and admitted to home health care on December 26, 2006 with a diagnosis of abnormality of gait and the contract allowed 6 SN and 6 PT visits prior to January 17, 2007, leaving 5 PT visits not covered. Case File in 1-275934469, Ex. 2, at 3. He had slow-healing wounds on his back, suffered from daily intractable pain in his lower back and right knee for which he received various pain medications, had pitting edema in the right foot, scoliosis of the back, and used a wheelchair and a front-wheeled walker. Case File in 1-275934469, Ex. 11, at 1, Ex. 13, at 1, Ex. 14, at 2, 5, 8, and 13. The beneficiary was assessed with a very high fall risk (scoring 40 points where anything over 15 called for fall precautions), and among the interventions in the SOC OASIS was a referral for PT to address home safety and falls prevention, gait training, therapeutic exercise and development of a HEP. Case File in 1-275934469, Ex. 14, at 15-17. At the discharge OASIS dated February 14, 2007, J.G. had improved levels of independence with basic ADLs and was no longer suffering from intractable pain. Case File in 1-275934469, Ex. 15, at 2, 7-8. The PT reports do document the gradual improvement in knee pain and increasing leg strength, but also continuing work on balance, gait and transfer training. Case File in 1-275934469, Ex. 21 *passim*. The reports from the 5 visits remaining at issue do not show any abrupt change before and after January 16, 2007 and record continued work on shuffling gait and negotiating steps and determining that J.G. was able to follow on with HEP thereafter. *Id.* at 5-10.

The record documents that the PT services were expected to and did result in a material improvement in the beneficiary's fall safety, mobility and ADLs. The appellant has adequately documented that the additional PT services were reasonable and necessary. We reverse the ALJ Decision.

F.G. (ALJ 1-275933356) - The beneficiary received 7 PT visits and 3 OT visits during the period at issue. The ALJ denied the PT services as not warranted but the QIC reconsideration (with which the ALJ said that he agreed) indicates that the PT services were allowed and not included in the unfavorable decision which was limited to the OT visits. ALJ Decision in 1-275933356, at 11. We therefore reverse the ALJ as to the PT visits.

The ALJ denied the OT on the grounds that an OT visit on October 13, 2004 (prior to his hospitalization from October 16-21, 2004) showed him as "independent with daily activities" so that OT intervention was not reasonable. ALJ Decision in 1-275933356, at 11. The OT assessment of October 13, 2004 actually shows the beneficiary requiring assistance with ADLs and with a goal of increasing them to independent with improved balance, safety, and endurance and reduced pain. Case File in 1-275933356, Ex. 20, at 2. That goal is shown as achieved on the visit of October 25, 2004 and patient was discharged with goals met. *Id.* at 3. The 3 OT visits are reasonable and necessary.

W.J. (ALJ 1-275912711) - The beneficiary received 2 SN visits during the period at issue, but appellant offers no argument for their necessity given that only one nursing note is in the record which reports that the patient and caregiver already knew how to manage his long-standing diabetes independently. Case File in 1-275912711, Ex. 16, at 1. The SN visits are therefore not reasonable or necessary and the primary issue is coverage of 12 PT visits received in the same timeframe.

The ALJ noted that W.J. had been in a SNF for three months and received PT and OT services there. ALJ Decision in 1-275912711, at 11. The ALJ also concluded that inconsistencies and omissions in the OASIS and PT evaluation make it impossible to assess functional ability changes.²² *Id.* The discrepancy on which the ALJ focuses relate to the target distance for ambulation (set as 200+ feet in his OASIS but at 30 feet with walker in his PT evaluation), whereas he was noted as ambulating 40 feet with walker two days later apparently already meeting

²² The ALJ also comments that "[i]nterestingly" the beneficiary lives on the third floor but goes to dialysis three days a week "using his wheelchair to ambulate up and down stairs with the help of his son." ALJ Decision in 1-275912711, at 11. It is not clear why the ALJ is interested in the ability or willingness of the beneficiary's son to roll his wheelchair up and down three floors in their walk-up apartment building in order that the father might receive life-saving dialysis treatments. This circumstance does not undercut the evidence of the beneficiary's functional limitations.

his goal. *Id.* The omission was the failure to note ADL levels in the SOC OASIS. *Id.*

