DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
Commissioner of the New Jersey Department of Human Services (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiary)	**** (HIC Number)
National Government Services, Inc. (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued two decisions dated October 8, 2008, which concerned Medicare coverage for home health services provided to beneficiary W.B. from October 22, 2005, through October 16, 2006, and to beneficiary D.W. from October 10, 2005, through December 3, 2006. In both cases, the ALJ determined Medicare would not cover the services at issue and that the beneficiary was liable for the non-covered services. The appellant has asked the Medicare Appeals Council to review these actions.

The Council reviews the ALJ's decision *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, since the appellant is not an unrepresented beneficiary. 42 C.F.R. § 405.1112(c). As set forth below, the Council reverses the ALJ's decision.

CASE BACKGROUND

The original claim for home health services to W.B. included numerous services provided between October 22, 2005, through October 16, 2006. At the hearing, the appellant withdrew its claim as to all but two sets of services: (1) four skilled

nursing visits and (2) eleven physical therapy visits. The ALJ denied the disputed visits as not medically reasonable or necessary and amounting to merely custodial care. ALJ Decision in ALJ Appea1 No. ****, at 7 (October 8, 2008)(ALJ Decision—W.B.). The ALJ also held the beneficiary responsible to pay for the home health services on the grounds that he or his representative "knew or should have known that Medicare might not pay for" them. Id.

ANALYSIS

1. The beneficiary did not have to be in an acute medical condition to qualify for home health services including skilled services, if otherwise reasonable and necessary.

The ALJ found that the beneficiary was homebound and suffered from paralysis due to post-polio syndrome with right-sided weakness and abnormality of gait, as well as other complicating conditions including diabetes, chronic renal failure, hypertension, and anemia. Id. at 6. The ALJ nevertheless states that the information that the beneficiary was homebound and had a physician certifying his need for home health services "alone does not militate in favor of the need for 'skilled' nursing services." Id. To the contrary, according to the ALJ, the beneficiary's condition was "stable and not acute." Id.

The legal authorities quoted in the ALJ Decision do not indicate any requirement that a beneficiary be acutely, rather than chronically, ill, in order to receive otherwise covered home health services. The Social Security Act (Act) requires (as relevant here) that the beneficiary be homebound, need skilled nursing care on an intermittent basis or physical therapy, have a plan for such care established and reviewed by a physician, and receive the services while under the care of a physician. Act § 1835(a)(2)(A). Nothing in this or the other statutory provisions cited precludes a homebound **chronically** ill beneficiary from receiving needed intermittent skilled nursing care or physical therapy under the care of a physician who has established and is reviewing a plan for such care. The regulation on beneficiary "qualifications for coverage of services" tracks the statutory provision and contains no distinction between chronic and acute illness. 42 C.F.R. § 409.42. It would seem clear, therefore, that the information to which the ALJ refers does indeed "militate in favor of" coverage for home health services.

This conclusion is further reinforced by a regulatory provision on skilled services requirements which the ALJ failed to address. Section 409.44(b)(3) provides in relevant part as follows:

> (ii) The skilled nursing care provided to the beneficiary must be reasonable within the context of the beneficiary's condition.
> (iii) The determination of whether skilled nursing care is reasonable and necessary must be based solely upon the beneficiary's unique condition and individual needs, **without regard to whether the illness or injury is acute, chronic, terminal or expected to last a long time**.

(Emphasis added.) We conclude that the beneficiary was not ineligible for skilled nursing care merely because his medical condition was chronic, not acute or unstable. In the following sections, we address whether the particular skilled services provided were reasonable and necessary.

2. Skilled nursing visits to administer intramuscular injections of Lupron for W.B. are covered services.

The ALJ's discussion of the skilled nursing visits at one point correctly refers to Lupron injections while elsewhere dismissing the administration of Lupron as merely "pre-pouring medication" and therefore not requiring skilled services. ALJ Decision-W.B. at 7. Reports for each of the visits in which Lupron was administered records its injection during the visit "im,' i.e. via intramuscular injection. Ex. 1, at 130 ("in the right deltoid" during the November 11, 2006, at 186 ("in the right deltoid" during February 22, 2006 visit), at 242 ("in the right upper arm" during June 14, 2006 visit), and at 263 ("in the right deltoid" during August 2, 2006 visit). The medical record makes abundantly clear that Lupron was not prepoured for later self-administration.[1]

The ALJ's confusion may have arisen from the fact that the visiting nurse also pre-poured other medications during each visit for later oral self-administration by the patient. Id. Similarly, the ALJ notes that the certifying physician ordered pre-pouring of medications, but overlooked that the physician

[1] The ALJ also omitted from her statement of conditions from which the beneficiary suffered in Finding of Fact 1 the diagnosis for which the Lupron injections were ordered, advanced prostate cancer.

also ordered injection of a 22.5 mg Lupron via syringe intramuscularly once every 3 months. Compare ALJ Decision—W.B. at 7 with Ex. 1, at 300-01.

