DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
Alta Bates Summit Medical Center (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiary)	Multiple (see attached) (HIC Number)
National Government Services, Inc. (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued three decisions dated April 23, 2009 concerning claims for inpatient rehabilitation hospital services provided to three beneficiaries by Alta Bates Summit Medical Center. The ALJ determined in each case that the claims did not qualify for Medicare coverage because he found that the record did not sufficiently demonstrate that each beneficiary needed hospital-level care, even though each may have benefited from the intense rehabilitative therapy. The appellant has asked the Medicare Appeals Council to review this action. For the reasons explained below, the Council reverses each of the ALJ decisions.

STANDARD OF REVIEW

The Council reviews the ALJ decisions de novo. 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's action to the exceptions raised by the party in the request for review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c).

APPLICABLE LEGAL AUTHORITY

In-patient rehabilitation facility (IRF) services are a form of hospital services covered under Part A of the Medicare program. Social Security Act (Act) §§ 1811, 1812. Coverage is limited to services that are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member . . ." Act § 1862(a); see also 42 C.F.R. § 411.15(k)(1). "Hospital" includes an institution where physicians provide or supervise the provision to inpatients of "rehabilitation services for the rehabilitation of injured, disabled, or sick persons." Act § 1861(e)(1); see also 42 C.F.R. § 409.3. The Centers for Medicare & Medicaid Services (CMS) has issued guidance on coverage of IRF services in the Medicare Benefit Policy Manual (MBPM). Section 110.1 provides that an IRF stay may be based on circumstances that are generally agreed to justify a medical or surgical patient's hospitalization, but may also be justified in some cases when --

> a patient's medical or surgical needs alone may not warrant inpatient hospital care, but hospitalization may nevertheless be necessary because of the patient's need for rehabilitative services. Patients needing rehabilitative services require a hospital level of care, **if they need a relatively intense rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade their ability to function**. There are two basic requirements that must be met for inpatient hospital stays for rehabilitation care to be covered:
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> 1. **The services must be reasonable and necessary** (in terms of efficacy, duration, frequency, and amount) for the treatment of the patient's condition; and
> 2. **It must be reasonable and necessary to furnish the care on an inpatient hospital basis, rather than in a less intensive facility such as a SNF, or on an outpatient basis**.
>
> Medicare recognizes that determinations of whether hospital stays for rehabilitation services are reasonable and necessary **must be based upon an assessment of each beneficiary's individual care needs**. Therefore, denials of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms, "the three hour rule," or any other "rules of thumb," are not appropriate.

MBPM, Ch. 1, § 110.1 (emphasis added). In addition to the two basic requirements, the IRF "must have physician orders for the patient's care" and pre-admission screening must be performed. MPBM, Ch. 1, §§ 110.2 & 110.2.1. (It is not disputed that the appellant met both of these provisions in regard to all three cases.) Medicare will cover in-patient assessments (which may include provision of therapy), "if preadmission screening information indicated that the patient had the potential for benefiting from an inpatient hospital program," usually of 3-10 days, if reasonable and necessary, "up to the point where it was determined that inpatient hospital rehabilitation was not appropriate, since preadmission screening cannot be expected to eliminate all unsuitable candidates." MPBM, Ch. 1, §§ 110.2 & 110.3.1.

The Manual also provides two examples of cases to illustrate when IRF services are or are not reasonable and necessary:

> Absent other complicating medical problems, the type of rehabilitation program normally required by a patient with a fractured hip during or after the non-weight-bearing period or a patient with a healed ankle fracture does not require an inpatient hospital stay for rehabilitation care. Accordingly, an inpatient assessment is not warranted in such cases. On the other hand, an individual who has had a CVA that left them significantly dependent in the activities of daily living (even after physical therapy in a different setting) might be a good candidate for a more extensive inpatient assessment if the patient has potential for rehabilitation and their needs are not primarily of a custodial nature.

MBPM, Ch. 1, § 110.3.2.[1] CMS also explains the general screening criteria for IRF services, as follows:

> Rehabilitative care in a hospital, rather than in a SNF or on an outpatient basis, is reasonable and necessary for a patient who requires a more coordinated, intensive program of multiple services than is generally found out of a hospital. A patient probably requires a hospital level of care if they have either one or more conditions requiring intensive and multi-disciplinary rehabilitation care, or a medical complication in addition to their primary condition, so that the continuing availability of a

[1] The ALJ quoted the first example but omitted the second.

