DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
Commissioner, New Jersey Department of Human Services (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 November 3, 2008, which concerned a claim for home skilled therapy services provided to the beneficiary from October 27, 2005, to October 21, 2006 (ALJ Decision). The ALJ determined the claimed services were not covered by Medicare and held the appellant, not the beneficiary, liable for the cost of the provided services. The appellant has asked the Medicare Appeals Council to review this action for the claim of services provided from May 22, 2006, to September 26, 2006.

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 modifies the ALJ Decision.

CASE BACKGROUND

This appeal is brought by New Jersey's Medicaid State agency (as statutory subrogee). The appeal is limited to the ALJ's denial of coverage for 19 speech therapy sessions provided to the beneficiary between May 22, 2006 and September 26, 2006.[1]

[1] The claim originally comprised all home health skilled therapy services provided to the beneficiary from October 27, 2005 through October 21, 2006, but at the hearing the appellant withdrew its claim as to all services except

The ALJ found, and the appellant does not contest, that the beneficiary was 38 years of age and suffering from brain injury, intracranial hemorrhage, and hypothyroidism during the relevant time period. ALJ Decision at 2, and record citations therein. Speech therapy orders were added to his care plan beginning with the certification period starting April 25, 2006. Id. The ALJ concluded that the beneficiary was homebound throughout the relevant period. ALJ Decision at 13.[2]

The ALJ described the services at issue as intended to "address articulation skills and speech clarity." Id. at 2. The ALJ denied coverage of speech therapy on the grounds that "there was no reasonable expectation of material improvement," from the treatment. He based that finding on testimony from the provider's Director of Quality Improvement that there was "no expectation of significant gains from speech therapy, even considering that some of the therapies may have been innovative and creative." Id. at 13.

APPLICABLE LAW

The regulations provide that, in order to qualify for home health services, a beneficiary must be –

(a) Confined to the home. The beneficiary must be confined to the home . . . .
(b) Under the care of a physician. The beneficiary must be under the care of a physician who establishes the plan of care. . . .
(c) In need of skilled services. The beneficiary must need at least one of the following skilled services as certified by a physician in accordance with the physician

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44 physical therapy sessions and the 19 speech therapy sessions at issue here. The ALJ denied coverage of all the services, but the appellant expressly elected not to appeal as to the physical therapy services. Appellant's Memorandum of Law in Support of Request to Review (RR Memo) at 1, n.1. Our decision therefore does not address or affect the resolution of the parts of the claim not before us on appeal.

[2] The original determination was based on a finding that the beneficiary was not homebound, while the reconsideration decision asserted that basis and also that the beneficiary had "plateaued in his advanced physical therapy" so that he was now receiving maintenance therapy. Ex. 1, at 669. The panel review attached to the reconsideration does not provide any substantiation or basis for finding the speech-language services, as opposed to the physical therapy, not reasonable or necessary because of any plateau or prior services. Id. at 648-659. The reconsideration decision merely makes the conclusory statement that "[o]verall, Medicare criteria were not met for the coverage of physical and speech therapies." Id. at 662.

> certification and recertification requirements for home health services under § 424.22 of this chapter.
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> * * *
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> (3) Speech-language pathology services that meet the requirements of § 409.44(c).

42 C.F.R. § 409.42.

Section 409.44(c) requires, inter alia, that speech-language pathology services must "relate directly and specifically to a treatment regime . . . that is designed to treat the beneficiary's illness or injury," and not relate merely to general physical welfare, such as "exercises to promote overall fitness." 42 C.F.R. § 409.44(c)(1). In addition, the speech-language pathology services must be reasonable and necessary, which includes the following components:

- The services must be "specific, safe and effective treatment for the beneficiary's condition" under "accepted standards of medical practice.
- The services must be "of such a level of complexity and sophistication or the condition of the beneficiary must be such that" only a qualified speech-language pathologist may perform them.
- The beneficiary's condition must be expected to "improve materially in a reasonable (and generally predictable) period of time" or 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."
- The services must be reasonable in "amount, frequency, and duration."

