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**Advance Beneficiary Notice (ABN)**

**What is the Medicare Advance Beneficiary Notice?**
The ABN (waiver of liability) form, CMS-R-131-G, is a written agreement between the provider and beneficiary that is based on an informed decision by the beneficiary to agree in advance to be financially liable for any amount Medicare may not pay on an equipment or supply claim. You must include what the equipment is and the reason you feel Medicare will not cover the item. An ABN must be signed and dated before the patient receives the equipment. For claims submitted to Medicare with an ABN include the ‘GA’ modifier on each line item you believe will be denied. Items that are never covered by Medicare do not require an ABN. The ABN should be kept in the patient’s file as proof of your right to bill the patient for items Medicare deems as not medically necessary.

**When a Supplier May Use an ABN**
- When the item is likely to be determined by the DME MAC as not “medically necessary”
- When a supplier fails to obtain Advance Determination of Medicare Coverage (ADMC)
- When a supplier receives a DME MAC denial for an ADMC request
- When a supplier wishes to standardize his inventory and provides a beneficiary with an upgrade at “no charge”
- When the beneficiary is currently using a “same or similar” item
- When the item(s) does not meet medical necessity coverage criteria or frequency guidelines specified in national or DME MAC local medical review policies (LMRP)

The following statements are examples of reasons a supplier may believe Medicare is likely to deny payment:
- Medicare does not usually pay for this many treatments or services
- Medicare usually does not pay for this service
- Medicare does not pay for this service because it is a treatment that has yet to be proven effective
- Medicare does not pay for this many services within this period of time
- Medicare does not pay for such an extensive treatment
- Medicare does not pay for this equipment for the illness or condition stated

**Using the ABN Form to Provide an Upgraded Item**
The ABN process provides suppliers the opportunity to provide beneficiaries with items that better meet their needs than the base item that Medicare will cover. In general, the beneficiary must agree at the outset to pay the difference between the Medicare covered item and the non-covered item. The ABN form is a written agreement that the beneficiary agrees to be personally financially liable for that amount. In addition, the upgrade process is designed to be used generally within the same product categories. For example, a beneficiary may want a wheelchair that is more lightweight or has more deluxe features than the standard Medicare covered wheelchair. In contrast, the ABN process cannot be used to upgrade from a walker to a wheelchair.

Suppliers are responsible for determining which of their inventory are “standard” products, and which are “upgrade” items. According to CMS, an upgrade is an item with features that go beyond what the physician ordered. An upgrade may include an excess component. An excess component may be an item feature, or service, and/or the extent of, number of, duration of, or expense for an item, feature or service, which is in addition to, or is more extensive and/or more expensive than, the item or service ordered by the physician, and which is reasonable and necessary under Medicare’s coverage requirements.

Therefore, suppliers may use the ABN process to provide Medicare beneficiaries with “upgraded” items, and collect from the beneficiary the difference between the Medicare covered item and the upgraded item. CMS has instructed suppliers to use the new ABN form to provide beneficiaries with upgraded items. When a beneficiary selects Option 1 on the ABN, indicating that he or she wants to receive the services, use the GA modifier on the 1500 claim form in item 24d. The GA modifier indicates that the supplier furnished an ABN and is on file in the supplier’s office. The GA modifier also documents the supplier’s expectation that Medicare will either not pay the claim in whole or will only partially cover the claim. Importantly, the Medicare payment rules that apply to the “standard” item ordered would be the payment rules the supplier must adhere to for the “upgrade” item. For example, if the standard item is a capped rental item, then the supplier must provide the upgraded item, regardless of its payment rules, on a rental basis. Finally, remember that you should use the ABN process to provide beneficiaries with an upgraded item when the beneficiary desires the upgrade item. You should not engage in any tactics that would be deemed to be coercive. State consumer protection laws will apply to protect beneficiaries from these kind of unscrupulous acts.

**Medicare Billing Instructions**
Suppliers are to bill 2 line items per claim for an upgraded item when the beneficiary requests an upgraded item. Both lines must be billed on the same claim.

Line 1 Bill appropriate HCPCS code for the item provided to the beneficiary with the **GA** or **GZ** modifier; with dollar amount of the upgraded item. If an upgrade was provided and an ABN is on file, the supplier must bill for the DMEPOS item provided with a **GA** modifier. If an upgrade was provided and there is no ABN on file, the supplier must bill for the DMEPOS item provided with the **GZ** modifier.
Line 2  Bill the appropriate HCPCS code for the item that was ordered by the physician with modifier GK with the actual charge or fee schedule amount. When upgrades are involved, the supplier must bill a second line on the same claim with the HCPCS code for the DMEPOS item ordered by the physician and the GK modifier.

Suppliers should bill their full charge on the claim line for the upgraded item (Line 1) and the full amount for the physician ordered/covered item (Line 2). If the upgrade is “within a code,” suppliers would still bill 2 line items – use the same code on both lines, but Line 1 would have the higher dollar amount. Both lines must be billed on the same claim.

Suppliers should bill both lines on the same claim in sequential order. Line 1 and associated Line 2 should follow each other.

**Use of Modifiers with ABN**

The following is an example of the modifiers to be used when billing a chargeable upgraded option with and without an ABN:

- **Upgrade with an ABN:** K0004 RR KH GA
  Item ordered by physician: K0001 RR KH GK

- **Upgrade without an ABN:** K0004 RR KH GZ
  Item ordered by physician: K0001 RR KH GK

**EXAMPLE**

**Standard Wheelchair (K0001) to a High Strength, Lightweight Wheelchair (K0004):**

1) Establish that the beneficiary desires to pay out of pocket the purchase price difference between the Medicare fee schedule amount for the covered standard wheelchair (K0001) and the high strength, lightweight wheelchair (K0004). This example assumes that the beneficiary desires the supplier’s “standard” K0004 item.

2) You must insert on the ABN form the expected partial denial, and you must clearly identify in the “Items and Services:” box the item with a specific description of the “excess component(s)” for which you expect denial. You must also state in the “Because:” box the reason that you expect Medicare to deny payment for the specified “excess component(s).”

3) Have the beneficiary review and complete the ABN form, CMS-R-131-G. Make sure the beneficiary chooses Option 1. If the beneficiary chooses Option 2, provide and bill for the standard wheelchair (K0001).

4) If the beneficiary chooses Option 1 on the ABN form, provide the high strength, lightweight wheelchair (K0004) and submit the HCFA-1500 claim form for the K0004, making sure you insert the “GA” modifier in item 24d.

5) Invoice and collect from the beneficiary the purchase price difference in the Medicare fee schedule for the K0001 and K0004. The price difference is the monthly rental amount difference between the Medicare allowable for a K0001 and the Medicare allowable for a K0004. Since these are both rental items, the supplier must collect the additional rental payments on a monthly basis. If the standard item provided is a purchase item, then the supplier can collect the differential at the time of the transaction.

6) Maintain a paper copy of the original signed ABN form in the event of a DME MAC audit.

7) Give a clear and legible copy to the beneficiary.

**Free Upgrade Option:**

Suppliers are permitted to furnish upgraded DMEPOS items and to charge the same price to Medicare and the beneficiary as they would charge for a non-upgraded item. This policy allows suppliers to furnish to beneficiaries, at no extra costs to the Medicare program or the beneficiary, a DMEPOS item that exceeds the non-upgraded item that Medicare considers to be medically necessary. Therefore, even though the beneficiary received an upgraded DMEPOS item, Medicare’s payment and the beneficiary's coinsurance would be based on the Medicare allowed payment amount for a non-upgraded item that does not include features that exceed the beneficiary’s medical needs.

Use the appropriate HCPCS code for the non-upgraded item that the physician ordered. A supplier may only charge for the non-upgraded item. Use the GL modifier (Medically unnecessary upgrade provided instead of standard item, no charge, no ABN) along with the HCPCS code. Make and model number of the upgraded item the supplier furnished and a description of why the item is an upgrade must be entered in item 19 on the claim form or sent as an attachment. If filing electronically, this information should be entered in the HAO record.

The reason for this may be that a supplier prefers to carry only higher-level models of medical equipment in order to reduce the costs of maintaining an inventory that includes a wide variety of different models and products. Also, a supplier may be able to reduce its costs for replacement parts and repairs if it includes in its inventory only certain product lines.

**Frequently Asked Questions**

**What is an Upgrade?**

On January 1, 2003 CMS approved an upgrade policy for beneficiaries for equipment and/or supplies. An “upgrade” is when a beneficiary wants to receive a product that is more deluxe, or has more features, or more closely fits his or her lifestyle than the product that Medicare will cover for the beneficiary based upon the beneficiary’s medical needs. At the same time, the beneficiary only pays out-of-pocket the difference in cost between the

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two items. In the absence of this upgrade option, the beneficiary would have to receive the upgraded item on a non-assigned basis, pay up front the entire cost of the upgraded product; and wait for Medicare to reimburse for the base Medicare covered product.

**What Kinds of Products Does the Upgrade Apply To?**
Beneficiaries can upgrade to any product that is generally in the same product (not payment) category. For example, a consumer may want to upgrade from a lightweight wheelchair to an ultra lightweight wheelchair, from a semi-electric bed to a full electric bed. In contrast, a beneficiary cannot upgrade from a cane to a wheelchair. The upgrade process applies to all Medicare Part B items and services, including durable medical equipment, prosthetics, orthotics, medical supplies, parenteral and enteral nutrition, and surgical dressings.

**Who's Choice is it to Upgrade?**
It is always the beneficiary who has the option to receive, or not, an upgraded item. Suppliers should not engage in any coercive tactics to "persuade" a beneficiary to choose an upgraded product. Remember, state consumer protection laws apply. A Medicare beneficiary has a right to request deluxe (or more functional) equipment, supplies or services than that which is prescribed by their physician and/or that which is normally considered medically necessary under existing Medicare coverage guidelines and payment policies.

These guidelines say that a consumer can only upgrade within the same category of product as the basic item prescribed by their physician. What are the *categories of products?*

- Ambulatory Aids
- Manual Wheelchairs
- Seating and Positioning Products
- Therapeutic Support Surfaces
- Nebulizers
- Diabetic Testing Equipment & Supplies
- Certain Enhancements to Home Oxygen Delivery Systems
- Bedside Commode
- Motorized/Power Wheelchairs
- Patient Lifts
- Hospital-type Beds
- Ostomy Supplies
- Surgical Dressings

**What if Most of My Medicare Customers Want to Upgrade? Will the DME MAC Scrutinize My Claims?**
While you should not routinely issue ABNs to beneficiaries as a general business practice, if the majority of your Medicare customers want to upgrade to a better item, it is appropriate for you to issue these beneficiaries an ABN to inform them of their potential financial liability. The DME MAC will be examining whether the ABNs you issue contain a specific reason why you believe Medicare will not pay (either in whole or in part) for the item you provide the beneficiary. Therefore, if you have a genuine doubt that Medicare will pay for the item, you should issue an ABN to the beneficiary, regardless of how many that turns out to be. A properly executed Advance Beneficiary Notice associated with a reasonable effort by the provider to serve their customer shall not in itself expose the provider to any legal challenges.

**What About Using the Upgrade Process for Dual Eligible Patients?**
The ABN process applies only to business transactions between Medicare beneficiaries and providers. The ABN process does not affect patients who are dually eligible for Medicare and Medicaid.
(A) Notifier(s):
(B) Patient Name: __________________________
(C) Identification Number: __________________________

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D)__________________________________________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D)__________________________________________ below.

<table>
<thead>
<tr>
<th>(D)</th>
<th>(E) Reason Medicare May Not Pay:</th>
<th>(F) Estimated Cost:</th>
</tr>
</thead>
</table>

WHAT YOU NEED TO DO NOW:
• Read this notice, so you can make an informed decision about your care.
• Ask us any questions that you may have after you finish reading.
• Choose an option below about whether to receive the (D)__________________________________________ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the (D)____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2. I want the (D)____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ OPTION 3. I don't want the (D)____________ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

[I] Signature: __________________________ [J] Date: __________________________

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.
Advanced Determination of Medicare Coverage (ADMC)

ADMC is a process by which the DME PSC will provide the supplier and beneficiary with a coverage decision prior to delivery of an item. Effective November 15, 2006, an ADMC is available as an option only for the following wheelchair base HCPCS codes and related options and accessories:

- E1161 Manual tilt-in-space wheelchair
- K0005 Ultralightweight manual wheelchair
- K0009 Other manual wheelchair base
- K0835-K0843 Group 2 single and multiple power option power wheelchair bases
- K0848-K0855 Group 3 no power option power wheelchair bases (Only if an alternative drive control interface is provided at the time of initial issue)
- K0856-K0864 Group 3 single and multiple power option power wheelchair bases
- K0868-K0871 Group 4 no power option power wheelchair bases (Only if an alternative drive control interface is provided at the time of initial issue)
- K0877-K0891 Group 4 and Group 5 single and multiple power option power wheelchair bases

When a particular wheelchair base is eligible for ADMC, all wheelchair options and accessories ordered by the physician for that patient along with the base HCPCS code will be eligible for ADMC.

ADMC requests cannot be submitted electronically.