Medicare regulations specifically list intramuscular injections as a service that qualifies as skilled nursing. 42 C.F.R. § 409.33(b)(1). While self-injection may be an appropriate route for some patients with some medications, such as injectable insulin used by diabetic patients able to safely self-administer, nothing in the ALJ's decision or in the medical records suggests that Lupron may be self-administered or that this patient was assessed as capable of self-administration of Lupron. On the contrary, a nursing assessment performed on April 19, 2006 expressly found that the beneficiary was "UNABLE to take injectable medication unless administered by someone else." Ex. 1, at 211. Furthermore, the treating physician expressly ordered that the visiting nurse inject the patient. Ex. 1, at 300-10.

The ALJ also makes a passing reference to the fact that Lupron injections were required "less frequently than 60 days" as part of characterizing the appellant's argument. ALJ Decision—W.B. at 7. It is not clear whether the ALJ based any part of her rejection of coverage for the skilled nursing visits on the low frequency of administration, but she does include in legal authority a Medicare Manual provision interpreting the statutory provision limiting home health services to those provided on an "intermittent basis." Id. at 4-6, citing Medicare Benefit Policy Manual (MBPM), Pub. 100-02, Ch. 7, § 30 and Section 1835(a)(2)(A) of the Social Security Act. The manual provides as follows –

> To meet the requirement for "intermittent" skilled nursing care, a patient must have a medically predictable recurring need for skilled nursing services. In most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60 days. . . .
>
> Since the need for "intermittent" skilled nursing care makes the patient eligible for other covered home health services, **the intermediary should evaluate each claim involving skilled nursing services furnished less frequently than once every 60 days**. In such cases, payment should be made only **if documentation justifies a recurring need for reasonable, necessary, and medically predictable** skilled nursing services.

* * *

> There is a possibility that a physician may order a skilled visit less frequently than once every 60 days for an eligible beneficiary if there exists an extraordinary circumstance of anticipated patient need that is documented in the patient's plan of care in accordance with 42 CFR 409.43(b). A skilled visit frequency of less than once every 60 days would only be covered if it is specifically ordered by a physician in the patient's plan of care and is considered to be a reasonable, necessary, and medically predictable skilled need for the patient in the individual circumstance.

MBPM, Ch. 7, §30 (underlying in original; bold emphasis added). In this case, as noted, the physician's orders specifically call for Lupron injections "q 3 months," i.e., every 90 days. Ex. 1, at 300-01. The timing is thus medically predictable. We have already explained why the use of skilled nursing care to perform the injection was reasonable and necessary. Nothing in the record contradicts the treating physician's assessment that the frequency of injection was also appropriate.

We therefore conclude that the four skilled nursing visits are covered services.

3. Eleven physical therapy visits for W.B. are covered services.

The visits remaining at issue took place between October 25, 2005, and November 29, 2005. The appellant asserts that these physical therapy services were provided in relation to the installation of a new stair lift mechanism to assist the beneficiary with difficulty navigating stairs in his home due to fatigue, pain and abnormality of gait attributed to post-polio syndrome and unequal leg length. Request for Review (W.B. RR) Br. at 6. The appellant further asserts that the skilled therapist was needed to teach the beneficiary how to safely transfer to and from the lift. Id. In addition, the appellant states that the therapist was "in the process of designing an appropriate home exercise program" for the beneficiary, and cites section 409.44(c)(2)(iii) of the Medicare regulations as providing coverage for physical therapy services which are "necessary to perform a safe and effective maintenance program required in connection with a specific disease . . . ." W.B. RR Br. at 7, quoting 42 C.F.R. § 409.44(c)(2)(iii) and citing MBPM, Ch. 7, §§ 40.2.1 and 40.2.2. The appellant alleges the

beneficiary improved measurably over the month as the therapist revised the exercise program. W.B. RR Br. at 7.

