SOCIAL SECURITY ADMINISTRATION
Office of Hearings and Appeals

DECISION

IN THE CASE OF	CLAIM FOR
MS. CELIA C[redacted] (Appellant)	Hospital Insurance Benefits
CELIA C[redacted] (Beneficiary)	196-14-0195 (HICN)
HIP Health Plan of Florida (Intermediary/PRO/HMO/CMP)	

This case is before the undersigned Administrative Law Judge on a request for hearing. A hearing was held on August 27, 1998 in New York, New York. The beneficiary and her husband, Jack C[redacted], were presented. She was represented by Lewis Golinker, Esq. Also present at the hearing was the beneficiary's speech pathologist, Jeri Weinstein. The Administrative Law Judge has carefully considered all of the documents identified in the record as exhibits, the testimony at the hearing, and the arguments presented.

The amount in controversy exceeds the $100.00 minimum to satisfy the statutory requirement for filing an appeal at the hearing level.

PROCEDURAL HISTORY

This case arises on a request for the payment of equipment on behalf of a Medicare beneficiary who has elected to enroll in and to have covered equipment furnished through a Health Maintenance Organization ("HMO") under contract with the Health Care Financing Administration ("HCFA") to provide a comprehensive range of health services in exchange for a fixed monthly fee, usually in advance, made by or on a member's behalf without regard to the amount of services actually rendered. This prepayment system differs from Medicare's traditional fee-for-service system and usually requires HMO members to obtain all medical services from the HMO (i.e., in-plan services) and not

from providers or physicians who do not belong to, or accept patients from, the HMO (i.e., out-of-plan services) except in certain emergency or urgent care situations or for services HCFA determines the member is entitled to have furnished by the HMO.

A request for medical services was submitted to HIP Health Plan ("HMO") on behalf of the beneficiary, requesting payment for an augmentative communication device, specifically a Lightwriter SL35-L ABD-K which the beneficiary's physician prescribed. After an unfavorable initial determination was made by the HMO, the Center for Health Dispute Resolution ("CHDR"), the special HCFA contractor responsible for processing requests for reconsideration and effectuating all claims involving the services of an HMO, affirmed the adverse determination upon reconsideration. Dissatisfied with those actions, the beneficiary/member filed a request for hearing before an independent Administrative Law Judge of the Office of Hearings and Appeals of the Social Security Administration ("SSA").

ISSUE

The issue to be decided is whether the HMO must authorize the medical equipment/services which the Medicare beneficiary/HMO member has requested.

CONCLUSION

It is the conclusion of the Administrative Law Judge that, under pertinent provisions of Medicare law and regulations, for the reasons discussed below, the HMO must authorize the medical equipment at issue.

LAW AND REGULATIONS

Section 1876 of the Act and HCFA Regulations at Subparts A through V of 42 CFR Part 417 authorize HCFA to enter into contracts with eligible HMOs to participate in the Medicare program under which an HMO will receive Medicare payment for furnishing comprehensive Medicare covered health services to Medicare Part A and Part B beneficiaries on a prepayment basis.

HCFA Regulations at 42 CFR 417.400 et seq. set forth the requirements an entity must meet in order to enter into a contract with CHFA as an HMO to be reimbursed, through capitalization payments, for services furnished to Medicare beneficiaries who are enrolled with the HMO.

HCFA Regulations at 42 CFR 417.420 provide that individuals who are entitled to Medicare benefits may elect to receive those benefits through an HMO.

HCFA Regulations at 42 CFR 417.436 provide that an HMO must maintain written membership rules which inform a beneficiary/ member of all benefits provided, of how and where to obtain services from or through the HMO, and of the restrictions on coverage the services furnished form services outside the HMO. These rules must be furnished to the beneficiary at the time of enrollment and on an annual basis thereafter.

HCFA Regulations at 42 CFR 417.440 provide that a Medicare enrollee of an HMO may be entitled to receive health care services, including available Part A and Part B services, supplemental (optional) services elected by enrollee, supplemental (mandatory) services imposed by a risk HMO, additional benefits from risk HMOs required by statute, and special supplemental plan benefits directly from, or through arrangements made by the HMO. A Medicare enrollee is entitled to receive timely and reasonable payment directly (or have payment made on his or her behalf) for services he or she obtained outside the HMO if those services are emergency services or urgently needed services as defined in 42 CFR 417.401 or services denied by the HMO and found upon appeal to be services the enrollee was entitled to have furnished by the HMO.

Section 1862(a) of the Act states, in pertinent part, that payment may not be made under Part A or Part B for expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1861 of the Act includes "durable medical equipment" within its definition of "medical and other health services." HCFA regulation 42 CFR section 414.202 provides, in pertinent part, that Durable Medical Equipment means equipment, furnished by a supplier or a home health agency 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.