W.J. had diagnoses of ESRD, diabetes, and congestive heart failure but these were largely well controlled, whereas he was recorded with a severity rating for 3 for abnormal gait. Case File in 1-275912711, Ex. 7, at 2. The SOC OASIS noted that he needed assistance from his caregiver (the son with whom he lived) several times during the day and night and that he needed assistance with all ADLs. *Id.* at 4. As the ALJ noted, the form is not completed to show the specific levels of assistance required for each ADL, although it does record his need for a walker or wheelchair. *Id.* at 12-13. The SOC OASIS does not refer to a goal of walking 200+ feet, but only a general of returning to PLOF without specifying as of what point in time. *Id.* at 16. The PT evaluation noted that the patient had been able to ambulate 200 feet or more in September 2003 "before infection and hospitalization," which the QIC and the ALJ apparently related backward as the PLOF to which the SOC OASIS must have been referring. Case File in 1-275912711, Ex. 17, at 1. This is not a reasonable reading. The PT evaluation provides specific measurable standards for the beneficiary's functioning at SOC, including needing moderate to maximum assist to ambulate ten feet with walker and to transfer from sitting to standing, poor standing balance, strength of 2 - 2+ in his extremities and pain in shoulders and knees. *Id.* The functional status of the individual ADLs is rated and diabetic neuropathy noted. *Id.* While it is true that on a visit two days later, W.J. was able to ambulate 40 feet with his walker, the distance dropped on the following visit and then gradually improved with notations that on some days the patient had greater pain or dizziness interfering with walking. Case File in 1-275912711, Ex. 18 *passim*. Contrary to the ALJ's statement, the PT discharge summary suffices to show that improvement toward goals took place, in that the distance ambulated rose to 50 feet with walker, less caregiver assistance was needed for ambulation and transfer from sitting to standing, balance had improved somewhat, and the patient had mastered a home exercise program. The PT visits are covered as reasonable and necessary.

G.K. (ALJ 1-275912409) - Nine SN visits and 6 PT were denied for the relevant time period. (The reconsideration noted that 4 previous PT visit had been allowed as necessary to instruct P.G. and his caregivers in a HEP. Case File in 1-275912409, Ex. 3, at 3.) The ALJ described the case as an "example of poor documentation" and pointed out that the beneficiary had received "128 units" of PT during his stay in a rehabilitation before his

release to home health. ALJ Decision in 1-275912409, at 11-12. The appellant offers no explanation for the SN services, but notes that the beneficiary faced different challenges in a home environment and needed to be transported three times a week for dialysis. Patient Ex. 34, in Vol. 1, at 1. While the documentation is less than perfect, the PT notes for the 6 visits show training of patient and caregiver in techniques to safely transfer into and out of car to travel for dialysis, to move to standing position, to improve gait and endurance, and ambulate safely on different surfaces using walker/wheelchair. Case File in 1-275912409, Ex. 19 *passim*. They report improved functionality in all these areas, which are reasonable goals for the beneficiary's situation, reflecting the PT evaluation and gait abnormality was reported as resolved to maximum rehabilitation possible on the discharge summary. Case File in 1-275912409, Exs. 14, 20. The SN visits are not covered but the PT visits are reasonable and necessary.

M.K. (ALJ 1-275908701) - The beneficiary received 12 PT visits during the period in question after his release from The ALJ recites information about a SOC OASIS mentioned by the contractor reviewers but no SOC OASIS appears in the record. Compare ALJ Decision in 1-275908701 with Case File in 1-275908701, Ex. 7, at 1-2. The plan of care indicates initial diagnoses of abnormal gait, lumbago, muscle weakness, anemia and partial blindness, with functional limitations in endurance and ambulation. Case File in 1-275908701, Ex. 9, at 1. A hospital discharge record indicates that M.K. had been released the previous month after an infectious disease episode causing altered mental status. Case File in 1-275908701, Ex. 12. The ALJ found that he had just left an extended care facility where he received rehabilitation.