The ALJ made factual findings that the treating physician's signed plan of care for the beneficiary ordered "a therapeutic home exercise program," that the services were provided during the time period as claimed, and that a "stair slide lift was installed and the physical therapist showed the beneficiary how to use it." ALJ Decision at 2, citing Ex. 1. The ALJ reasoning for nevertheless rejecting coverage of these services is as follows:

> The need for a skilled physical therapist to provide these services is not justified by the mere fact that it was provided.

ALJ Decision at 7. This explanation, while certainly true, is wholly inadequate. The question before the ALJ was not whether the mere provision of services proved their reasonableness and necessity. The question before the ALJ was whether the evidence of record established that the services were reasonable and necessary. As the ALJ gave no indication that she considered the testimony and evidence presented on that question, we review the contents of the record as they bear on the relevant question.

The record contains the physician's order and plan of care for physical therapy during the relevant period calling for visits 1-2 times per week. Ex. 1, at 300-1. The physician assessed the beneficiary's rehabilitation potential as "fair." Id. at 300. An OASIS assessment form from October 19, 2005 notes that the patient's home has stairs which "MUST be used by patient (e.g., to get to toileting, sleeping, eating areas)," as well as stairs to reach the other parts of the house and to get outside. Ex. 1, at 122. The assessment also records the patient having no pain that interferes "with activity or movement." Id. However, the physical therapist's (PT) note for an October 17, 2005 visit describes chronic intermittent pain in the right hip addressed with rest and medication. Id. at 125. The note further noted pain reduction during use of right leg based on retraining for position change and weight-bearing activities and notes plan of care to "[e]stablish/upgrade home exercise program." Id.

Visits by the PT are documented for the following dates:

- Ex. 1, at 119 October 25, 2005 – Reports that "stair use training continues . . . in attempt to negotiate full flight of steps to main level of home" and that exercise and "gait training activities continue" with patient able to negotiate four steps using bilateral railing but displaying "guarding," with "fatigue and pain noted in ascending 4th step."

- Ex. 1, at 117 - October 27, 2005 – Reports review of the home exercise program and observation of balance activities to assess compliance, continuation of stair use training, and documents "slow progress" in using stairs with railings while stating that "use of stair glide type of lift is recommended as yet."

- Ex. 1, at 115 - November 1, 2005 – Reports teaching patient and caregivers the "correct use of stairlift recently installed in home for safe transfer" and negotiation of last two steps to first floor. Records range of motion and gait activities with walker "continued," and recommended installation of grab bars to improve "safety and independence."

- Ex. 1, at 113 - November 3, 2005 – Records that stair lift transfers are now safe at both ends, while still recommending grab bars on lower level. Reports an ongoing assessment of "needs for access to outside.

- Ex. 1, at 111 - November 8, 2005 – Reports review of stair lift safety and discussion of fall prevention. "Hip pain seems reduced with tolerance for walker use increasing."

- Ex. 1, at 109 – November 10, 2005 – Reports review of correct stair lift use and fall prevention and notes progress in "increasing activity levels," with the lift facilitating access to the first floor. Records need to work on the 7-8 steps "still needed for access to outside."

- Ex. 1, at 107 - November 15, 2005 – Gait safety without orthotic for leg length discrepancy reviewed to prevent falls.

- Ex. 1, at 105 – November 17, 2005 – Home exercise plan "revised for active hip flexion and ext[ension] as tolerated." Notes reduction in right hip pain and that

exercise to lower extremities and standing activities "provided as ordered."

- Ex. 1, at 103 – November 23, 2005 – Notes patient improvement in negotiation of two stairs to first floor and an ability for partial weight bearing on right leg without pain.

- Ex. 1, at 101 – November 25, 2005 – Review of activities to weight-shift to right leg and of safety plan for standing and transfer. Notes patient now able to ambulate "distances needed for toileting and transfer to stairglide from bedroom area," and that use of active assisted range of motion is "productive" on flexion but still limited abduction of right hip.

- Ex. 1, at 99 – November 29, 2005 – Notes that exercise and gait activities continue "as ordered," and that safe gait activities and stair use were reviewed. Reports range of motion "increased with SLR [straight leg raise] to 80 degrees and abduction to 15 degrees noted at right hip wo [without] pain this visit."