> physician is required to ensure safe and effective treatment.

MBPM, Ch. 1, § 110.4. The Manual then provides a set of detailed criteria for when intensive rehabilitation is needed, but specifies that these criteria are only intended for use by Qualified Independent Contractors in making initial decisions on the level of care. Id. If a claim does not meet these criteria, the claim should not be denied but referred to a physician reviewer to assess based on "their knowledge, expertise and experience, and upon an assessment of each beneficiary's individual care needs rather than on fixed criteria." Id.

The criteria include physician involvement about which the Manual states:

> A patient's condition must require the 24-hour availability of a physician with special training or experience in the field of rehabilitation. This need should be verifiable by entries in the patient's medical record that reflect frequent and direct, and medically necessary physician involvement in the patient's care; i.e., at least every two to three days during the patient's stay. This degree of physician involvement which is greater than is normally rendered to a patient in a SNF is an indicator of a patient's need for services generally available only in a hospital setting.

MBPM, Ch.1, § 110.4.1. They also include 24-hour rehabilitative nursing, a relatively intense level of rehabilitation (usually at least 3 hours per day of physical or occupational therapy), a multi-disciplinary team approach, a coordinated care plan (with biweekly meetings), practical improvement, realistic goals (generally "self-care or independence in the activities of daily living; i.e., self-sufficiency in bathing, ambulation, eating, dressing, homemaking, etc., or sufficient improvement to allow a patient to live at home with family assistance rather than in an institution"), and a reasonable period of time. MBPM, Ch.1, §§ 110.4.2 – 110.4.7.

ANALYSIS

Before the ALJ, the appellant challenged the reopening of these claims as part of a recovery audit contractor review for the overpayments. The ALJ rejected the appellant's claims that the

contractors lacked good cause as not cognizable in the administrative appeals process. A.D. and J.H. ALJ Decisions at 9; I.W. ALJ Decision at 8-9. The ALJ concluded that the appellant's contention that the redetermination should be reversed as untimely was inconsistent with the facts. ALJ Decisions at 9. The appellant has not challenged either of these conclusions on appeal to the Council.

The issues before us center on whether the services provided in each case were reasonable and necessary. Below, we set out the relevant facts established in the record as to the services provided to each beneficiary and apply the legal standards discussed above to the individual circumstances of each. For the reasons explained below, we conclude that the record does not support the ALJ's denial of coverage for services at issue provided to I.W., J.H., or A.D.

1. Services provided to I.W. from April 20 through May 7, 2004, were reasonable and necessary under applicable legal authority.

I.W. was an 88-year old woman who was admitted to the IRF on April 20, 2004 with "exacerbation of bilateral lower extremity weakness, secondary to polymyositis," especially on the right side, as well as pain when lifting her right arm. I.W. Ex. 8, at 272. She had been admitted to the acute care hospital on April 5, 2004 with abdominal distention, the cause of which was not conclusively identified, but she was treated there for an active urinary tract infection and found to also have a thoracic aortic aneurysm and degenerative disc problems on cervical and thoracic scans. I.W. Ex. 8, at 278. Neurosurgery determined that she was not a good candidate for surgical treatment. I.W. Ex. 8, at 272. She had been on prednisone for 12 years to manage a giant cell arteritis and had had polymyalgia rheumatic since 1997. I.W. Ex. 8, at 277-78. She had also been on Coumadin since 2003 for recurrent deep vein thrombosis with pulmonary emboli, which was held during the acute admission due to renal insufficiency and then reestablished. I.W. Ex. 8, at 272 and 276. She was discharged to a skilled nursing facility where she stayed from April 9, 2004 to April 20, 2004 and then transferred to the IRF for "aggressive, intensive inpatient rehabilitation." I.W. Ex. 8, at 273.

