

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DEPARTMENTAL APPEALS BOARD

ORDER OF MEDICARE APPEALS COUNCIL  
REMANDING CASE TO ADMINISTRATIVE LAW JUDGE  
Docket Number: M-11-1228

**In the case of**

Evercare by United  
Healthcare  
\_\_\_\_\_  
(Appellant)

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\_\_\_\_\_  
(Enrollee)

Evercare by United  
Healthcare/ Evercare Plan DP  
\_\_\_\_\_  
(MA Organization (MAO)/plan)

**Claim for**

Medicare Advantage (MA)  
Benefits (Part C)  
\_\_\_\_\_

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\_\_\_\_\_  
(HIC Number)

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\_\_\_\_\_  
(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated January 25, 2011. The ALJ found that Evercare by United Healthcare, the MAO offering "Evercare Plan DP," the Medicare Advantage plan in which the beneficiary was enrolled ("Evercare" or "plan"), is required to authorize and cover a group II power wheelchair for the enrollee. The MAO has asked the Medicare Appeals Council (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 Improvement and Protection 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 plan's request for review is admitted into the record as Exhibit (Exh.) MAC-1.

For the reasons stated below, the Council remands this case to an ALJ for further consideration.

### BACKGROUND

The enrollee, who was 76-years-old at the time pre-authorization for the power wheelchair was requested, had diagnoses that included end-stage rheumatoid arthritis, coronary artery disease, polycythemia, and hypertension. Exh. 3, at 4, 9, 16. On August 23, 2010, the enrollee's physician conducted a face-to-face examination. *Id.* at 15-16. On August 23, 2010, the enrollee's physician prescribed a "Group 2 Motorized Power Wheelchair" with duration indicated as "lifetime." *Id.* at 9.

On September 21, 2010, "The Scooter Store," the supplier from which the enrollee intended to obtain the equipment, submitted a request to the plan for pre-authorization of the purchase of HCPCS codes K0823 (group II power wheelchair) and E2365 x 2 (batteries). Exh. 3, at 1.<sup>1</sup> The plan, initially and on reconsideration, and the Independent Review Entity (IRE,) on further reconsideration, denied coverage of the equipment on the basis that the documentation did not meet Medicare coverage criteria for a power wheelchair. Exh. 1, at 5-6, 19-20, 25. On January 7, 2011, the enrollee requested a hearing before an ALJ. *Id.* at 3. The record does not indicate that the appellant sent a copy of its request for ALJ hearing to the plan.

On January 25, 2011, the ALJ issued a fully favorable decision for the enrollee. The ALJ explained that the decision was "being issued in the absence of a hearing, as careful consideration of all the documents identified in the

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<sup>1</sup> CMS developed the Healthcare Common Procedure Coding System (HCPCS) to set forth "uniform national definitions of services, codes to represent services, and payment modifiers to the codes." 42 C.F.R. § 414.40.

record . . . has resulted in a decision favorable to the [enrollee]." Dec. at 1 *citing* 42 C.F.R. § 405.1038(a). The ALJ concluded that the plan was required to cover the power wheelchair pursuant to the coverage criteria set forth in National Coverage Determinations (NCD) Manual (CMS Pub. 100-03), section 280.3. Dec. at 8. Specifically, the ALJ found that "the Enrollee's diagnoses and the treating physician's examination . . . support the conclusion the Enrollee suffers from a mobility limitation that significantly impairs his ability to perform several mobility related activities of daily living in his home." *Id.* The ALJ further found that "the Enrollee cannot use a walker or cane, due to his weak knees and shortness of breath, which cause him balance and trunk instability and put him at an increased and very real risk for falls." *Id.*

In the request for review before the Council, the plan contends that it was not given "due process" because the ALJ did not allow it to participate in the adjudication of the appeal. Exh. MAC-1, at 5. Specifically, the plan explains that it "was not given formal notice of hearing, was not made a party to the adjudication of this appeal, [and was not] provided an opportunity to provide its evidence for maintaining its position denying coverage of a Group 2 Power wheelchair." *Id.* The plan also notes that it did not waive its right to a hearing. *Id.* Next, the plan contends that the documentation does not meet Medicare coverage criteria for a power wheelchair. *Id.* at 5-10. The plan maintains that the ALJ did not correctly apply the coverage criteria set forth in NCD 280.3 and did not apply the specific documentation requirement set forth in Local Coverage Determination (LCD) L23613, *LCD for Power Mobility Devices*, and in Policy Article A41136, *Local Coverage Article for Power Mobility Devices*. *Id.*

## DISCUSSION

### Right to a Hearing

The Council agrees with the plan that the ALJ erred in issuing a decision on the record without providing all parties an opportunity for a hearing. An ALJ may issue a "wholly favorable" decision without giving the parties prior notice and without holding a hearing, if the evidence in the hearing record "supports a finding in favor of appellant(s) on every issue . . . ." 42 C.F.R. § 405.1038(a). In the instant case, the ALJ found that the plan was required to authorize and cover a power wheelchair. While this is a wholly favorable

determination for the enrollee, it is an *unfavorable* determination for the plan, which is a "party" with hearing rights under Medicare Part C.<sup>2</sup> See 42 C.F.R. § 422.602(c).