The regulations provide that skilled services for rehabilitation include "[t]herapeutic exercises or activities" which must be done by or supervised by a qualified PT based on either the type of exercise or the patient's condition in order to be done safely and effectively. 42 C.F.R. § 409.33(c)(2). In addition, "[g]ait evaluation and training" to restore function in a patient whose walking ability is impaired by a "skeletal abnormality" and "[r]ange of motion exercises" which are "part of the active treatment of a disease state" causing reduced mobility are also components of skilled services. 42 C.F.R. § 409.33(c)(3). Furthermore, maintenance therapy that requires "the specialized knowledge and judgment of a qualified therapist" to design and set up after an initial evaluation with "periodic reassessment of the patient's needs" constitutes skilled services. 42 C.F.R. § 409.33(c)(4). On the other hand, skilled services do not include general "supervision of exercises which have been taught to the patient; including the actual carrying out of maintenance programs," such as "performance of the repetitive exercises required to maintain function" or improve gait, or passive range of motion exercises for paralyzed extremities "not related to a specific loss of function, or "assistive walking." 42 C.F.R. § 409.33(d)(13).

The medical records discussed above and other documents and testimony in the record support a conclusion that the PT was providing therapeutic exercises and activities that required skilled-level performance and/or supervision given the condition of this 75-year old with partial paralysis from post-polio syndrome, a skeletal abnormality of uneven leg length further interfering with his ability to ambulate, intermittent pain in his right hip, and other medical diagnoses which could affect strength and balance in performing exercises. The range of motion therapy provided was related to a specific loss of function, was not merely passive movement of paralyzed limbs, and indeed resulted in significant improvement in use of the right hip with benefits to the beneficiary's ability to ambulate safely with his walker and to climb stairs.

The QIC decision which was appealed to the ALJ stated that "[d]ocumentation supports that physical therapy services consisted of repetitive exercises and maintenance." Ex. 8, at 450. The ALJ did not comment on this finding. The PT reports summarized above demonstrate that more than the performance of repetitive exercises occurred during the visits, which focused on progressive assessment and revision of the therapeutic exercise program to meet specific progress goals on stairlift use, negotiation of stairs, and improved safety in walker use to improve the beneficiary's ability to perform activities of daily living and regain full access to his home. Nothing in the record indicates that 11 visits are an inappropriate level of services to produce the documented improvements and to design and set up implementation of a maintenance program for this particular beneficiary.[2]

We therefore conclude that the eleven physical therapy visits were covered services.[3]

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[2] We note that our decision addresses only the limited home health services for which the appellant continues to seek payment. We express no opinion on whether the original range of home health services provided from October 22, 2006 through October 16, 2006 would have been covered.

[3] The ALJ's conclusion that the beneficiary is liable for costs is plainly erroneous in light of her factual finding that no advance beneficiary notice of non-coverage was documented. Compare ALJ Decision at 3 with id. at 7. The decisions at earlier levels of review all agreed that the beneficiary was not informed that the services would not be covered and that the liability therefore remained with the provider. Ex. 8. Given that we conclude that the services are covered by Medicare, we need not further address liability here.

4. 48 physical therapy sessions and 97 home health aide visits to D.W. were covered services.

The appellant originally sought coverage for all home health services provided to D.W. from October 10, 2005 through December 3, 2006. At the ALJ hearing, however, the appellant withdrew its claim for 17 skilled nursing visits but maintained its claim as to 48 physical therapy sessions and 97 home health aide visits. ALJ Decision-D.W. at 1 n.1; Hearing CD. The ALJ found that the 38-year-old beneficiary suffered from multiple sclerosis, neurogenic bladder, osteoporosis, and dyspnea on exertion. Id. at 2. She further found that the beneficiary's physician signed a certification for each relevant period to the effect that the beneficiary was confined to her home and in need of intermittent skilled nursing services. Id., citing Ex. 1, at 321-44. The physician also signed home health care plans that provided for skilled physical therapy twice weekly (allowing substitution of telephone assessment when appropriate as "condition stabilizes"), a home health aide for personal care and activities of daily living (ADL) assistance, and a home exercise program. Id. The ALJ also noted that the nursing notes from the relevant period do not show "any acute changes in her condition," any "wounds or decubitis ulcers",[4] or any falls in the preceding three months. Id., citing Ex. 1, at 290-98.

