Department of Health and Human Services
OFFICE OF MEDICARE HEARINGS AND APPEALS
Miami, Florida

Appeal of:	OMHA Appeal No.:
Enrollee:	Medicare: **Part C**
HICN: *******1828A**	Before: Administrative Law Judge

DECISION
FAVORABLE

After careful consideration of the evidence in the record and the arguments presented in the hearing, a FAVORABLE decision is entered for ("Appellant").

Procedural History

This case is before the Administrative Law Judge ("ALJ") on appeal from an unfavorable decision made by Blue Cross and Blue Shield of Michigan ("BCBS"), the beneficiary's Medicare Health Management Organization and Maximus Federal Services, Medicare Manage Care & PACE Reconsideration Project (Maximus) (Ex. 1, pp. 30-32, 80-82, 88-89, 101-104). In its reconsideration re-opening dated October 10, 2017, Maximus agreed that BCBS did not have to preapprove an additional 131 hours of skilled outpatient physical therapy services. (Ex. 1, pp. 80-82)

Appellant timely filed a request for an ALJ hearing that was received by the Office of Medicare Hearings and Appeals ("OMHA") on November 1, 2017. (Ex. 3) The remaining amount in controversy meets the jurisdictional requirements for a hearing before OMHA.[1] Therefore, the jurisdictional predicates are met and the claim for services which is covered by this decision is properly before the ALJ for *de novo* review.

Appellant has been properly notified at the redetermination and reconsideration levels of this appeal that the regulations require full and early presentation of the evidence, and that additional evidence may not be submitted to the ALJ unless good cause is shown.[2] Appellant submitted Letters from Dr. dated 09/22/2017 and the therapist, dated 09/27/2017. Since the limitation on the submission of new evidence is not applicable to Part

[1] 81 Fed. Reg. 65651 (September. 23, 2016)
[2] 42 CFR §§405.1018 and 405.1028

C appeals, the documentation received from Appellant was admitted into the record as Exhibit 6, pp. 13-14. *See* 42§§422.562(d)(2)(vi)

A telephone hearing was held on December 19, 2017. [illegible] represented the and knowingly waived the right to legal counsel. (Hearing CD) Present and testifying on behalf of Appellant was [illegible] Grievance and Appeals Team Lead represented the plan. Present and testifying on behalf of the plan were: S[illegible] and Appeals Manager; [illegible] Grievances and Appeals Coordinator; Sr. Medical Director; [illegible], Physician Consultant; Medical Director; and [illegible], Vice President, Utilization Management. The QIC was notified of the hearing but elected not to participate. The exhibits 1-6 were admitted into the record without objections.

After a thorough review of the record and the testimony presented at the hearing, the ALJ concludes that BCBS does have to cover skilled outpatient physical therapy services 2-3 times a week as directed by the treating physician.

Issues

1. Whether the contract coverage provisions have been met warranting payment?

Findings of Fact

1. The enrollee, a 32 year old male, suffers from a traumatic brain injury ("TBI") and seizures after a 2008 fall [illegible] (Ex. 2, pp. 1-5)

2. BCBS paid for physical therapy ("PT") services 3 hours per day, three times per week from 2011 until the early part of 2017 when EviCore (BCBS third party payer) notified the enrollee's representative that services were being terminated. (Ex. 1, pg. 97) The enrollee's representative appealed to BCBS who subsequently authorized six (6) months of PT, *i.e.* March 2017 to September 18, 2017.

