**Department of Health and Human Services**
**DEPARTMENTAL APPEALS BOARD**
**Appellate Division**

In re CMS LCD COMPLAINT: Wheelchair Options/Accessories (L11462)
Docket No. A-11-50
Decision No. 2389
June 20, 2011

# FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

We sustain the January 24, 2011 decision of Administrative Law Judge Keith W. Sickendick, dismissing the Local Coverage Determination (LCD) complaint filed by Permobil, Inc. on behalf of the Aggrieved Party (AP). *Wheelchair Options/Accessories (LCD ID No. L11462)*, DAB CR2314 (2011) (ALJ Decision). We conclude that the policy not to cover the requested item does not meet the definition of an LCD for which ALJ and Board review is available.

## Legal Background

An LCD is defined as a Medicare contractor's determination whether or not to cover a particular Medicare item or service on a contractor-wide basis "in accordance with section 1862(a)(1)(A)" of the Social Security Act (Act).[1] Act § 1869(f)(2)(B); 42 C.F.R. § 400.202. Section 1862(a)(1)(A) of the Act bars Medicare payment for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury," with exceptions not relevant here. That provision is referred to as the "medical necessity" standard. *See, e.g., CMS LCD Complaint: Homeopathic Medicine and Transfer Factor,* DAB No. 2315, at 2 (2010); *LCD Appeal of Non-coverage of Intravenous Immunoglobulin*, DAB No. 2059, at 2 (2007), *aff'd sub nom. S.A., R.A.S., R.S., and M.W. v. Leavitt,* Civ. No. 07-0200-CV-W-GAF (D. Mo. June 30, 2008), *aff'd, S.A.; R.A.S.; R.S.; M.W. v. Sebelius,* 352 F. App'x 134 (8th Cir. 2009). An LCD is issued by a Medicare contractor in a particular region and applies the medical necessity standard for that region but is not binding beyond the issuing contractor. *LCD Appeal of Non-coverage of Intravenous Immunoglobulin* at 2.

Section 1869(f)(2) of the Act and the regulations at Part 426 permit Medicare beneficiaries denied coverage for items or services on the basis of an LCD to challenge the validity of the LCD by filing an "LCD complaint" before an ALJ. 42 C.F.R.

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[1] The current version of the Act can be found at http://www.socialsecurity.gov/OP_ Home/ssact/ssact.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section.

§§ 426.110; 426.320; 426.400; *see generally* 42 C.F.R. Part 426, subparts C, D. The ALJ's review authority, however, is limited to hearing challenges to contractor policies **that meet the definition of LCDs**, and does not extend to any policy that is not an LCD as defined in the Act and regulations. 42 C.F.R. §§ 426.325(a), (b)(5), (b)(12); 426.405(d)(5). An ALJ decision dismissing a complaint may be appealed to the Board. 42 C.F.R. § 426.465(a)(2). The standard of review that the Board applies is "whether the ALJ decision contains any material error, including any failure to properly apply the reasonableness standard." 42 C.F.R. § 426.476(b).

The item at issue here was claimed as durable medical equipment (DME). DME is among the "medical and other health services" for which sections 1832(a) and 1861(s)(6) of the Act authorize Medicare payment. Section 1861(n) of the Act contains a non-exclusive list of DME items including "a power-operated vehicle that may be appropriately used as a wheelchair . . . used in the patient's home . . . ." The regulations define DME as "equipment that— (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 (emphasis added).

## Case Background

The ALJ accepted for the purposes of his decision that the AP suffers from multiple sclerosis and is non-ambulatory without a power wheelchair, and that her physician reports that she will benefit medically from being able to stand. ALJ Decision at 6. The AP's request for coverage for a power seat elevator was denied on the ground that "[p]owered accessories for wheelchair is/are not a Medicare covered benefit and is/are excluded from coverage under your Health Plan." A. Ex. 4, at 1. The denial was upheld on reconsideration on the ground that "Power Seat Elevator is 'not a covered benefit' per Medicare/CMS Policy Article A19846 as 'not primarily medical in nature'." A. Ex. 5, at 2. Policy Article A19846, "Wheelchair Options/Accessories - Policy Article," issued by DME MAC contractor Noridian Administrative Services (Noridian) states, as relevant here, that "[a] power seat elevation feature (E2300) and power standing feature (E2301) are noncovered because they are not primarily medical in nature." A. Ex. 3, at 2. It is referenced as a "related document" in Noridian LCD L11462, "Wheelchair Options/Accessories," the LCD that the AP seeks to challenge. A. Ex. 2.

