DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-12-987

In the case of	**Claim for**
Meadow View Manor c/o Extendicare Health Services, Inc. (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
National Government Services (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated February 2, 2012, concerning outpatient occupational therapy (OT) services furnished to the beneficiary from March 1, 2011, through March 21, 2011. The ALJ determined that the services were reasonable and necessary under section 1862(a) of the Social Security Act (Act), but denied payment for the services because the physician's orders and plan of treatment were signed by an advanced practice registered nurse (APRN) on behalf of the physician rather than the physician himself. The ALJ did not determine the party liable for the non-covered charges. The appellant has asked the Medicare Appeals Council (Council) to review this action. The Council enters the appellant's request for review dated March 1, 2012, and attachments into the record as Exhibits (Exhs.) MAC-1 and MAC-2, respectively.[1]

[1] The attachments consisted of new evidence containing excerpts to the Wisconsin Administrative Code and the Medicare Benefit Policy Manual (MBPM) (CMS Pub. 100-02). Because the new evidence supports the appellant's contention of an issue raised by the ALJ for the first time, the Council finds good cause for admitting the new evidence into the record. 42 C.F.R. § 405.1122(c).

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. *Id*. § 405.1112(c).

As set forth below, the Council modifies the ALJ's decision to correct the basis for the coverage denial and to determine the party liable for the non-covered charges.

BACKGROUND

The beneficiary lived in the appellant's facility since July 31, 2006. Exh. 3, at 44. Her medical diagnoses included rheumatoid arthritis, degenerative disc disease, hypertension, and history of falls. *Id*. During the dates of service, the appellant provided physical therapy (PT) and OT services to the beneficiary. Exh. 1, at 4-7.

As relevant here, on February 16, 2011, an APRN signed and certified an OT plan of treatment (POT) for the beneficiary on behalf of the physician. Exh. 2, at 16. The POT is largely illegible, but the legible portions show that the beneficiary had a treatment diagnosis of abnormal posture and the POT contained orders for "self care/home management training" and wheelchair management. *Id*. The POT also shows that the goals of the OT services were to enable the beneficiary to propel her wheelchair to the dining room and to tolerate sitting in the wheelchair without complaints of discomfort. *Id*.

The appellant subsequently sought coverage for the PT and OT services furnished to the beneficiary from March 1, 2011, through March 21, 2011. Exh. 1, at 4-7. On initial determination, the Medicare contractor covered the PT services, but denied coverage for the OT services, which were billed under CPT codes 97024 (diathermy), 97535 (self-care management training), and 97542 (wheelchair management training).[2] *Id*. The appellant appealed the coverage denial for the OT services, but on redetermination, the contractor denied coverage and held the appellant liable for the non-covered charges. Exh. 3, at 39,

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[2] The Centers for Medicare & Medicaid Services (CMS) has developed the Healthcare Common Procedure Coding System (HCPCS) to establish "uniform national definitions of services, codes to represent services, and payment modifiers to the codes." 42 C.F.R. § 414.40(a). CPT codes are Level I HCPCS codes and are 5-position numeric codes representing physician services.

citing LCD for Outpatient Physical and Occupational Therapy Services (LCD L26884).[3] On reconsideration, the Qualified Independent Contractor (QIC) affirmed the redetermination's coverage and liability conclusions. Exh. 4, at 50-52.

As discussed above, upon further appeal, the ALJ denied coverage for the OT services because the physician's orders and plan of treatments were signed by an APRN. Dec. at 4-5. The ALJ further concluded that "[b]ecause the services are not being denied under [section] 1862 of the Act, liability cannot be waived." *Id.* at 5. The ALJ did not ultimately determine the party liable for the non-covered charges. *Id.*

In the request for review, the appellant argues that the MBPM allows for an APRN to sign a plan of care on behalf of a physician. Exh. MAC-1, at 1, *citing* MBPM, Ch. 15, § 220(A).[4] The appellant also argues that its state and local laws do not prohibit this practice. *Id.*

DISCUSSION

Coverage

Medicare coverage for outpatient OT services requires that the services be (1) furnished under a written POT, (2) while the individual is or was under the care of a physician, and (3) the services are medically reasonable and necessary. Act §§ 1835(a)(2)(C), 1862(a)(1)(A); *see also* 42 C.F.R. § 410.59; MBPM, Ch. 15, § 220. The Council agrees with the appellant that the ALJ erred by concluding that the APRN may not sign certifications or orders on behalf of the physician. Medicare regulations make clear that a nurse practitioner may sign certification statements and establish POTs. 42 C.F.R. §§ 410.61(b)(5), 424.11(e). The MBPM also states that a nonphysician practitioner (NPP) such as a nurse practitioner may certify therapy services. MBPM, Ch. 15, §§ 220(A); 220.1.3(C). Accordingly, the Council finds that the case contains the proper signatures.

However, despite the proper signatures, we find that Medicare does not cover the OT services furnished to the beneficiary

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[3] Contractor LCDs can be found using the search function in the Medicare Coverage Database (MCD) at www.cms.hhs.gov/mcd.

[4] Manuals issued by the CMS can be found at http://www.cms.gov/manuals.

because they were not medically reasonable and necessary under section 1862(a)(1)(A) of the Act. As relevant here, the MBPM provides that outpatient therapy services are considered reasonable and necessary if the following conditions are met:

- The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist.
- There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state.
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice.

