DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL

In the case of	**Claim for**
R.C. (Appellant)	Medicare Advantage (MA) (Part C)
**** (Enrollee)	**** (HIC Number)
Tufts Health Plan (MA Organization (MAO))	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated April 23, 2009. The ALJ's decision found that a seat lift for a power wheelchair was not covered under Policy Article A19829. The ALJ concluded that the policy article was a coverage decision with which the MAO and the enrollee must comply, pursuant to 42 C.F.R. § 422.101. In *dicta*, the ALJ stated that he could have declined to follow the policy article under 42 C.F.R. § 405.1062 and allowed coverage, if the beneficiary had been enrolled in Original Medicare, rather than in the MA plan. The ALJ held that the MA plan was not required to make payment for the seat lift. The enrollee has asked the Medicare Appeals Council (MAC or Council) to review that decision.

The regulation codified at 42 C.F.R. § 422.608 states that "[t]he regulations under part 405 of this chapter regarding MAC review apply to matters addressed by this subpart to the extent that they are appropriate." The regulations "under part 405" include the appeals process found at 42 C.F.R. part 405, subpart I, and the expedited determinations and reconsiderations of provider service terminations process found at 42 C.F.R. part 405, subpart J. With respect to Medicare "fee-for-service" appeals, the subpart I and J 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 (Mar. 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), it is "appropriate" to apply, with certain exceptions, the legal provisions and principles codified in 42 C.F.R. part 405, subparts I and J to this case.[1] The Council reviews this matter *de novo*.

The Council has carefully considered the record which was before the ALJ and the appellant's request for review. The Council has entered the Request for Review into the record as Exhibit (Exh.) MAC-1. No response to the request for review has been received from the MAO.

The Council incorporates the Procedural History, Issues, Findings of Fact, and Legal Framework set forth in the ALJ's decision herein by reference. The Council does not adopt the ALJ's Analysis, and Conclusions of Law. For the reasons stated below, the Council modifies the rationale for the ALJ's decision to clarify that the requested seat lift is not covered under National Coverage Determination 280.4. The Council affirms that the MA plan is not required to pay for a power seat elevation system.

LEGAL STANDARDS

A MAO offering a MA plan must provide enrollees with "basic benefits," which are all items and services covered by Medicare Part A and Part B available to beneficiaries residing in the plan's service area. 42 C.F.R. § 422.101(a). A MA plan must comply with NCDs, LCDs, and general coverage guidelines included in original Medicare manuals and instructions. 42 C.F.R. § 422.101(b). By regulation, NCDs are also binding on ALJs and the Medicare Appeals Council. 42 C.F.R. § 405.1060.

[1] As noted by CMS, "the provisions that are dependent upon qualified independent contractors would not apply since an independent review entity conducts reconsiderations for MA appeals." 70 Fed. Reg. 4676 (January 28, 2005).

BACKGROUND

The enrollee has multiple sclerosis and is bed or wheelchair confined. He requests a seat lift elevation system to help with transfers to and from bed, to raise him up in order to reach overhead, and to sit at a pub-height table for eating. The MA plan and the independent review entity denied coverage under Local Policy Article A19829. Exh. 2, 3, and 4. The policy Article states that a power seat elevation system is noncovered because it is not primarily medical in nature. *See,* Exh. 3 at 25, and Exh. 4 at 5. The ALJ agreed that the seat lift was noncovered under the terms of that Policy Article.

The appellant quotes section 1862(a)(1)(A) of the Social Security Act (Act), and asserts that a seat lift is necessary for his daily independence and full access to his home. The Council does not doubt that the seat lift is useful to the enrollee. However, section 1862(a)(1)(A) of the Act excludes items and services from coverage unless they are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. That section does not serve as an affirmative coverage provision for every item that may be useful. Medicare excludes many useful items as comfort items under section 1862(a)(6), or as convenience items under NCD 280.1.[2]

The Centers for Medicare and Medicaid Services (CMS) has published NCD 280.4, which exclusively delineates the limited circumstances in which a seat lift is covered.[3] The NCD is based on the reasonable and necessary provision of section 1862(a(1)(A) of the Act.[4] In its entirety, the NCD provides:

> Reimbursement may be made for the rental or purchase of a medically necessary seat lift when prescribed by a physician for a patient with severe arthritis of the

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[2] For example, a "standing," or pub table, is excluded as a convenience item under NCD 280.1, as are over–the-bed tables.