The first page of the ADMC request must contain all of the following demographic information:

- Beneficiary information
  - Name, HICN, Address, Date of birth
- Place of service
- ICD-9 diagnosis code (narrative description is not sufficient)
- Supplier information
  - Name, NSC number, Address, Phone number
- Physician’s information
  - Name, UPIN, Address, Phone number

If the information listed above is not present, the request will be rejected.

**Power Wheelchair Documentation**
Include all of the following items:

1. The order the supplier received within 45 days following the completion of the face-to-face examination. This order must contain the following:
   - Beneficiary name
   - Description of the item. This may be general – e.g., “power wheelchair” or “power mobility device” – or may be more specific.
   - Date of the face-to-face examination. If the evaluation involved multiple visits, enter the date of the last visit.
   - Pertinent diagnoses/conditions that relate to the need for the power wheelchair.
   - Length of need
   - Physician’s signature
   - Date of physician signature

There must be a date stamp or equivalent on the order to indicate when it was received by the supplier.

2. A detailed product description signed and dated by the physician that lists the specific wheelchair base and all options and accessories that will be separately billed. For each item there must be a HCPCS code and either a narrative description of the item or the manufacturer name/model. The detailed product description must also list the supplier’s charge and the Medicare fee schedule allowance for each item. (If there is no fee schedule allowance, the supplier must enter “not applicable”.) If the manufacturer name/model for the wheelchair base is not included on the detailed product description, the supplier must provide this information.

3. Reports of the face-to-face examination and specialty evaluation by the physician and PT/OT. There must be a date stamp or equivalent on the reports to indicate when they were received by the supplier. Reports from a PT/OT must include an attestation statement from the supplier indicating that the PT/OT has no financial relationship with the supplier.

4. A report of the on-site home assessment which establishes that the beneficiary is able to use the wheelchair ordered to assist with ADLs in the home.

**Manual Wheelchair Documentation**
Include all of the following items:

1. Detailed written order that lists the specific wheelchair base that is to be provided and each option/accessory that will be separately billed. The order must also specify which HCPCS code is associated with each item on the order. This information may be entered by the supplier but the order must be signed and dated by the physician.

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2. Information from the patient's medical record that documents that the coverage criteria have been met.
3. A home assessment which establishes that the beneficiary or caregiver is able to use the wheelchair ordered to assist with ADLs in the home.

Additional Guidance on Documentation

Any information that is provided that explains the medical necessity for separately billed options and accessories must use the same short description for the item that is used in the detailed product description or detailed written order.

If the patient's weight and/or height are needed to support the medical necessity for items that are ordered, that information should be included on the first page of the ADMC request.

Even if the majority of the face-to-examination is performed by a PT/OT, the ADMC request must also include the report of the face-to-face examination with the physician.

For wheelchair cushions, include the manufacturer, the product name, the model number, and the width of wheelchair cushion(s) that are provided. Make certain that the product is listed on the PDAC Product Classification List and that the HCPCS code on the ADMC is the one specified by the PDAC.

If the patient currently has a wheelchair or a power operated vehicle (POV), the ADMC request must indicate the reason why it is being replaced.

ADMC Process

Upon receipt of an ADMC request, the PSC will make a determination within 30 calendar days. The PSC will provide the supplier and beneficiary with its determination, either affirmative or negative, in writing. If it is a negative determination, the letter will indicate why the request was denied.

If a wheelchair base receives a negative determination, all accessories will also receive a negative determination. If a wheelchair base receives an affirmative determination, each accessory will receive an individual determination.

An affirmative determination only relates to whether the item is reasonable and necessary based on the information submitted. An affirmative determination does not provide assurance that the beneficiary meets Medicare eligibility requirements nor does it provide assurance that any other Medicare requirements (e.g., place of service, Medicare Secondary Payer) have been met. Only upon submission of a complete claim can the DME MAC make a full and complete determination. An affirmative determination does not extend to the price that Medicare will pay for the item. Finally, the PSC may review selected claims on a pre-payment or post-payment basis and may deny a claim or request an overpayment if it determines that an affirmative determination was made based on incorrect information.

An affirmative ADMC is only valid for items delivered within six months following the date of the determination. If the wheelchair is not delivered within that time, the supplier has the option of either submitting a new ADMC request (prior to providing the item) or filing a claim (after providing the item).

If any of the items on the ADMC request were described by HCPCS code K0108 and if those items were provided, the supplier must ensure that the narrative description used on the claim matches the narrative description used on the ADMC determination letter.

If a wheelchair base receives an affirmative determination, the supplier may not submit a separate ADMC request for additional accessories. If options or accessories are provided that were not listed on the ADMC request, the supplier must obtain a product description for these items and whatever information is appropriate to document the medical necessity for the additional item(s).

A negative ADMC may not be appealed because it does not meet the regulatory definition of an initial determination since no request for payment is being made. However, if the ADMC request for the wheelchair base is denied and if the supplier obtains additional medical documentation, an ADMC request may be resubmitted. ADMC requests may only be resubmitted once during the six-month period following a negative determination. If the wheelchair base is approved, but one or more accessories are denied, an ADMC request may not be resubmitted for those accessories. If a supplier provides a wheelchair and/or accessories following a negative determination, a claim for the item should be submitted. If new information is provided with the claim, coverage will be considered. If the claim is denied, it may be appealed through the usual process.
Any Medicare beneficiary (or his/her authorized representative), or a supplier who accepts assignment on a claim has the right to appeal a decision made by the DME MAC. Beneficiaries have the right to appeal a decision regardless of whether or not the claim was filed as assigned or non-assigned. There are five levels in the appeals process as provided by Medicare regulations:

<table>
<thead>
<tr>
<th>Level</th>
<th>Where to File Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redetermination</td>
<td>DME MAC</td>
</tr>
<tr>
<td>Reconsideration</td>
<td>QIC</td>
</tr>
<tr>
<td>ALJ Hearing</td>
<td>Carrier or HHS OMHA Field Office if heard by a QIC</td>
</tr>
<tr>
<td>Medicare Appeals Council Review</td>
<td>ALJ Hearing Office</td>
</tr>
<tr>
<td>Judicial Review Provided in DAB</td>
<td>Decision Letter</td>
</tr>
</tbody>
</table>

Each level must be completed for each claim at issue prior to proceeding to the next level of appeal.

**Redetermination Process**
The first step in the appeals process is the re-determination, which is conducted by the DME MAC. The re-determination process provides a complete re-examination of all information submitted with the original claim. Any new information or medical evidence should be submitted with the request for re-determination and will be evaluated fully in accordance with the Medicare law regulating the re-determination process. Every effort will be made by the reviewer to clarify any questions that may arise in the course of the re-determination, (e.g., calling the beneficiary or his/her representative or the physician who prescribed the equipment). The reviewer is someone who did not participate in the original decision. The opinion of medical consultants specializing in the services being re-determined may also be requested.

The time limit for requesting a re-determination is 120 days from the date of issuance of the remittance notice. This time limit applies to both written and telephone re-determinations. The DME MAC review staff will determine if the request was filed timely or if good cause was established for a request not filed timely.

The DME MAC re-determination staff has 60 days to complete a re-determination. A re-determination may be requested by telephone or in writing, depending on the circumstances.

**Redetermination Requests**
The payee, (i.e., the beneficiary or his/her representative), or the supplier of an assigned claim may complete a request for redetermination, CMS-20027 (05/05) form, which may be obtained online at: [http://www.cms.hhs.gov/forms/CMS20027.pdf](http://www.cms.hhs.gov/forms/CMS20027.pdf). All requests for redetermination submitted by beneficiaries must be in writing, by using the CMS-20027 (05/05) form, or by submitting a written statement.

You should send additional information in the same mailing as the written redetermination request. If no additional information is submitted, a decision will be made based on the information available. The payee may also submit a written outline of his or her dissatisfaction with the original determination made on the claim(s) in question. The request for redetermination should be clearly indicated if not submitted on the CMS-20027 (05/05) form.

The completed CMS-20027 (05/05) form or the payee's written statement should be sent to the designated Multifunctional Team that processed the claim. The CMS-20027 (05/05) form must indicate the beneficiary's full name as it appears on the remittance notice or his/her Health Insurance Card, the Health Insurance Claim number, and the claim control number as it appears on the remittance notice. In addition, include any new information or medical evidence that may assist the DME MAC in reevaluating the claim(s).

**Decisions**
The redetermination decision will result in one of three dispositions:

**Affirmation**
The reviewer may find the original claim disposition to be accurate and affirm the original disposition. A letter will be sent to the appellant explaining the decision and the grounds on which the affirmation is based. A carbon copy of all decisions will be sent to the beneficiary if the appellant on an assigned claim is the supplier.

**Dismissal**
The reviewer may determine the request was not submitted timely, the request is a duplicate of another pending or resolved request for the same claim(s), or the claim has been resubmitted separately and is being reprocessed outside the scope of the review request. The reviewer will dismiss the request and send a letter to the appellant explaining the dismissal. If the reviewer dismisses the request on grounds of timeliness, consideration will be given to the potential for a reopening. (See the re-openings section later in this chapter.)

**Reversal**
The reviewer may find in favor of the appellant and will take action to reverse the original decision. A fully favorable reversal will result in an adjusted claim with the Medicare Summary Notice (MSN) to the beneficiary and, if assigned, the Remittance Advice to the supplier, serving as notice of the
decision. A partially favorable decision will result in an adjusted claim with an accompanying MSN, and (if assigned) remittance advice, serving as notice of the decision as well as a letter to the appellant explaining the reason for the partially favorable decision.

**Appeal Rights for Dismissals**

Effective for re-determinations issued on or after January 1, 2006, parties to the re-determination have the right to appeal a dismissal of a re-determination request to the QIC. A party to the re-determination may appeal the dismissal if he/she believes the dismissal is incorrect.

The reconsideration request must be filed at the QIC within 60 days of the date of the dismissal. When the QIC performs its reconsideration of the dismissal, it will decide if the dismissal was correct. If it determines that the contractor incorrectly dismissed the re-determination, it will vacate the dismissal and remand the case to the contractor for reopening. It is mandatory for the contractor to reopen any case that is remanded to it and issue a new decision. The QIC’s reconsideration of a contractor’s dismissal of a re-determination request is final and not subject to further review.

**Reconsideration**

The second step in the appeals process is the reconsideration which is conducted by the Qualified Independent Contractor (QIC). A re-determination must be issued on the claim(s) in dispute before requesting the second level of appeal.

The reconsideration process provides a complete re-examination of the information contained in the re-determination case file. Any new information or medical evidence must be submitted with the request for reconsideration and will be evaluated fully in accordance with the Medicare law regulating the reconsideration process.

The adjudicator performing the reconsideration is an independent reviewer of the appeal. Requests on claims that were denied due to medical necessity will be reviewed by a panel of physicians and other health professionals.

The QIC adjudication staff has 60 days to complete a reconsideration decision.

**Reconsideration Requests**

Any individual dissatisfied with the DME MAC’s re-determination may file a request for reconsideration to the QIC within 180 days of receipt of the re-determination. There is no minimum amount in controversy for reconsideration requests.

Effective December 1, 2006, the request for reconsideration made by a beneficiary, provider, supplier, or State and must be filed with the designated QIC.

The request must be made in writing either on the form CMS 20033 (available at [http://www.cms.hhs.gov/forms/CMS20033.pdf](http://www.cms.hhs.gov/forms/CMS20033.pdf) or must contain the following items:

- The beneficiary's name;
- Medicare health insurance claim number;
- The specific service(s) and item(s) for which the reconsideration is requested and the specific date(s) of service;
- The name and signature of the party or representative of the party; and
- The name of the contractor that made the re-determination.

Any additional documentation, new information or medical evidence that may assist the QIC in reevaluating the claim(s) should be attached to the written reconsideration request. If no additional information is submitted, a decision will be made based on the documentation contained in the DME MAC re-determination case file.

**NOTE:** To aid in the processing of your request and to avoid significant delays, a copy of the re-determination letter should accompany your reconsideration request.

**Administrative Law Judge (ALJ)**

If the appellant remains dissatisfied following the carrier fair hearing and the remaining amount in controversy is $130.00 or more, the appellant has the right to a hearing before an Administrative Law Judge (ALJ). The request for ALJ hearing must be in writing and must be received within 60 days from the date of the reconsideration. Requests for ALJ hearings must be filed to the Office of Medicare Hearings and Appeals (OMHA) at the following locations depending on the place of service (for DMEPOS claims, the place of service is defined as the beneficiary’s address of record):

**OMHA Field Office Locations**

**Arlington, Virginia (Mid-Atlantic Field Office and Headquarters)**

1700 N. Moore St., Suite
Arlington, VA 22209
Phone: 866-231-3087

The Mid-Atlantic Field Office provides overflow capacity to process appeals from any of the other 3 offices.
Form CMS-5011A/B can be used to request an ALJ hearing. The hearing request is then forwarded to the ALJ with a complete copy of the carrier fair hearing file. The office of the ALJ will advise the appellant of the schedule for the hearing or preparations needed for the hearing. The ALJ will consider the file that has been forwarded by the carrier hearing department and any additional information or evidence submitted by the appellant. The ALJ Request form can be found online at http://www.cms.hhs.gov/forms.