The ALJ found that a physician consultant recorded no "focal deficit" in the lower extremities on strength testing. I.W. ALJ Decision at 2; I.W. Ex. 8, at 278. I.W. was noted, however, to have swelling and decreased sensation in her legs, especially

the right which had required a skin graft after an earlier fall. I.W. Ex. 8, at 274. She also had decreased endurance and shortness of breath with activity. Id. The ALJ characterized the IRF treatment plan as merely to continue the current medications, monitor renal function, and follow up with her rheumatologist and primary care physician. I.W. ALJ Decision at 2. Those steps were indeed reported by the consulting physician on her admission to IRF based on his understanding from the IRF physician. However, her physician orders on IRF admission included 13 medications, and also planned for a bowel and bladder management program, training for self-administration of medication, and evaluation and appropriate treatment by physical and occupational therapists as well as a neuropsychologist. I.W. Ex. 3, at 49. The ALJ did not explain why the consulting physician should have recorded, or even been aware of, all of the planning being done on the first day of the beneficiary's admission to the IRF, since her assessment and care-planning might well not have been completed at that point.

The appellant's medical director argued that progress notes show "daily direct contact by a physiatrist throughout the patient's stay," writing at least one order each day and close monitoring and adjustment in light of complex interactions among her medications and potential complications. I.W. Request for Review (RR) at 2-3. He also asserted that the patient received three hours daily of therapy services, as well as specialized attention 24 hours a day from rehabilitation nurses who could reinforce therapeutic techniques and provide continuous monitoring of progress as well as safety and education for the patient. Id. at 6-7.

The ALJ acknowledged that the beneficiary had "a complicated medical history," but then opined that "her active co-morbidities had been treated so effectively on an outpatient basis that she was modified independent in many ADLs and independent in some ADLs **prior to her hospital admission**." I.W. ALJ Decision at 10 (emphasis added). Her relatively high ADL functionality before the exacerbation of her illness that put her in the hospital does not undercut the physician's assessment that after her acute treatment she needed intensive rehabilitation to regain her previous independence. Nor does it suggest that her numerous co-morbidities were irrelevant to the level of services needed to manage her safely during such rehabilitation efforts. Furthermore, the fact that an initial stay in a SNF on release from the acute care hospitalization ended in a return to hospital-level care suggests that the

beneficiary's medical and rehabilitative needs could not in fact be fully met in a lower-intensity setting. This contradicts the ALJ's conclusion that there was no showing that I.W. could not have been provided with the services she needed in a SNF or through home health. Cf. I.W. ALJ Decision at 10.

The ALJ's suggestion that SNF personnel routinely monitor anti-coagulant and Lasix therapy does not demonstrate that the physicians treating I.W. were unreasonable in concluding that this patient's medication needs were too complicated to be managed in a SNF. The appellant reported that I.W. took not only Lasix but two other blood pressure medications, her anti-coagulant levels were titrated daily, and the prednisone she took for her secondary illnesses affected fatigue and endurance levels for therapy. I.W. RR at 2-3. These assertions are supported by the clinical records. See, e.g., I.W. Ex. 8, at 281-91 (physician orders), 333-99 (medication records).

Further, the ALJ's approach to determining whether I.W. "required," as opposed to merely "desired or benefited from," relatively intensive rehabilitation is not consistent with the guidance provided in the manual provisions set out above. Cf. I.W. ALJ Decision at 10. The fundamental question is whether I.W. needed "a relatively intense rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade" her functional ability. MBPM, Ch. 1, § 110.1. Such services are generally needed where a patient has "either one or more conditions requiring intensive and multi-disciplinary rehabilitation care, or a medical complication in addition to their primary condition, so that the continuing availability of a physician is required to ensure safe and effective treatment." MBPM, Ch. 1, § 110.4. This patient had, in addition to the exacerbation of her polymyositis, numerous other serious conditions requiring calibration of medication and monitoring of renal function, hypertension and other co-morbid conditions. I.W. RR at 7; I.W. Ex. 8 passim. The ALJ does not adequately explain why these conditions and complications do not evidence need for in-hospital rehabilitation nor why he discounts the opinions of appellant's physicians – both the certifying physician and the medical director – that continuing availability of physician care was required to ensure safe and effective treatment of her condition. Cf. I.W. ALJ Decision passim; but see Hearing CD; I.W. RR at 1-3; I.W. Ex. 8 at 272-75.