PT is ordered to establish a HEP and provide training on bed mobility, balance, transfer, and gait using a wheeled walker. *Id.* The goals were to be able to transfer independently or with supervision, to ambulate safely without assistive device, to decrease pain in back and ankles, and to improve balance and gait by time of discharge. *Id.* at 1-2. The PT plan of care included measurable status and outcome goals. Case File in 1-275908701, Ex. 13; see also Ex. 14. PT visit notes show small but appreciable improvements in measured goals, including with transfers and ability to ambulate in home with only hand-held assist, and notes absence of pain and improved mobility on all ADLs. Case File in 1-275908701, Ex. 15; see also Ex. 16, at 10 (discharge OASIS). The omission of the SOC OASIS from the record on appeal obscures the trigger for M.K.'s entry into home

health. The documents undercut the ALJ's assertion that no change occurred in the beneficiary's functional abilities for transferring and ambulation. *Cf.* ALJ Decision in 1-275908701, at 11. The services received were reasonable and necessary and the ALJ decision is reversed.

F.K. (ALJ 1-275926213) - The ALJ denied coverage for 6 PT visits after 4 PT visits were allowed at the redetermination level for development of a HEP. ALJ Decision in 1-275926213, at 11. The ALJ concluded that no credible evidence supported the appellant's claim that correcting a gait disturbance (ataxic gait) required a skilled therapist and that the additional PT was merely to improve strength, activity tolerance and distance walked which can be done through a HEP. *Id.*

CMS has the following policy relating to gait training:

Gait evaluation and training furnished a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality require the skills of a qualified physical therapist and constitute skilled physical therapy and are considered reasonable and necessary if they can be expected to improve materially the patient's ability to walk. Gait evaluation and training which is furnished to a patient whose ability to walk has been impaired by a condition other than a neurological, muscular, or skeletal abnormality would nevertheless be covered where physical therapy is reasonable and necessary to restore the lost function.

* * *

Repetitive exercises to improve gait or to maintain strength and endurance and assistive walking are appropriately provided by nonskilled persons and ordinarily do not require the skills of a physical therapist. Where such services are performed by a physical therapist as part of the initial design and establishment of a safe and effective maintenance program, the services would, to the extent that they are reasonable and necessary, be covered.

MBPM, Ch. 7, § 40.2.2.C. This beneficiary was released to home health after about three weeks in a SNF with diagnoses including pneumonia and gait disturbance. Case File in 1-275926213, Ex. 11, at 2. THE SOC OASIS documents SOB when walking more than 20 feet or climbing stairs, substantially reduced levels of functioning in bathing, ambulation, and other ADLs from PLOF,

and use of a walker. *Id. passim*. The PT evaluation indicates ataxic gait with minimal assistance and walker for 20 feet on even surface and impaired leg strength and balance and coordination. Case File in 1-275926213, Ex. 15. Visit reports show balance training, and gait training performed by the therapist, as well as HEP instruction, although the measurable entries in the notes focus on improvements in ambulatory distance and in strength. Case File in 1-275926213, Ex. 16.

Clearly, gait and balance training require skilled therapy to design and establish, but at some point repetitive exercises to improve gait can be taught for a HEP. Indeed, the penultimate PT report plans discharge with HEP encouraging further gait improvement, among other things. Case File in 1-275926213, Ex. 16, at 8. At discharge, she was noted not only as ambulating much further, however, but as doing so without any assistance or device and as having improved dynamic stability enough to reduce fall risk. Case File in 1-275926213, Ex. 17. While much improvement occurred in the earlier visits, however, the visit reports at issue speak to working on motor control, gait cadence, mechanics on uneven terrain, introduction of fall recovery and stairs, and show a continued need for intervention on balance until the last visit. *Id.* Overall, the documentation supports the need for the additional 6 PT visits and the ALJ decision is reversed.

B.M. (ALJ 1-275918621) - The ALJ denied coverage for 5 PT visits on the grounds that these visits (after February 18, 2004) were "mainly focused on increasing strength, endurance and distance ambulated" which did not require a skilled therapist. ALJ Decision in 1-275918621, at 11. (Another 8 PT visits as well as 9 SN visits were covered at the redetermination level.) B.M. was discharged from the hospital on January 21, 2004 after treatment for respiratory failure and COPD, and had other diagnoses including diabetes and generalized weakness, as well as impaired decision-making. Case File in 1-275918621, Ex. 13, at 2. He was short of breath with minimal exertion, had shallow breath sounds and required oxygen. *Id.* at 6. He used a wheelchair or walker and was initially unable to do any upper or lower extremity exercises, so the focus was on teaching him to change from using accessory muscles for breathing to using his diaphragm. Case File in 1-275918621, Ex. 14, at 1; Ex. 15 *passim*. His PT assessment records multiple areas of deficit in kinesthetic awareness, safety judgment, strength of all four limbs, gait problems, endurance and balance. Case File in 1-275918621, Ex. 16, at 1-2. By February 19, the PT notes shows that patient "is still forgetting proper technique for