If you combine multiple claims to meet the minimum amount in controversy for an ALJ appeal request ($130), you must specify in your appeal request the specific claims that are being aggregated. If your request does not specifically state or list the designated claims that are being aggregated, each claim will be treated as an individual request and those not meeting the amount in controversy will be dismissed.

**Department Appeals Board (DAB)**

If the appellant does not agree with the Administrative Law Judge's decision, he or she may ask the Appeals council to review the decision. To file an appeal, the appellant or his representative must request in writing within 60 days from the date of the ALJ decision that the Departmental Appeals Board review the ALJ's decision. The request may be filed at any Social Security office or mailed to the address listed in the ALJ's hearing decision.
Judicial Review
If the appellant is still dissatisfied after the Appeals Council review and the amount in controversy is at least $1,260.00, the appellant is entitled to judicial review before a federal district court judge within 60 days. The Appeals Council decision will provide the appellant with instructions on how to request U.S. District Court review.

Development of Appeals
For individual claims submitted by physicians or suppliers and others who furnish items and services to Medicare beneficiaries, the responsibility for gathering and submitting documentation that supports claims and appeals rests with the provider. The DME MAC will offer guidance and assistance as necessary, but the responsibility for identifying what is needed and where it is located is the provider's responsibility.

Documentation for Appeals
Only the appellant can decide on the documentation that best supports the claim. The following could be considered:
- Test results;
- Medical history; (i.e., physician's progress notes)
- Documentation of severity or acute onset;
- Consultation reports;
- Billing forms;
- Referrals;
- Plan of treatment;
- Nurse’s notes; and
- Copies of communications between physician and/or beneficiary, hospital, carrier, supplier, laboratory, etc.

Re-Openings
Re-openings are not, in a legal sense, appeals. They are discretionary actions taken after a claim is closed to correct an error, in response to suspected fraud or in response to the receipt of information not available or known to exist at the time the claim was initially processed. Re-openings should be done rarely, on individual cases, or on a group of cases adversely affected by a systems error. They initiated by the DME MAC at its own volition or in response to a request by a beneficiary or provider, and then only after the appeal rights provided by law are exhausted. A reopening of a carrier claim decision, irrespective of the level to which the decision is appealed, is conducted at the discretion of the carriers, hearing officers, Administrative Law Judge, and the Appeals Council.

The DME MAC can reopen:
- Within 12 months of the date of the initial or revised determination for any reason acceptable to it.
- After 12 months, but before four years of the date of notice of the initial or revised determination, for good cause, which is defined as follows:
  1. New and material evidence, i.e. information, which could not have been available at the time of the initial request or not available for a timely request for re-determination;
  2. Clerical or computation errors on the part of the carrier; or
  3. The evidence that was considered clearly shows on its face that an error was made.
- At any time, when the carrier finds:
  1. Fraud or similar fault, or
  2. In response to a court order.

The CMS policy is to reopen only after appeal rights are exhausted, or the time limit for requesting an appeal has expired.

If the reason for denial is appealable to the Social Security Administration (SSA), the DME MAC will refer the reopening request to SSA. Following are the denial reasons appealable to SSA:
- Beneficiary is not entitled to Part B and
- Beneficiary is not eligible for benefits.
Medicare Assignment Agreement

Under Medicare law, acceptance of assignment requires the physician or supplier to accept the carrier's determination of the allowable (approved) charge as full reimbursement. Medicare will reimburse 80 percent of this allowable amount if the deductible has been met. The beneficiary is responsible for the remaining 20 percent, which is the coinsurance, plus any portion of the $124.00 calendar-year deductible satisfied by the claim, and the full charge for any services not covered by Medicare.

This means that for services covered under the assignment agreement, the physician or supplier cannot bill the beneficiary for the difference between the allowable amount and the actual charge. If the beneficiary has supplemental insurance in addition to Medicare, his/her private carrier may be billed only 20 percent of the allowable charge determination. Agreements between the physician/supplier and the beneficiary as to reimbursement of amounts exceeding the allowable charge are superseded by the assignment agreement.

Once the assignment agreement is made, it cannot be revoked in whole or in part without the consent in writing of both the supplier and the beneficiary. This can only be changed before the claim is processed and the DME MAC has made and sent notice of its approved charge determination. Although the assignment cannot be rescinded after the notice of determination (MSN or remittance notice) has been sent, either party may appeal the DME MAC's determination.

When possible assignment violation is indicated either through the DME MAC review or on the basis of a beneficiary complaint, the DME MAC will contact the supplier to be certain the provisions of the assignment agreement are understood by his or her office staff. Where a violation has occurred, assurance will be obtained by the DME MAC that a refund or corrected bill will be sent to the beneficiary.

NOTE: If neither the assigned nor non-assigned box on the CMS 1500 claim form is checked and the supplier is nonparticipating, the claim must be processed as a non-assigned claim and payment made to the beneficiary. Please do not overlook checking the appropriate box on the claim form.

Assignment Violations
The Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95-142) provide penalties for repeated violations of the assignment agreement. The law provides that any person who knowingly, willfully, and repeatedly violates the assignment agreement shall be guilty of a misdemeanor subject to a maximum fine of $2,000 and/or six months imprisonment.

The amendments also provide that when a supplier has been convicted of a criminal offense related to his involvement in Medicare or Medicaid, he or she will be suspended from Program participation.

Collecting The 20 Percent Coinsurance
Medicare law also requires that on assigned claims, there must be an effort on the part of the supplier to collect from the beneficiary any deductible amount applied to a claim and the coinsurance, which is the 20 percent of the allowable or approved charge. If the supplier has a policy of consistently waiving the deductible and/or coinsurance from or on behalf of the Medicare beneficiary, the actual amount the supplier accepts as the full fee could be considered that supplier's customary charge.

When the DME MAC finds that the routine and consistent waiver of coinsurance or deductible amounts from or on behalf of Medicare beneficiaries by a supplier constitutes a reduction of that supplier's actual charges, the DME MAC must:

- Process the current claims received involving the services of the supplier on the basis of the actual charges made, (i.e., the amounts the supplier actually expects to receive);
- Record and accumulate data on the corrected actual charges of the supplier for future use in updating customary charge screens; and
- Notify the supplier in writing regarding the determination it has made and the basis for that determination.

If the supplier does not generally waive payment of the deductible and/or coinsurance, but will do so on occasion in consideration of the beneficiary's limited financial condition or inability to pay, the DME MAC will not consider this a reduction of the actual charge.

Similarly, not collecting the deductible and/or coinsurance in situations where the cost of billing and collecting exceeds or is disproportionate to the amount being billed will not be considered a reduction of the actual charge.

Participating Program
The Deficit Reduction Act of 1984 (Public Law 98-369) established a participating physician and supplier program. A participating supplier is one who voluntarily enters into an agreement to accept assignment for all services provided to Medicare beneficiaries for the 12-month period beginning January 1st of a particular year. The enrollment period to become a participating provider is near the end of the year prior to the particular year. This agreement is renewed automatically unless the NSC is notified in writing of termination during the subsequent enrollment period. A supplier who chooses not to participate may still accept assignment on a claim by claim basis.

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**Audit Types**
- Program Integrity – Reviews documentation and record content
- Utilization Review – Verifies need and frequency
- Electronic Claims Submission – Authenticity, signature on file
- Phone
- Mail
- On-site

**Medicare Audit Request Letters**
Be very careful in preparing your package to send to the specified investigative specialist at any of the DME MAC Fraud Investigative Units. The majority of the audit letters will request the following:
- Signed, completed delivery ticket (verify they meet Medicare guidelines)
- Signed pickup slips
- Completed Assignment of Benefits
- Billing statements (coinsurance billings)
- Physician’s orders
- Correspondence to or from the beneficiary
- Photograph and/or detailed description of the service provided
- Service and repair records
- Rent or purchase options
- Patient’s date of birth

Include any and all additional documentation such as clinical notes, physician notes, discharge notes and orders, home health care nursing notes, etc. When the information provided does not meet the criteria for medical necessity, Medicare will request a full refund.

**Will you be Audited?**
The following list represents examples of possible reasons why your company might be audited:
- Beneficiary or Insurance complaints
- You bill more than one million dollars per year
- Limited mix of products
- Frequent claims for abused items
- Over utilization of a certain code
- Repetitive errors on claims
- Inconsistent charge pattern
- Significant change in fees

**Are You Ready For an Audit?**
By periodically conducting the following procedures you will insure your readiness for an audit:
- Do internal audits on your company
- Review company paperwork and flow for HIPAA compliance
- Review documentation for completeness, accuracy and compliance
- Provide continuing education for your staff
- Provide new hire training
- Become an accredited company

**Auditing Your Billing Department**
Review the following:
- Review your aged accounts receivable
- Review explanation of benefits
- Watch down coding trends
- Track denial types and patterns
- Track number of review requests
- Review Medicare information requests
- Review patient billing statements

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Auditing Patient Files
Does the patient's file contain the following documents signed by the patient or physician when applicable?

- Supplier standards
- Original physician's order
- Written order prior to delivery
- Delivery ticket (proof of delivery)
- Pickup slip (including detailed information about item and date of pick up)
- Advance Beneficiary Notice (ABN)
- Assignment of benefits
- Release of information
- Rent/purchase agreement
- All documentation from physician, hospital, etc.
- Current copies of patient's insurance cards (front and back)
- Detailed descriptions of all equipment patient has received

Auditing Patient File Documentation

- **Supplier Standards** – Are they signed and dated by the patient and your company representative

- **Delivery Ticket**
  1. Is it legible?
  2. Does it include:
     - The patient's full name
     - The patient's complete address
     - The patient's correct phone number
     - Quantity of equipment or supply
     - Make, model and manufacturer
     - Serial Number
     - Is it signed and dated by the patient (or caregiver) and your company representative. (Note: if the patient is unable to sign, a caregiver may sign but must state their relationship to the patient and the reason why the patient cannot sign and date it themselves)

- **Assignment of Benefits**
  1. Equipment and/or supply itemized
  2. Each product class requires a signed form
  3. Requires patient signature and date
  4. Include company representative signature and date

- **Supporting Documentation**
  1. OT, PT, RN, RTS reports
  2. Patient evaluation
  3. Seating and Mobility evaluation
  4. Physician progress notes
  5. Lab reports
  6. Discharge notes
  7. Patient communications

- **HCPCS Codes**
  1. Use of correct HCPCS codes and modifiers
  2. Upcoding
  3. Verify correct coding with PDAC (877-735-1326)
What Physicians Need to Know
The following documentation requirements are effective for power mobility device (PMD) claims on or after June 5, 2006. Coverage criteria for PMDs are found in the National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE). MAE includes but is not limited to canes, crutches, walkers, manual wheelchairs, POVs/scooters and power wheelchairs. For a power operated vehicle (POV)/scooter or power wheelchair to be covered, the treating physician must conduct and document a face-to-face examination of the patient and provide a detailed written order to the medical equipment supplier. The documentation and written order must be received by the supplier within 45 days of the date of the face-to-face examination.

National Coverage Determination
An algorithmic process is used to determine the presence of a mobility deficit as well as determine the appropriate MAE necessary to compensate for the mobility deficit. Sequential consideration of the following 9 questions provides clinical guidance for the coverage of equipment of appropriate type and complexity to restore the patient’s ability to perform mobility related activities of daily living (MRADLs). MRADLs are identified as bathing, dressing, feeding, grooming, and toileting.

1. Does the beneficiary have a mobility limitation causing an inability to perform one or more mobility-related activities of daily living in the home? A mobility limitation is one that:
   a. Prevents the beneficiary from accomplishing the MRADLs entirely, or
   b. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform MRADLs, or
   c. Prevents the beneficiary from completing the MRADLs within a reasonable time frame.

2. Are there other conditions that limit the beneficiary’s ability to perform mobility-related activities of daily living at home?
   a. Some examples are significant impairment of cognition or judgment and/or vision.
   b. For these beneficiaries, the provision of a wheelchair might not enable them to perform mobility-related activities of daily living if the comorbidity prevents effective use of the MAE or reasonable completion of the tasks even with a wheelchair.

3. If these other limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of mobility equipment will be reasonably expected to materially improve the beneficiary’s ability to perform mobility-related activities of daily living in the home?
   a. A caregiver, for example a family member, may be compensatory, if consistently available in the beneficiary's home and willing and able to safely operate and transfer the beneficiary to and from the wheelchair and to transport the beneficiary using the wheelchair.
   b. If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of MAE coverage if it results in the beneficiary continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of a mobility assistive equipment.

4. Does the beneficiary demonstrate the capability and the willingness to consistently operate the device safely?
   a. Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.
   b. A history of unsafe behavior in other venues may be considered.

5. Can the functional mobility deficit be sufficiently resolved by the prescription of a cane or walker?
   a. The cane or walker should be appropriately fitted to the beneficiary for this evaluation.
   b. Assess the beneficiary’s ability to safely use a cane or walker.

