

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-332

In the case of

Claim for

Home Medi Service, Inc.

(Appellant)

Supplementary Medical
Insurance Benefits (Part B)

(Beneficiary)

(HIC Number)

NHIC, Corp.

(Contractor)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated September 21, 2010, which concerned Medicare coverage for a power wheelchair (HCPCS code K0822) and accessories the appellant-supplier furnished to the beneficiary on November 25, 2009.¹ The ALJ determined that Medicare did not cover the power wheelchair and accessories because they were not medically reasonable and necessary. The ALJ further found that the appellant-supplier was liable for the non-covered costs under section 1879 of the Social Security Act, and not eligible for waiver of recoupment of the overpayment under section 1870. 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). The appellant's request for review is admitted into the record as Exhibit (Exh.) MAC-1.

¹ 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).

The Council has considered the record and exceptions set forth in the appellant's request for review. For the reasons explained below, the Council reverses the ALJ's decision and finds that the power wheelchair and accessories are covered.

BACKGROUND

The beneficiary was born ***. She has used a power wheelchair since at least June 2, 2003, and is described by her physician as wheelchair bound. Exh. 7 at 12, 18. She spends 12 to 16 hours per day in a wheelchair. *Id.* at 18. The beneficiary's conditions include cerebrovascular disease with dense left hemiplegia, hypertension, hyperlipidemia, diabetes mellitus, Padgett's disease, etc. Exh. 3, at 3; Exh. 7, at 18.

She saw her physician on December 18, 2008, for a power mobility evaluation. Subsequently, she saw the physician again on July 1, 2009, for a power wheelchair, because the December 2008 paperwork had expired. Exh. 3, at 3. The July 1, 2009 progress note further indicated that "there has been no significant change in this [beneficiary's] condition and I feel [the beneficiary] still remains a candidate as per the discussion of my December 18, 2008 progress note regarding [the beneficiary's] needs and ability to handle a powered motor vehicle device." *Id.* The record contains a physician signed referral for a wheelchair seating evaluation, dated August 12, 2009. Exh. 7, at 16. A physical therapist completed a "Functional Seating & Mobility Evaluation" (Evaluation) on October 16, 2009. *Id.* at 18-22. The physician countersigned that Evaluation on October 29, 2009, indicating concurrence. *Id.* at 22. On the same date, the physician signed a prescription that contained a detailed product description of all the items ordered.² Exh. 3, at 1. Then, on November 25, 2009, the beneficiary received the power wheelchair at issue. Exh. 2, at 3.

Initially, the claim was paid in part. Exh. 2, at 3. Specifically, payment was allowed for the power wheelchair and batteries (HCPCS codes K0822 and E2365). *Id.* Payment was denied for all other accessories. *Id.* Upon redetermination, the Medicare contractor denied coverage. Exh. 4 at 1. The contractor indicated that the items were denied because they were not medically necessary as the beneficiary was capable of using a quad cane walker to walk 10-15 feet. *Id.* at 2.

² The record also contains another prescription for a power wheelchair, signed July 1, 2009, that does not indicate the other items ordered. Exh. 3, at 6.

Applying that same analysis, the contractor determined that there was an overpayment and that the power wheelchair and batteries were not covered by Medicare. *Id.* Finally, the contractor found the supplier liable for the non-covered services. *Id.* On reconsideration, the Qualified Independent Contractor (QIC) also denied coverage, finding that the face-to-face examination was invalid. Exh. 6 ,at 2. The QIC did not make a liability determination. *Id.* at 1-3.

The ALJ determined that the evidence was insufficient to show that the power wheelchair was necessary, and thus, was not covered by Medicare. Dec. at 9-10. The ALJ found that:

The medical records provided in this case do not support the physical therapist's reason for the new power wheelchair. The physician's medical notes state that a motorized wheelchair allows patient to remain self-sufficient. Exh. 5, p.9. However, the physician fails to provide documentation to show why the existing power wheelchair is not sufficient to meet the Beneficiary's medical needs.

Id. at 10. The ALJ also found that the appellant-supplier was liable for the non-covered costs, and that a waiver of recoupment of the overpayment would not be granted. *Id.* at 11.

The appellant asserts in its request for review that the record shows that the power wheelchair was needed to allow the beneficiary to remain independent in the mobility-related activities of daily living (MRADLs). Exh. MAC-1. The appellant argues that while the beneficiary can stand and take some steps, the beneficiary is not independent and it is unsafe. *Id.* The appellant also notes specific statements in the Evaluation that show the beneficiary is unable to propel a manual wheelchair. *Id.* The appellant asserts that the record documents that the beneficiary's current wheelchair was inadequate. *Id.* Further, the appellant notes that the beneficiary's condition also prevents them from operating a power operated vehicle. *Id.* The appellant also pointed out specific items documented by the physician or the physical therapist that support its argument. *Id.*

DISCUSSION

As a preliminary matter, the Council addresses the appellant's submission of additional documentation. The appellant has submitted numerous pages with its request for review. All, but one, of those pages are duplicative of items already in the record. The Council notes that some of the duplicates, submitted with the appellant's request for review, are more legible than the copies within the record. As such, the Council admits into the record any of these duplicate pages that are found to be a more legible copy, than what currently exists in the record. The one page of new evidence submitted with the request for review is a "Home Assessment Evaluation Form." The appellant has not asserted that it has good cause for submitting any new evidence. Pursuant to 42 C.F.R. § 405.1122(c)(2), the Council finds no good cause to admit this document into the record at this late stage in the proceedings.