diaphragmatic breathing but states he is getting better at it," and is now able to do two sets of 5 repetitions of therapeutic and balance exercises as well and has moved from 0 ambulatory distance to 20 feet. Case File in 1-275918621, Ex. 15, at 8. On that date, the physician ordered three additional PT visits. Case File in 1-275918621, Ex. 10, at 3. Each visit saw an increase in repetition; bed mobility training could be discontinued first and then bed to chair transfer training (presumably as he was able to master those abilities.) *Id.* at 8-10. By the final visit, the patient is able to remember the proper technique for breathing, has a HEP on which he and the caregiver have been educated, and is now able to ambulate 45 feet with his walker. *Id.* at 11; see also Ex. 14, at 1. The clinical records supports that the additional PT visits were reasonable and necessary and we therefore reverse the ALJ decision.

B.M. (ALJ 1-275685890) - This beneficiary had received 7 covered PT visits during the preceding coverage period and then received one PT visit in the period November 4-26, 2004 which the ALJ denied on the grounds that "the documentation does not support the need to restart PT services" after the beneficiary was discharged a month earlier. ALJ Decision in 1-275685890, at 11. The ALJ also stated that the beneficiary's goal "to get better" was too vague to show an expectation that she would improve materially. *Id.*

In fact, the documentation shows that the "recertification was for rehab (PT) [secondary] to recent fall." Case File in 1-275685890, Ex. 17, at 2. The recertification OASIS shows daily (but not constant) pain in lower extremities at level 4 exacerbated by ambulation and SOB with moderate exertion. The initial PT visit assessment showed minimal to moderate assistance needed for bed mobility, transfers, dressing and other ADLs, ambulation of 20 feet with a wheeled walker, poor dynamic balance and less than fair static balance, and problems with strength, endurance and gait safety. Case File in 1-275685890, Ex. 13, at 1. The goals set by the PT assessment were to improve standing balance to fair to good; increase leg strength from 3 to 4 on a scale of 1-5; and improve gait using the walker to 100 feet with standby assist. PT was discontinued after the first assessment visit because the beneficiary was hospitalized after chest pain. Case file in 1-275685890, Ex. 10, at 4.

We find no merit to the ALJ's conclusions that the cause for renewed PT services was not documented or that the goals were vague. We therefore reverse the ALJ decision.

M.M. (ALJ 1-275905814) - The ALJ denied coverage of 1 SN visit and 3 PT visits after June 30, 2007 (noting that 9 PT visits were paid in the preceding period) on the grounds that the documentation "does not show that there was a reasonable potential for the beneficiary to have a medical complication or any predictable skilled care needs" and that "the nursing notes indicate that generalized observations, ongoing assessments, and repetitive teaching were provided." ALJ Decision in 1-275905814, at 9-10.

The physician sought SN and PT evaluations due to ligament injury, two falls and difficulty walking. Case File in 1-275905814, Ex. 12, at 2. She had had a previous hospital admission and SNF discharge due to falls, and after another recent fall, she reported feeling weaker. Case File in 1-275905814, Ex. 13, at 1 (multidisciplinary care conference). SOC OASIS showed that the patient needed assistance with transferring and used a walker to ambulate. Case File in 1-275905814, Ex. 10, at 12. The patient had a history of total knee replacement and multiple falls and was experiencing intractable pain in the right shoulder and both knees made worse by movement or ambulation and requiring breakthrough medication two to three times a day. *Id.* at 2, 5. She was assessed with weakness in her lower extremities, reduced range of motion in her knees, and functional limitations in endurance and ambulation. *Id.* at 11-12. The SN visit was for assessment only and resulted in instruction to the patient on preventing further falls and injuries and management medications and a recommendation for PT for balance, gait training, and strength. *Id.* at 15. The ALJ's comments on "ongoing assessments and repetitive teaching" shown in "nursing notes," are inconsistent with the record. The physician agreed with the evaluation that no further SN services were needed (nor were any provided) but that PT was needed for gait training, balance, endurance, safety and strength. Case File in 1-275905814, Ex. 12, at 3-4.