[3] The Medicare National Coverage Determination Manual (MNCDM), Pub. 100-03, publishes all NCDs.

[4] The forward to the MNDCM states that: "[a]ll decisions that items, services, etc. are not covered are based on §1862(a)(1) of the Act (the "not reasonable and necessary" exclusion) unless otherwise specifically noted. Where another statutory authority for denial is indicated, that is the sole authority for denial. Where an item, service, etc. is stated to be covered, but such coverage is explicitly limited to specified indications or specified circumstances, all limitations on coverage of the items or services because they do not meet those specified indications or circumstances are based on §1862(a)(1) of the Act."

> hip or knee and patients with muscular dystrophy or other neuromuscular disease when it has been determined the patient can benefit therapeutically from use of the device. In establishing medical necessity for the seat lift, the evidence must show that the item is included in the physician's course of treatment, that it is likely to effect improvement, or arrest or retard deterioration in the patient's condition, and that the severity of the condition is such that the alternative would be chair or bed confinement.
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> Coverage of seat lifts is limited to those types which operate smoothly, can be controlled by the patient, and effectively assist a patient in standing up and sitting down without other assistance. Excluded from coverage is the type of lift which operates by a spring release mechanism with a sudden, catapult-like motion and jolts the patient from a seated to a standing position. Limit the payment for units which incorporate a recliner feature along with the seat lift to the amount payable for a seat lift without this feature.

The NCD covers a seat lift for those individuals who cannot arise from a bed or a seated position, but who can ambulate once standing in order to perform activities of daily living. In this case, the enrollee is confined to a wheelchair or bed even with the use a seat lift, which would only assist in a transfer to and from wheelchair to bed. Using the seat lift to reach overhead or eat at a pub table does not help in the diagnosis or treatment of illness or injury. In addition, although a seat lift may assist the appellant with certain tasks of daily living, it does not actually improve the functioning of a malformed body member by effecting improvement, or arresting or retarding deterioration in the enrollee's condition. Accordingly, we conclude that NCD 280.4 appropriately controls the disposition of this case, and that the seat lift is not covered.

There is a direct conflict between NCD 280.4, which provides that a seat lift may be covered in some instances, and Policy Article A19829, which states that a seat lift is never covered because it is not primarily medical in nature, and thus cannot satisfy the definition of durable medical equipment in 42 C.F.R. § 414.202. By regulation, the NCD is binding on the MA plan,

the ALJ, and the Council. We therefore find that it is entitled to greater weight than a contractor policy. We conclude, however, that the ALJ erred in the first place in finding that the Policy Article was binding under 42 C.F.R. § 422.101.

The ALJ correctly stated that MA plans must comply with Local Coverage Determinations (LCDs) pursuant to the regulations at 42 C.F.R. § 422.101. The applicable Original Medicare contractor has issued LCD 11473 and Policy Article A19829, which both apply to wheelchairs. *Compare* Exh. 2 at 7-23, and 24-37. Only determinations regarding whether a device is covered under section 1862(a)(1)(A) of the Act are covered by LCDs. Policy Articles, in contrast, address instead whether a benefit category is met or an item or service is otherwise statutorily excluded. Medicare Program Integrity Manual, Pub. 100-08, Chapter 13, section 13.1.3. A Policy Article is not the same as an LCD.

Sections 1852(a)(2)(C) and 1858(g) of the Act require an MA plan to comply LCDs. See, also, section 1869(f)(2)(B) for the definition of LCDs. We presume that Congress intended a common definition of LCDs to apply in both Original Medicare and the Part C MA program.[5] *See, also,* Medicare Managed Care Manual, Pub. 100-16, chapter 4, section 30.1 (referring to an MA plan complying with a Local Coverage Determination). Thus, an MA plan must only comply with LCDs regarding whether a device is covered under section 1862(a)(1)(A) of the Act. The ALJ did not cite to any authority, and we are aware of none, which requires MA plans to comply with policy articles. We find that a MA plan must comply with LCDs, but that a Policy Article is not binding.

[5] Public Law 108-173, §948(b)(2) amended section 1852(a)(2)(C) to refer specifically to a local coverage determination, instead of a local coverage policy.

DECISION

It is the decision of the Medicare Appeals Council that the MAO is not required to pay for a power wheelchair seat lift, which is excluded from coverage under section NCD 280-4 as not medically reasonable and necessary. The ALJ's decision is modified accordingly.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: September 28, 2009