42 C.F.R. § 409.44(c)(2)(i)-(iv).

ANALYSIS

The appellant objects to the ALJ's finding that there was no reasonable expectation of beneficiary improvement as unfounded and based solely on oral statements made by the provider's representative at the hearing which conflict with the weight of the evidence in the record. A review of the record as a whole

indicates that the ALJ's finding is not supported by substantial evidence.

The ALJ does not explain why he did not consider evidence from the medical records that the speech-language therapy was aimed at improving the beneficiary's dysphagia in swallowing, rather than merely his speaking abilities. Nor does he explain why he did not credit evidence in the record, discussed below, of specific and measurable improvements which the beneficiary actually achieved in the course of the therapy.

May 4, 2006 speech therapy notes in the record indicated that a speech therapist who had been working with the beneficiary on oral-motor abilities and articulation skills referred him to another practitioner with suitable equipment available to evaluate his suitability for stimulation therapy to address his swallowing problems. Ex. 7, at 500. The second speech-language pathologist assessed him on May 22, 2006, found reduced labial tone, strength and function, reduced lingual strength, reduced laryngeal elevation, and pooling of saliva in mouth. The speech-language pathologist recommended a barium swallow study for further assessment, which the physician added to the plan of care. Id. at 501, 540.

Based on the results, dysphagia therapy was ordered twice a week for 8 weeks in the care plan signed by the physician. Ex. 8, at 579. The notes of the subsequent therapy sessions document treatment with neuromuscular electrical stimulation, use of exercises with straws and musical instruments to train muscles, training in exercises and techniques to be tried between sessions in an effort to improve ability to swallow different consistencies and to increase function. Ex. 8, at 544-49. The therapist noted "increased ability to control secretions during eating," and an ability to "sip from a smaller diameter straw," and recommended a repeat barium swallow study to evaluate the beneficiary's response to treatment after four weeks of treatment. Id. at 546, 547. The study completed on August 1, 2002 "revealed significant improvement in bolus formation and oral stage of swallow" since the onset of the therapy. Id. at 549.

The physician prescribed continuing dysphagia therapy, including neuromuscular electrical stimulation, one to two times a week. Ex. 9, at 582. The therapy notes of the second four week period record "steady improvements," and identify specific skills and abilities acquired and increased, such as the ability to purse

lips, to blow bubbles, to drink thin liquids without coughing, to eat foods that he could not previously tolerate, to swallow capsules with a teaspoon of milk, and to complete phoneme repetition with less cuing. Ex. 9, at 584-588. Improvements in strength and function were observed. Id.

The testimony of the home health provider representative at the hearing acknowledged that the beneficiary had made some progress in the dysphagia therapy using the new neuromuscular electrical stimulation approaches, but asserted that overall they did not expect his prognosis from the traumatic brain injury "overall" to improve significantly. She also asserted that the services were provided in good faith based on approval by the state Medicaid agency.

The ALJ made no reference to the dysphagia goals and therapy and offered no reason to disregard the medical records indicating that measurable and significant improvement did occur. Nor did he explain why he concluded that no material benefit could be expected from a therapy which in fact yielded concrete benefits. That conclusion was the only basis on which the ALJ denied coverage, since he made no finding that the therapy was not otherwise reasonable and necessary. Nothing in the record suggests that the therapy was not a specific, safe and effective treatment for the beneficiary's dysphagia, that the services could have been delivered by anyone other than a skilled speech-language therapist, or that the frequency and duration of the services was unreasonable.

CONCLUSION

For the reasons explained above, we modify the ALJ Decision only as to the 19 speech-language pathology services provided between May 22, 2006 and September 26, 2006. We conclude that those services were medically reasonable and necessary and were covered under Medicare. We do not disturb the ALJ's conclusions

as to the other home health services that were at issue before him.

MEDICARE APPEALS COUNCIL

/s/ Leslie Sussan
Board Member

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: May 5, 2009