Section 2100 of the Carriers Manual further provides that expenses for the rental or purchase of durable medical equipment are reimbursable if three requirements are met. These requirements are: (1) the equipment meets the definition of durable medical equipment; (2) the equipment is necessary and reasonable for the treatment of the beneficiary's illness or injury or to improve the functioning of a malformed body member; and (3) the equipment is used in the beneficiary's home.

Section 60-9 of the Coverage Issues Manual is a national coverage determination and is comprised of the durable medical equipment reference list. That list is designed as a quick reference tool for determining the coverage status of certain items for equipment. Section 60-9 provides that when a claim for equipment does not fall logically into any of the listed generic categories, a determination must be based upon section 2100ff of the Carriers Manual and section 3113ff of the Intermediary Manual. In addition, section 60-9 discloses whether coverage for an item is denied as being not primarily medical in nature under section 1861(n) of the Act or a personal comfort item under section 1862(a)(6) of the Act.

EVALUATION OF THE EVIDENCE

The evidence establishes that the beneficiary/member suffers from pseudobulbar palsy and Amyotrophic Lateral Sclerosis, commonly known as Lou Gehrig's disease. This condition affects the beneficiary's ability to speak and, thereby prevents effective communication with her family and medical personnel. In July 1997 Jeri Weinstein, Chief of speech/language pathology at Beth Israel Medical Center conducted an augmentative communication evaluation and reported that the beneficiary/member had severe weakness and spasticity of the oral musculature. She was totally unable to speak and was, therefore, unable to communicate effectively. She also had severe drooling which she controlled by keeping a tissue in her mouth. She had severe oral stage dysphagia which limited her diet to puree and liquids, and she complained of coughing during meals. Her cognitive skills and receptive language were intact. However, her writing was slow and poorly intelligible.

Ms. Weinstein further stated that the beneficiary's inability to communicate effectively limited her ability to participate in her prescribed therapies or communicate her functional daily needs. "Even more critical is the fact that [the beneficiary's] inability to communicate places her in continuous personal jeopardy. The inability to inform a caretaker, medical team or

emergency services of potential or immediate complication places her at risk for personal injury." (Exhibit 2.)

During the evaluation, several devices were demonstrated to the beneficiary. A Lightwriter was selected as most useful, in particular because it was portable. As a result of the beneficiary's progressive symptoms, Ms. Weinstein recommended purchase of the Lightwriter for the beneficiary's rehabilitation. (Exhibit 2.)

The reconsideration determination denying coverage was based on the CIM which does not generally cover communication devices. However, the hearing officer for the Center for Dispute Resolution did not fully consider Medicare regulations or the circumstances of the case. The medical documentation supplied by the appellant provides ample evidence that the Lightwriter communication device was reasonable and necessary to improve the functioning of a malformed body member, in this case the beneficiary's ability to speak. (Exhibits 2, 12, 13, 15, 16.)

The augmentative communication device at issue meets the definition of durable medical equipment. It is constructed and designed for repeated use and is used in the home. It is primarily and customarily used to serve the medical purpose of enabling its user to communicate when she could not otherwise do so due to a serious medical condition. It would not be useful for an individual without such serious medical condition.

The Carrier's manual requirements are also met. As detailed above, the equipment meets the definition of durable medical equipment. In addition, the equipment was necessary and reasonable for the treatment of the beneficiary's illness and malformed body member, and the equipment would be used in the beneficiary's home.

The CIM section 60-9 was misapplied, and the communication device was not considered as durable medical equipment. Accordingly, the undersigned finds that the augmentative communication device prescribed by the beneficiary's physician should have been covered as a benefit the beneficiary is entitled to under the Medicare program. The HMO is directed to authorize the medical equipment at issue.

FINDINGS

After careful consideration of the entire record, the Administrative Law Judge makes the following findings:

1. The amount in controversy exceeds $100.00 which meets the jurisdictional requirement.

2. The beneficiary/member request the HMO to supply a Lightwriter augmentative communication device.

3. The equipment at issue is reasonable and necessary for the treatment of the beneficiary's/member's speech impairment due to her Lou Gehrig's disease.

4. The equipment at issue meets the definition of durable medical equipment.

5. The HMO must authorize coverage of the equipment at issue.

DECISION

It is the decision of the Administrative Law Judge that the HMO must authorize coverage of the Lightwriter augmentative communication device requested by the beneficiary/member.

HELEN C. ANYEL
Administrative Law Judge

DEC 0 2 1998

Date