

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: 10-1730

In the case of

Claim for

D.B.C.

(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 June 10, 2010, which concerned Medicare coverage for a power wheelchair (HCPCS code K0861)¹ and related accessories provided to the beneficiary by National Seating & Mobility, Inc. The ALJ limited his decision to whether the beneficiary had possession of the wheelchair and the "Jay2 Gel Contour Cushion". The ALJ found that the seat cushion was medically reasonable and necessary and thus covered by Medicare. The beneficiary has asked the Medicare Appeals 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 as in this case. 42 C.F.R. § 405.1112(c).

¹ The Centers for Medicare & Medicaid Services (CMS) have 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 the exceptions set forth in the appellant's request for review, dated August 7, 2010. The Council enters the appellant's request for review as exhibit (Exh.) MAC-1, Local Coverage Determination (LCD) L23613, *LCD for Power Mobility Devices*, into the record as Exh. MAC-2, and LCD L11451, *Wheelchair Options/Accessories*, into the record as Exh. MAC-3. As set forth below, the Council reverses the ALJ's decision.

BACKGROUND

CIGNA Government Services (CIGNA), the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for Jurisdiction C on the date of service at issue, informed the supplier, National Seating & Mobility, that it has received Medicare payment in error for a power wheelchair and related accessories for which it had submitted claims. Exh. 1 at 19. The supplier requested an appeal and the DME MAC found, on redetermination, that the record lacked evidence that the supplier met coverage elements specified in LCD L23613. *Id.* at 11. The supplier then requested reconsideration from a Qualified Independent Contractor (QIC), which found that the supplier met the face-to-face requirements set forth in the applicable LCD and covered the power wheelchair and accessories with the exception of the "Jay2 Gel Contour Cushion" claimed using HCPCS code K0669. *Id.* at 3. The QIC found that the documentation for the cushion failed to support Medicare coverage and found the supplier responsible for the non-covered supply. *Id.* at 4.

In response to the QIC's coverage findings, the beneficiary requested an ALJ hearing. *Id.* at 1. In his request, dated March 18, 2010, the beneficiary states,

I have requested that Medicare not pay for the wheelchair because it was not delivered in proper working order. *To this day, I still do not have the wheelchair, nor has it ever been in my possession.*

Id., see also Dec. at 6. (Emphasis added). Reference also Hearing CD at 9:39:44-9:41:38.

The ALJ determined that, because the "overpayment issue" was resolved at the QIC, the issues before him were the issues of Medicare coverage of the seat cushion and whether the beneficiary was in possession of the wheelchair. Dec. at 6. The ALJ determined that while the beneficiary lacked possession

of the wheelchair, the supplier would allow him to "pick up the chair immediately". *Id.* at 7. The ALJ further found that the cushion was medically reasonable and necessary and thus covered by Medicare. *Id.*

DISCUSSION

Issues before the ALJ and the Medicare Appeals Council

The issues before the ALJ include all the issues brought out in the initial determination, redetermination, or reconsideration that were not decided entirely in a party's favor. 42 C.F.R. § 405.1032(a). In this case, the DME MAC and QIC issued decisions concerning Medicare coverage for the power wheelchair and accessories. See Exh. 1 at 3, 11; see also Dec. at 1. The appellant beneficiary requested hearing because he did not believe that Medicare should pay for a wheelchair he did not have and which was not suited to his needs. Thus, the Council finds that the ALJ erred in limiting his decision to Medicare coverage of the "Jay2 Gel Contour Cushion". The Council will engage in a *de novo* review of all coverage issues in this case.

Medicare Coverage for Power Wheelchairs and Accessories

An ALJ and the Council are bound by statutes, e.g. the Act, regulations, NCDs, and CMS Rulings. 42 C.F.R. §§ 405.1060(a)(4), 405.1063. Neither an ALJ nor the Council is bound by contractor local coverage determinations (LCDs), local medical review policies (LMRPs), or CMS 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). An ALJ or the Council must explain the reasoning for not following an LCD or program guidance in a particular case. See 42 C.F.R. § 405.1062(b).

Medicare coverage of durable medical equipment, such as a power wheelchair, is governed by the Medicare provisions of the Social Security Act (Act), the implementing regulations and Medicare guidance, including, here, LCD L23613, *LCD for Power Mobility Devices*,² and LCD L11451, *Wheelchair Options / Accessories*. See Act, § 1861(n), see also Medicare NCD Manual (NCDM) (CMS Pub.