The ALJ characterized the PT after June 29, 2005 as focusing only on increasing strength, endurance and ambulating distance which do not require skilled services and as lacking objective measures of pain or strength. ALJ Decision in 1-275905814, at 10. The post-June 29, 2005 PT visit notes report provision of training in ADLs, transfer, gait and balance, work on active range of motion, changing stride length to increase safety, and

focus on fall prevention with safe use of a quad cane. Case File in 1-275905814, Ex. 15, 9-11. The last note states that the patient is now independent with cane and is discharged with goals met. *Id.* at 11. The record does not disclose a reason why the last three PT visits were not reasonable and necessary to achieving that goal. The documentation amply supports the appellant's assertion that the physician and therapist were responding to the potential for further falls with the obvious risks of additional injuries given the patient's documented history and age (74). Patient Ex. 2, in Vol. 2, at 1-2.

We reverse the ALJ Decision.

C.P. (ALJ 1-275927205) - This beneficiary received 1 SN visit at which the SOC OASIS was performed and blood drawn. No further SN services were provided, although they were called for in the physician's plan of care, because the caregiver declined them. Case File in 1-275927205, Ex. 12, at 1; Ex. 13, at 2, 4. As mentioned earlier, an initial evaluation visit is an administrative cost of the home health agency if the beneficiary is not determined to be suitable for home health but is covered as the first home health visit if the beneficiary is suitable and services are provided. Venipuncture for blood tests does not alone justify coverage of a SN visit unless other skilled services are needed. Thus, CMS explains that -

[V]enipuncture for the purposes of obtaining a blood sample can no longer be the sole reason for Medicare home health eligibility. However, if a beneficiary qualifies for home health eligibility based on a skilled need other than solely venipuncture (e.g., eligibility based on the skilled nursing service of wound care and meets all other Medicare home health eligibility criteria), medically reasonable and necessary venipuncture coverage may continue during the 60-day episode under a home health plan of care. Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act specifically exclude venipuncture, as a basis for qualifying for Medicare home health services if this is the sole skilled service the beneficiary requires. However, the Medicare home health benefit will continue to pay for a blood draw if the beneficiary has a need for another qualified skilled service and meets all home health eligibility criteria.

MBPM, Ch. 7, § 40.1.2.13.

Therefore, whether the SN visit is covered depends on whether other qualifying home health services were covered, specifically

here 6 PT visits. (The additional 5 OT visits and 1 SW visit are dependent on whether the qualifying PT services were covered.)

The ALJ denied coverage of the PT visits stating that the documentation did not show "a significant decline or change in the beneficiary's functional ability at the time of the initial PT evaluation from his usual baseline," that he had already received "93 units of PT and 90 units of OT" in a SNF, and that the PT documentation contained discrepancies. ALJ Decision in 1-275927205, at 11.

The appellant argued that this 78-year old was hospitalized for hip surgery in April before which he was independent with all ADLs and mobility, now needs a walker, cane bedside commode, and shower bench, and has a history of falls and fracture and a prior heart attack. Patient Ex. 13, in Vol. 2, at 1-2; Ex. 14, at 1. He had just returned home from the rehabilitation center, and faced "numerous conditions" in home not presented in the SNF setting, such as carpeting, narrow doorways, and small bathrooms, so that "the home therapy program finishes the process started in the rehab center" but is not replaced by it. *Id.*

The SOC OASIS shows a new diagnosis in preceding two weeks of atrial fibrillation, with the primary diagnoses for home health being muscle weakness, anemia, and hip pain and relevant history of cardiac problems and right hip replacement post fracture. Case File in 1-275927205, Ex. 11, at 1-2. The beneficiary is documented as having daily intermittent pain in his back and right hip ranging up to level 5 and made worse by movement and ambulation. *Id.* at 5. He is assessed as needing a walker for ambulation, assistance of another person or a device for bathing and transferring, and unable to do light meal preparation, laundry, housekeeping or shopping. *Id.* at 12-13.