3. [illegible] the Physical Therapy Center, PT progress notes from 01/2/2017 (1st visit) to 09/05/2017 (85th visit) are part of the record. (Ex. 2, pp. 6-45) Then, [illegible] the physical therapist, requested authorization for additional therapy for the diagnosis of generalized muscle weakness, difficulty walking and intercranial injury. (*Id.* at 31) [illegible] used the 08/03/2017 (76th visit) re-evaluation report to support the need for therapy. (*Id.* at 34-37) The enrollee was described as ambulating a distance of 100 feet with bilateral upper extremity support in a duration of 1 minute and 15 seconds, and 1 minute and 23 seconds with improved step length and consistency between Left and right. The therapeutic interventions consisted of: neuromuscular re-education, gait training, therapeutic activities, and therapeutic exercises. Neuromuscular re-education focused on improving activation of gluts and trunk muscles, with dissociated movement patterns. Gait training focused on improving stance leg control and cadence with walking. Therapeutic activities focused on improving stairs mobility. And, therapeutic exercise consisted of cycling. The therapist opined that the enrollee would benefit from continued skilled physical therapy to improve left upper extremity and bilateral lower extremity muscle activation, range of motion and muscle strength to achieve and maintain neutral trunk alignment and balance in various position, independence with

basic ADLs, and ability to ambulate indoor and outdoor distances. He would also benefit from riding the RT 300 e stim bike to improve lower extremity muscle strength and activation.

4. BCBS and Maximus denied the physical therapist's request for additional services. (Ex. 1, pp. 80-82, 88-89, 101-104).

5. issued a letter of medical necessity referencing to published research focused on the need for continued therapy after brain injury have documented gains many years after the injury. tated that in this case PT focused on increasing muscle activation of the upper extremities, lower extremities, and trunk muscles which would allow the enrollee to perform his activities of daily living and functional tasks. And, that neuroplastic changes after a brain injury are ongoing and can be achieved through practice of functional tasks in a skilled setting. (Ex. 1, pp. 68-69) A 2011 published article title Harnessing Neuroplasticity for Clinical Applications was part of the record. (*Id.* at 117-151)

6. Letters of Medical Necessity were also issued by the enrollee's treating physicians, Dr. Brain Injury Medicine, and D: , Neurological Disorders. (Ex. 2, pp. 1-5) Dr. Fellows states that the enrollee's ambulatory status for household distance, and up and down stairs to his bedroom is remarkable. (*Id.* at 5) That maintaining and improving the enrollee's at this level of function is imperative because there is no first floor bedroom in the family home. And, that although the enrollee has experienced breakthrough seizures throughout 2016 and 2017, they are working on stabilizing the pharmacological program. explained that the enrollee's accomplishment has taken 10 years and that recovery is very slow due to the severity and complexity of his neurologic injury, he was still at 2 person assist 24/7. (*Id.* at 1) That if PT services were to stop his muscle strength and current physical abilities would decline.

7. After issuing a reconsideration decision, Maximus reopened the case and approved 4 additions visits, and denied 131 outpatient PT visits. (*Id.* at 30-32) A Maximus review addendum indicated that the physician reviewer had found that most research in this topic to date were not rigorous and that well-designed and controlled studies of the effectiveness of rehabilitation interventions in the setting of TBI are needed. (*Id.* at 52) Dr. a Physician Reviewer, opined that the enrollee could continue therapy with a home program, that the recovery period after the TBI had passed, that a maintenance program could be implemented at home or at the gym which he attended. And, that the therapy provided at was based on neuroplasticity, which based on [illegible] suggest recovery can be limited, experimental and no time period given.

Legal Framework

I. ALJ Review Authority

A. Jurisdiction

An individual who, or an organization that, is dissatisfied with the reconsideration of an initial determination is entitled to a hearing before the Secretary of the Department of Health and Human Services ("HHS"), provided there is a sufficient amount in controversy and a request for hearing is filed in a timely manner.[3]

[3] Social Security Act (Act) § 1869(b)(1)(A)

In implementing this statutory directive, the Secretary has delegated her authority to administer the nationwide hearings and appeals system for the Medicare program to OMHA.[4] The ALJs within OMHA issue the final decisions of the Secretary, except for decisions reviewed by the Medicare Appeals Council.[5]