Permobil, Inc. filed an LCD complaint before the ALJ. CMS and Noridian moved to dismiss the complaint for lack of jurisdiction on the ground that the policy supporting the denial of coverage was not an LCD and was thus not subject to ALJ review.

The ALJ noted that an LCD "is a determination of the Medicare contractor as to whether or not a particular item or service meets the reasonable and necessary requirement of section 1862(a)(1)(A) of the Act." *Id.* at 7 (emphasis added). The ALJ reasoned that

coverage "was not denied in this case based upon a LCD that a power seat elevation feature or power standing feature is not reasonable and necessary for the treatment of illness, injury, or to improve function," but was instead denied "based upon a CMS determination and guidance to its contractor that a power seat elevation feature or power standing feature is not DME within the meaning of section 1861(n) of the Act. *Id.* at 8 (emphasis added). The ALJ concluded that, by law, he had "no authority under section 1869(f)(2)(A) of the Act to review a determination by CMS that an item is not DME within the meaning of section 1861(n) and not subject to Medicare coverage on that basis." *Id.* at 7-8. As evidence of CMS's determination and guidance, the ALJ cited, in addition to the Noridian Policy Article, an email dated October 14, 2003 from a Technical Advisor with CMS's Division of DME; CMS's response to comments concerning coverage of wheelchair accessories, dated August 15, 2008; and an affidavit from the Director of the CMS Division of DMEPOS Policy to the effect that "power elevation" or "power standing" were considered "noncovered by reason of [section] 1861(n)" of the Act, do "not meet the definition of DME for Medicare benefit purposes," and "are not eligible for coverage under the [DME] benefit." *Id.*, citing C. Ex. 1; CMS Ex. 1, at 2; and CMS Ex. 2, at 2. The ALJ thus concluded he had no jurisdiction and dismissed the complaint. ALJ Decision at 8. The AP timely appealed the ALJ Decision to the Board.

**Analysis**

CMS moves on appeal that the LCD complaint be dismissed, on the same grounds as adopted in the ALJ Decision. CMS argues that the policy supporting the denial of coverage was not based on the "medical necessity" standard of section 1862(a)(1)(A) of Act (and was thus not an LCD subject to ALJ review), but was instead based on a determination that the requested item was not DME for which Medicare coverage is available. Permobil, Inc. declined the opportunity to respond to CMS's motion to dismiss.

As CMS notes in its motion, the Board on March 29, 2011 issued a decision dismissing a different LCD appeal filed by Permobil for a different AP following a denial of coverage for a "power seat elevator for a power wheelchair," on essentially the same grounds that CMS argues here. *CMS LCD Complaint: Wheelchair Options/Accessories (L11451)*, DAB No. 2370 (2011). In that case, as here, coverage was denied based on a policy article titled "Wheelchair Options/Accessories - Policy Article," stating that power seat elevators are "not primarily medical in nature." DAB No. 2370, at 3; A. Ex. 5, at 2 (reconsideration decision); A. Ex. 3, at 2 (Policy Article A19846). Also as here, the policy article was referenced in an LCD for "Wheelchair Options/Accessories." While the policy article and LCD in that case were issued by a different contractor and bear different numerical designations, they are, as relevant here, substantively identical to the ones in this case.

In DAB No. 2370, the Board agreed with CMS that coverage had been denied "based on the determination in the policy article that a power seat elevator has been determined not to qualify as DME under section 1861(n)" of the Act. DAB No. 2370, at 6. The Board held that the basis for the denial of coverage was "a policy determination that is not an LCD as defined in the Act and regulations subject to review, and that is expressly excluded from [the ALJ's] review by the governing regulations." *Id.* The Board concluded that dismissal was required by LCD regulations stating that "[o]nly LCDs" that are currently effective may be challenged and that "[t]he ALJ does not have authority to . . . [c]onduct a review of any policy that is not an LCD," and forbidding review of "[c]ontractor decisions that are not based on section 1862(a)(1)(A) of the Act" (the medical necessity standard) or review of "[a]ny other policy that is not an LCD" as defined in the regulations. *Id.* at 6-7, citing 42 C.F.R. §§ 426.325(a), (b)(5), (b)(12); 426.405(d)(5). The Board held that "the limited review process applicable only to LCDs was not available here." DAB No. 2370, at 8.

Permobil has not responded to CMS's motion to dismiss, and has given us no reason to revisit our holding in DAB No. 2370. Accordingly, and we adopt and incorporate here the analysis in that decision.

## Conclusion

For the reasons explained above, we sustain the ALJ Decision dismissing the LCD complaint, on the ground that it seeks review of a matter that is outside the scope of review granted to the ALJ and the Board.

/s/
Sheila Ann Hegy

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member