6. Does the beneficiary’s typical environment support the use of wheelchairs or scooters/POVs?
   a. Determine whether the beneficiary's environment will support the use of mobility assistive equipment.
   b. Keep in mind such factors as temperature, physical layout, surfaces, and obstacles, which may render an item of mobility assistive equipment unusable in the beneficiary’s home.

7. Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair in the home through the course of the performance of mobility-related activities of daily living during a typical day? The manual wheelchair should be optimally configured (seating options, wheelbase, device weight and other appropriate accessories) for this determination.
   a. Limitations of strength, endurance, range of motion, coordination and absence or deformity in one or both upper extremities are relevant.
   b. A beneficiary with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair should be determined based on the beneficiary’s physical characteristics and anticipated intensity of use.
   c. The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.
   d. Assess the beneficiary’s ability to safely use a manual wheelchair.
8. Does the beneficiary have sufficient strength and postural stability to operate a power-operated vehicle (POV/scooter)?
   a. A POV is a 3 or 4-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation.
   b. The beneficiary’s home should provide adequate access, maneuvering space and terrain for the operation of a POV/scooter.
   c. Assess the beneficiary’s ability to safely use a POV/scooter.

9. Are the additional features provided by a power wheelchair needed to allow the beneficiary to perform one or more mobility-related activities of daily living?
   a. These devices are typically controlled by a joystick or alternative input device, and can accommodate a variety of seating needs.
   b. The beneficiary’s home should provide adequate access, maneuvering space and terrain for the operation of a PWC.
   c. Assess the beneficiary’s ability to safely use a power wheelchair.

**Physician Orders**
The order must contain all 7 of the following elements:
1. Beneficiary’s name;
2. Description of the item that is ordered. (This may be general or specific)
3. Date of completion of the face-to-face examination;
4. Pertinent diagnoses/conditions that relate to the need for the power mobility device;
5. Length of need;
6. Physician’s signature;
7. Date of physician signature.

**Supporting Documentation**
Along with the prescription the physician must also provide supporting documentation, which will include pertinent parts of the medical record that clearly support the need for a PMD in the home. Physicians should only provide the information that relates to the need for a PMD. This documentation should be sufficient enough to:
- Delineate the history of events leading up to the request for a PMD
- Identify the mobility deficit to be corrected by the PMD
- Document that other treatments do not obviate the need for a PMD
- Document that the patient lives in an environment that supports the use of a PMD
- Document that the patient or caregiver is capable of safe operation of the PMD

**Face-to-Face Exam**
The face-to-face exam must be conducted prior to writing an order for a PMD. The supplier must receive a copy of the examination report and written order within 45 days after the face-to-face examination is completed. If this examination is performed during a hospital or nursing home stay, the supplier must receive the report of the examination within 45 days after discharge. The supplier must have this information on file prior to dispensing a PMD.

The report of the face-to-face examination should provide information relating to the following questions:
- What is this patient’s mobility limitation and how does it interfere with the performance of ADLs?
- Why can't a cane or walker meet this patient's mobility needs in the home?
- Why can't a manual wheelchair meet this patient's mobility needs in the home?
- Why can't a POV (scooter) meet this patient's mobility needs in the home?
- Does this patient have the physical and mental abilities to operate a PWC safely in the home?

The 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.
- Symptoms
- Related diagnoses
- History
  - How long the condition has been present
  - Clinical progression
  - Interventions that have been tried and the results
  - Past use of walker, manual wheelchair, POV, or power wheelchair and the results
- Physical exam
  - Weight
  - Impairment of strength, range of motion, sensation, or coordination of arms and legs
  - Presence of abnormal tone or deformity of arms, legs, or trunk
  - Neck, trunk, and pelvic posture and flexibility
  - Sitting and standing balance
• Functional assessment – any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person
  – Transferring between a bed, chair, and PMD
  – Walking around their home – to bathroom, kitchen, living room, etc. – provide information on distance walked, speed, and balance

**Role of Physical or Occupational Therapist**
The physician may refer the patient to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), to perform part of this face-to-face examination. (This person may not be an employee of the supplier or have any financial relationship with the supplier). Exception: If the supplier is owned by a hospital, a PT/OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination.

If a patient is referred to the PT/OT before being seen by the physician, then once the physician has received and reviewed the written report of this examination, the physician must see the patient and perform any additional examination that is needed. The report of the physician’s visit should state concurrence or any disagreement with the PT/OT examination. In this situation, the physician must provide the supplier with a copy of both examinations within 45 days after the face-to-face examination.

If the physician saw the patient to begin the examination before referring the patient to a PT/OT, then if the physician sees the patient again in person after receiving the report of the PT/OT examination, the 45-day period begins on the date of that second physician visit. However, it is also acceptable for the physician to review the written report of the PT/OT examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the physician must send a copy of the note from his/her initial visit to evaluate the patient plus the annotated, signed, and dated copy of the PT/OT examination to the supplier. The 45-day window begins when the physician signs and dates the PT/OT examination.

**Physician Reimbursement**
CMS has created add-on code **G0372** for which physicians will receive an additional payment of approximately $21.60 from Medicare for the work necessary to provide this information to the supplier. The face-to-face exam should be coded and billed to Medicare at the appropriate evaluation and management level (i.e. **99213**). In order to receive the additional reimbursement physicians must bill the appropriate evaluation and management code and **G0372** on the same claim form.

**Miscellaneous**
The physician must sign and date a supplier prepared detailed product description which lists the specific base (HCPCS code and manufacturer name/model) and all options/accessories that will be billed separately. The supplier must receive this document back prior to delivery of the equipment.

Additional information on power mobility devices can be found by visiting the following website: [http://www.cms.hhs.gov/coveragegeninfo/06_wheelchair.asp?](http://www.cms.hhs.gov/coveragegeninfo/06_wheelchair.asp?)
What Suppliers Need to Know
Effective May 5, 2005 CMS released a new National Coverage Determination (NCD) for mobility assistive equipment (MAE). This policy addresses the medical necessity of all MAE including, but not limited to, canes, crutches, walkers, manual wheelchairs, power wheelchairs and POVs/Scooters.

The new NCD extends national coverage of MAE to those who have mobility deficits sufficient enough to impair their ability to participate in mobility related activities of daily living (MRADLs) in customary areas of the home. MRADLs are defined as toileting, eating, dressing, grooming and bathing.

Nine Questions to Determine Coverage
An algorithmic process is used to determine the presence of a mobility deficit as well as determine the appropriate MAE necessary to compensate for the mobility deficit. The algorithm consists of nine questions and sequential consideration of these questions provides clinical guidance for the coverage of equipment of appropriate type and complexity to restore the ability to perform MRADLs.

Interim Final Rule/PMD Final Rule
On August 26, 2005, CMS issued a new regulation making significant changes to the requirements for prescribing and documenting power operated vehicles and power wheelchairs, now known as power mobility devices (PMDs). These changes were outlined in the CMS Interim Final Rule (IFR), “Conditions for Payment of Power Mobility Devices” and were effective October 25, 2005. The rule required ordering physicians to conduct a face-to-face examination with the patient, provide a detailed written order and deliver this information to the supplier within 30 days of the exam. 

The IFR was delayed by President Bush on December 30, 2005 and re-issued as a final rule on April 5, 2006. The final rule, effective June 5, 2006, is significantly similar to the IFR except the time limit for physicians to provide documentation and a detailed written order to the supplier is extended from 30 days to 45 days.

Prescription/Written Order
As part of the final ruling, it will be necessary for the physician or treating practitioner (physician assistant, nurse practitioner or clinical nurse specialist) to conduct a face-to-face examination prior to prescribing a PMD. Upon completion of the face-to-face exam the physician or treating practitioner must provide the supplier with a signed and dated written order within 45 days of the exam. (Exception: If this examination is performed during a hospital or nursing home stay, the supplier must receive the report of the examination within 45 days after discharge). The prescription must include the following 7 elements:

- Beneficiary’s name
- Date of the face-to-face exam
- Diagnosis and conditions that the PMD is expected to modify
- Description of the item ordered
- Length of need
- Physician signature
- Date prescription was written

If the order described above does not identify the specific type of PMD that is provided, then the supplier must clarify this by obtaining another written order which lists the specific PMD that is being ordered and any options and accessories that will be separately billed. The supplier may enter these items. This order must be signed and dated by the treating physician and must be received by the supplier prior to dispensing the power mobility device – this does not have to be received within the 45 day window.

Supporting Documentation
Along with the prescription the physician must also provide supporting documentation, which will include pertinent parts of the medical record that clearly supports the need for a PMD in the home. Physicians should only provide the information that relates to the need for a PMD. This documentation should be sufficient enough to:

- Delineate the history of events leading up to the request for a PMD
- Identify the mobility deficit to be corrected by the PMD
- Document that other treatments do not obviate the need for a PMD
- Document that the patient lives in an environment that supports the use of a PMD
- Document that the patient or caregiver is capable of safe operation of the PMD

Face-to-Face Examination
This face-to-face examination does not necessarily have to occur at a single visit and is not always performed by a single individual. For example, the physician may refer the patient to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), to perform part of this face-to-face examination. (This person may not be an employee of the supplier or have any financial relationship with the supplier. Exception: If the supplier is owned by a hospital, a PT/OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination.) In these situations, the documentation requirements and the start of the “45-day window” for getting documentation to the supplier depend on whether the physician saw the patient in person to begin the examination prior to the referral.

A. If the patient was referred to the PT/OT before being seen by the physician, then once the physician has received and reviewed the written report of this examination, the physician must see the patient and perform any additional examination that is needed. The report of the physician’s visit should state concurrence or any disagreement with the PT/OT examination. In this situation, the physician must provide the supplier with a copy of both examinations within 45 days after the face-to-face examination with the physician.
B. If the physician saw the patient to begin the examination before referring the patient to a PT/OT, then if the physician sees the patient again in person after receiving the report of the PT/OT examination, the 45-day period begins on the date of that second physician visit. However, it is also acceptable for the physician to review the written report of the PT/OT examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the physician must send a copy of the note from his/her initial visit to evaluate the patient plus the annotated, signed, and dated copy of the PT/OT examination to the supplier. The 45-day window begins when the physician signs and dates the PT/OT examination.

C. Finally, there may be cases in which the physician has treated a patient for an extended period of time and the information recorded at the face-to-face examination refers to previous notes in the medical record. In that case, copies of those previous notes should also be forward to the supplier.

Miscellaneous

1. CMS has created code G0372 for which physicians will receive an additional payment of $21.60 from Medicare for the work necessary to provide this information to the supplier.

2. This face-to-face requirement is not necessary when only accessories for a PMD are ordered; standard documentation requirements apply which includes a detailed written order prior to billing the item and documentation in the medical record supporting the medical necessity for the item.

3. If the POV or power wheelchair is a replacement of a similar item that was previously covered by Medicare, a face-to-face examination is not required.

4. The supplier is required to have the prescription and supporting documentation prior to dispensing the PMD.

5. In order to document that the order was received within 45 days of the face-to-face exam, the supplier must date stamp (or equivalent) the order upon receipt.

6. The supplier must prepare a detailed product description which lists the specific base (HCPCS code and manufacturer name/model) and all options and accessories that will be billed separately. For claims with dates of service on or after 08/24/2006, the supplier must list their charge and the Medicare allowable for each separately billed item. The physician must sign and date this document and the supplier must receive it back prior to delivery of the equipment. This document must be date stamped also.

7. For claims with dates of service on or after 08/24/06, delivery of the equipment must be within 120 days of the face-to-face exam. For power wheelchairs going through the Advance Determination of Medicare Coverage (ADMC), delivery must be within 6 months following the determination.

8. For claims received by the DME contractor on or after 08/10/2006, if documentation from a PT/OT is to be considered as part of the face-to-face exam there must be a signed and dated attestation by the supplier that the therapist has no financial relationship with the supplier.

For the detailed documents on these regulations and policies please visit: http://www.cms.hhs.gov/coverage/wheelchairs.asp
## POWER MOBILITY DEVICE ORDER FORM

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Face-to Face Exam:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment Ordered:</td>
<td></td>
</tr>
<tr>
<td>Diagnoses:</td>
<td></td>
</tr>
<tr>
<td>Length of Need:</td>
<td></td>
</tr>
<tr>
<td>Physician Signature:</td>
<td></td>
</tr>
<tr>
<td>Today's Date:</td>
<td></td>
</tr>
</tbody>
</table>
**Patient Demographic Information**

- Patient Name
- Street Address (Apt #, Suite #) and mailing address, if different from street address
- Phone Number
- Social Security Number
- Sex of patient
- Date of Birth
- Diagnosis that supports medical necessity for Equipment requested
- Ordering Physician (First and last name, middle initial if available)
- Ordering Physician Mailing Address and Phone Number
- Patient's signature

**Equipment Information**

- Full description of the item ordered
- Include description of all accessories required
- Is the item a rental or purchase?
- Ask about equipment the patient has had previously (watch for similar equipment within the last 5 years)

**For Medicare Patients**

- Valid Healthcare Identification Number (HIC) usually 10-11 alphanumeric digits
- Patient height and weight
- Copay information if applicable
- Obtain secondary insurance information if applicable

**For Medicaid Patients**

- Valid Medicaid identification number
- Verify current month eligibility
- Authorization number, if applicable
- Medicaid pays 100% of allowable, some states require small copay

**For Private Insurance Patients**

- Obtain subscriber's name and identification number
- Are you a participating provider, if PPO or HMO plan?
- Is there a specific contract price?
- Is CMN or Prior Authorization required?
- Does the company only rent or purchase equipment?
- Does the patient have copay requirements?