In addition to the uncontradicted medical opinions, the ALJ should have considered the actual level of services that I.W. received while in the IRF as evidencing her level of need. The manual suggests that a medical record showing "frequent and direct, and medically necessary physician involvement in the patient's care; i.e., at least every two to three days during the patient's stay" would be "**an indicator of a patient's need** for services generally available only in a hospital setting."[2] MBPM, Ch. 1, § 110.4.1 (emphasis added). I.W.'s medical records demonstrate almost daily progress notes and medication reviews and changes by physicians during her stay. I.W. Ex. 8, passim. In the absence of persuasive contrary evidence, the clinical record thus indicates that I.W. did need in-hospital level rehabilitation. The record also evidences regular coordination through documented assessments, care plans with specific targets, weekly summaries, progress notes, and care conferences (April 22, April 30, and May 6) among multiple disciplines including occupational therapy, physical therapy, nursing, social work, and neuropsychology. See, e.g., I.W. Ex. 8, at 461-475. This evidence further substantiates I.W.'s need for hospital-level services.

This clinical record also belies the ALJ's characterization of the appellant's treatment plan as consisting merely of continuing existing medication, monitoring renal function because of diuretics, and consulting her primary care physician and rheumatologist. I.W. ALJ Decision at 2. Her admission and therapeutic assessments also demonstrate impairments from her pre-hospitalization baseline considerably greater than the ALJ acknowledges with his references to "mild weakness" in one arm and no "focal deficits" in her legs. Id. As the ALJ notes, prior to the exacerbation of her illness, I.W. had been able to live with her daughter using a wheelchair and a 4-point wheeled walker to ambulate short distances. I.W. ALJ Decision at 2, citing I.W. Ex. 8, at 462. The ALJ does not note that the assessment, signed by two physical therapists (PTs), also describes I.W.'s current status on arriving at the IRF as presenting with "significant weakness [and decreased] endurance which limits her functional mobility & balance" and concludes

[2] While the absence of a record of such frequent intervention is not a basis to deny a claim, documentation of such visits clearly indicates a need for hospital-level care. As appellant argues, SNFs are only required to provide for monthly physician visits (bimonthly after 90 days). I.W. RR at 3, citing 42 C.F.R. § 483.45. While this regulation does not preclude more frequent physician visits and consultations when needed by a resident, we agree that the level of care contemplated in a SNF would not usually include near daily direct physician involvement.

that she "would benefit from inpt [inpatient] rehab to address these issues as well as [patient]/family education." I.W. Ex. 8, at 462.

Her gait on the PT evaluation was rated at level 2[3] and her dynamic postural alignment at 4 with discharge goals of 6. Id. Her gait on stairs was rated untestable due to her weakness and endurance, with a goal of raising it to 2. Her home entrance required a step up and she lived in a two-story residence, although the ALJ opined that she might not need to go upstairs. I.W. ALJ Decision at 2. A neurological evaluation showed deficits in motor control and noted altered sensation (tingling) in her legs, although she was able to sense touch. I.W. Ex. 8, at 461. She described pain in her left knee and had shortness of breath on moderate exertion. I.W. Ex. 8, at 460-61. Physical therapy totaling 60-90 minutes per day was provided every weekday. I.W. Ex. 8, at 463.

The occupational therapy (OT) evaluation notes that I.W. had previously been capable of modified independence in her activities of daily living (ADLs) and reflects reductions in her need for supervision or stand-by assists for standing up, static and dynamic balance, and transfers. I.W. Ex. 8, at 464. She has pain in her knee and shoulder aggravated by standing. Id. Her endurance deficit impacts her ability to perform ADLs standing, and her seated abilities to perform hygiene, dressing, and toileting are at levels 4-5, with a goal of raising them all to 6. I.W. Ex. 8, at 465. Occupational therapy was provided almost every day for periods of time totaling between 15 and 120 minutes per day.

By her discharge after two weeks in the IRF, I.W. had succeeded in raising all her ADL levels, most of them to her goal level, and had regained the ability to live at her daughter's home with modified independence. I.W. Ex. 8, at 475. She was able to ambulate with her walker up to 150 feet and had exceeded her goal in stair climbing. I.W. Ex. 8, at 475-76. Her motor control was improved. Id. While she continued to have limitations in range of motion and endurance, she clearly benefited sufficiently from appellant's services to enable her to live at home with family assistance rather than in an institution.