For this primary reason, the case must be remanded so that the ALJ can offer all parties an opportunity for a hearing, with prior notice. However, in issuing a new decision or other action on remand, the ALJ should also apply LCD L23613 and address the plan's position on covering out-of-network durable medical equipment suppliers.

Applicable Local Coverage Determination (LCD) L23613

A MAO offering a MA plan must provide enrollees with "basic benefits," which are all items and services covered by original (fee-for-service) Medicare Part A and Part B available to beneficiaries residing in the plan's service area. 42 C.F.R. § 422.101(a). LCD L23613 sets forth specific documentation requirements for coverage of a power mobility device. LCD L23613 provides:

The [face-to-face examination] report should provide pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.

- History of the present condition(s) and past medical history that is relevant to mobility needs
  - o Symptoms that limit ambulation
  - o Diagnoses that are responsible for these symptoms
  - o Medications or other treatment for these symptoms
  - o Progression of ambulation difficulty over time
  - o Other diagnoses that may relate to ambulatory problems
  - o How far the patient can walk without stopping
  - o Pace of ambulation

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<sup>2</sup> Under Medicare Part C, "parties to a hearing" are "the parties to the reconsideration, the MA organization, and any other person or entity whose rights with respect to the reconsideration may be affected by the hearing, as determined by the ALJ." 42 C.F.R. § 422.602(c).

- o What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used
  - o What has changed to now require use of a power mobility device
  - o Ability to stand up from a seated position without assistance
  - o Description of the home setting and the ability to perform activities of daily living in the home
- Physical examination that is relevant to mobility needs
    - o Weight and height
    - o Cardiopulmonary examination
    - o Musculoskeletal examination
      - Arm and leg strength and range of motion
    - o Neurological examination
      - Gait
      - Balance and coordination

The evaluation should be tailored to the individual patient's conditions. The history should paint a picture of the patient's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the patient's ambulatory difficulty or impact on the patient's ambulatory ability.

The ALJ based his decision on the coverage criteria for mobility assistive equipment set forth in NCD 280.3. NCD 280.3 requires the use of a sequential assessment process, based on clinical criteria listed on a flow chart, to determine whether a beneficiary requires and can benefit from a mobility assistive device, and if so, what type of device. LCD L23613 requires that similar clinical criteria be met and, as described, also sets forth specific documentation requirements. An ALJ is not bound by LCDs, but will give them substantial deference if they are applicable to a particular case. 42 C.F.R. § 405.1062(a). If an ALJ declines to follow an LCD, then the ALJ decision must explain the reasons why the policy was not followed. *Id.* at § 405.1062(b). As noted by the plan in the request for review, the ALJ did not apply LCD L23613 in this case. The ALJ concluded that the plan was required to cover the requested

power wheelchair without considering the presence of or lack of supporting objective evidence in the record. Dec. at 8-9.

Plan's Policy Regarding Out-of-Network Providers and Suppliers

Finally, the Council finds that the ALJ failed to consider the plan's policy regarding "out-of-network" providers and suppliers.<sup>3</sup> In the reconsideration decision dated November 1, 2010, the plan noted that "The Scooter Store" is an "out-of-network and non-contracted [supplier]." Exh. 1, at 19-20. The plan explained that, if the enrollee met plan and Medicare coverage criteria for a power wheelchair in the future, the plan would authorize the equipment through an in-network participating/contracted provider only. *Id.* at 20. With respect to out-of-network providers and suppliers, the plan's 2010 Evidence of Coverage (EOC) states: "You can get your care from an out-of-network provider, however, that provider must participate in Medicare. We cannot pay a provider who has decided not to participate in Medicare. You will be responsible for the full cost of the services you receive." Exh. 2, at 35.

**DIRECTIONS ON REMAND**

The ALJ shall offer all parties the opportunity for an ALJ hearing and shall provide notice of the hearing to the plan and the enrollee. The ALJ shall issue a new decision, consistent with the above analysis. In issuing a new decision, the ALJ should apply all relevant coverage criteria for a group II power wheelchair, including LCD L23613. If the ALJ departs from the applicable coverage criteria, the ALJ must explain why he or she is not following it. The ALJ should also consider all relevant provisions of the plan's EOC, including the plan's policy regarding coverage of services and equipment furnished by out-of-network providers and suppliers.

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<sup>3</sup> The plan defines "network providers" as "the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept payment in full." Exh. 2, at 32.

The ALJ may take further action not inconsistent with this order.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson  
Administrative Appeals Judge

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

Date: September 7, 2011