**For Worker's Compensation Patients**

- Obtain complete information on patient's employer
- Claims mailing address
- Date of injury
- Patient's claim number
- Allowable diagnoses
- Is Prior Authorization required?

**Insurance Verification Process**

It is extremely important to the operation of your DME business to make sure that your billing department verifies insurance. Verification should be done during order intake and not after equipment has been delivered.

- Obtain copies of both front and back of patient's insurance card
- Validate effective date of coverage
- Confirm that coverage is in effect for your date of service
- Ask specifically if the insurance plan is an HMO and confirm if your company is in or out of network
- Verify whether or not a prior authorization is required
- Obtain contact name and phone number, in case of problems with authorization
- Verify claims mailing address, if not filing electronically

© 2011 Invacare Corporation. All information contained herein obtained from freely available U.S. government sources, including the Medicare Supplier Manual. This information is not intended to be, nor should it be considered billing or legal advice for any individual claim. Providers are responsible for determining the appropriate billing codes and other related documentation when submitting claims to the Medicare Program and should consult an attorney or other advisor to discuss specific situations in further detail. Rev. 01/11 JHS
# Suggested Intake Form

<table>
<thead>
<tr>
<th>Order taken by:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral Person Calling in Order:</td>
<td>Telephone:</td>
</tr>
</tbody>
</table>

## BENEFICIARY INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address:</td>
<td>Gender: Male Female</td>
</tr>
<tr>
<td>City, State, Zip:</td>
<td>Weight: Height:</td>
</tr>
<tr>
<td>Telephone:</td>
<td>Medicare Number:</td>
</tr>
</tbody>
</table>

### Name of Legally Responsible Representative:

<table>
<thead>
<tr>
<th>Relationship to beneficiary:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address:</td>
</tr>
<tr>
<td>City, State, Zip:</td>
</tr>
<tr>
<td>Telephone:</td>
</tr>
</tbody>
</table>

## ORDERING PHYSICIAN INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
<th>UPIN #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address:</td>
<td></td>
</tr>
<tr>
<td>City, State, Zip:</td>
<td>Telephone:</td>
</tr>
<tr>
<td>Specialty:</td>
<td></td>
</tr>
</tbody>
</table>

## QUESTIONS FOR THE BENEFICIARY

<table>
<thead>
<tr>
<th>Has the beneficiary ever received the same or similar supplies/equipment?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, list equipment/supplies:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who was it purchased or rented from?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date purchased or if rented, how many months?</td>
<td>Date of past setup:</td>
<td>Date equipment was returned:</td>
</tr>
<tr>
<td>Was item returned to original supplier?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Why was the item returned?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the item being replaced?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Is there a new medical necessity?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Describe condition for previous need:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe new/changed condition:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the beneficiary enrolled in a Medicare HMO/managed care program?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Has the beneficiary been enrolled in a Medicare HMO/managed care program and is returning to Fee-For-Service (FFS)?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

## QUESTIONS FOR THE SUPPLIER

### If providing repairs on equipment obtain the following information for the item being repaired:

<table>
<thead>
<tr>
<th>Manufacturer:</th>
<th>Model Name or Number:</th>
<th>Serial Number:</th>
<th>Purchase Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason or nature of repairs:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have medical necessity to file for repairs?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Does the beneficiary meet criteria for item being repaired?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Where will the item be used?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did I photocopy the Medicare card and/or other insurance cards?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Do I have a dispensing order and/or a detailed written order?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Will I need a Certificate of Medical Necessity (CMN)?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Do I have supporting documentation on file to meet medical necessity?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Should I obtain an Advance Beneficiary Notice (ABN)?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>What is the primary diagnosis?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>List any other diagnoses if applicable:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is Medicare the beneficiary’s primary or secondary insurer?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Is the beneficiary or beneficiary’s spouse employed?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Is the current condition related to employment, auto or other accident?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Is the beneficiary nearing Medicare eligibility?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If yes, give eligibility date:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do I need to obtain a one-time authorization form?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Did the beneficiary sign and date this intake form?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Beneficiary Signature:</th>
<th>Date Signed:</th>
</tr>
</thead>
</table>

This is just a suggested intake form and suppliers can model one to fit their particular type of business. For example if you are providing oxygen there may be certain questions you need to ask regarding oxygen patients or if you are providing wheelchairs there may be certain questions pertinent to wheelchairs. These are the basic questions to aid you in compiling information at the time of intake. This form does not in anyway replace obtaining an Advance Beneficiary Notice (ABN) if there is reason to believe the item(s) may be denied due to medical necessity reasons. Please refer to the DME MAC Region D Supplier Manual, Chapter 3, for information about same or similar equipment and ABNs and the Limitation of Liability section in Chapter 6 for more information.
Manual Wheelchair Bases

Coverage Criteria
A manual wheelchair is covered if:
   a) Criteria A, B, C, D, and E are met; and
   b) Criterion F or G is met.

A. The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.

A mobility limitation is one that:
   1) Prevents the patient from accomplishing an MRADL entirely, or
   2) Places the patient at reasonably determined heightened risk when performing an MRADL; or
   3) Prevents the patient from completing an MRADL within a reasonable time frame.

B. The patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

C. The patient's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.

D. Use of a MWC will significantly improve the patient’s ability to participate in MRADLs and the patient will use it on a regular basis in the home.

E. The patient has not expressed an unwillingness to use the manual wheelchair that is provided in the home.

F. The patient has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. (Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function).

G. The patient has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

If the manual wheelchair will be used inside the home and the coverage criteria are not met, it will be denied as not medically necessary. If the manual wheelchair is only for use outside the home attach the GY modifier, it will be denied as non-covered.

A standard hemi-wheelchair (K0002) is covered when the patient requires a lower seat height (17” to 18”) because of short stature or to enable the patient to place his/her feet on the ground for propulsion.

A lightweight wheelchair (K0003) is covered when
   1. a patient cannot self-propel in a standard wheelchair in the home and
   2. the patient can and does self-propel in a lightweight wheelchair.

A high strength lightweight wheelchair (K0004) is covered when
   1. a patient self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair; and/or
   2. the patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.

A high strength lightweight wheelchair is rarely medically necessary if the expected duration of need is less than three months.

Coverage of an ultra-lightweight wheelchair (K0005) is determined on an individual consideration basis.

If a K0005 wheelchair base is determined to be not medically necessary but criteria are met for a less costly wheelchair and if it is billed as a rental, payment will be based on the least costly alternative (K0001 - K0004). However, since K0005 is in a different payment category, if it is billed as a purchase it will be denied as not medically necessary.

A heavy-duty wheelchair (K0006) is covered if the patient weighs more than 250 pounds or the patient has severe spasticity.

An extra heavy-duty wheelchair (K0007) is covered if the patient weighs more than 300 pounds.

If the additional coverage criteria for a K0002, K0003, K0004, K0006, or K0007 wheelchair are not met but the criteria for another manual wheelchair base are met, payment will be based on the allowance for the least costly medically appropriate alternative.

Payment is made for only one wheelchair at a time. Backup chairs are denied as not medically necessary. One month's rental of a wheelchair is covered if a patient-owned wheelchair is being repaired.

HCPCS Modifiers
   EY No physician or other licensed health care provider order for this item or service
   GY Item or service statutorily excluded or doesn't meet the definition of any Medicare benefit category
Specific required documentation on file

An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available to the DME MAC upon request. Items billed to the DME MAC before the supplier has received a signed and dated order must be submitted with an EY modifier added to each affected HCPCS code.

If the wheelchair is only to be used for mobility outside the home, the GY modifier must be added to the code.

Effective For claims with dates of service on or after 05/01/2007; suppliers must add a KX modifier to the code for the manual wheelchair base only if all of the coverage criteria in the Indications and Limitations of Coverage section of this policy have been met. If the coverage criteria are not met, the KX modifier must not be used.

**HCPCS Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1161</td>
<td>Manual adult size wheelchair, includes tilt in space</td>
</tr>
<tr>
<td>E1229</td>
<td>WC, pediatric size, not otherwise specified</td>
</tr>
<tr>
<td>E1231</td>
<td>WC, pediatric size, tilt-in-space, rigid, adjustable, with seating system</td>
</tr>
<tr>
<td>E1232</td>
<td>WC, pediatric size, tilt-in-space, folding, adjustable, with seating system</td>
</tr>
<tr>
<td>E1233</td>
<td>WC, pediatric size, tilt-in-space, rigid, adjustable, without seating system</td>
</tr>
<tr>
<td>E1234</td>
<td>WC, pediatric size, tilt-in-space, folding, adjustable, without seating system</td>
</tr>
<tr>
<td>E1235</td>
<td>WC, pediatric size, rigid, adjustable, with seating system</td>
</tr>
<tr>
<td>E1236</td>
<td>WC, pediatric size, folding, adjustable, with seating system</td>
</tr>
<tr>
<td>E1237</td>
<td>WC, pediatric size, rigid, adjustable, without seating system</td>
</tr>
<tr>
<td>E1238</td>
<td>WC, pediatric size, folding, adjustable, without seating system</td>
</tr>
<tr>
<td>K0001</td>
<td>Standard wheelchair</td>
</tr>
<tr>
<td>K0002</td>
<td>Standard hemi (low seat) wheelchair</td>
</tr>
<tr>
<td>K0003</td>
<td>Lightweight wheelchair</td>
</tr>
<tr>
<td>K0004</td>
<td>High strength, lightweight wheelchair</td>
</tr>
<tr>
<td>K0005</td>
<td>Ultra lightweight wheelchair</td>
</tr>
<tr>
<td>K0006</td>
<td>Heavy-duty wheelchair</td>
</tr>
<tr>
<td>K0007</td>
<td>Extra heavy-duty wheelchair</td>
</tr>
<tr>
<td>K0009</td>
<td>Other manual wheelchair/base</td>
</tr>
</tbody>
</table>

Adult manual wheelchairs (K0001-K0009, E1161) are those which have a seat width and a seat depth of 15” or greater. For codes K0001-K0009, the wheels must be large enough and positioned such that the user could propel the wheelchair. In addition, specific codes are defined by the following characteristics:

**Adult tilt-in-space wheelchair (E1161)**

Ability to tilt the frame of the wheelchair greater than or equal to 45 degrees from horizontal while maintaining the same back to seat angle.

**Lifetime Warranty:** On side frames and cross-braces

The following features are included in the allowance for all adult manual wheelchairs:

- Seat Width: 15” - 19”
- Seat Depth: 15” – 19”
- Arm Style: Fixed, swingaway, or detachable; fixed height
- Footrests: Fixed, swingaway, or detachable

Codes K0003-K0007 and E1161 include any seat height.

A MWC with a seat width and/or depth of 14” or less is considered a pediatric size wheelchair and is billed with codes E1231-E1238 or E1229.

Codes E1050 - E1060, E1070 - E1200, E1220 - E1224, E1240 - E1295 should only be used to bill for maintenance and service for an item for which the initial claim was paid by the local carrier prior to transition to the DME MAC.

Wheelchairs with individualized features, which meet the needs of a particular patient, are billed by selecting the correct code for the wheelchair base and then using appropriate codes for wheelchair options and accessories. If the frame of the wheelchair is modified in a unique way to accommodate the patient, bill the code for the wheelchair base and bill the modification with code K0108.

**Documentation Requirements**

It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available to the DME MAC upon request.
An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and be available upon request. Items billed before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code.

Documentation that the coverage criteria have been met must be present in the patient’s medical record. The exception is information about whether the patient’s home can accommodate the wheelchair, which may be documented by the supplier. For manual wheelchairs, the assessment does not need to be conducted in the patient’s home. Information from the patient’s medical record and the supplier must be available upon request.

Manual wheelchairs described by codes E1161, E1231-E1234, K0005 and K0009 are eligible for Advance Determination of Medicare Coverage (ADMC). Refer to the ADMC chapter in the Supplier Manual for details concerning the ADMC process.

If documentation of the medical necessity for a K0005 wheelchair is requested, it must include a description of the patient’s routine activities. This may include the types of activities the patient frequently encounters and whether the patient is fully independent in the use of the wheelchair. Describe the features of the K0005 base which are needed compared to the K0004 base.

Documentation for individual consideration might include information on the patient’s diagnosis, the patient’s abilities and limitations as they relate to the equipment (e.g., degree of independence/dependence, frequency, and nature of the activities the patient performs, etc.), the duration of the condition, the expected prognosis, and past experience using similar equipment.

