

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-213

In the case of

Ottawa County Riverview
Nursing Home

(Appellant)

(Beneficiary)

National Government Services

(Contractor)

Claim for

Supplementary Medical
Insurance Benefits (Part B)

(HIC Number)

(ALJ Appeal Number)

INTRODUCTION

The Administrative Law Judge (ALJ) issued a decision dated August 31, 2010, which concerned occupational therapy (OT) services provided under the Medicare Part B benefit to the beneficiary, then a resident of a skilled nursing facility (SNF), from March 23, 2009, through March 31, 2009. The ALJ determined that the services were not covered and that the appellant was liable for non-covered charges. The appellant has asked the Medicare Appeals Council (Council) to review this action. The Council admits the appellant's request for review and enclosures, and subsequent interim correspondence, into the administrative record as Exhibits (Exhs.) MAC-1 and MAC-2.

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 set forth below, the Council reverses the ALJ's decision.

APPLICABLE LEGAL AUTHORITIES

The Council adopts and incorporates the ALJ's statement of "Principles of Law" herein. Dec. at 3. Medicare regulations also provide coverage requirements for skilled OT services, as follows:

[Occupational therapy] services must be reasonable and necessary. To be considered reasonable and necessary, the following conditions must be met:

(i) The services must be considered under accepted standards of medical practice to be a specific, safe, and effective treatment for the beneficiary's condition.

(ii) The services must be 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 only by . . . a qualified occupational therapist or a qualified occupational therapy assistant under the supervision of a qualified occupational therapist Services that do not require the performance or supervision of . . . an occupational therapist are not considered reasonable or necessary . . . occupational therapy services, even if they are performed by or supervised by [an] occupational therapist. . . .

(iii) There must be an expectation that the beneficiary's condition will improve materially in a reasonable (and generally predictable) period of time based on the physician's assessment of the beneficiary's restoration potential and unique medical condition, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific disease, or the skills of a therapist must be necessary to perform a safe and effective maintenance program. . . .

(iv) The amount, frequency, and duration of the services must be reasonable.

42 C.F.R. § 409.44(c); Medicare Benefit Policy Manual (MBPM)(Pub. 100-02), Ch. 15 § 220.2.¹ Regulations further provide that "[g]eneral supervision of exercises which have been taught to the patient; including the actual carrying out of

¹ Manuals issued by the Centers for Medicare & Medicaid Services (CMS) can be found at <http://www.cms.hhs.gov/manuals>.

maintenance programs, i.e., the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services" 42 C.F.R. § 409.33(d)(13).

DISCUSSION

On appeal, the appellant argues that the ALJ erred by concluding that, "[w]hile the record established a need for rehabilitation due to a decline in the Beneficiary's overall ability to function, the record fails to show that the beneficiary required the skills of a licensed therapist" for the eight OT sessions. Exh. MAC-1, at 1. The appellant maintains that the skills of a licensed therapist were required to assess the beneficiary's "deficits in strength, range of motion, and mobility that were related to her decline in function," including sit/stand technique for transfer as well as diathermy and stretching for range of motion. *Id.* The appellant points to the beneficiary's prior discharge from OT on January 6, 2009, as establishing functional benchmarks that evidence the beneficiary's "significant decline" from then until the dates of service. *Id.* The appellant also argues that the physician approved services including therapeutic exercise, therapeutic activities, activities of daily living (ADL) retraining, and modalities (moist hot pack, ultrasound, electrical stimulation, and diathermy) to improve range of motion. *Id.* The appellant cites the beneficiary's documented progress in several areas as supporting medical necessity. *Id.* at 2.

The ALJ found that, as of January 6, 2009, the 93 year old beneficiary's level of function included grooming with set up, bathing and toilet transfers with minimal assistance, and wheelchair propulsion with stand by assistance. Dec. at 2. On March 3, 2009, the physician ordered OT services because of "the patient's decline in simple ADLs and in mobility with a diagnosis of lack of coordination." *Id.*² The ALJ noted that a treatment plan was established and, at that time, the beneficiary's level of function included minimal assistance in

² On March 23, 2009, the physician ordered OT 5x/wk for 30 days. Exh. 6, at 2. Treatment records indicate that the beneficiary also received services on April 2, 2009, and April 3, 2009. *Id.* at 12. The OT Evaluation and ALJ decision indicate that the services were billed to Medicare Part B, and the initial determination, redetermination, and reconsideration reflect dates of service from March 23, 2009, through March 31, 2009. Dec. at 1; Exhs. 6, at 6, 9; 4, at 1; 3, at 1. The Council's decision is thus confined to dates of service March 23, 2009, through March 31, 2009.

