

appellant requested reconsideration by a Qualified Independent Contractor (QIC). The QIC denied coverage because the documentation, as submitted to the QIC, did not include a detailed face-to-face examination from the physician, thus, the QIC determined the criteria for the Local Coverage Determination (LCD) for Power Mobility Devices (L21271) were not met. Exh. 5, at 9.

The appellant timely requested a hearing before an ALJ. On March 6, 2009, the ALJ conducted a hearing, by telephone, in which the appellant's representative participated. In the decision, the ALJ denied coverage finding that the documentation generally did not support a finding that the power wheelchair and accessories were medically reasonable and necessary for the beneficiary. The ALJ concluded that payment could not be made for the items pursuant to section 1833(e) of the Social Security Act (Act). The ALJ also determined that Section 1879 of the Act did not apply to this case because payment was denied pursuant to section 1833(e) of the Act, which addresses lack of documentation, and not section 1862 of the Act, which addresses whether an item is reasonable and medically necessary. Thus, the ALJ found that the appellant was liable for the noncovered items. Dec. at 8-10.

In its request for review, the appellant reiterated that it had submitted medical records that document the beneficiary's medical conditions including edema, osteoarthritis and degenerative disc disease, and that these conditions compromised her activities of daily living. The appellant specifically pointed to the physician's progress note dated February 5, 2008, to show that the beneficiary's physician had remarked that the beneficiary had mobility difficulties in dressing, bathing, and feeding. Additionally, he contended that the physician had documented that other assistive devices such as a walker, cane, or manual wheelchair would not meet the mobility needs of the beneficiary. The appellant also asserted that the February 5, 2008 progress note that the beneficiary's physician signed is a record of the face-to-face examination. The appellant's final contention was that the ALJ had applied the "bed or chair confined" standard to determine whether a power wheelchair was necessary for the beneficiary. *See, generally*, Exh. MAC-1.

DISCUSSION

An ALJ and the Council are bound by statutes, regulations, National Coverage Determinations (NCDs), and CMS Rulings. 42 C.F.R. §§ 405.1060(a)(4), 405.1063. Neither an ALJ nor the Council is bound by contractor 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 and the Council must explain the reason for not following such a policy in a specific case. 42 C.F.R. § 405.1062(b). Any decision to disregard a policy "applies only to the specific claim being considered and does not have precedential effect." *Id.*

Medicare coverage of durable medical equipment, such as a wheelchair, is governed by the applicable provisions of the Social Security Act, the implementing regulations and Medicare guidance, including, here, LCD L21271 (*Power Mobility Devices*). As reflected in the LCD, 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 the LCD 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).

CMS has also issued a NCD concerning mobility assistive equipment (MAE), which includes power mobility devices. The NCD predates, but is not superseded by, the regulations. Medicare NCD Manual (NCDM) (CMS Pub. 100-03), § 280.3.A (eff. May 5, 2005).¹ According to the NCD, "MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit

¹ 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).

sufficient to impair their participation in mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing" within the home. NCDM § 280.3.B. The NCD defines a mobility limitation as one that prevents the beneficiary from accomplishing MRADLs entirely, places the beneficiary at a heightened risk of morbidity or mortality as a result of attempting to participate in the MRADL, or prevents the beneficiary from completing the MRADL in a reasonable time. NCDM § 280.3.B.1.

The Council has considered the applicable regulations, NCD, LCD and the beneficiary's medical documentation and finds that the appellant has not established that the power wheelchair and accessories provided to the beneficiary were medically reasonable and necessary. The documentation submitted does not substantiate the medical necessity for the items, as required by the regulations. Accordingly, the Council modifies the ALJ decision to reflect that Medicare coverage for the power wheelchair and accessories is denied pursuant to section 1862 of the Act, and not section 1833(e) of the Act.

The Council has considered the documentation that the appellant has submitted as the face-to-face examination, and finds that it does not meet the criteria listed in LCD 21271. The Council agrees with the ALJ that the February 5, 2008 face-to-face evaluation submitted by the appellant "[is] wholly insufficient as a medical record that is required to substantiate the need for a power wheelchair." Dec. at 9. The documentation in the record purporting to support the medical necessity of the power wheelchair provided to the beneficiary is limited in scope and is general at best. According to the applicable NCD and LCD, the clinical criteria must include consideration of limitations of strength, endurance, range of motion, coordination, and absence of deformity in one, or both, upper extremities to determine whether a beneficiary has sufficient upper extremity function to propel a manual wheelchair in the home in order to participate in mobility-related activities of daily living. NCDM § 280.3(B)(7); LCD L21271. We concur with the ALJ that the notes that the beneficiary's physician provided in her face-to-face evaluation are not a clinical description of the beneficiary's inability to propel a manual wheelchair.

The relevant LCD requires that the face-to-face examination include "pertinent information" about a beneficiary's condition that requires the use of a powered wheelchair. See LCD 21271.

As part of the LCD, the contractor gives examples of details that can be included in the face-to-face examination, including: symptoms that limit ambulation, diagnoses that are responsible for these symptoms, pace of ambulation, and a musculoskeletal examination which details arm and leg strength and range of motion. See LCD 21271. The document that the appellant has provided is only partially legible and does not provide quantitative measurements of strength, range of motion, or fatigue. Other than the partially legible physician notes that cover barely half a page, the appellant has not provided any other substantive medical records that document the beneficiary's condition. Pursuant to the applicable statutory provisions, regulations and Medicare guidance, including LCD 21271, the submitted documentation does not support a conclusion that the power wheelchair provided to the beneficiary was medically reasonable and necessary.

The appellant argues in its request for review that the ALJ used the "bed or chair confined" standard in determining whether Medicare would cover the powered wheelchair. However, there is nothing in the ALJ decision to support the appellant's contention that the ALJ used this standard in deciding this case. Moreover, the ALJ's ultimate decision to deny coverage of the device is supported by the evidence of record.

However, the ALJ did not analyze the issue of liability under the applicable provisions. The ALJ found that section 1879 of the Act did not apply to this case, concluding that the denial of coverage was appropriately based on section 1833(e) of the Act. He also found that the appellant was liable for the noncovered cost of the power wheelchair and the accessories. The Council agrees that the appellant was liable, but as explained above, the Council finds that the grounds for denial in this case are based on section 1862(a)(1) of the Act and not section 1833(e). In addition, the Council finds that there is no evidence the beneficiary knew, or reasonably should have known, that the power wheelchair and accessories would not be covered by Medicare. Therefore, under section 1879 of the Act, the beneficiary is not financially liable for these items. However, because the supplier is expected to know, or have constructive knowledge of, Medicare coverage and documentation rules, it is liable for the noncovered costs of the wheelchair and accessories.

DECISION

It is the decision of the Medicare Appeals Council that the power wheelchair and associated accessories, supplied to the beneficiary on February 12, 2008, were not covered by Medicare because they were not medically necessary and that the appellant is liable for the noncovered costs of the items. The hearing decision is modified accordingly.

MEDICARE APPEALS COUNCIL

/s/ M. Susan Wiley
Administrative Appeals Judge

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: October 27, 2009