### K0001 - Standard Manual Wheelchair:

<table>
<thead>
<tr>
<th>Medicare Category:</th>
<th>Capped Rental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Allowable:</td>
<td>$48 to $55</td>
</tr>
<tr>
<td>Coverage Criteria:</td>
<td>Covered when it is necessary to provide the patient with a wheelchair for functional mobility within the residence</td>
</tr>
<tr>
<td>Typical User:</td>
<td>Short or long term user who needs functional mobility</td>
</tr>
<tr>
<td>Characterizations:</td>
<td>Weight: Greater than 36 lbs.</td>
</tr>
<tr>
<td></td>
<td>Seat Width: 15” to 19”</td>
</tr>
<tr>
<td></td>
<td>Seat Depth: 15” to 19”</td>
</tr>
<tr>
<td></td>
<td>Seat Height: 19” or greater</td>
</tr>
<tr>
<td></td>
<td>Arm Style: Fixed, swing away, or detachable; fixed height</td>
</tr>
<tr>
<td></td>
<td>Footrests: Fixed, swing away, or detachable</td>
</tr>
<tr>
<td></td>
<td>Weight Capacity: 250 pounds or less</td>
</tr>
<tr>
<td>Wheelchair Features:</td>
<td>Interchangeability, value and complexity reduction</td>
</tr>
<tr>
<td>Invacare Products:</td>
<td>IVC 900, IVC Tracer EX2, Atlas, Veranda</td>
</tr>
</tbody>
</table>

### K0002 -- Standard Hemi (low seat) Manual Wheelchair:

<table>
<thead>
<tr>
<th>Medicare Category:</th>
<th>Capped Rental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Allowable:</td>
<td>$72 to $85</td>
</tr>
<tr>
<td>Coverage Criteria:</td>
<td>Covered when the patient requires a lower seat to floor height (17” to 18”) because of short stature or to enable the patient to place his/her feet on the ground for propulsion</td>
</tr>
<tr>
<td>Typical User:</td>
<td>Patients of short stature and users who use their feet for propulsion</td>
</tr>
<tr>
<td>Characterizations:</td>
<td>Weight: Greater than 36 lbs.</td>
</tr>
<tr>
<td></td>
<td>Seat Width: 15” to 19”</td>
</tr>
<tr>
<td></td>
<td>Seat Depth: 15” to 19”</td>
</tr>
<tr>
<td></td>
<td>Seat Height: Less than 19”</td>
</tr>
<tr>
<td></td>
<td>Arm Style: Fixed, swing away, or detachable; fixed height</td>
</tr>
<tr>
<td></td>
<td>Footrests: Fixed, swing away, or detachable</td>
</tr>
<tr>
<td></td>
<td>Weight Capacity: 250 pounds or less</td>
</tr>
<tr>
<td>Wheelchair Features:</td>
<td>True dual axle positioning, low seat to floor height and weighs less than 36 pounds</td>
</tr>
<tr>
<td>Invacare Products:</td>
<td>IVC Tracer EX2</td>
</tr>
</tbody>
</table>
K0003 - Lightweight Manual Wheelchair:

Medicare Category: Capped Rental
Medicare Allowable: $79 to $93
Coverage Criteria: Covered when the patient cannot self-propel in a standard wheelchair using arms and/or legs and the patient can and does self-propel in a lightweight wheelchair.

Typical User: Patients with weak extremities that cannot propel heavier chairs

Characterizations:
- Weight: 34 to 36 lbs.
- Seat Width: 15” to 19”
- Seat Depth: 15” to 19”
- Seat Height: Includes any seat height
- Arm Style: Fixed, swing away, or detachable; fixed height
- Footrests: Fixed, swing away, or detachable
- Weight Capacity: 250 pounds or less

Wheelchair Features: Interchangeability, multiple seat widths, depths and arm styles, true axle positioning, weighs 36 pounds or less

Invacare Products: IVC Tracer SX5

K0004 - High Strength, Lightweight Manual Wheelchair:

Medicare Category: Capped Rental
Medicare Allowable: $119 to $140
Coverage Criteria: Covered when a patient meets the criteria in (1) and/or (2):
1) The patient self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair
2) The patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.

A high strength lightweight wheelchair is rarely medically necessary if the expected duration of need is less than three months (e.g., post-operative recovery).

Typical User: Long term moderately active patients

Characterizations:
- Lifetime Warranty: On side frames and cross braces
- Weight: Less than 34 lbs.
- Seat Width: 15” to 19”
- Seat Depth: 15” to 19”
- Seat Height: Includes any seat height
- Arm Style: Fixed, swing away, or detachable; fixed height
- Footrests: Fixed, swing away, or detachable

Wheelchair Features: Variable seat widths, depths or heights, low maintenance and weighs less than 34 pounds

Invacare Products: Patriot, IVC 9000 SL, IVC 9000 XT, Insignia
K0005 – Ultra Lightweight Manual Wheelchair:

Medicare Category: Purchase or Capped Rental
Medicare Allowable: Rental: $164 to $193
                      Purchase: $1648 to $1939
Coverage Criteria: Coverage is determined on an individual consideration basis.

If a K0005 wheelchair base is determined to be not medically necessary but criteria are met for a less costly wheelchair, payment will be based on the least costly alternative (K0001 – K0004). However, since K0005 is in a different payment category it will be denied as not medically necessary if billed as a purchase.

Initial claims for K0005 must include a description of the patient's routine activities. This may include what types of activities the patient frequently encounters, and whether the patient is fully independent in the use of the wheelchair. Describe the features of the K0005 base, which are needed compared to the K0004 base. This information should be attached to a hard copy claim or entered in the narrative field of an electronic claim.

Typical User: Very active, young or working person
Characterizations: Lifetime Warranty: On side frames and cross braces
                   Weight: less than 30 lbs.
                   Adjustable rear axle position
                   Seat Width: 15” to 19”
                   Seat Depth: 15” to 19”
                   Seat Height: Includes any seat height
                   Arm Style: Fixed, swing away, or detachable; fixed height
                   Footrests: Fixed or swing away, or detachable

Wheelchair Features: Adjustable rear axle position, maximum versatility and performance, increased stability, facilitates patient growth and weighs less than 30 pounds
Invacare Products: MVP, XTRA, A4, Pro Spin X4, Compass XE, AX3, Crossfire T6, Crossfire T6A, Crossfire T7A

K0006 - Heavy Duty Manual Wheelchair:

Medicare Category: Capped Rental
Medicare Allowable: $111 to $131
Coverage Criteria: Covered if the patient weighs more than 250 pounds or the patient has severe spasticity.
Typical User: Obese patient
Characterizations: Seat Width: 15” to 19”
                   Seat Depth: 15” to 19”
                   Seat Height: Includes any seat height
                   Arm Style: Fixed, swing away, or detachable; fixed height
                   Footrests: Fixed, swing away, or detachable
                   Weight Capacity: Greater than 250 pounds

Wheelchair Features: Interchangeability, accommodates patient weighing greater than 250 pounds, reinforced back and seat upholstery, allows for varied seat widths and depths
Invacare Products: IVC 900, IVC Tracer SX5
K0007 - Extra Heavy-Duty Wheelchair:

Medicare Category: Capped Rental
Medicare Allowable: $159 to $187
Coverage Criteria: Covered if the patient weighs more than 300 pounds.
Typical User: Morbidly obese patient
Characterizations:
- Seat Width: 15” to 19”
- Seat Depth: 15” to 19”
- Seat Height: Includes any seat height
- Arm Style: Fixed, swing away, or detachable; fixed height
- Footrests: Fixed, swing away, or detachable
- Weight Capacity: Greater than 300 pounds

Wheelchair Features: Accommodates patients weighing greater than 300 pounds, has reinforced back and seat upholstery, allows for varied seat widths and depths, frame reinforcements and ease of maneuverability.

Invacare Products: IVC 9000 XDT, IVC 9000 Topaz, Trace IV

K0009 – Other Manual Wheelchair/Base

Medicare Category: Purchase or Capped Rental
Medicare Allowable:
- Rental: IC (Individual Consideration)
- Purchase: IC (Individual Consideration)
Coverage Criteria: Individual consideration.

Documentation for individual consideration might include:
- information on the patient's diagnosis
- the patient's abilities and limitations as they relate to the equipment
- the duration of the condition
- the expected prognosis
- past experience using similar equipment

Claims must include:
- a narrative description of the item
- the manufacturer
- the model name or number (if applicable)
- information justifying the medical necessity for the item

Typical User: Small adult or pediatric patients whose multiple special needs cannot be accommodated in lower end wheelchairs.
Characterizations: Custom
Wheelchair Features: Customized wheelchair, allows growth capability, adjustability accommodates multiple seating systems and can be reversed configured
Invacare Products: Top End Terminator, Crossfire Titanium

E1161 – Manual Adult Wheelchair with Tilt in Space:

Medicare Category: Purchase or Capped Rental
Medicare Allowable:
- Rental: $210 to $248
- Purchase: $2109 to $2481
Coverage Criteria: Individual consideration. For patients with advanced special medical needs

Typical User: Patient requiring tilt and recline feature to maintain functional positioning for activities of daily living (ADL’s)
Characterizations:
- Lifetime Warranty: On side frames and cross braces
- Tilt: Ability to tilt the frame greater than 45 degrees from horizontal with same back to seat angle

Wheelchair Features:
- Tilt in space, tilt angle indicator, 55 degree tilt range, consistent center of gravity range, telescoping front end, built in 2” drop base and positive lock mechanism
Invacare Products: Solara, Solara 2G, Solara 3G, Compass SPT, Compass SPT Limited, Spree XT

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Basic Coverage Criteria
All of the following basic criteria (A-C) must be met for a power mobility device (K0800-K0898) or a push-rim activated power assist device (E0986) to be covered. Additional coverage criteria for specific devices are listed below.

A. The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:
   • Prevents the patient from accomplishing an MRADL entirely, or
   • Places the patient at reasonably determined heightened risk of morbidity/mortality secondary to the attempts to perform MRADLs; or
   • Prevents the patient from completing an MRADL within a reasonable time frame.

B. The patient's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.

C. The patient does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.
   • Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
   • An optimally-configured MWC is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories.

Power Operated Vehicles (K0800-K0808, K0812)
A POV is covered if all of the basic coverage criteria (A-C) have been met and if criteria (D-I) are also met.

D. The patient is able to:
   • Safely transfer to and from a POV, and
   • Operate the tiller steering system, and
   • Maintain postural stability and position while operating the POV in the home.

E. The patient's mental capabilities (e.g., cognition) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home.

F. The patient’s home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided.

G. The patient's weight is less than or equal to the weight capacity of the POV that is provided and greater than or equal to 95% of the weight capacity of the next lower weight class POV – i.e., a HD POV is covered for 285 – 450 lbs; a VHD POV is covered 428 – 600 lbs.

H. Use of a POV will significantly improve the patient’s ability to participate in MRADLs and the patient will use it in the home.

I. The patient has not expressed an unwillingness to use a POV in the home.

K0800  POV, group 1 standard, patient weight capacity ≤ 300 lbs
K0801  POV, group 1 heavy duty, patient weight capacity, 301-450 lbs
K0802  POV, group 1 very heavy duty, patient weight capacity 451-600 lbs
K0806  POV, group 2 standard, patient weight capacity ≤ 300 lbs
K0807  POV, group 2 heavy duty, patient weight capacity 301-450 lbs
K0808  POV, group 2 very heavy duty, patient weight capacity 451-600 lbs
K0812  POV, not otherwise classified

If a POV will be used inside the home and coverage criteria A-I are not met, it will be denied as not medically necessary.

If a POV will only be used outside the home, it will be denied as non-covered. Group 2 POVs (K0806-K0808) have added capabilities that are not needed for use in the home. If a one of these devices is provided, it will be denied as noncovered.

Power Wheelchairs (K0813-K0891, K0898)
A power wheelchair is covered if:
   a. All of the basic coverage criteria (A-C) are met; and
   b. The patient does not meet coverage criterion D, E, or F for a POV; and
   c. Either criterion J or K is met; and
   d. Criterion L, M, N, and O are met; and
   e. Any coverage criteria pertaining to the specific wheelchair type are met.

J. The patient has the mental and physical capabilities to safely operate the power wheelchair that is provided; or

K. If the patient is unable to safely operate the power wheelchair, the patient has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair that is provided; and

L. The patient's weight is less than or equal to the weight capacity of the power wheelchair that is provided and greater than or equal to 95% of the weight capacity of the next lower weight class PWC – i.e., a HD PWC is covered for 285 – 450 lbs; a VHD PWC is covered for 428 – 600 lbs; an EHD PWC is covered for 570 lbs or more.

M. The patient's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the PWC that is provided.

N. Use of a power wheelchair will significantly improve the patient’s ability to participate in MRADLs and the patient will use it in the home. For patients with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver.
The patient has not expressed an unwillingness to use a power wheelchair in the home.

If the PWC will be used inside the home and coverage criteria (A-E) are not met it will be denied as not reasonable and necessary.

If a PWC will only be used outside the home, it will be denied as non-covered.