The ALJ does not explain the basis for his assertion that C.P. had not experienced a change from his "usual baseline" necessitating PT services. Possibly the comment was based on the fact that the prior and current level of functioning in ADLs were the same in the SOC OASIS. *Id.* at 12-13. Such a perspective ignores the fact that the OASIS asks for prior level of functioning "14 days prior to state of care date." *Id.* at 12. In this case, it is documented that the hip replacement surgery caused a major change from the beneficiary's "usual baseline" and that the preceding months were spent in a rehabilitation SNF in order to partially regain previous functional abilities. The

change that occurred immediately prior to SOC was not a loss of function but a gain in function adequate to permit him to return to a home setting from the institutional placement. The ALJ does not identify any legal authority for the proposition that a decline in function immediately before home health is a prerequisite to coverage of otherwise needed services for a recently de-institutionalized beneficiary.

The other main reason given by the ALJ for denying coverage - that PT and OT services were provided in the SNF - does not, in itself, demonstrate that the beneficiary already received all reasonable and necessary services prior to his discharge. This determination requires a case-specific assessment of the medical condition of the beneficiary on entering and leaving the facility, the nature of the remaining deficits and likelihood of further recovery of function, the kind of services still needed and whether they demand a skilled therapist, and so on. The ALJ undertook no such analysis (either in this case, nor many others already discussed). The significant improvement documented from PT by discharge suggests that 6 PT and 5 OT visits were not excessive in facilitating safe adjustment to the home environment and helping the beneficiary approximate his actual baseline in independent functioning.

The ALJ does not explain what he considers to constitute a discrepancy leading to him to question coverage of the services. The rating of ADL levels in the SOC OASIS performed by the nurse are not identical to the PT evaluation, which shows a need for standby assistance for bed mobility, transfers and dressing, and minimal assistance for bathing, feeding, and meal preparation. *Compare* Case File in 1-275927205, Ex. 12-13, with Ex. 19.²³ The PT evaluation agrees that the beneficiary needs a walker for ambulation, but adds that he can manage uneven surfaces and steps with standby assistance (questions not asked in the OASIS form) and uses a hemiplegic gait. Case File in 1-275927205, Ex 19. The two forms break down the ADLs into different groupings - for example, the OASIS form does not assess bed mobility apart from transferring, while the PT form divides it into 3 specific

²³ The OT evaluation again breaks down ADLs differently (distinguishing bathing the upper and lower body for example), rates them on a different six-point scale, and was performed on a third day. Case File in 1-275927205, Ex. 22, at 1. We therefore similarly find no discrepancy in the evaluation there of moderate assistance needed for bathing the lower body and minimal for bathing the upper body. While PT and OT differ in their rating of bed mobility and transfers, those differences do not undercut the OT conclusion that the beneficiary suffered from deficits in ADLs, transfer ability, and range of motion/strength, and needed training in safety, energy conservation, and a HEP. *Id.* at 2.

movement abilities. They provide different ratings for levels of independence with each ADL and define the levels differently. They are designed by and for the concerns of different disciplines despite including a number of overlapping areas. In addition, these particular forms were completed on different visits five days apart, so it is entirely possible that the beneficiary's level of functioning or observed condition differed slightly. We see nothing in the way the two forms were completed that undercuts the conclusion of the PT evaluator (adopted by his doctor) that the beneficiary was at risk for further falls due to impairment in his leg coordination and weakness. Case File in 1-275927205, Ex. 19.

PT notes record teaching on safety issues, techniques for hand and foot placement during transfers, self-pacing, stair training, and balance and strength improvement. Case File in 1-275927205, Ex. 18. PT discharge noted improvement in strength and standing balance, independent ability with walker and on stairs up to 3 steps, and increased safety awareness. Case File in 1-275927205, Ex. 17. The OT notes reflect carrying out the plan for ADL retraining, functional transfer, balance and safety training, and therapeutic exercise, as well as addressing environmental hazards like clutter. Case File in 1-275927205, Exs. 18, 20. On discharge, the OT summary stated that his strength had improved, he was now independent with his ADLs and ambulation with his walker with improved standing balance and able to do light home management tasks. Case File in 1-275927205, Ex. 20.

The clinical record support that the beneficiary needed and benefited from the services provided and has no basis to conclude that the visits were excessive. We therefore reverse the ALJ decision.

M.R. (ALJ 1-275930580) - This 92-year old beneficiary received 4 SN visits but the primary home health services were 10 PT visits. The ALJ gave no specific reason beyond the usual recitation for denying the SN, but opined that the PT documentation was conflicting. ALJ Decision in 1-275930580, at 11.

