DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
Visiting Nursing Association of Western NY, Inc. (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiary)	**** (HIC Number)
National Government Services (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated June 1, 2009, concerning Medicare coverage for physical therapy services provided by the appellant home health agency to the beneficiary on November 21, 2007, through January 2, 2008. The ALJ determined Medicare did not cover the services at issue and held the appellant liable for the non-covered services. The appellant has asked the Medicare Appeals Council (Council) to review this action.

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, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c).

As a preliminary matter, the appellant submitted additional documentation with its July 13, 2009, request for review. By letter dated October 6, 2009, the appellant clarified that it had not submitted new evidence with its appeal and that the documents submitted to the Council had already been submitted earlier in the appeals process. Thus, the Council finds that there is no good cause to admit this documentation and excludes the documents submitted with the appellant's request for review as duplicative of evidence already contained in the record, pursuant to 42 C.F.R. § 405.1122(c). We enter the remaining

portions of the appellant's request for review into the record as exhibit (exh.) MAC-1, the Council's October 1, 2009, letter as exhibit MAC-2, and the appellant's October 6, 2009, letter as exhibit MAC-3.

As explained more fully below, the Council reverses the ALJ's decision and grants coverage for the physical therapy services at issue because they were medically reasonable and necessary for the beneficiary.

BACKGROUND

The beneficiary, an 85 year old female, was admitted to home health care on November 21, 2007, with diagnoses of degenerative joint disease of the right shoulder and arthritis of the lower extremities. Exh. 2 at 6. Her medical history also includes hypothyroidism, hypertension, high cholesterol, and a mastectomy due to breast cancer. *Id.* The beneficiary's physician ordered physical therapy once a week for one week, and twice a week for five weeks, to increase the beneficiary's range of motion, manage pain, provide gait training, and evaluate and treat the beneficiary's condition. Exhs. 2 at 6, 3 at 57. The appellant home health agency furnished the beneficiary with 11 physical therapy visits from November 21, 2007, through January 2, 2008, and seeks Medicare coverage for these services. Exh. 1.

Initially, and on redetermination, the Medicare contractor denied coverage for this claim on the basis that the documentation did not support that the services were medically necessary. Exh. 4. On appeal, the Qualified Independent Contractor (QIC) also denied coverage for the services at issue. Exh. 5. The QIC reasoned, "[w]hile the physical therapy evaluation supports a decline in function to warrant skilled intervention, the Outcome and Assessment Information Set (OASIS) does not." *Id.* at 84.

After conducting a hearing with the appellant's representative on May 13, 2009, the ALJ issued a decision denying coverage for the services at issue. Dec. at 1, 8. The ALJ determined that the "OASIS did not support a significant functional impairment to warrant therapy, as her prior and current levels of function were the same. The Beneficiary did not demonstrate any significant improvement and for that reason, the services are not covered by Medicare." *Id.* at 8

Before the Council, the appellant asserts that the ALJ repeated the QIC's error by relying on the OASIS form to deny coverage, because the form's "prior functional level" was designed to compare national outcomes, not to measure decline in function. Request for Review. The appellant asserts that Medicare should cover the services at issue because the therapy documentation is a better source to judge the presence of a significant functional decline. *Id.*

DISCUSSION

Introduction

In order for a beneficiary to qualify for Medicare coverage of home health services, he or she must be confined to the home, under the care of a physician, in need of skilled services, under a plan of care, and the services must be provided by a participating home health agency. 42 C.F.R. § 409.42.

The Centers for Medicare and Medicaid Services (CMS) provides the following guidance on interpreting the requirement that a beneficiary be "confined to the home" in its Medicare Benefit Policy Manual (MBPM):

> An individual does not have to be bedridden to be considered confined to the home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort.
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> Generally speaking, a patient will be considered to be homebound if they have a condition due to an illness or injury that restricts their ability to leave their place of residence except with the aid of: supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated.

MBPM, CMS Pub. 100-02, Ch. 7 at § 30.1.1.

In this case, the record reflects that the beneficiary resided in an independent living facility which provided assistance with

grocery shopping, meal preparation, yard and house work. Exh. 2 at 4. Previously, the beneficiary "was independent throughout the facility with just a cane." *Id.* However, at the time the physical therapy began, the beneficiary ambulated with a rolling walker for longer, out-of-room distances such as to and from meals. *Id.* There is nothing in the record to suggest that the beneficiary was other than confined to her home. Thus, the Council finds, based on the beneficiary's reliance on supportive devices, that she was homebound because leaving home would require a considerable and taxing effort.

Further, the "Home Health Certification and Plan of Care," signed and dated by the beneficiary's physician, indicates that the beneficiary was indeed "under the care of a physician," and "under a plan of care" as required by 42 C.F.R. § 409.42. *Id.* at 6. The document also reflects that the services were provided by the appellant, a participating home health agency. *Id.* Satisfaction of the above coverage criteria have not been raised as an issue at any point in the administrative appeals process. Therefore, we conclude that they have been satisfied. The sole issue remaining is whether the beneficiary needed skilled services.