A hearing before an ALJ is only available if the remaining amount in controversy is $100 or more.[6] The request for hearing is timely if filed within sixty days after receipt of the notice of the QIC's reconsideration decision.[7]

B. Scope of Review

Under the implementation policy of the Centers for Medicare and Medicaid Services ("CMS"), United States Department of Health and Human Services ("HHS"), all Medicare Part B claims which have been issued a reconsideration by a Qualified Independent Contractor ("QIC") are governed by the ALJ Hearing Procedures outlined in 42 C.F.R. §§ 405.1000 et seq.[8]

The issues before the ALJ include all the issues brought out in the initial determination, redetermination, or reconsideration that were not decided entirely in [the Appellant's] favor. However, if evidence presented before the hearing causes the ALJ to question a favorable portion of the determination, he or she will notify [the Appellant] before the hearing and may consider it an issue at the hearing.[9]

The ALJ may decide a case on the record and not conduct an oral hearing if the appellant and all the parties indicate in writing that they do not wish to appear before the ALJ at an oral hearing or if the evidence in the hearing record supports a finding in favor of the appellant on every issue.[10]

C. Standard of Review

The [Office of Medicare Hearings and Appeals] is staffed with Administrative Law Judges who are appointed pursuant to the Administrative Procedure Act. They act as independent finders of fact in conducting hearing pursuant to §1869 of the Act. ALJs conduct *"de novo" hearings of the* facts and law. See 70 Fed. Reg. 36386 (June 23, 2005).

II. Legal Authority Binding on ALJs

An ALJ is bound only by statutes enacted by Congress, regulations issued under the Act, rulings issued by CMS, and national coverage decisions in effect during the period at issue.[11] An

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[4] *See* 70 Fed. Reg. 36386, 36387 (June 23, 2005)
[5] *Id*
[6] *See* CMS Rul. 02-1, 67 Fed. Reg. 62478, 62480 (Oct. 7, 2002); 70 Fed. Reg. 11420, 11423 (Mar. 8, 2005); 72 Fed. Reg. 73348 (Dec. 27, 2007)
[7] 42 C.F.R. § 405.1002(a)
[8] 70 Fed. Reg. 11424 (March 8, 2005)
[9] 42 C.F.R. § 405.1032
[10] 42 C.F.R. § 405.1038
[11] 42 CFR §405.1060

ALJ should consider, but is not bound by, any other policy statements, instructions, and guides issued by CMS or by any Local Medical Review Policy or Local Coverage Determination.[12] While not binding on the ALJ, however, these manual and policy sections are entitled to substantial deference.[13]

III. Principles of Law

A. Statutes and Regulations- Medicare Advantage Program

The Medicare Advantage (MA) Program, Part C of the Title XVIII of the Act, provides that a MAO offering a MA plan must provide enrollees, at a minimum, with all basic Medicare-covered services by furnishing the benefits directly or, through arrangements, by paying for the benefits. MAOs may also provide mandatory and supplemental benefits through their plans. See §1852(a) of the Act.

Title 42 of the Code of Federal Regulations, Part 422 provides the rules and regulations that govern the MA Program. Pursuant to 42 C.F.R. §422.100(c), a "MA plan includes at a minimum basic benefits, and also may include mandatory and optional supplemental benefits." 42 C.F.R. §422.101(a) indicates that each MAO must "[p]rovide coverage of, by furnishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare (if the enrollee is entitled to benefits under both parts) or by Medicare Part B (if entitled only under Part B) and that are available in the plan's service area. Services may be provided outside of the service area of the plan if the services are accessible and available to enrollees."

