DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-705

In the case of	**Claim for**
Allied Home Medical, Inc. (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
CIGNA Government Services (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated November 16, 2010, which concerned Medicare coverage for a power wheelchair (HCPCS code K0823), batteries (HCPCS code E2365 x 2), detachable adjustable armrests (HCPCS code E0973 x 2), and elevating leg rests (HCPCS code E0990 x 2) furnished to the beneficiary on December 16, 2008.[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 determined that the supplier was liable for the non-covered costs. 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 Council enters the appellant's request for review into the record as Exhibit (Exh.) MAC-1.

The Council has reviewed the record and considered the appellant's exceptions. The Council adopts the ALJ's ultimate

[1] CMS developed the Healthcare Common Procedure Coding System (HCPCS) to set forth "uniform national definitions of services, codes to represent services, and payment modifiers to the codes." 42 C.F.R. § 414.40.

conclusion as to coverage and liability. However, as set forth below, the Council modifies the ALJ's analysis to find that the documentation of record does not establish that the beneficiary was unable to self-propel a manual wheelchair.

BACKGROUND AND PROCEDURAL HISTORY

The beneficiary was an 80-year-old male with diagnoses of low back pain, coronary artery disease, diabetes mellitus, and osteoarthritis. Exh. 3, at 1. He had a surgical history of coronary artery bypass grafts taken from both arms. *Id.* at 10. On October 27, 2008, the beneficiary's physician conducted a face-to-face examination.[2] *Id.* at 3-5. On November 6, 2008, the beneficiary's physician prescribed a power mobility device with elevating leg rests with duration indicated as "lifetime." *Id.* at 1. The power wheelchair and accessories were delivered to the beneficiary on December 16, 2008. *Id.* 6.

Medicare initially denied the claim for the power wheelchair and accessories because Medicare guidelines were not met. Exh. 4, at 1. Similarly, on redetermination, the contractor determined that the documentation did not meet the applicable Medicare coverage criteria. *Id.* at 1-2. The contractor also determined that the physician order was invalid. *Id.* at 2. The contractor found that the supplier was responsible for the non-covered costs. *Id.* at 2-3. On further appeal, the Qualified Independent Contractor (QIC) agreed that the documentation did not support the medical necessity of the power wheelchair and accessories. Exh. 5, at 2. Specifically, the QIC found that the documentation did not demonstrate that the beneficiary did not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair. *Id.*

DISCUSSION

The ALJ concluded that documentation did not meet the criteria for Medicare coverage of a power wheelchair set forth in the National Coverage Determinations (NCD) Manual (CMS Pub. 100-03), section 280.3 and in Local Coverage Determination (LCD) L23613, *LCD for Power Mobility Devices* L23613. Dec. at 1-9. Specifically, the ALJ determined that the beneficiary did not have a mobility limitation that impaired his ability to participate in one or more mobility-related activities of daily

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[2] The "Face-to-Face Mobility Examination Report" was originally dated October 18, 2008. That date is crossed out and the report is re-dated October 27, 2008. Exh. at 3.

living (MRADLs) and that the beneficiary's mobility limitation could be sufficiently resolved through the use of a cane or walker. *Id.* The ALJ also determined that the beneficiary did not have sufficient upper extremity strength to self-propel a manual wheelchair in his home to perform his MRADLs. *Id.*

In the request for review before the Council, the appellant, through its representative, contends that the ALJ was "inconsistent" by finding that the beneficiary could not safely or adequately perform his MRADLs with a manual wheelchair but could perform them with a cane or walker. Exh. MAC-1, at 4. The appellant maintains that this finding is "not supported by reason." *Id.* The appellant explains: "It is clear that it is far more difficult for a patient with pain and weakness in arms and back to hold himself upright and support his own weight using a cane and walker than it would be for the same patient to sit in a manual wheelchair and propel himself." *Id.* The appellant also contends that the ALJ erred by determining that the patient did not have a mobility limitation which significantly impaired his ability to perform at least one MRADL. *Id.* The appellant states that the standard for this coverage criterion is "whether the [beneficiary] cannot perform at least one MRADL in a timely and safe manner, and not whether [he] can do so at all." *Id.* The appellant maintains that the beneficiary's physician found that the beneficiary could complete his MRADLs with great difficulty only and was not able to perform them in a timely or safe manner as a result of his very slow ambulation. *Id.*

The documentation consists of a prescription for the equipment, a "Face-to-Face Mobility Examination Report" dated October 27, 2008, doctor's notes dated October 27, 2008, June 23, 2008, and November 16, 2007, and lab reports from 2006 through 2008. *See* Exh. 3. LCD L23613 sets forth documentation requirements for coverage of a power mobility device. It states:

> The evaluation should be tailored to the individual patient's conditions. The history should paint a picture of your patient's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the patient's ambulatory difficulty or impact on the patient's ambulatory ability.