The ALJ opined that the physician certification of the need for home health services indicates that the beneficiary "may have been homebound, but it does not militate in favor of the need for 'skilled' nursing services." ALJ Decision-D.W. at 7. She further states that, "[t]o the contrary, the record when viewed in its totality indicates the Beneficiary's condition was stable and not acute." Id. As discussed earlier, a chronic rather than acute condition does not per se preclude coverage of skilled nursing services when medically reasonable and necessary, but in this instance the claim for skilled nursing was not before the ALJ so we need not consider it further. 42 C.F.R. § 409.44(b)(3)(iii).

[4] We note that the ALJ appears to have ignored record evidence that the beneficiary did, during the relevant period, suffer from decubitis ulcer and a fungal infection, and needed management of a surgical wound resulting from the installation of a pump for continuous infusion of muscle relaxant). See, e.g., Ex. 1, at 325 (certification for period starting October 10, 2005), at 332 (certification for period starting February 7, 2006), at 255 (PT note from October 6, 2005 noting decubitis ulcer), and at 318 (nurses note on continuing open surgical wound as of December 3, 2006).

As to the physical therapy and home health aide services, the ALJ acknowledged that the appellant argued that the services may be covered even if they might be regarded as maintenance because the condition of the beneficiary was such that they could only be "safely and effectively performed" by a skilled therapist, pursuant to 42 C.F.R. § 409.44(c)(2)(iii).[5] The ALJ noted the contractor's argument that the "amount, duration, and frequency of treatment has to be reasonable given the totality of the circumstances," and concluded that "a home exercise program could have been created and implemented by the family . . . ." ALJ Decision-D.W. at 7. As to physical therapy, the ALJ concluded that the stated goal that the beneficiary "reach her maximum level of independence was not reasonable given the progressively deteriorating nature of MS." Id. If neither skilled nursing or skilled physical therapy was reasonable and necessary, then the provision of home health aide services alone could not be covered because these are "dependent" services. 42 C.F.R. § 409.45(a).

The only evidence that the ALJ cited for her conclusion that the family could have "created and implemented" a home exercise program is a nursing note from December 24, 2005 which indicates that the beneficiary's father was "very involved" in her care, and knowledgeable about her medications and disease process. ALJ Decision-D.W. at 7, citing Ex. 1, at 119. The indication of active parental involvement does not establish whether either parent was able, physically or otherwise, to undertake all needed activities without skilled therapeutic involvement. Elsewhere, the nurses record that the parents are "forgetful." Ex. 1, at 283. The PT's notes indicate an ongoing effort to train the patient and caregivers in safe transfers, safe use of equipment,[6] increased balance and bed mobility, home exercises, and performance of passive range of motion activities. See, e.g., Ex. 1, at 222. The record suggests, however, that the involvement of a skilled professional remained necessary because of complicating conditions which the ALJ failed to address.

The appellant points out, and the medical record substantiates, that, in addition to multiple sclerosis, the beneficiary suffered from severe lordosis (spinal curvature), extreme hypertonicity, and a rare inherited connective tissue disorder known as Ehlers-Danlos Syndrome (EDS). D.W. RR Br. at 4-5; see, e.g., Exs. 10, at 513, and 1, at 254, 325. The appellant's

[5] The ALJ misstates the citation as 42 C.F.R. § 409.44(c)(3).
[6] The beneficiary needed a two-person assist and a Hoyer lift for transfers. See, e.g., Ex. 1, at 238.

counsel read into the record at the hearing information about EDS from Mercks' Manual. Hearing CD. Among the symptoms common to EDS patients are fragility (the attending physician noted the beneficiary was very fragile, at Ex. 10, at 513), joint hypermobility with potential for joint dislocations, easily torn or bruised skin, and abnormal curvature of feet and spine (in addition to severe lordosis, the beneficiary had an acquired ankle-foot defect recorded at Ex. 1, at 325). See Hearing CD. The beneficiary reported intermittent pain at levels ranging from 5 to 10 on a 10-point scale. See, e.g., Ex. 1, at 297 (August 2006 OASIS report).