Pursuant to 42 C.F.R. §422.111, a MAO must disclose to each enrollee electing a MA plan it offers, in a clear, accurate, and standard form, and at the time of enrollment and at least annually thereafter, the detailed content of plan description, including, but not limited to, the plan's service area, benefits, access, out-of-area coverage, emergency coverage, supplemental benefits, prior authorization and review rules, grievance and appeal procedures, quality improvement programs, disenrollment rights, and catastrophic caps and single deductibles, and premiums and cost-sharing, such as co-payments, deductibles and coinsurance.
Section 1832 of the Act establishes the scope of benefits under the Medicare Part B supplementary medical insurance program. Part B of the Act entitles a beneficiary to have payment made to him or her on his or her behalf for medical and other health services. *See* § 1832 (a) (2) of the Act; 42 CFR §410.3(a) (1).

Section 1861 of the Act includes as Medical and Other Health Services

(s) (2) (D) outpatient physical therapy services and outpatient occupational services

Section 1861 of the Act defines:

(g) The term "outpatient occupational therapy services" has the meaning given the term "outpatient physical therapy services" in subsection (p), except that "occupational" shall be substituted for "physical" each place it appears therein.

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[12] 42 CFR §405.1062

[13] *Id*; *Lyng v. Payne.* 476 U.S. 926, 939 (1986).

(p) The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

(1) who is under the care of a physician (as defined in paragraph (1), (3), or (4) of section 1861(r)), and
(2) with respect to whom a plan prescribing the type, amount, and duration of physical therapy services that are to be furnished such individual has been established by a physician (as so defined) or by a qualified physical therapist and is periodically reviewed by a physician (as so defined);

...
The term "outpatient physical therapy services" also includes speech-language pathology services furnished by a provider of services, a clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection.
....

See also 42 C.F.R. §§ 410.59 (Outpatient occupational therapy services; Conditions) **410.60** (Outpatient physical therapy services: Conditions); 410.61 (Plan of Treatment Requirements for Outpatient Rehabilitation Services); 410.62 (Outpatient speech –language pathology services; Conditions and exclusions); **424.24** (Requirements for medical and other health services furnished by providers under Medicare Part B).

B. Policy and Guidance

42 C.F.R. §422.101(b) provides the each MAO must also comply with CMS' national coverage determinations (NCDs), general coverage guidelines included in Medicare manuals and instructions, and written coverage decisions of local Medicare contractors with jurisdiction for claims in the geographic area in which services are covered under the MA plan. An ALJ is bound only by statutes enacted by Congress, regulations issued under the Act, rulings issued by CMS, and national coverage decisions in effect during the period at issue. *See* 42 C.F.R. §§ 405.1060, 405.1062. Pursuant to § 1869 (b)(3)(A) of the Act, and codified at 42 C.F.R. § 405.8 an Administrative Law Judge may not disregard, set aside, or otherwise review a National Coverage Determination (NCD).

Additionally, CMS and its contractors have issued policy guidance that describe criteria for coverage of selected types of medical items and services in the form of manuals and local medical review policies ("LMRPs") or local coverage determinations ("LCDs"). Specific to the instant case, the CMS, *Medicare Benefit Policy Manual (MBPM) (Internet-Only Manual Publ'n 100-2)*, Ch. 15, §220.1 - Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance and §220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services.

In addition, CMS and its contractors have issued policy guidance that describe criteria for coverage of selected types of medical items and services in the form of manuals and local medical review policies ("LMRPs") or local coverage determinations ("LCDs").

C. Financial Liability

Medicare policy states that the financial liability protection "...provisions apply to individuals enrolled in the Medicare Fee-For-Service (FFS) program (Parts A and B), but are not applicable to Medicare M+C (Part C) enrollees nor to non-Medicare enrollees.

Analysis

Maximus, at the reopening, approved 4 hours and denied 131 hours of the pre-authorize skilled outpatient physical therapy services requested. (Ex. 1, pp. 30-32) Maximus found that after 85 PT visits the enrollee had improved with therapy, and that the medical record failed to support that the services could only be delivered by a specialized skill, knowledge and judgment of a qualified therapist.

Appellant's representative argues that they support full recovery and not maintaining the enrollee at his current level of activity. (Ex. 1, pp. 105-106) That, the enrollee does is not "home bound" thus home therapy services are not available to him. And, that their home do not offer the type of equipment necessary to perform/safe therapy.