The SOC OASIS indicates that the patient was released from a rehabilitation where she was treated for a hip fracture and atrial fibrillation, used a pacemaker, and now presented with abnormal gait and limited range of motion in that joint. Case File in 1-275930580, Ex. 13, at 2, 5. She had memory deficits, forgetfulness, confusion in new situations, and anxious on a

daily basis. *Id.* at 8-9. She was SOB on moderate exertion and had fallen from a prior level of independence to complete dependence on others for dressing and bathing, unable to transfer herself, unable to participate in any housekeeping, laundry or shopping, and using a bedside commode and wheelchair. *Id.* at 7, 9-11. She was assessed at high risk for falls with impaired physical mobility. *Id.* at 13. SN was planned to monitor for medical condition and instruct the patient and caregiver on safety, medications and disease management and PT was planned to "regain ambulation" for the patient, improve ADLs and establish a HEP. Case File in 1-275930580, Exs. 9, 14.

The PT evaluation, however, shows the beneficiary as needing only minimal assist for dressing, transfers, and bathing and only moderate assist for meal preparation and home making. Case File in 1-275930580, Ex. 10, at 1. She is able to ambulate 10 feet with a walker, but has poor standing balance and lacks a HEP. *Id.* These discrepancies, noted by the ALJ, are substantial enough to raise some question about the actual status of the beneficiary and her needs on start of care. The appellant argued that the patient's age after a hip fracture made slower progress unavoidable and that the return to a home necessitated assistance to cope with new obstacles to mobility. Patient Ex. 17, at 2. The therapist does report "steady but slow progress," and transfer and balancing training, along with instruction on a HEP. Case File in 1-275930580, Ex. 15, at 5. On December 12, 2003, M.R. was hospitalized with pneumonia. Case File in 1-275930580, Ex. 16. As a result, no discharge assessment was made to document where the patient was in relation to the two SOC assessments or the goals set.

The ALJ also relied on the beneficiary's receipt of PT and OT services in the SNF. ALJ Decision in 1-275930580, at 11. In this case, a PT note from the SNF is in the record and indicates that the patient was then at moderate to maximum assist and had received short-term PT, but had the potential to make further improvements. Case File in 1-275930580, Ex. 20.

While it is clear that 4 SN visits were reasonable and necessary to ensure safe management of the patient's disease process, fall risk, and medications on release from the SNF, it is less clear what number of PT visits were appropriate based on this documentation. We conclude that the ALJ decision should be modified to provide coverage for 4 SN visits and 4 PT visits, which would ensure sufficient time to teach a HEP since the PT documented that the beneficiary did not have such a program on discharge from the SNF.

R.W. (ALJ Decision in 1-275736766) - We found above that this beneficiary was homebound, but the ALJ also denied her 4 SN visits and 10 PT visits as not reasonable and necessary because skilled services were not warranted. ALJ Decision in 1-275736766, at 11. The primary diagnosis leading to the home health referral was knee weakness and pain rated as poorly controlled with existing treatment, according to the SOC OASIS. Case File in 1-275736766, Ex. 9, at 2. Additional diagnoses included abnormal gait, osteoarthritis and hypertension. Case File in 1-275736766, Ex. 11, at 1. The beneficiary was not recently discharged from any institutional placement and had not had a change in treatment or condition in the preceding two weeks except onset of a need to use an assistive device (walker) to ambulate. Case File in 1-275736766, Ex. 9, at 1-2, 9-10, 12. The pain was described as chronic at level 3/10 and precipitated by mobility. *Id.* at 5

On discharge the pain level was reduced to 1-2/10 but the patient still required a walker. Case File in 1-275736766, Ex. 10, at 2, 6. The SN services were planned to provide assessment of all systems and educate patient and caregivers on pain control, diet, medication compliance, and safety and self-care issues. Case File in 1-275736766, Exs. 12-14. The nursing notes show assessments of pain level and instructions on pain management and avoidance, noting that medication did not relieve pain. Case File in 1-275736766, Ex. 15, at 1-3. The first and second post-OASIS visits note a continuing need for more instruction and the third indicates that the patient was not in pain and verbalized understanding. *Id.* The patient then requested discontinuation of SN visits. Case File in 1-275736766, Ex. 12, at 4.