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[3] These ranking levels are based on a standardized rating system for functional activity levels between 0 which would represent no ability or not tested and 7 which would represent independence.

The ALJ also makes the conclusory statement that, even if "the threshold requirements were established," the services would not be covered because the record does not show that I.W. "needed close medical supervision by a physician with specialized training or experience in rehabilitation, 24-hour rehabilitation nursing, or a relatively intense level of rehabilitation services. I.W. ALJ Decision at 10 (citations omitted). The three manual provisions which the ALJ cites - MBPM, chapter 1, §§ 110.4.1, 110.4.2, and 110.4.3 – are, as mentioned above, not in fact "coverage criteria," as the ALJ called them, but merely markers for the contractor of situations that are clearly covered rather than calling for individualized medical review. Id. Further, the daily physician visits included many by Dr. ***, whom the appellant identifies as a board-certified physiatrist, which would seem to meet the first marker. See I.W. RR at 2; I.W. Ex. 8 passim. The clinical records reflect 24-hour nursing care and interventions with special precautions for high risks in the area of falls and skin integrity, close monitoring of bilateral pedal edema, and observations of weakness, exhaustion, rash, and movement limitations. I.W. Ex. 8 at 432-458. We have already discussed the evidence of I.W.'s need for relatively intense rehabilitation. We therefore conclude that the ALJ's reference to other coverage criteria does not provide any independent basis to uphold the denial.

Based on our de novo review of the clinical record, we reverse the ALJ's conclusion that the services provided to I.W. by the appellant were not covered by Medicare.

2. Services provided to J.H. from July 10 through July 23, 2004 were reasonable and necessary under applicable legal authority.

J.H. was 83 years old and had recently moved in with his daughter when he suffered two falls from which he could not get up and was taken to the emergency room. J.H. ALJ Decision at 2, citing J.H. Ex. 10, at 830. He was diagnosed with Parkinson's disease and scans of his brain revealed extensive cerebral atrophy, chronic extensive deep white matter ischemic changes, lacunar infarcts, without evidence of hemorrhage or other abnormalities. J.H. Ex. 10, at 729, 733, and 789. J.H. was

transferred to the IRF on July 10, 2004 and was released July 23, 2004.[4]

The ALJ states that no rationale was given for why J.H. "needed to be admitted to the IRF." J.H. ALJ Decision at 2, citing J.H. Ex. 10, at 784. The cited page is in a physician report on J.H.'s rehabilitation admission. The physician, appellant's Medical Director, sets out the patient's chief complaint as "[m]ultiple falls with weakness of the lower extremities" and states that he is "felt to be unstable given his weakness of the extremities and the multiple falls" and that he is therefore "being transferred to rehabilitation for intensive therapy and in preparation for him to be discharged home." J.H. Ex. 10, at 784. The ALJ does not acknowledge this aspect of the assessment or explain why it does not constitute a "rationale" for needing IRF admission. The ALJ does quote a PT evaluation stating that J.H. would "benefit from intensive PT rehab program for education on Parkinson's, gait, balance training and safety education to prevent falls and return home with daughter safely," and notes an intake assessment which indicates by checking off items that J.H. met the "criteria" for IRF services and cannot have needs met at a lower level of care. J.H. ALJ Decision at 2, quoting J.H. Ex. 10, at 830, and citing J.H. Ex. 10, at 783. The ALJ nevertheless concludes that the services could have been provided in a SNF because J.H.'s condition was "stable" on admission to the IRF and he had no active co-morbidities or complications that justified IRF-level care. J.H. ALJ Decision at 10.