grooming, "2 maximum assist with bathing and toilet transfers," and "poor wheel chair propulsion ability." *Id.* In his analysis, the ALJ stated that the beneficiary had "experienced a functional decline which could be addressed by a course of outpatient rehabilitation," but then found that the evidence failed to establish that the skills of a licensed therapist were required. *Id.* at 3-4. In response to questioning, the appellant's representative "indicated that the therapist was familiar with the patient and the patient's prior level of function and expected that the patient would improve in a reasonable period of time." *Id.* The ALJ found this testimony insufficient to establish that the skills of a licensed therapist were required. *Id.*, citing MBPM, Ch. 15, §§ 220.2(B), (C). The ALJ concluded that the OT services from March 23, 2009, through March 31, 2009, were not covered by Medicare and that the appellant was liable for non-covered charges under section 1879 of the Social Security Act (Act). *Id.*

On March 4, 2009, the physician noted that the beneficiary had "depression with some increased symptomology partially related to parkinsonian symptoms. We are going to try her on an Exelon patch 4.6 for 24 hours. Get rid of her Mirapex and see if we can help stabilize that as she's also having some early dementia symptomology which may be related to early Alzheimer's versus parkinsonian dimension." Exh. 6, at 18.³ The beneficiary would continue Lexapro for depression, while the physician stated that he would "see if we can stabilize the mood issue with Exelon and follow up." *Id.*

On March 29, 2009, the physician noted that the beneficiary "continu[ed] to have some emotional outbreaks over the past three weeks." Exh. 6, at 18. Her Exelon patch had been placed on hold for one week, but no difference was noted. *Id.* The physician had prescribed OT secondary to the beneficiary's decline, but "[n]o significant changes there." *Id.* Her Exelon patch was resumed, but there was "[r]eally not a whole lot of change emotionally." *Id.* The physician noted that the beneficiary was worse at lunch time and that the appellant staff had "been trying to get her more involved in activities." *Id.* The plan was to discontinue the Exelon patches, hold the Mirapex medication, continue the anti-depressant, and add a low dose of

³ Exelon (Rivastigmine) is indicated for treatment of Alzheimer's Disease, while Mirapex (Pramipexole) is indicated for treatment of Parkinson's Disease. <http://www.nlm.nih.gov/> (August 29, 2011).

Xanax anti-anxiety medication at lunch time and "see how the next couple of weeks go with that." *Id.*

On April 7, 2009, the appellant prepared a quarterly assessment Minimum Data Set (MDS) form which indicates that the beneficiary had modified independence in cognitive skills for daily decision making. Exh. 1, at 20. She was documented as having indicators of depression, anxiety, and sad mood, but the MDS states that the "indicators present [were] easily altered." *Id.* With respect to ADLs, the beneficiary required extensive one person assistance with respect to locomotion off the unit, dressing, toilet use, and bathing. *Id.* Her conditions were noted as unstable, i.e., "fluctuating, precarious, or deteriorating." *Id.* at 22. She had received training in skills required to return to the community (e.g., ADLs) and OT in the prior 14 days. *Id.* at 22-23. Her "overall self sufficiency" level was unchanged from 90 days before. *Id.*

The Council agrees with the ALJ that the beneficiary experienced a functional decline prior to the physician's order for the OT services. Dec. at 4. However, the Council disagrees that the skills of a licensed therapist were not medically necessary to address that decline. More specifically, the Council finds that the record establishes "an expectation that the beneficiary's condition [would] improve materially in a reasonable (and generally predictable) period of time based on the physician's assessment of the beneficiary's restoration potential and unique medical condition" 42 C.F.R. § 409.44(c)(iii). The record indicates that, on January 6, 2009, the beneficiary required, in part, minimal assistance with both bathing and toilet transfer. Exh. MAC-1, at 1. At the onset of the instant services, the beneficiary required maximum assistance from two persons for the same functions. *Id.* The Council finds that, on the facts of this case, this decline supports the intervention of skilled rehabilitation services in response.

The record also indicates that the physician attempted more than one intervention in response to the beneficiary's decline, including the eight OT visits. On March 29, 2009, the physician determined that there were no "significant changes" resulting from the OT and made further medication changes. Exh. 6, at 18. This conclusion, however, does not obviate the reasonable expectation for material improvement at the time the services were ordered on March 23, 2009. *Id.* at 2. In fact, the MDS, dated April 7, 2009, reflects that the beneficiary required a

one person assist with toilet transfers, indicating improvement since the evaluation. Compare Exh. 6, at 21 with Exh. MAC-1, at 1. The Council thus finds that the OT services were reasonable and necessary and are covered under the Medicare Part B benefit.

DECISION

It is the decision of the Medicare Appeals Council that the occupational therapy services provided from March 23, through March 31, 2009, are covered by Medicare Part B. The decision of the ALJ is reversed.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

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

Date: September 7, 2011