² LCD L23613, effective in its revised format for supplies provided after October 1, 2006, is available at the Medicare Coverage Database at <http://www.cms.gov/mcd>. A copy of the LCD has been entered into the record as Exh. MAC-2.

100-03), § 280.3.A (*eff.* May 5, 2005).³ As reflected in LCD L23613, Section 1833(e) of the Act precludes Medicare payment to any provider of services unless "there has been furnished such information as necessary in order to determine the amounts due such provider." Both LCD L23613 and 42 C.F.R. § 410.38(a)(2)(iii), require a physician to provide supporting documentation (including pertinent parts of the beneficiary's medical record) to the supplier within 45 days after the face-to-face examination. A supplier may not dispense a power mobility device to a beneficiary until the supplier has received both the prescription and the supporting documentation from the physician. 42 C.F.R. § 410.38(c)(4). The supplier must keep the supporting documentation on file and make it available to CMS and its agents upon request. 42 C.F.R. § 410.38(c)(5). Among other criteria, the LCD specifically requires that "the delivery of the [power wheelchair] must be within 120 days following the completion of the face-to-face examination." (Emphasis in original). See "Miscellaneous", Exh. MAC-2 at 8.

The record indicates that the beneficiary met face-to-face with a physician on May 30, 2008. Exh. 2 at 38. In support of Medicare coverage, the supplier provided the DME MAC and the QIC with medical documentation which included a statement, signed by the beneficiary on September 25, 2008, that attests that the beneficiary took physical possession of the power wheelchair 119 days after the face-to-face physician assessment. *Id.* at 43. However, in his request for an ALJ hearing and in his request for review, the beneficiary stated that he did not receive the power wheelchair on September 25, 2008. Exh. 1 at 1, Exh. MAC-1. Reference also Hearing CD at 9:39:44 - 9:41:38, 9:44:32 - 9:49:11. The representative for the QIC stated that had the medical review panel known that the beneficiary did not actually have physical possession of the wheelchair, "it would have affected their decision." *Id.* at 9:39:44 - 9:41:38. Further, the supplier concedes that the beneficiary was never in physical possession of the wheelchair despite demanding the beneficiary sign the document stating he received the wheelchair on September 25, 2008. *Id.* at 9:53:32 - 10:00:31.

³ The preamble to the interim final rule makes clear that the requirements of the NCD apply in conjunction with the requirements of the regulation for coverage of power mobility devices. Medicare Program; Conditions for Payment of Power Mobility Devices, including Power Wheelchairs and Power-Operated Vehicles, Interim Final Rule with Comment Period, 70 Fed. Reg. 50,940, 50,943 (August 26, 2005).

Based on the sworn testimony of the supplier and the beneficiary, the Council finds that the beneficiary was not in physical possession of the wheelchair at any time before the date of the ALJ hearing (June 8, 2010). Further, the record reflects that the beneficiary took physical possession of the wheelchair at the insistence of the supplier only after the ALJ issued his decision on June 10, 2010, and therefore, the wheelchair was delivered more than 120 days after the face-to-face physician consult. Exh. MAC-1. However, the beneficiary is unable to use, and does not use, the wheelchair because it was not fitted properly and is unsuitable for his needs. The supplier has been unable to make the necessary modifications. Thus, the Council finds that the guidelines set forth for Medicare coverage of power wheelchairs in LCD L23613 were not met. Accordingly, the wheelchair at issue is not medically reasonable and necessary.

Options and accessories for wheelchairs are covered if the beneficiary has a wheelchair that meets Medicare coverage criteria and the option/accessory itself is medically necessary. See LCD L11451, Exh. MAC-3.⁴ Having found that the wheelchair at issue was not medically reasonable and necessary, the Council further finds that all the associated accessories are likewise not covered by Medicare.

The supplier is liable for the wheelchair and accessories under section 1879 of the Social Security Act, because it knew or should have known that a wheelchair that was not delivered within 120 days and which was unusable by the beneficiary could not be medically reasonable and necessary.

The Council finds that the supplier received Medicare payment in error for a power wheelchair and accessories which resulted in an overpayment of \$15,589.74. Exh. 1 at 12, 19-21.

⁴ LCD L11451 is available at the Medicare Coverage Database at <http://www.cms.gov/mcd>. A copy of the LCD has been entered into the record as Exh. MAC-3.

Accordingly, the Council reverses the ALJ's June 10, 2010, decision and finds the supplier is responsible for the non-covered durable medical equipment and accessories.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/ M. Susan Wiley
Administrative Appeals Judge

Date: November 22, 2010