The Council agrees with the ALJ that the documentation does not demonstrate that the beneficiary had a mobility limitation that significantly impaired his ability to participate in one or more MRADLs. The documentation is contradictory as to whether the beneficiary was able to independently perform his MRADLs. The face-to-face examination states that the beneficiary was unable to bathe, move from room to room, or use the toilet without the aid of a power mobility device. Exh. 3, at 4. However, a doctor's note from the same day states that the beneficiary was able to cook, care for himself, and go to the bathroom on his own. *Id.* at 10.

As the appellant correctly explains, NCD 280.3 and L23613 provide that a "mobility limitation" is one that:

- Prevents the beneficiary from accomplishing an MRADL entirely, or
- Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
- Prevents the beneficiary from completing an MRADL within a reasonable time frame.

Thus, evidence that the beneficiary was able to perform his MRADLs independently does not necessarily establish that the power wheelchair is not covered by Medicare. As discussed, the appellant argues that the beneficiary's mobility limitation prevented him from completing his MRADLs safely and within a reasonable time frame. *See* Exh. MAC-1, at 4. In support, the appellant references the physician's statement that the beneficiary "can do this ADL's but not in a timely manner [and] of slow ambulation [and] with great difficulty." Exh. 3, at 10 (sic); *see* Exh. MAC-1, at 4. The physician also states that the beneficiary had poor endurance, difficulty walking without assistance, and walked very slowly with a slight stoop. Exh. 3, at 4, 10.

However, the objective evidence in the record does not support these statements. The documentation indicates that the beneficiary did not experience shortness of breath at rest or on exertion, did not have poor balance, and had mild lower body weakness with a strength score of 5/5 for all of his extremities. *Id.* at 3, 10. Moreover, the Council notes that the record does not contain objective evidence indicating how far the beneficiary could walk without stopping, the pace of

ambulation, or measurements of the beneficiary's gait, as contemplated by L23613.

The Council further agrees with the ALJ's determination that the record fails to show that the beneficiary's mobility limitation could not sufficiently and safely be resolved by the use of an appropriately fitted cane or walker. Dec. at 7. Rather, as the ALJ noted, the record indicates that the beneficiary "does have a cane at home, but does not use it all the time," which suggests that the beneficiary does use a cane some of the time. Dec. at 7; *see* Exh. 3, at 10. Moreover, there is no evidence that the beneficiary's mobility limitation could not be resolved by the use of a walker.

Finally, the Council concludes that the record does not establish that the beneficiary lacked sufficient upper extremity strength to self-propel a manual wheelchair. Dec. at 7. In support of his findings to the contrary, the ALJ referenced the October 27, 2008, doctor's note, which states that it would be difficult for the beneficiary to self-propel a manual wheelchair due to the bypass grafts taken from his arms. Dec. at 7; *see* Exh. 3, at 10. The ALJ also referenced the face-to-face examination, which states that the beneficiary had pain in his arms and lower back that would make it difficult for the beneficiary to self-propel a manual wheelchair. Dec. at 7; *see* Exh. 3, at 4. However, the Council finds that the totality of the evidence does not establish that the beneficiary was unable to use a manual wheelchair. The documentation indicates that the beneficiary experienced only mild upper body weakness and that he could "[move] all extremities appropriately with 5/5 strength." Exh. 3, at 4, 10. The documentation further provides that the reason the beneficiary did not use a manual wheelchair was because it was "uncomfortable" to him in his lower back area. *Id* at 10. Finally, the Council notes that the beneficiary's physician describes the beneficiary's upper body pain as "moderate." *Id.* at 4. For these reasons, the Council finds that the documentation of record is inadequate to demonstrate that the beneficiary was unable to self-propel a manual wheelchair.

With respect to liability, the ALJ found that the appellant had notice of the applicable Medicare coverage criteria for the equipment. Therefore, the ALJ determined the appellant was liable for the non-covered costs of the power wheelchair and accessories under Section 1879 of the Social Security Act.

Dec. at 8-9. The appellant does not make any contentions regarding liability. Thus, the Council finds no basis to disturb the ALJ's finding on liability.

Accordingly, the Council modifies the ALJ's decision. The Council finds that the wheelchair and accessories at issue are not covered by Medicare and that the appellant is liable for the non-covered costs.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

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

Date: July 29, 2011