DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
C.H. (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
CIGNA Government Services (Contractor)	**** (ALJ Appeal Number)

The Medicare Appeals Council has decided, on its own motion, to review the Administrative Law Judge's (ALJ's) decision dated July 16, 2009, because there is an error of law material to the outcome of the claim. *See* 42 C.F.R. § 405.1110. The ALJ's decision allowed Medicare Part B coverage for an adjustable bed (HCPCS code A9270) purchased by the beneficiary from Mattressmax Factory Outlet on January 11, 2008.

In its September 8, 2009, motion for referral, the Centers for Medicare & Medicaid Services (CMS) asserts that the ALJ erred by finding coverage in this case because the item does not meet the definition of durable medical equipment (DME). CMS's referral memorandum is admitted into the record as Exhibit (Exh.) MAC-1.

We limit our consideration of the ALJ's action to those exceptions raised by CMS. *See* 42 C.F.R. § 405.1110(c). For the reasons and bases articulated below, the Council reverses the ALJ's decision and finds that the item at issue is not covered by Medicare Part B.

BACKGROUND

The beneficiary has psoriatic arthritis, degenerative disc disease in the lumbar spine, and severe joint pain, among other medical conditions. Exh. 3 at 1; Record at 7-24 (not marked with exhibit number(s)). The record indicates that, on January

11, 2008, Dr. *** signed a prescription for an adjustable bed. In the prescription, Dr. *** stated: "Please let [the] patient have power bed – history [of] psoriatic arthritis and difficulty with mobility and asleep." Exh. 3 at 1. On January 11, 2008, the beneficiary purchased a "Twin Englander Adjustable Bed," along with a foam mattress, at Mattressmax Factory Outlet. Exh. 3 at 2 (itemized invoice from Mattressmax). The bed and mattress apparently were sold together, as a set, for $1667.67; the total purchase price was $1,800, which included sales tax. *Id.*

The DME Medicare contractor considered the beneficiary's unassigned claim for reimbursement of the cost of the bed and mattress together as a claim for one item, coding it under HCPCS code A9270 (non-covered item or service). Exh. 2 at 8. On redetermination, the contractor affirmed the denial, explaining that the adjustable bed is not DME and that the beneficiary is liable for the non-covered cost of $1800. Exh. 2 at 4-5 (redetermination); Exh. 3 at 2 (Mattressmax invoice). The Qualified Independent Contractor (QIC) agreed with the contractor as to both coverage and liability. Exh. 1.

On further review, the ALJ determined that the adjustable bed is covered by Medicare Part B as DME.[1] The ALJ concluded that the bed is medically necessary for the beneficiary and meets the definition of DME. He stated:

> The item at issue can withstand repeated use, is appropriate for use in the home (it is a bed), while it does not customarily serve a medical purpose in this instance it primarily serves the medical purpose of helping the beneficiary's lumbar degenerating discs, psoriatic arthritis, mobility and sleep and while it could be used in the absence of illness, it appears that the most efficacious application of the adjustable bed is for a person with an illness.

Dec. at 4.

In its referral memorandum, CMS argues that the ALJ erred in concluding that the adjustable bed is DME covered by Medicare

[1] The ALJ did not separately address the question of coverage for the mattress. Perhaps the ALJ referred specifically to the adjustable bed, but not the mattress, and considered the claim as for one item (bed and mattress together), for consistency with the contractor's and the QIC's decisions.

Part B. Exh. MAC-1. The beneficiary has not filed a response to the CMS memorandum.

DISCUSSION

We do not doubt that the adjustable bed (including the mattress used with the bed) helps the beneficiary, who, as stated, has psoriatic arthritis and lumbar disc problems. The ALJ would agree with this statement, as he determined that the bed is medically necessary for the beneficiary. Medicare, however, is a defined benefits program. Not all items or services, even if they are medically reasonable and necessary for a beneficiary, are covered.