Certainly, physical therapy on the topics mentioned may be provided in a SNF. The salient issues are whether the patient required a relatively intense level of PT and other rehabilitative services beyond what would be normally available in a SNF or home health setting and/or needed a level of active medical management of his total condition that required in-patient status. The appellant points out that the patient had urinary problems secondary to a history of bladder cancer and prostate hypertrophy which required active physician management, including two emergency room visits to reinsert a Foley catheter, repeated episodes of blood in the urine, and a urinary tract infection. J.H. RR at 2; J.H. Ex. 10, at 788, 818. His hypertension medication was changed twice during his stay due to

[4] The appellant's request for review for J.H. mistakenly gives the dates of service as September 17, 2003 through October 3, 2003, but the dates given by the ALJ are in accord with the medical records provided by appellant.

interaction with the urinary problems. Id. The appellant also notes (and the record reflects) that J.H. suffered from severe to profound hearing loss, involuntary movements, and cognitive problems including mental confusion, inability to follow directions, and impulsivity sufficient to call for a one-on-one attendant for nights and evenings. J.H. RR at 2, 4; J.H. Ex. 10, at 790-91. His vision in both eyes was impaired. J.H. Ex. 10, at 832.

The appellant's medical director asserts that J.H. required and received daily, medically necessary involvement from him, as a board-certified physiatrist, and that the physician wrote "at least one order for 13 of the 13 days" that J.H. was in the IRF. J.H. RR at 2-3. This assertion is supported by the clinical record. J.H. Ex. 10, at 713-29, 790-96. The record also reflects almost daily follow-up visits from his hospital physician. J.H. Ex. 10, at 713-29. The appellant further asserts that J.H.'s neurologist requested intensive rehabilitation to address "lower extremity weakness, loss of balance, cogwheel rigidity, and impaired postural reflexes with retropulsion and lateral pulsion." J.H. RR at 2. A neuropsychological evaluation noted problems with attention, slowed processing, forgetfulness and anxiety, with a need for "a lot of education & support." J.H. Ex. 10, at 839-40.

The clinical record demonstrates that J.H. received daily PT services lasting 60-90 minutes involving therapeutic exercise, neurological retraining, gait activities and treatment to improve functional activities. J.H. Ex. 10, at 831. On admission, his functional levels were at 2 for gait on stairs and in community and at 4 for gait with standby assistance and an assistive device, with tendency to shuffle, unsteadiness, and distraction. J.H. Ex. 10, at 830. He was noted to have kyphotic posture and a pelvic tilt affecting his ability to sit, stand, and transfer where he was previously independent, as well as limited trunk flexibility and stiffness. Id. at 829-833. He also received occupational therapy, focusing on regaining ADLs and developing a home program, each day after July 14, 2004, with evaluation visits and care-planning involvement on the earlier days. Id. at 834. He was also evaluated by a speech-language pathologist and was seen daily for therapy to improve comprehension and expression. Id. at 835-38.

Given that the symptoms and diagnosis of Parkinson's disease were fairly new developments for a patient who had previously

been capable of living independently but now had repeated falls, the decision of J.H.'s physicians to attempt intensive rehabilitation and training in order to maximize his chances of returning to reside safely with his daughter does not appear unreasonable. While the degree of his functional impairment was not severe in most areas, the appellant has correctly pointed out that addressing them was complicated by his serious sensory and cognitive impairments. The IRF developed an individualized care plan with weekly updates and documented multidisciplinary conferences and progress updates. J.H. Ex. 10, at 843-46. The discharge summary and functional independence measures reflect achievement of his goals in most areas, except bladder management, documenting the benefits he received and his ability to return to his daughter's home. Id. at 847-48. While the ALJ acknowledged that J.H. "may have benefited from his IRF admission," the ALJ concluded that his needs could have been managed in a SNF. ALJ Decision at 10.

We disagree. The medical record supports the appellant's position that J.H.'s individual care needs required a more intense level of rehabilitation to forestall institutionalization. In looking at the bookend examples given in the manual to evaluate such needs, we conclude that J.H. more closely resembles a person with a recent stroke who becomes significantly dependent in ADLs but has potential for rehabilitation and needs beyond the custodial than an individual with an uncomplicated hip or ankle fracture. MBPM, Ch. 1. § 110.3.2. We therefore reverse the ALJ's denial of coverage.

3. Services provided to A.D. from March 8 through March 18, 2005 were reasonable and necessary under applicable legal authority.