Specific Types Of Power Wheelchairs

A Group 1 PWC (K0813-K0816) or a Group 2 PWC (K0820-K0829) is covered if all of the coverage criteria (A-E) for a PWC are met and the wheelchair is appropriate for the patient's weight.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Patient Weight Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0813</td>
<td>PWC, group 1 standard, portable, sling/solid seat and back</td>
<td>&lt; 300 lbs</td>
</tr>
<tr>
<td>K0814</td>
<td>PWC, group 1 standard, portable, captains chair</td>
<td>&lt; 300 lbs</td>
</tr>
<tr>
<td>K0815</td>
<td>PWC, group 1 standard, sling/solid seat and back</td>
<td>&lt; 300 lbs</td>
</tr>
<tr>
<td>K0816</td>
<td>PWC, group 1 standard, captains chair</td>
<td>&lt; 300 lbs</td>
</tr>
<tr>
<td>K0820</td>
<td>PWC, group 2 standard, portable, sling/solid seat/back</td>
<td>&lt; 300 lbs</td>
</tr>
<tr>
<td>K0821</td>
<td>PWC, group 2 standard, portable, captains chair</td>
<td>&lt; 300 lbs</td>
</tr>
<tr>
<td>K0822</td>
<td>PWC, group 2 standard, sling/solid seat/back</td>
<td>&lt; 300 lbs</td>
</tr>
<tr>
<td>K0823</td>
<td>PWC, group 2 standard, captains chair</td>
<td>&lt; 300 lbs</td>
</tr>
<tr>
<td>K0824</td>
<td>PWC, group 2 heavy duty, sling/solid seat/back</td>
<td>301-450 lbs</td>
</tr>
<tr>
<td>K0825</td>
<td>PWC, group 2 heavy duty, captains chair</td>
<td>301-450 lbs</td>
</tr>
<tr>
<td>K0826</td>
<td>PWC, group 2 very heavy duty, sling/solid seat/back</td>
<td>451-600 lbs</td>
</tr>
<tr>
<td>K0827</td>
<td>PWC, group 2 very heavy duty, captains chair</td>
<td>451-600 lbs</td>
</tr>
<tr>
<td>K0828</td>
<td>PWC, group 2 extra heavy duty, sling/solid seat/back</td>
<td>&gt; 601 lbs</td>
</tr>
<tr>
<td>K0829</td>
<td>PWC, group 2 extra heavy duty, captains chair</td>
<td>&gt; 601 lbs</td>
</tr>
</tbody>
</table>

A Group 2 seat elevator PWC is statutorily noncovered.

If a PWC with a seat elevator (K0830, K0831) is provided, it will be denied as noncovered.

A Group 2 Single Power Option PWC (K0835 – K0840) is covered if all of the coverage criteria (A-E) for a PWC are met and if:

A. Criterion 1 or 2 is met; and
B. Criterion 3 and 4 is met.

1. The patient requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control).
2. The patient meets coverage criteria for a power tilt or a power recline seating system and it is being used on the wheelchair.
3. The patient has had a specialty evaluation performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features. The PT/OT, or physician may have no financial relationship with the supplier.
4. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Patient Weight Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0835</td>
<td>PWC, group 2 standard, single power option, sling/solid seat/back</td>
<td>&lt; 300 lbs</td>
</tr>
<tr>
<td>K0836</td>
<td>PWC, group 2 standard, single power option, captains chair</td>
<td>&lt; 300 lbs</td>
</tr>
<tr>
<td>K0837</td>
<td>PWC, group 2 heavy duty, single power option, sling/solid seat/back</td>
<td>301-450 lbs</td>
</tr>
<tr>
<td>K0838</td>
<td>PWC, group 2 heavy duty, single power option, captains chair</td>
<td>301-450 lbs</td>
</tr>
<tr>
<td>K0839</td>
<td>PWC, group 2 very heavy duty, single power option, sling/solid seat/back</td>
<td>451-600 lbs</td>
</tr>
<tr>
<td>K0840</td>
<td>PWC, group 2 extra heavy duty, single power option, sling/solid seat/back</td>
<td>&gt; 601 lbs</td>
</tr>
</tbody>
</table>

If a Group 2 Single Power Option PWC is provided and these criteria are not met (including but not limited to situations in which it is only provided to accommodate a power seat elevation feature, a power standing feature, or only power elevating legrests) it will be denied as not reasonable and necessary.

A Group 2 Multiple Power Option PWC (K0841-K0843) is covered if all of the coverage criteria (A-E) for a PWC are met and if:

A. Criterion 1 or 2 is met; and
B. Criterion 3 and 4 is met.

1. The patient meets coverage criteria for a power tilt and recline seating system and it is being used on the wheelchair.
2. The patient uses a ventilator which is mounted on the wheelchair.
3. The patient has had a specialty evaluation performed by a licensed/certified medical professional, such as a PT/OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features. The PT/OT, or physician may have no financial relationship with the supplier.
4. The wheelchair is provided by a supplier that employs a RESNA-certified ATP who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

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300 lbs
300 lbs
300 lbs
300 lbs
300 lbs

If a Group 2 Multiple Power Option PWC is provided and these criteria are not met it will be denied as not reasonable and necessary.

A Group 3 PWC with no power options (K0848-K0855) is covered if:
1. All of the coverage criteria (A-E) for a PWC are met; and
2. The patient’s mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and
3. The patient has had a specialty evaluation performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features. The PT/OT, or physician may have no financial relationship with the supplier; and
4. The wheelchair is provided by a supplier that employs a RESNA-certified ATP who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

PWC, group 3 standard, sling/solid seat/back, patient weight capacity < 300 lbs
PWC, group 3 standard, captains chair, patient weight capacity < 300 lbs
PWC, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301-450 lbs
PWC, group 3 heavy duty, captains chair, patient weight capacity 301-450 lbs
PWC, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451-600 lbs
PWC, group 3 very heavy duty, captains chair, patient weight capacity, 451-600 lbs
PWC, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity > 601 lbs
PWC, group 3 extra heavy duty, captains chair, patient weight capacity > 601 lbs

If a Group 3 PWC is provided and these criteria are not met it will be denied as not reasonable and necessary.

A Group 3 PWC with Single Power Option (K0856-K0860) is covered if:
1. All of the coverage criteria (A-E) for a PWC are met; and
2. The patient’s mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and
3. The patient requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control).
4. The patient meets coverage criteria for a power tilt or a power recline seating system and it is being used on the wheelchair.
5. The patient has had a specialty evaluation performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features. The PT/OT, or physician may have no financial relationship with the supplier; and
6. The wheelchair is provided by a supplier that employs a RESNA-certified ATP who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

PWC, group 3 standard, single power option, sling/solid seat/back, patient weight capacity < 300 lbs
PWC, group 3 standard, single power option, captains chair, patient weight capacity < 300 lbs
PWC, group 3 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301-450 lbs
PWC, group 3 heavy duty, single power option, captains chair, patient weight capacity 301-450 lbs
PWC, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451-600 lbs
PWC, group 3 very heavy duty, single power option, captains chair, patient weight capacity 451-600 lbs
PWC, group 3 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity > 601 lbs
PWC, group 3 extra heavy duty, single power option, captains chair, patient weight capacity > 601 lbs

A Group 3 PWC with Multiple Power Options (K0861-K0864) is covered if:
1. All of the coverage criteria (A-E) for a PWC are met; and
2. The patient’s mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and
3. The patient meets coverage criteria for a power tilt and recline seating system and it is being used on the wheelchair.
4. The patient uses a ventilator which is mounted on the wheelchair.
5. The patient has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features. The PT/OT, or physician may have no financial relationship with the supplier; and
6. The wheelchair is provided by a supplier that employs a RESNA-certified ATP who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

PWC, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity < 300 lbs
PWC, group 3 standard, multiple power option, captains chair, patient weight capacity < 300 lbs
PWC, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301-450 lbs
PWC, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301-450 lbs
PWC, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451-600 lbs
PWC, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity > 601 lbs

If a Group 3 Single Power Option or Multiple Power Options PWC is provided and these criteria are not met it will be denied as not reasonable and necessary.
A skin protection and/or positioning seat or back cushion that meets coverage criteria is provided.

K0840, K0843, K0860 – K0864, K0870, K0871, K0879, K0880, K0886, K0890, K0891

The wheelchair is provided by a supplier that employs a RESNA-certified ATP who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

Multiple Power Options:

1. The patient meets coverage criteria for a power tilt or a power recline seating system and it is being used on the wheelchair.
2. The patient meets coverage criteria for a power tilt and recline seating system and it is being used on the wheelchair.
3. The patient uses a ventilator which is mounted on the wheelchair.

K0890 PWC, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity ≤ 125 lbs
K0891 PWC, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity ≤ 125 lbs

If a Group 5 PWC is provided but all the coverage criteria are not met it will be denied as not reasonable and necessary.

A push-rim activated power assist device (E0986) for a manual wheelchair is covered if all of the following criteria are met:

1. All of the criteria for a power mobility device listed in the Basic Coverage Criteria section are met; and
2. The patient has been self-propelling in a manual wheelchair for at least one year; and
3. The patient has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT/OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the need for the device in the patient's home. The PT/OT, or physician may have no financial relationship with the supplier.
4. The wheelchair is provided by a supplier that employs a RESNA-certified ATP who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

If all of the coverage criteria are not met, it will be denied as not medically necessary.

**MISCELLANEOUS:**

A POV or PWC with Captain's Chair is not appropriate for a patient who needs a separate wheelchair seat and/or back cushion. If a skin protection and/or positioning seat or back cushion that meets coverage criteria is provided with a POV or a PWC with Captain's Chair, the POV or PWC will be denied as not reasonable and necessary.

For patients who do not have special skin protection or positioning needs, a power wheelchair with Captain's Chair provides appropriate support. Therefore, if a general use cushion is provided with a power wheelchair with a sling/solid seat/back instead of Captain's Chair, the wheelchair and the cushion(s) will be covered only if either criterion 1 or criterion 2 is met:

1. The cushion is provided with a covered power wheelchair base that is not available in a Captain's Chair model – i.e., codes K0839, K0840, K0843, K0860 – K0864, K0870, K0871, K0879, K0880, K0886, K0890, K0891; or
2. A skin protection and/or positioning seat or back cushion that meets coverage criteria is provided.

If one of these criteria is not met, both the PWC with a sling/solid seat and the general use cushion will be denied as not reasonable and necessary.

If a HD, VHD, or EHD PWC or POV is provided and if the patient's weight is outside the range listed in criterion G or L above (i.e., for HD – 285 – 400 lbs, for VHD – 428 – 600 lbs, for EHD – 570 pounds or more), it will be denied as not reasonable and necessary.

An add-on to convert a manual wheelchair to a joystick-controlled power mobility device (E0983) or to a tiller-controlled power mobility device (E0984) will be denied as not reasonable and necessary.

Payment is made for only one wheelchair at a time. Backup chairs are denied as not reasonable and necessary.
One month's rental of a PWC or POV (K0462) is covered if a patient-owned wheelchair is being repaired. Payment is based on the type of replacement device that is provided but will not exceed the rental allowance for the power mobility device that is being repaired.

A power mobility device will be denied as not reasonable and necessary if the underlying condition is reversible and the length of need is less than 3 months (e.g., following lower extremity surgery which limits ambulation).

A POV or PWC which has not been reviewed by the Pricing, Data Analysis, and Coding (PDAC) contractor or which has been reviewed by the PDAC and found not to meet the definition of a specific POV/PWC (K0899) will be denied as not reasonable and necessary.

The following power wheelchairs are eligible for Advance Determination of Medicare Coverage (ADMC):

1. A Group 2, 3, 4 or 5 Single Power Option or Multiple Power Options wheelchair (K0835–K0843, K0856–K0864, K0877–K0891)—whether or not a power seating system will be provided at the time of initial issue.
2. A Group 3 or 4 No Power Option wheelchair (K0848–K0855, K0868–K0871) that will be provided with an alternative drive control interface at the time of initial issue.

The delivery of the PMD must be within 120 days following completion of the face-to-face examination. (Exception: For PWCs that go through the ADMC process and receive an affirmative determination, the delivery must be within 6 months following the determination.)

Reimbursement for the wheelchair codes includes all labor charges involved in the assembly of the wheelchair. Reimbursement also includes support services, such as delivery, set-up, and education about the use of the PMD.

Upgrades that are beneficial primarily in allowing the patient to perform leisure or recreational activities are noncovered.

HCPCS MODIFIERS:

- **EY** – No physician or other licensed health care provider order for this item or service
- **GA** – Waiver of liability statement issued as required by payer policy, individual case
- **GY** – Item or service statutorily excluded or doesn’t meet the definition of any Medicare benefit category
- **GZ** – Item or service expected to be denied as not reasonable and necessary
- **KX** – Requirements specified in the medical policy have been met

If the face-to-face examination requirements have not been met, the **GY** modifier must be added to the codes for the PMD and all accessories.

If the PMD or push-rim activated power assist device that is provided is only needed for mobility outside the home, the **GY** modifier must be added to the codes for the item and all accessories.

A **KX** modifier may be added to the code for a power mobility device and all accessories only if one of the following conditions is met:

1. If all of the coverage criteria specified in this LCD have been met for the product that is provided; or
2. If there is an affirmative Advance Determination of Medicare Coverage (ADMC) for the product that is provided; or
3. If a Group 4 PWC is provided and if all of the coverage criteria for a comparable Group 3 PWC have been met.