Regulations provide that a "condition that does not ordinarily require skilled services may require them because of special medical complications." 42 C.F.R. § 409.32(b); see also 42 C.F.R. § 409.44(c)(2)(ii)(if services not complex/sophisticated, beneficiary's condition "must be such that the services required can safely and effectively be performed only by a qualified" PT). CMS policy further explains that skilled therapy services are covered even when the services themselves may not be highly complex or sophisticated, "where there is clear documentation that, because of special medical complications (e.g., susceptible to pathological bone fractures), the skills of a therapist are need to provide services which do not need the skills of a therapist." MBPM, Ch. 7, § 40.2.2. Services must be needed because the beneficiary's condition is expected to "improve materially," or to establish a "safe and effective maintenance program" for a specific disease or "the skills of a therapist" are necessary to perform a safe and effective maintenance program. 42 C.F.R. § 409.44(c)(iii).

The PT here provided direct services by movement and massage to reduce pain and spasms, with the PT notes reflecting that the beneficiary improved after PT visits. See, e.g., Ex. 1, at 324 and 327 (physician certification notes patient "continues to benefit from PT for pain management and Rom exercises"), at 209 (PT note of September 11, 2006 that patient "reports feeling much better with rx"). The appellant agreed that setting up a maintenance program for the home health aides to take over was a goal, but reported that this goals was frustrated because the home health aides were afraid or unwilling to touch her, failed to handle her correctly, and either left or were fired for those reasons. Hearing CD; D.W. RR Br. at 6; Ex. 1, at 333 (physician certification of April 8, 2006), at 133 (PT notes of February 7, 2006), at 144 (PT notes of March 9, 2006), at 148 (PT notes of March 20, 2006).

We are persuaded that the totality of circumstances surrounding the beneficiary's complicated condition justifies her physician's conclusion that she required skilled PT support for maintenance therapy. The contractor's assertion, adopted by the ALJ, that all of the necessary services could have been provided by the parents after training is belied by the record evidence that multiple home health aides were unable to learn to provide safe and effective treatment with the required frequency.

As far as the ALJ's conclusion that PT services were not covered because the goal was not reasonable, this conclusion is not factually or legally sound. The record makes clear that there was no prospect of the beneficiary recovering sufficiently to be independent in the sense of no longer needing total assistance with ADLs. The cited goal, however, was only "**her** maximum level of independence." ALJ Decision-D.W. at 7 (emphasis added). The physician noted physical therapy goals of balance training and bed mobility, and assessments for posture, strength, coordination, endurance and tolerance to activity and indicated that the beneficiary's rehabilitation potential was "fair." Ex. 1, at 338. Within this context, it is not unreasonable for the PT to aim to maximize the beneficiary's capacity to manage her body even within the context of a progressive and unpredictable disease process. Moreover, this goal was only one of several set for the PT process, including decreasing pain and tension in neck and low back area and ensuring that the patient and caregivers become safe in performing transfers, which are plainly reasonable. Finally, the ALJ identified no legal requirement that a beneficiary must reasonably be expected to achieve independence in order for otherwise reasonable and necessary PT services to be covered, and such a requirement would be inconsistent with the regulatory provision that the "restoration potential of a patient is not the deciding factor in determining whether skilled services are needed" and that, even when "medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities." 42 C.F.R. § 409.32(c). The ALJ gave no other reason, and we find none, for determining that the beneficiary was not in need of skilled PT services during the period at issue.

Given that conclusion, we find nothing in the ALJ Decision or the record supports a finding that the number of PT visits provided over the months at issue was not reasonable and

necessary. We therefore conclude that the 48 PT visits are covered.

As noted, home health aide services are covered only when and for as long as the beneficiary needs skilled home health services, including physical therapy. 42 C.F.R. § 409.45(a). Since we have reversed the ALJ's conclusion that the beneficiary's physical therapy services were not reasonable and necessary, the home health aide visits now meet that condition. The services provided by the home health aides unquestionably fall within those contemplated by regulation, including personal care for an individual requiring total assist for all ADLs, assistance with transfers and bed mobility, providing support to skilled therapy where able to do so safely and effectively, all within physician's orders. 42 C.F.R. § 409.45(b). No basis has been demonstrated to conclude that the number of visits over the months at issue was not reasonable and necessary. We therefore conclude that the 97 home health aide visits are covered.[7]

CONCLUSION

The decision of the Medicare Appeals Council in both cases is fully favorable to the appellant for the reasons explained above.

MEDICARE APPEALS COUNCIL

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

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

Date: May 22, 2009

[7] In this case, as with the preceding one, the ALJ wrongly concluded that the beneficiary is liable for costs despite finding that no advance beneficiary notice in the record. ALJ Decision-D.W. at 3, 8. Given that we conclude that the services are covered, we again need not address liability.