A.D. was 84 years old and was independent in mobility and ADLs and living in a home with 40 steps to the entrance (and 3 more to his bedroom) when he suffered a CVA in early March 2005. A.D. Ex. 12, at 621-27, 752, 764. He was admitted to the hospital where he was determined to have atrial fibrillation and a hemorrhagic infarct with ischemic changes and left hemianopsia.[5] Id. at 622. He had a prior history of heart attack and an enlarged heart. Id. at 621-22. After

[5] The ALJ mistakenly states that A.D. was admitted to the hospital on April 8, 2005, but the clinical records show that he was actually admitted to the hospital on March 3, 2005 and to the IRF on March 8, 2005. Compare A.D. ALJ Decision at 2 with A.D. Ex. 12, at 621.

conservative treatment in the hospital, A.D. showed improvement and was referred by his physician for intensive therapy for which he was "felt to be an excellent rehabilitation candidate." Id. In addition to the CVA and cardiac issues, A.D. had poorly-controlled diabetes, was hypertensive with anticoagulant therapy contraindicated due to the hemorrhagic stroke, was on medication for hyperlipidemia, was anemic, and had a history of hyperthyroidism but was taking medications that could alter thyroid functions. Id. at 621, 625-27.

On admission to the IRF, he had motor control deficits in his lower extremities, required minimal assistance to stand (slight loss of balance), walk, dress and transfer and supervision for eating, grooming and bathing. A.D. Ex. 12, at 622-24. His ability to manage stairs was rated at 2 and he was rated 4-5 on most other functional activities with a goal of returning to levels 6-7 on all functions. Id. at 752. His cognitive abilities were also somewhat compromised due to intermittent confusion and short-term memory deficits. Id. at 621. The hemianopsia caused additional safety and balance issues. Id. His overall rehabilitative goals were to learn to compensate for the blindness on one side and to be able to return home with improved mobility and safety. Id. In addition, he was determined during the rehabilitation assessment to have dysphagia and in need of nutritional services to minimize risk. Id. at 655. Given this documentation in the clinical record, we cannot understand the ALJ's comment that the "record does not indicate if or why" A.D. needed intensive therapy. A.D. ALJ Decision at 2.

The appellant argues that the physician had to titrate the medications on a daily basis due to large fluctuations in blood pressure, uncontrolled diabetes, the need to stop Coumadin (which he had been taking due to multiple pulmonary emboli after an abdominal aortic aneurysm repair the prior year) because of the nature of his stroke and still manage the atrial fibrillation, and the potential for interactions affecting his thyroid. A.D. RR at 2. During A.D.'s stay, according to appellant, the physician arranged a consult with an ear, nose and throat specialist who found signs of Gastric Esophageal Reflux Disease which required additional medication and precautions. Id.; A.D. Ex. 12, at 647.

The clinical records support these assertions, documenting very frequent physician's orders for tests and medication reviews,

and almost daily visits by either a physiatrist or consulting physician. A.D. Ex. 12, at 631-57. During his stay, he received physical therapy daily for 60-90 minutes. Id. at 753. Occupational therapy provided treatment on seven days for 60-105 minutes and participated in evaluation and case conferences. Id. at 758. In addition, he received speech therapy on seven occasions (from 30-90 minutes each) to improve his dysphagia, comprehension and expression and cognitive declines. Id. at 751. His clinical treatment records document progress notes from neuropsychology reflecting 6 visits. Id. at 640-55, 762-63. He also received consults for social work and recreational therapy. Id. at 764-65. The record includes weekly summaries and notes reflecting multidisciplinary care-planning and conferences. Id. at 766-71. By the time of his discharge, A.D. had regained modified independence in his ADLs, was independent in transfers, and could ambulate and climb 12 steps with stand-by assistance. Id. at 771. He was able to meet the goal of being discharged to his home. Id.

A.D. appears to be virtually the canonical exemplar of an appropriate candidate for in-patient level rehabilitative services set out in the Manual discussed above. MBPM, Ch. 1. § 110.3.2. Clearly, his needs were more than custodial given his numerous medications and co-morbidities. We therefore conclude that the IRF services were reasonable and necessary and reverse the ALJ's non-coverage decision.

DECISION

It is the decision of the Medicare Appeals Council that the ALJ decisions in each of the cases set out above are reversed and the claims at issue are covered by Medicare.

MEDICARE APPEALS COUNCIL

/s/ Leslie A. Sussan, Member
Departmental Appeals Board

/s/ Susan Yim
Administrative Appeals Judge

Date: October 26, 2009