

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-2376

In the case of

Claim for

D.C.

(Appellant)

Medicare Advantage (MA)
(Part C)

(Enrollee)

(HIC Number)

Bravo Achieve Benefit Plan

(MA Organization (MAO)/MA
Plan)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated July 19, 2011. The ALJ upheld the MA plan's denial of the enrollee's request for authorization for coverage of a Tempur-pedic bed. The appellant-enrollee has asked the Medicare Appeals Council to review the ALJ's decision.

The regulation codified at 42 C.F.R. § 422.608 states that "[t]he regulations under part 405 of this chapter regarding MAC [Medicare Appeals Council] review apply to matters addressed by this subpart to the extent that they are appropriate." The regulations "under part 405" include the appeal procedures found at 42 C.F.R. part 405, subpart I. With respect to Medicare "fee-for-service" appeals, the subpart I procedures pertain primarily to claims subject to the Medicare, Medicaid and SCHIP Benefits Act of 2000 (BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). 70 Fed. Reg. 11420, 11421-11426 (March 8, 2005). The Council has determined, until there is amendment of 42 C.F.R. part 422 or clarification by the Centers for Medicare & Medicaid Services (CMS), that it is "appropriate" to apply, with certain exceptions, the legal provisions and principles codified in 42 C.F.R. part 405, subpart I, to this case.

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 enrollee's timely-filed request for review is admitted into the administrative record as Exh. MAC-1. The Council provided the MA plan a copy of the enrollee's request for review. The plan has not filed exceptions to the enrollee's request.

For the reasons set forth below, the Council adopts the ALJ's decision.

DISCUSSION

The enrollee has chronic back pain. Her medical history includes multiple back surgeries, including two lumbar spinal fusions. She has difficulty sleeping due to back pain. Her medical care providers recommended that she sleep in a Tempur-pedic bed. Exhs. 3 at 15-18; 13. The enrollee asks the Council to review the ALJ's unfavorable decision, issued July 19, 2011.

The ALJ upheld the MA plan's denial of preauthorization for coverage of a Tempur-pedic bed. The ALJ did so on the basis that the Tempur-pedic bed is not a covered benefit under original Medicare, or the plan's Evidence of Coverage, the terms of which are consistent with original Medicare coverage guidelines for durable medical equipment (DME). Dec. at 5-6; Exhs. 4 at 20 and 5 at 29 (plan's decisions); Exh. 1 (paper copy of, and compact disc containing, Evidence of Coverage). In so doing, the ALJ reasoned that, while the record clearly documents chronic back pain and a Tempur-pedic bed may be helpful to the enrollee in relieving back pain for more restful sleep, the bed does not meet Medicare's definition of covered DME because a bed does not primarily serve a medical purpose. Dec. at 5, *citing* section 1861(n) of the Social Security Act (Act), 42 C.F.R. section 414.202, and Medicare Benefit Policy Manual (MBPM), CMS Pub. 100-02, Ch. 15, Section 110.1. The ALJ went on to explain, "While the Enrollee's pain is a result of a medical condition, a Tempurpedic Bed is not *medical treatment* for her pain." Dec. at 5.

Before the Council, the enrollee states: "I disagree with the ALJ's decision because nobody is hearing anything I'm saying[.] I'm in pain 24-7[.] There is no more surgery's that I can have

due to my heart. So please help me get some rest and peace of mind, it's been 9 years & I have not slep[t] in bed." Exh. MAC-1.

The Council has considered the record and the enrollee's contentions. The Council acknowledges, as the ALJ did, that the record amply establishes the enrollee's chronic back pain for which she takes multiple narcotic medications. We also are aware that more than one doctor determined that a Tempur-pedic bed could help the enrollee get more restful sleep.

Medicare is a defined-benefits program. And an MA plan may not be required to cover or pay for an item or service that Medicare does not recognize as a covered item or service. As the ALJ explained, Medicare DME guidelines are applicable to this case and one of those is that the item at issue must meet the definition of DME. Dec. at 5. As the ALJ also explained, one element of the definition of Medicare-covered DME is that the item primarily and customarily serves a medical purpose. A Tempur-pedic bed, as the ALJ explained, may be beneficial, or even medically necessary, for the enrollee, but beds (including Tempur-pedic beds) "are available to the general population" and is primarily and customarily used for a non-medical purpose. *Id.* Because such Medicare coverage guidelines are not met, and the plan's Evidence of Coverage provisions are modeled after Medicare guidelines for DME, the plan may not be ordered to cover a Tempur-pedic bed. *Id.* at 5, 6.¹ We also recognize that Tempur-pedic is a special type and brand of bed. But the Tempur-pedic bed is in fact a bed, and beds typically are not

¹ The elements of the definition of DME are: (1) can withstand repeated use; (2) is primarily and customarily used to serve a medical purpose; (3) generally is not useful to an individual in the absence of an illness or injury; and (4) is appropriate for use in the home. 42 C.F.R. § 414.202; see also National Coverage Determination (NCD) 280.1, Medicare National Coverage Determinations Manual (NCDM), Pub. 100-03, Chapter 1, Part 4, Section 280.1. Medicare covers DME if it (1) meets the definition of DME; (2) is medically "reasonable and necessary"; and (3) the equipment is used in a beneficiary's (or enrollee's) home. Medicare Benefit Policy Manual (MBPM), Pub. 100-02, Chap. 15, § 110. All elements must be met for the item to be considered DME. MBPM, Ch. 15, § 110.1.

By regulation, NCDs are binding on ALJs and the Council. 42 C.F.R. § 405.1060(a)(4). ALJs and the Council are not bound by program guidelines, such as manual provisions, but must give substantial deference to them if they are applicable to a case. See 42 C.F.R. §§ 405.1062(a) and (b). MA plans are bound to follow NCDs, LCDs, and general coverage guidelines in original Medicare manuals and instructions. 42 C.F.R. § 422.101(b).

used for medical purposes, and generally are useful to individuals who do not have illness or injury.

The ALJ's decision is legally sound. The enrollee's contentions provide no cause for changing the ALJ's decision. The Council adopts the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

Date: September 23, 2011