Original Medicare under Social Security Act of §1862(a)(20) states that outpatient physical therapy services are covered if reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. The regulations further explain that

> (a) To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.
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> (b) A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually nonskilled (such as those listed in § 409.33(d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes.
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> (c) The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in § 409.33.

42 C.F.R. § 409.32

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Guidance is provided in *MBPM* which states that outpatient physical therapy "[t]o be covered...must be skilled therapy services.... A service is not considered a skilled therapy service merely because it is furnished by a therapist or by a therapist/therapy assistant under the direct or general supervision, as applicable, of a therapist. If a service can be self-administered or safely and effectively furnished by an unskilled person, without the direct or general supervision, as applicable, of a therapist, the service cannot be regarded as a skilled therapy service even though a therapist actually furnishes the service. Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a therapist furnishes the service." MBPM, Ch. 15, §220.2 (A) And that "Rehabilitative therapy may be needed, and improvement in a patient's condition may occur, even when a chronic, progressive, degenerative, or terminal condition exists. For example, a terminally ill patient may begin to exhibit self-care, mobility, and/or safety dependence requiring skilled therapy services. The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient's condition or to maximize his/her functional abilities. The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist, or whether they can be safely and effectively carried out by nonskilled personnel.." MBPM, Ch. 15, §220.2 (C)

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BCBS's Evidence of Coverage for 2017, under chapter 4 Medical Benefit Charts (what is covered and what you pay), states that it will cover rehabilitation services, which includes physical therapy when

> "...[t]hese services are covered only when the services are specific, safe and effective treatment for your condition. The amount, frequency and time period of the services needs to be reasonable, and they need to complex or only qualified therapists can do them safely and effectively. To be eligible your condition must be expected to improve in a reasonable and generally-predictable period of time." (Ex. 1, pg. 68)

In this instance, BCBS denied this pre-authorization request on the basis that the Enrollee's treatment did not require the complex skills of a licensed therapist. However, at the hearing the BCBS representative testified that the benefits should be denied because the Plan changed the coverage starting in January of 2017 to add a requirement that in order to receive Physical Therapy the patient had to be expected to recover in a reasonable period of time. (Hearing CD, Ex. 4, EOC p. 68) This Judge finds that the requirement that the patient must be expected to recover in a reasonable period of time is in violation of the *Jimmo*[14] settlement. This Judge further notes that

[14] In 2013, CMS entered into the *Jimmo v. Sebelius* Settlement Agreement involving coverage pertaining to skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) benefits. http://www.medicareadvocacy.org/wp-content/uploads/2013/01/Order-Granting-Final-Approval.012413.pdf See, Settlement Agreement, *Jimmo v. Sebelius,* No. 5:11-cv-00017-cr (D. Vt. Jan. 24, 2013)

As a result of the settlement, CMS first issue a Fact Sheet disavowing the use of an "improvement standard", reaffirming the standard of review, laying out forthcoming activities clarifying policy, and conducting an educational campaign informing stakeholders on the written materials. In this communication, CMS explained that:

the EOC or Plan, does not place any limits on how many Physical Therapy visits an Enrollee may receive, nor does the Plan limit the dollar amount that can be paid for an Enrollee's Physical Therapy. The issue in this appeal is not whether the Enrollee is expected to recover in a reasonable period of time, the issue is whether the services are reasonable, effective treatments for the patient's condition and require the skills of a therapist. MBPM, Ch. 15, Sec. 220.2(c) The Enrollee's treating physician submitted a statement dated September 22, 2017, which says, *inter alia*, that the Enrollee continues to require the skilled care of a Physical Therapist 2-3 days a week for ongoing recovery, improvement in function, and maintenance of his status. The treating physician further stated that without the subject Physical Therapy the Enrollee's muscle strength and current physical abilities would decline, and his quality of life and general health would suffer. The treating physician further stated that the Physical Therapy prescribed for the Enrollee was not for the purpose of treating cognitive impairment. The treatment is for his motor skills, strengthening, gait training, and balance. (Ex. 2, pp. 1-2, 3) This Judge is well aware that BCBS has had physicians opine that the Enrollee no longer needed the Physical Therapy, and that the therapy should be limited to what the Enrollee has already received. Those physicians have not examined the Enrollee, nor have they have conducted any tests on the Enrollee, so therefore those physicians are not neutral uninterested witnesses. The physician who testified for BCBS at the hearing on this appeal is actually a full time employee of BCBS and he admitted that he had not reviewed all of the medical records, including all of the Physical Therapy notes prior to testifying at the hearing that the Enrollee only needed therapy visits once a month. This Judge further finds that the treating physician is in the best position to determine what treatments are medically

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The Medicare statute and regulations have never supported the imposition of an "Improvement Standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition. A beneficiary's lack of restoration potential cannot, in itself, serve as the basis for denying coverage, without regard to an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question. Conversely, coverage in this context would not be available in a situation where the beneficiary's care needs can be addressed safely and effectively through the use of *nonskilled* personnel.

Thus, such coverage depends not on the beneficiary's restoration potential, but on *whether skilled care is required*, along with the underlying reasonableness and necessity of the services themselves. Any Medicare coverage or appeals decisions concerning skilled care coverage must reflect this basic principle.

CMS issued a *Jimmo v. Sebelius* Settlement Agreement Fact Sheet which indicated that under the term of the agreement, it would complete manual revisions and educational campaign by January 23, 2014. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf)

Nearly a year after the *Jimmo v. Sebelius* Settlement Agreement, as a condition of the settlement, CMS revised the *Medicare Benefit Policy Manual (MBPM)* to clarify coverage standards. The revised *MBPM* reinforced the fact that "Medicare coverage does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care." CMS, *Medicare Benefit Policy Manual (MBPM) (Internet-Only Manual Publ'n 100-2)*, Ch. 15, §220.2.Reasonable and Necessary. As to rehabilitative therapy, it clarifies that the service is designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. It explains that "[i]mprovement is evidenced by successive objective measurements whenever possible. If an individual's expected rehabilitation potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, rehabilitative therapy is not reasonable and necessary." *Id.* at §220.2.C Rehabilitative Therapy. And, that "[s]ervices that can be safely and effectively furnished by nonskilled personnel or by PTAs or OTAs without the supervision of therapists are not rehabilitative therapy services."

necessary for his patient, and the treating physician's testimony and statements are therefore given great weight by this Judge. The argument has been made that this Enrollee has been on Physical Therapy for many years, and that he cannot continue to receive Physical Therapy indefinitely. Actually, the Enrollee can receive the Physical Therapy treatments indefinitely because (1) the Plan does not place any limits on the number of Physical Therapy visits, nor does it place a time limitation on the Physical Therapy visits, and (2) the provisions of the *Jimmo* settlement state that as long as the Physical Therapy is necessary for maintenance purposes, it must be covered. This Judge finds that the Physical Therapy treatments recommended by the treating physician of 2-3 times a week Enrollee are reasonable, effective and they require the skills of a licensed Physical Therapist, and that therapy can only be performed by skilled personnel. This Judge further orders BCBS to authorize and cover the Enrollee's Physical Therapy treatments of 2-3 times a week as directed by the treating physician.

Conclusion

It is the decision of the ALJ that BCBS cover Physical Therapy treatments of 2-3 times a week as directed by the treating physician.

Order

The QIC's decision is hereby **REVERSED** and the Medicare contractor is **DIRECTED** to process the claim in accordance with this decision

SO ORDERED.

Dated: JAN 11 2018

Gerald Wayne Hynum
Administrative Law Judge

GWH: sm