The Council first notes that, in determining whether the new wheelchair was needed, the ALJ analyzed whether the prior wheelchair was still appropriate. Dec. at 10. However, the Medicare Benefit Policy Manual (MBPM) provides:

If the item of equipment has been in continuous use by the patient on either a rental or purchase basis for the equipment's useful lifetime, the beneficiary may elect to obtain a new piece of equipment....

The reasonable useful lifetime of durable medical equipment is determined through program instructions. In the absence of program instructions, carriers may determine the reasonable useful lifetime of equipment, but in no case can it be less than 5 years.

MBPM, CMS Pub. 100-2, Ch. 15, § 110.2 (italics added). The power wheelchair at issue was furnished to the beneficiary more than five years after the previous power wheelchair was furnished. See Exh. 2, at 3; Exh. 7, at 18. Thus, the beneficiary may receive a new power wheelchair, without regard to the existence of the previous wheelchair, provided she satisfies the requirements for coverage anew.

Medicare will cover the power wheelchair furnished to the beneficiary on November 25, 2009, if the documentation submitted by the appellant meets the Medicare coverage criteria set forth in the applicable national coverage determination (NCD) and

local coverage determination (LCD).³ NCD 280.3 provides that “[m]obility assistive equipment (MAE) is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing” in the home. NCD 280.3.B. The NCD defines a mobility limitation as one that prevents the beneficiary from completing the MRADL, places the beneficiary at a heightened risk of morbidity or mortality as a result of attempting to participate in the MRADL, or keeps the beneficiary from finishing the MRADL in a reasonable time. *Id.* at 280.3.B.1. The NCD requires the use of a sequential assessment process, based on clinical criteria, to determine whether a beneficiary requires and can benefit from a mobility assistive device and if so, what type of device. For example, the NCD requires consideration of whether a cane or walker can resolve the beneficiary’s functional mobility deficit and whether the beneficiary typically has the upper extremity function to propel a manual wheelchair to participate in MRADLs. *Id.* at 280.3.B.5, 280.3.B.7.

LCD L21271 requires that similar clinical criteria be met. LCD L21271 describes the documentation requirements for the face-to-face examination, which include a history of the beneficiary’s condition and the beneficiary’s medical history relevant to mobility, and a physical examination that is pertinent to the beneficiary’s mobility. Relevant elements of the history may include diagnoses related to the symptoms, other diagnoses that affect ambulation, the beneficiary’s endurance when walking and current use of assistive devices. Pertinent items of note during a physical examination include the beneficiary’s range of motion, arm and leg strength, weight, height, and gait. Further, an evaluation by a therapist counter-signed by the physician may qualify as a face-to-face evaluation. The 45 day period begins when the physician countersigns and dates the therapist’s report. *See, e.g.,* Exh. 7 at 10.

On *de novo* review, the Council finds that the evidence amply demonstrates the medical necessity of the power wheelchair at issue. The December 18, 2008, and July 1, 2009, reports from

³ An ALJ and the Council are bound by statutes, regulations, national NCDs and Medicare Rulings. 42 C.F.R. §§ 405.1060(a)(4) and 405.1063. Neither an ALJ nor the Council is bound by a LCD or Medicare program guidance such as program memoranda and manual instructions, “but will give substantial deference to these policies if they are applicable to a particular case.” 42 C.F.R. § 405.1062(a).

the treating physician outline her medical problems which result in limited use of the left upper extremity and inability to engage in functional ambulation.

More specific details are contained in the Evaluation, signed by the physical therapist on October 16, 2009, and the physician on October 29, 2009, indicated that the beneficiary had only limited ambulation, and could only walk 10-15 feet when using a quad cane, with caregiver assistance. Exh. 7, 18-22. The beneficiary weighed 85 pounds and was 5 feet 6 inches tall. The beneficiary remained in the previous power wheelchair for 12-16 hours a day. In the prior power wheelchair, the beneficiary was able to groom and feed herself at an independent level, and was able to complete bathing, toileting and meal preparation at a modified independent level. Further, in the prior chair the beneficiary was able to complete transfers with minimal assistance. However, the beneficiary did require maximum assistance with dressing.

The Evaluation also provided information on the beneficiary's upper and lower extremity range of motion and strength, as well as the beneficiary's upper extremity coordination and motor control. For instance, the beneficiary's left hand had a "non-functional grip." It also indicated that the beneficiary had a knee extension of 2/5 and a hip flexion of 2/5. The Evaluation provided some general information on the beneficiary's health and physical condition. She had pelvic obliquity with a slumped and left-flexing contorted seated posture, which required special positioning. The Evaluation also showed that other assistive devices would be inadequate for this beneficiary due to weakness. Her limited ability to stand and ambulate were adequate to assist with transfers, but were inadequate to attend to the full range of mobility related activities of daily living. In sum, the evidence paints a clear picture of the beneficiary's functional abilities and limitations that meet the requirements of LCD L21271.

Options and accessories for wheelchairs are covered if the beneficiary has a wheelchair that meets Medicare coverage criteria and the item(s) are medically necessary. LCD L11473. Having found that the wheelchair at issue was medically reasonable and necessary, the Council further finds that all the associated accessories are likewise covered by Medicare.

DECISION

It is the decision of the Medicare Appeals Council that the power wheelchair and accessories furnished on November 25, 2009, at issue are covered by Medicare. The ALJ's September 21, 2010, decision is reversed.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

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

Date: September 29, 2011