MBPM, Ch. 15, § 220.2(B).

Additionally, LCD L26884,[5] the applicable LCD not discussed by the ALJ, provides additional coverage guidelines and states that "[s]*ervices related to activities for the general good and welfare of patients, such as general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation, do not constitute (covered) therapy services*." (italics in original). The LCD also states that "if at any point in the treatment of an illness or injury it is determined that the treatment is not rehabilitative, or becomes repetitive and does not require the unique skills of a therapist, the services are non-covered." LCD L26884.

The record indicates that the beneficiary had received OT services from February 11, 2011, through February 18, 2011, but was subsequently placed on "hold" for further OT services while awaiting the delivery of a wheelchair cushion. Exh. 2, at 21, 29, 31. On March 7, 2011, and March 8, 2011, the appellant resumed OT services to provide diathermy services. *Id.* at 22,

[5] ALJs and the Council must give substantial deference to LCDs. 42 C.F.R. § 405.1062(a). Should an ALJ or the Council decline to follow a LCD, the decision must explain the reasons why the policy was not followed. *Id.* § 405.1062(b). Further, an ALJ and the Council may not set aside or review the validity of a LCD for purposes of a claim appeal. *Id.* § 405.1062(c).

33; Exh. 1, at 7. At that time, the wheelchair cushion was still on order and the diathermy treatment addressed the beneficiary's complaint of shoulder pain with the use of a *wheeled walker*. Exh. 2, at 33. The diathermy treatments however were not related to the beneficiary's POT goals of increasing *wheelchair* mobility and comfort, and therefore, were not furnished under a written plan of treatment as required by 42 C.F.R. § 410.59(a)(2). *Id.* at 16, 22. Additionally, the order for diathermy did not state the duration and frequency for the treatment, and therefore, there is no way to determine whether the clinician expected that the beneficiary's condition would improve significantly in a reasonable (and generally predictable) period of time. *Id.* at 22; MBPM, Ch. 15, § 220.2(B).

On March 7, 2011, and March 8, 2011, the appellant also resumed OT services to provide self-care management training. Exh. 1, at 7; Exh. 2, at 33-34. The training consisted of asking the beneficiary to perform various finger and shoulder stretches and instructing the beneficiary regarding toileting task transfers with a *wheeled walker*. Exh. 2, at 33-34. However, these trainings were also not related to the beneficiary's POT goals of increasing *wheelchair* mobility and comfort, and therefore, were not furnished under a written plan of treatment as required by 42 C.F.R. § 410.59(a)(2). Additionally, the record does not show that the beneficiary had a functional deficit or medical condition that would warrant such training and the beneficiary had even questioned the usefulness of the training. *See, e.g., id*. at 23, 34. Therefore, the self-care management training appears to be for the general good and welfare of the beneficiary, and therefore, is not a covered therapy service. LCD L26884.

Lastly, the appellant provided OT services for wheelchair management training on March 14, 2011, and March 15, 2011. Exh. 1, at 7; Exh. 2, at 35. The training consisted of asking the beneficiary to propel the wheelchair to the dining room and observing the beneficiary's wheelchair positioning and foot contact. Exh. 2, at 35. However, the beneficiary had previously received such training and had already been able to propel the wheelchair for up to 212 feet and to the dining room on February 17, 2011, and February 18, 2011, respectively. *Id.* at 29, 31, 35. The record also does not indicate that the beneficiary had a functional deficit or medical condition during the period at issue that would warrant these additional

trainings. Therefore, the wheelchair management trainings were repetitive and ceased to be rehabilitative. LCD L26884. Accordingly, the services did not require the unique skills of a therapist and are not covered by Medicare. *Id.*

In sum, we find that the OT services at issue are not covered by Medicare because they were not medically reasonable and necessary under section 1862(a)(1)(A) of the Act.

Liability

Because we are denying coverage under section 1862(a)(1)(A) of the Act, the limitation on liability provision under section 1879 of the Act becomes applicable. *See* Act § 1879. Specifically, section 1879(a)(2) of the Act provides that the limitation on liability applies when a beneficiary or provider did not know, and could not reasonably have been expected to know, that the item or service was not covered by Medicare.

In this case, the record does not contain any evidence, such as an Advanced Beneficiary Notice (ABN), showing that the beneficiary had knowledge of the non-coverage before receiving the services. *See generally* CMS Ruling 95-1; Medicare Claims Policy Manual (MCPM) (CMS Pub. 100-04), Ch. 30, § 40.2 (evidence of beneficiary knowledge). The Council therefore finds that the beneficiary did not know and could not reasonably have been expected to know that the services were not covered by Medicare.

The Council however finds that the appellant, as a provider participating in the Medicare program, knew or had reason to know that Medicare would not cover the OT services at issue. *See* 42 C.F.R. § 411.406(e); MCPM, Ch. 30, §§ 40.1-40.1.2. Accordingly, the appellant is liable for the non-covered charges under section 1879 of the Act.

DECISION

The Council finds that the OT services furnished to the beneficiary from March 1, 2011, through March 21, 2011, are not covered by Medicare. The Council also finds that the appellant is liable for the non-covered charges.

The ALJ's decision is modified consistent with this decision.

MEDICARE APPEALS COUNCIL

/s/ Stanley I. Osborne, Jr.
Administrative Appeals Judge

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

Date: June 20, 2012