DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

AMENDED DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-2511

In the case of	**Claim for**
Loyalsock Mobility (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 July 5, 2011, which concerned payment for a power wheelchair (K0823) and accessories. The ALJ determined that there was insufficient documentation to establish that Medicare coverage of this device was reasonable and necessary, and that the appellant was liable under Title XVIII § 1879 of the Social Security Act for any charges related to the items. 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 limits 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).

In a decision dated March 30, 2012, the Council reversed the ALJ's decision. This amended decision reflects only a change in the name of the appellant to Loyalsock Mobility, and is the same in all other respects, continuing to reverse the ALJ's decision.

BACKGROUND

The beneficiary is a 60-year-old female who suffered a stroke in March 2002 which resulted in left hemiplegia. Exh. 3 at 16. She is primarily dependent on her wheelchair for her mobility needs, and at the time of service was using a power wheelchair in generally poor functional condition which she had used for more than five years. *Id.*; Exh. 3 at 18. The beneficiary's physician prescribed a new power wheelchair (K0823) and accessories (E2365, E0973, E2615, K0108), which were provided by the appellant on April 21, 2010. Exh. 13 at 5-6.

The appellant's claim for reimbursement was initially denied, and an unfavorable redetermination decision was issued August 6, 2010. *Id.* at 4. The Qualified Independent Contractor also issued an unfavorable reconsideration decision on November 2, 2010. *Id.* The appellant filed a Request for Hearing before an Administrative Law Judge, which was held via telephone on June 9, 2011. *Id.* On July 5, 2011, the ALJ issued a decision denying coverage for the items due to "insufficient documentation to establish that the Medicare coverage, payment and reasonable and necessary requirements have been met." *Id.* at 16.

DISCUSSION

The ALJ decision denied coverage for the items in question because the beneficiary's mobility evaluation "did not address whether the patient's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker" as required by Local Coverage Determination (LCD) L27239[1]. Exh. 13 p. 15. Further, the decision noted that the beneficiary was able to propel a manual wheelchair in the home, and cited Section 1861(n) of the Social Security Act in stating that "durable medical equipment is to be for the beneficiary's use at home, and the beneficiary's ability to use a manual wheelchair at home would preclude the power mobility device wheelchair coverage in this case." *Id.*

The appellant, in its Request for Review (admitted as exhibit MAC-1), disagrees with these aspects of the ALJ's decision. MAC-1 at 2. Specifically, as to the patient's ability to use a cane to accomplish MRADLs, the appellant notes that the beneficiary has very limited use of her left foot and left arm, and to expect that she could use her right arm to hold a cane to

[1] Available at http://www.medicarenhic.com/

support herself while also accomplishing her MRADLs is unrealistic. *Id.* Indeed, the Functional Mobility Evaluation notes a number of MRADLs that the beneficiary would not be able to accomplish without her power mobility platform, including meal preparation ("unable to carry essential items to fulfill the meal preparation process") and housecleaning ("unable secondary to increased risks for falls"). Exh. 3 at 20. This same document notes that the beneficiary "can ambulate short distances between 5-10 feet utilizing a quad cane," adding that "[m]aximum distance is 20 feet." *Id.* The document, signed by the beneficiary's physician, also notes "a definitive safety concern due to lack of motor control" and increased risk for falls. *Id.* at 21. Accordingly, the documentation demonstrates that the beneficiary's mobility limitation cannot be sufficiently or safely resolved with the use of a cane or walker, in satisfaction of the requirements of L27239, as well as the Medicare National Coverage Determinations Manual, section 280.3.

LCD L27239 also allows coverage for a power wheelchair when the beneficiary "does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day." The ALJ's decision cites the Functional Mobility Evaluation's statement that the beneficiary is adequately able to propel a manual wheelchair within her home. Exh. 13 at 15. However, as the appellant points out in its Request for Review, the standard is not one of propulsion, but of propulsion "to perform MRADLs during a typical day." L27239. The above evaluation states that the beneficiary is able to propel her wheelchair with her non-affective lower limb around her home. Exh. 3 at 21. Using one's leg to propel a manual wheelchair strongly suggests against sufficient upper extremity function, especially in light of the appellant's non-functional left arm. Additionally, it is noted that if she were using a manual wheelchair, she would be unable to exit her home in the event of an emergency. Exh. 3 at 21. For these reasons, the beneficiary would not be able to perform MRADLs using a manual wheelchair. The appellant has met the documentation requirements, along with all other requirements for coverage of the power wheelchair and accessories.

DECISION

It is the decision of the Medicare Appeals Council that the power wheelchair and accessories supplied by the appellant are covered by Medicare. The ALJ's decision is reversed.

MEDICARE APPEALS COUNCIL

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

/s/ Terrah A. Dews
Appeals Officer

Date: April 12, 2012