The Council agrees with CMS that the ALJ erred when he determined that the adjustable bed at issue is DME. Section 1832(a) of the Social Security Act (Act) provides benefits under Medicare Part B for "medical and other health services." Section 1861(s)(6) of the Act defines "medical and other health services" as including DME. Section 1861(n) of the Act lists certain items that are classified as DME, and adjustable beds are not listed in section 1861(n). By its own terms, however, section 1861(n) is not an exhaustive list of those items that qualify as DME.

Medicare covers DME if it (1) meets the definition of DME; (2) is medically "reasonable and necessary"; and (3) the equipment is used in the beneficiary's home. *See* Medicare Benefit Policy Manual (MBPM), CMS Pub. 100-02, Ch. 15, § 110. DME is defined as equipment that can withstand repeated use; is primarily and customarily used to serve a medical purpose; generally is not useful to an individual in the absence of an illness or injury; and is appropriate for use in a patient's home. 42 C.F.R. § 414.202.

The Medicare National Coverage Determinations Manual (NCDM),[2] CMS Pub. 100-03, Ch. 1, Part 4, Section 280.1 provides a DME reference list. The list includes "Beds – Lounges (power or manual)" and provides that coverage would be denied for these items on the basis that they are comfort or convenience items not considered primarily medical in nature.[3] That beds, in

[2] By regulation, National Coverage Determinations (NCDs) are binding on ALJs and the Council. 42 C.F.R. § 405.1060(a)(4).

[3] The DME reference list indicates that coverage may be allowed for manual or power *hospital* beds, alternating pressure pads, gel floatation pads, and

general, are not considered primarily medical in nature was a point the ALJ himself acknowledged; he also conceded that beds are items typically used in the absence of an illness or injury. Dec. at 4.

However, the ALJ erred to the extent he concluded that the adjustable bed at issue is nonetheless DME because it "primarily serves the medical purpose of helping the beneficiary's lumbar degenerating discs, psoriatic arthritis, mobility and sleep and . . . it appears that the most efficacious application of the adjustable bed is for a person with an illness." Dec. at 4. In effect, the ALJ concluded that the evidence of medical necessity of an item for a beneficiary, as he found in the instant case, could be the basis for concluding that an item is DME *even if certain criteria for the definition of DME are not met*. We disagree because such a conclusion is inconsistent with the cited NCD provisions, to which the Council and the ALJ are bound. 42 C.F.R. § 405.1060(a)(4). As we explained, there are specific criteria that an item must meet for it to be considered DME, and if the item does not meet those criteria, coverage may be denied even if it is medically necessary. The adjustable bed at issue and the mattress purchased with the bed do not meet the definition of DME and coverage is not warranted on this basis.

Liability

Having found that the items are not covered, we now address liability for the non-covered cost. If items or services are not covered on the basis that they are not medically reasonable and necessary, section 1879 of the Act provides financial protections to both providers and beneficiaries where neither knew, nor could reasonably have been expected to know, that the items or services at issue would not be covered. Here, however, the denial of the claim is based on a finding that the item at issue does not constitute DME and is not covered under that basis. Accordingly, section 1879 of the Act does not apply to

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mattresses where certain criteria are met and they are prescribed for certain medical conditions. *See* NCDM, Ch. 15, §§ 280.1 and 280.7. There is no evidence that the adjustable bed at issue in this case was a *hospital* bed prescribed consistent with the criteria in NCDM, Ch. 15, § 280.7. Nor is there evidence that the items purchased by the beneficiary on January 11, 2008, included a pressure or gel floatation pad or mattress that may be covered DME consistent with NCDM, Ch. 15, sections 280.1 and 280.7, whether considered alone, or with the adjustable bed in question.

this claim. The beneficiary can and will be held liable for the non-covered cost.

DECISION

It is the decision of the Medicare Appeals Council that the adjustable bed and mattress (coded A9270), purchased by the beneficiary on January 11, 2008, do not constitute DME and are not covered by Medicare. The beneficiary is liable for the non-covered costs.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

/s/ M. Susan Wiley
Administrative Appeals Judge

Date: October 28, 2009