The PT evaluation took place 3 days after the SOC OASIS assessment and documented pain at level 4-5/10 in the right knee and lower back. Case File in 1-275736766, Ex. 16. The patient was assessed with multiple gait abnormalities, including uneven stride and cadence, wide base, and forward flexed trunk. *Id.* at 1. She was able to ambulate only 10 feet on even surfaces with a walker. The PT plan was to begin with training for bed mobility, transfers, and gait, safety education, and development of a HEP, with a goal of independence in bed mobility and transfers (from minimal assist) and improved gait, balance and safety. *Id.* at 2. The PT notes reflect instruction on HEP but also introduction of specific techniques and training at each session. Case File in 1-275736766, Ex. 17 *passim*. At discharge, the PT reported complete resolution of bed mobility,

transfers, balance and safety problems and improved gait on uneven surfaces and longer distance, and discharged her with a HEP. Case File in 1-275736766, Ex. 18.

The ALJ is correct that the documents do not reveal the onset date of the chronic knee pain, but the ALJ does not identify a requirement that home health services be provided within any specific time period after onset. The pain was not successfully controlled with the existing therapy so the situation was unresolved at SOC, and it was reasonable to assess whether skilled PT services could improve the pain to at least a manageable level. Therefore, at least the assessment visits of SN and PT would be covered. Three more SN visits to assess and monitor the disease processes, pain levels and triggers, medication compliance and safety were a reasonable response to the identified risk of falls and further injury. The PT services were provided with reasonable goals for improving her functioning in ways that required skilled services in addition to the development and teaching of a HEP.

We reverse the ALJ decision.

4. Cases adopted without detailed discussion

The ALJ Decisions relating to the beneficiaries listed below contain adequate rationales supported by sufficient documentation in the records. We therefore adopt those decisions without further discussion: G.C. (ALJ 1-275929891); P.H. (ALJ 1-275913076); and E.I. (1-275912826).

5. Modification regarding waiver of liability

As discussed above, the Act provides that a beneficiary or supplier may be held liable for items or services that are not covered under section 1862(a)(1) of the Act, when they knew or could reasonably have been expected to know of the noncoverage. Section 1879(c) of the Act. A beneficiary is deemed to have knowledge of noncoverage only based upon prior written notice or evidence of actual knowledge, whereas a provider or supplier is presumed to have knowledge of noncoverage based upon various notices to the medical community. CMS Rulings 95-1.IV.B.2, *citing* 42 C.F.R. § 411.406 and 95-1.IV.A, *citing* 42 C.F.R. § 411.404; MCPM Ch. 30, §§ 40.1, 40.2, 40.3.

In post-payment review cases, when a determination is made that Medicare will not pay for noncovered services under section 1879, an overpayment has occurred. Section 1870 of the Act

provides authority for recovering overpayments made to providers or other persons. Recovery of an overpayment can be waived when the provider or person is found to be "without fault" in creating the overpayment. Section 1870(b) of the Act; Medicare Financial Management Manual (MFMM)(Pub. 100-06) Ch. 3, § 70.3; see also MFMM Ch. 3, § 90 ("A provider is liable for an overpayment unless it is found to be without fault.") A provider is liable for an overpayment when it billed for services that the provider should have known were non-covered. *Id.* § 90.1.H, *cross-referencing* MCPM Ch. 30 (limitation on liability provisions).

For those cases discussed above in which the Council has adopted the ALJ decision or modified the ALJ decision in a manner which retains any unfavorable conclusions, we have agreed with the ALJ that the relevant home health services were not reasonable and necessary under section 1862(a)(1)(A) of the Act. The Council found no evidence, however, that the appellant had given any beneficiary prior written notice of non-coverage, as required to establish beneficiary liability under 1879 of the Act. We therefore further modify all ALJ decisions for which unfavorable conclusions on overpayment continue in effect to hold that the appellant, not any beneficiary, is liable for the non-covered services under section 1870 of the Act, based upon Medicare issuances to the medical community. The Council also finds that the appellant is not without fault and is liable for the overpayments under section 1870 of the Act.

CONCLUSION

It is the decision of the Medicare Appeals Council that the ALJ decisions at issue be modified or reversed in accord with the instructions set forth in the previous sections.

MEDICARE APPEALS COUNCIL

/s/ Leslie Sussan
Member, Departmental Appeals Board

/s/ Constance B. Tobias
Chair, Departmental Appeals Board

Date: September 14, 2009