Skilled Services

In addition to the criteria discussed above, a beneficiary must need "skilled services" in the form of intermittent skilled nursing services, physical therapy services, speech-language pathology services, or occupational therapy services to qualify for Medicare coverage. 42 C.F.R. § 409.42(c).

At the outset, we wish to clarify that the skilled services at issue are skilled therapy services. The ALJ's decision mistakenly referred to the beneficiary's need for skilled nursing services. Dec. at 8 ("The medical records in this case do not support that the Beneficiary required skilled nursing services.").

As relevant here, the physical therapy services provided must meet the criteria set forth in 42 C.F.R. § 409.44(c). To be considered reasonable and necessary, the physical therapy services must be:

1) considered under accepted standards of medical practice to be a specific, safe, and effective treatment for the

beneficiary's condition;

2) of such a level of complexity and sophistication or the condition of the beneficiary must be such that the services required can safely and effectively be performed by a qualified physical therapist;

3) done with an expectation that the beneficiary's condition will improve materially in a reasonable (and generally predictable) period of time; and

4) of a reasonable amount, frequency, and duration.

42 C.F.R. § 409.44(c).

Before the Council, the appellant asserts that the OASIS B functional items, relied upon by the QIC and the ALJ, "are not sensitive enough to differentiate between using a rolling walker and a standard cane, although this represents a significant functional decline (in fact in the revised OASIS C assessment due out in January of 2010, the functional items have been changed to reflect a difference between rolling walker and a standard cane)." Exh. MAC-1. We agree.

The OASIS is an "instrument/data collection tool used to collect and report performance data by home health agencies. . . . Since fall 2003, CMS has posted on www.medicare.gov a subset of OASIS-based quality performance information showing how well home health agencies assist their patients in regaining or maintaining their ability to function." CMS Medicare Home Health Quality Initiatives, available at http://www.cms.hhs.gov/HomeHealthQualityInits/ (last visited Nov. 18, 2009). Thus the main purpose of the OASIS is to report and compare national outcomes, not to measure decline in function. Although an OASIS may inform a coverage determination, it should not form the exclusive basis for the determination. "A coverage denial is not made solely on the basis of the reviewer's general inferences about patients with similar diagnoses or on data related to utilization generally but is based upon objective clinical evidence regarding the beneficiary's individual need for care." 42 C.F.R. § 409.44(a). Thus, in this instance, we find that the ALJ erred in basing his coverage determination on the beneficiary's OASIS scores.[1]

[1] In its final rule issued January 25, 1999, CMS stated that the OASIS focuses on outcomes of care. It was developed as a system of outcome measures that could be used specifically for outcome-based quality improvement and

After considering the evidence, the Council finds the physical therapy services at issue were reasonable and necessary pursuant to section 1862(a) of the Social Security Act (Act), and therefore are covered by Medicare. The record, taken as whole, supports the conclusion that the beneficiary experienced a decline in function for which the physical therapy services provided were reasonable and necessary.

Specifically, the "Home Health Certification and Plan of Care" reflects that the beneficiary experienced an exacerbation of arthritis that left her ambulating with a rolling walker as opposed to her prior status of ambulating with a cane. Exh. 2. The beneficiary's receipt of a cortisone injection in her right shoulder the week prior to starting therapy further supports the premise that the beneficiary had experienced an exacerbation of her chronic condition. *Id.*

Further, the beneficiary's Tinetti Gait and Balance Assessment scores revealed significant improvement. Exh. 3 at 53. Upon initial evaluation, the beneficiary's score was 7/28, which indicates that she had a risk of severe falls. *Id.* Upon discharge, this score had improved to 18/28, signifying a moderate fall risk. *Id.*

CMS has provided additional coverage guidance in the MBPM:

> 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.

CMS Pub. 100-02, MBPM, Ch. 7 at § 40.2.2.C. In this case, the beneficiary's ability to walk was impaired by arthritis. The physical therapy visit notes reflect that skilled gait training occurred during each visit. Exh. 3 at 10-52. Thus, the Council finds that the therapy could reasonably have been expected to improve materially the beneficiary's ability to ambulate and satisfies the coverage criteria set forth in 42 C.F.R. §

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evaluation in home health agencies. The final rule also stated that the OASIS, while helpful for patient assessment, is not a care planning tool and was not designed to be a comprehensive patient assessment. 64 Fed. Reg. 3764, 3772 (January 25, 1999).

409.44(c). While the beneficiary's goals and improvements during this episode of care were somewhat modest, the physical therapy services were of a reasonable amount, frequency, and duration to enable her to regain range of motion and manage pain, and remain in her independent living community.

DECISION

It is the decision of the Medicare Appeals Council that the physical therapy services furnished to the beneficiary on November 21, 2007, through January 2, 2008, were reasonable and necessary, and thus, covered by Medicare. Accordingly, the hearing decision is reversed.

MEDICARE APPEALS COUNCIL

/s/ M. Susan Wiley
Administrative Appeals Judge

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: November 20, 2009