If the requirements for use of the KX modifier or **GY** modifier are not met, the **GA** or **GZ** modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter **GA** on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or **GZ** if they have not obtained a valid ABN.

Claim lines billed without a **KX**, **GA**, **GY**, or **GZ** modifier will be rejected as missing information.

Orders

The order that the supplier must receive within 45 days after completion of the face-to-face examination must contain all of the following elements:

1. Beneficiary’s name
2. Description of the item ordered. (e.g., “power operated vehicle,” “power wheelchair,” or “power mobility device” or may be more specific.
3. Date of completion of the face-to-face examination
4. Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
5. Length of need
6. Physician’s signature
7. Date of physician signature

A date stamp or equivalent must be used to document receipt date.

If a written order containing all of these required elements is not received by the supplier within 45 days after completion of the face-to-face examination an **EY** modifier must be added to the HCPCS codes for the PMD and all accessories. The order must be available on request.
Once the supplier has determined the specific power mobility device that is appropriate for the patient based on the physician’s order, the supplier must prepare a written document (termed a detailed product description) that lists the wheelchair base and all options and accessories that will be separately billed. For the wheelchair base and each option/accessory, the supplier must enter all of the following:

- HCPCS code
- Narrative description of the item
- Manufacturer name and model name/number
- Supplier’s charge
- Medicare fee schedule allowance

For a POV or power wheelchair to be covered, the supplier must receive from the treating physician a written order containing all the elements specified in the Documentation Requirements section of the Local Coverage Determination within 45 days after completion of the physician’s face-to-face examination and prior to delivery of the device. (Exception: If the examination is performed during a hospital or nursing home stay, the supplier must receive the order within 45 days after discharge.) If these requirements are not met, the claim will be denied as non-covered.

If the detailed product description for the specific device is not obtained prior to delivery, payment will not be made for the item even if the documentation is subsequently obtained. If a similar item is provided by an unrelated supplier who has obtained the required documentation prior to delivery, it will be eligible for coverage.

A power mobility device may not be ordered by a podiatrist. If it is, it will be denied as non-covered.

**Face-To-Face Examination**

For a POV or PWC to be covered, the treating physician must conduct a face-to-face examination of the patient before writing the order and the supplier must receive a written report of this examination within 45 days after completion of the face-to-face examination and prior to delivery of the device. If this requirement is not met, the claim will be denied as non-covered. (Exceptions: If this examination is performed during a hospital or nursing home stay, the supplier must receive the report of the examination within 45 days after discharge.)

If the POV or PWC is a replacement during the 5 year useful lifetime of an item in the same performance group that was previously covered by Medicare, a face-to-face examination is not required. Note: Replacement during an item’s useful lifetime is limited to situations involving loss or irreparable damage from a specific accident or natural disaster.

The physician may refer the patient to a licensed/certified medical professional, such as a PT or OT, who has experience and training in mobility evaluations to perform part of the face-to-face examination. This person may have no financial relationship with the supplier. (Exception: If the supplier is owned by a hospital, PT or OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination.)

If the patient was referred before being seen by the physician, then once the physician has received and reviewed the written report of this examination, the physician must see the patient and perform any additional examination that is needed. The report of the physician’s visit shall state concurrence or any disagreement with the LCMP examination. In this situation, the physician must provide the supplier with a copy of both examinations within 45 days after the face-to-face examination with the physician.

If the physician saw the patient to begin the examination before referring the patient to an LCMP, then if the physician sees the patient again in person after receiving the report of the LCMP examination, the 45-day period begins on the date of that second physician visit. However, it is also acceptable for the physician to review the written report of the LCMP examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the physician must send a copy of the note from his/her initial visit to evaluate the patient plus the annotated, signed, and dated copy of the LCMP examination to the supplier. The 45-day period begins when the physician signs and dates the LCMP examination.

The report of the face-to-face examination should provide information relating to the following questions.

<table>
<thead>
<tr>
<th>For POVs and PWCs</th>
<th>What is this patient’s mobility limitation and how does it interfere with the performance of activities of daily living?</th>
</tr>
</thead>
<tbody>
<tr>
<td>For POVs and PWCs</td>
<td>Why can’t a cane or walker meet this patient’s mobility needs in the home?</td>
</tr>
<tr>
<td>For POVs and PWCs</td>
<td>Why can’t a manual wheelchair meet this patient’s mobility needs in the home?</td>
</tr>
<tr>
<td>For POVs</td>
<td>Does this patient have the physical and mental abilities to transfer into a POV and to operate it safely in the home?</td>
</tr>
<tr>
<td>For PWCs</td>
<td>Why can’t a POV (scooter) meet this patient’s mobility needs in the home?</td>
</tr>
<tr>
<td>For PWCs</td>
<td>Does this patient have the physical and mental abilities to operate a power wheelchair safely in the home?</td>
</tr>
</tbody>
</table>

The 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
  - Symptoms that limit ambulation
  - Diagnoses that are responsible for these symptoms

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- Medications or other treatment for these symptoms
- Progression of ambulation difficulty over time
- Other diagnoses that may relate to ambulatory problems
- How far the patient can walk without stopping
- Pace of ambulation
- What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used
- What has changed to now require use of a power mobility device
- Ability to stand up from a seated position without assistance
- 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
  - Weight and height
  - Cardiopulmonary examination
  - Musculoskeletal examination
    - Arm and leg strength and range of motion
  - 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.

A date stamp or equivalent must be used to document receipt date. The written report of this examination must be available on request.

Physicians shall document the examination in a detailed narrative note in their charts in the format that they use for other entries. The note must clearly indicate that a major reason for the visit was a mobility examination.

Many suppliers have created forms which have not been approved by CMS which they send to physicians and ask them to complete. Even if the physician completes this type of form and puts it in his/her chart, this supplier-generated form is not a substitute for the comprehensive medical record as noted above. Suppliers are encouraged to help educate physicians on the information needed to document a patient’s mobility needs.

Physicians shall also provide reports of pertinent laboratory tests, x-rays, and/or other diagnostic tests (e.g., pulmonary function tests, cardiac stress test, electromyogram, etc.) performed in the course of management of the patient.

If the report of a licensed/certified medical professional (LCMP) examination is to be considered as part of the face-to-face examination, there must be a signed and dated attestation by the supplier that the LCMP has no financial relationship with the supplier. (Note: Evaluations performed by an LCMP who has a financial relationship with the supplier may be submitted to provide additional clinical information, but will not be considered as part of the face-to-face examination by the physician.)

Although patients who qualify for coverage of a power mobility device may use that device outside the home, because Medicare’s coverage of a wheelchair or POV is determined solely by the patient’s mobility needs within the home, the examination must clearly distinguish the patient’s abilities and needs within the home from any additional needs for use outside the home.

**Specialty Evaluation**

The specialty evaluation that is required for patients who receive a Group 2 Single Power Option or Multiple Power Options PWC, any Group 3 or Group 4 PWC, or a push-rim activated power assist device is in addition to the requirement for the face-to-face examination. The specialty evaluation provides detailed information explaining why each specific option or accessory – i.e., power seating system, alternate drive control interface – is needed to address the patient’s mobility limitation. There must be a written report of this evaluation available on request.

**Home Assessment**

Prior to or at the time of delivery of a POV or PWC, the supplier or practitioner must perform an on-site evaluation of the patient’s home to verify that the patient can adequately maneuver the device that is provided considering physical layout, doorway width, doorway thresholds, and surfaces. There must be a written report of this evaluation available on request.

**Miscellaneous**

A POV or power wheelchair with Captain’s Chair is not appropriate for a patient who needs a separate wheelchair seat and/or back cushion. If a skin protection and/or positioning seat or back cushion that meets coverage criteria is provided with a POV or a power wheelchair with Captain’s Chair, the POV or PWC will be denied as not medically necessary.

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If a patient needs a seat and/or back cushion but does not meet coverage criteria for a skin protection and/or positioning cushion, it is appropriate to provide a Captain's Chair seat (if the code exists) rather than a sling/solid seat/back and a separate general use seat and/or back cushion. If a general use seat and/or back cushion is provided with a power wheelchair with a sling/solid seat/back, total payment for those items will be based on the allowance for the least costly medically appropriate alternative – e.g., the code for the comparable PWC with Captain's Chair, if that code exists.

If a patient's weight can be accommodated by a PWC with a lower weight capacity than the wheelchair that is provided, payment will be based on the allowance for the least costly medically appropriate alternative.

A seat elevator is a non-covered option on a power wheelchair. Therefore, if a Group 2 Seat Elevator PWC (K0830, K0831) is provided and if all of the criteria for a PWC are met, payment will be based on the allowance for the least costly medically appropriate Group 2 PWC without seat elevator.

The delivery of the PMD must be within 120 days following completion of the face-to-face examination. (Exception: For PWCs that go through the ADMC process and receive an affirmative determination, the delivery must be within 6 months following the determination.)

An add-on to convert a manual wheelchair to a joystick-controlled power mobility device (E0983) or to a tiller-controlled power mobility device (E0984) will be denied as not medically necessary.

Payment is made for only one wheelchair at a time. Backup chairs are denied as not medically necessary. One month's rental of a PWC or POV (K0462) is covered if a patient-owned wheelchair is being repaired. Payment is based on the type of replacement device that is provided but will not exceed the rental allowance for the power mobility device that is being repaired.

A power mobility device will be denied as not medically necessary if the underlying condition is reversible and the length of need is less than 3 months (e.g., following lower extremity surgery which limits ambulation).

A POV or PWC which has not been reviewed by the PDAC or which has been reviewed by the PDAC and found not to meet the definition of a specific POV/PWC (K0899) will be denied as not medically necessary.

It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available to the DME MAC upon request.

If the requirements related to a face-to-face examination are not met, the GY modifier must be added to the codes for the PMD and all accessories.

If a POV or PWC is only for use outside the home, it will be denied as non-covered.

If the power mobility device or push-rim activated power assist device that is provided is only needed for mobility outside the home, the GY modifier must be added to the codes for the item and all accessories.

A KX modifier may be added to the code for a power mobility device and all accessories only if one of the following conditions is met:

1. If all of the coverage criteria specified in this LCD have been met for the product provided; or
2. If there is an affirmative ADMC for the product that is provided; or
3. If a Group 4 PWC is provided and all coverage criteria for a comparable Group 3 PWC are met.

The following power wheelchairs are eligible for Advance Determination of Medicare Coverage (ADMC):

1. A Group 2, 3, 4 or 5 Single Power Option or Multiple Power Options wheelchair (K0835-K0843, K0856-K0864, K0877-K0891) – whether or not a power seating system will be provided at the time of initial issue.
2. A Group 3 or 4 No Power Option wheelchair (K0848-K0855, K0868-K0871) that will be provided with an alternative drive control interface at the time of initial issue.

Reimbursement for the wheelchair codes includes all labor charges involved in the assembly of the wheelchair and support services, such as delivery, set-up, and education about the use of the PMD.

Items provided to the beneficiary may include upgraded components which are substituted for the basic component and are billed separately. One example is a power seating system. When this is provided, the base code used should be that with a sling/solid seat/back. Another example is the provision of an expandable controller when the base code includes a non-expandable controller but is capable of an upgrade.

Upgrades that are beneficial primarily in allowing the patient to perform leisure or recreational activities are non-covered.

The only products that may be billed using codes K0800-K0898 are those products for which a written coding verification determination has been made by the Pricing, Data Analysis and Coding Contractor (PDAC). A Product Classification List with devices which have received a coding verification determination can be found on the PDAC web site (www.dmepdac.com).

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If a power mobility device has not received a written coding verification determination from the PDAC or if the PDAC determines that the product does not meet the requirements of any code, it must be billed with code K0899.

**Definitions**

**Power Mobility Device (PMD)** - Base codes include both integral frame and modular construction type PWCs and POVs.

**Power Wheelchair (PWC)** - Chair-like battery powered mobility device for people with difficulty walking due to illness or disability, with integrated or modular seating system, electronic steering, and four or more wheel non-highway construction.

**Power Operated Vehicle (POV)** - Chair-like battery powered mobility device for people with difficulty walking due to illness or disability, with integrated seating system, tiller steering, and three or four-wheel non-highway construction.

**Patient Weight Capacity** – The terms Standard Duty, Heavy Duty, etc., refer to weight capacity, not performance. For example, the term Group 3 heavy duty PWC denotes that the PWC has Group 3 performance characteristics and patient weight handling capacity between 301 and 450 lbs. A device is not required to carry all the weight listed in the class of devices, but must have a patient weight capacity within the range to be included. For example, a PMD that has a weight capacity of 400 lbs is coded as a Heavy Duty device.

**Portable** - A category of devices with lightweight construction or ability to disassemble into lightweight components that allows easy placement into a vehicle for use in a distant location.

**PWC Basic Equipment Package** - Each PWC is to include all these items on initial issue (i.e. no separate billing/payment at initial issue):
- Lap belt or safety belt (E0978). Shoulder or chest straps may be billed separately (E0960).
- Battery charger single mode (E2366)
- Complete set of tires and casters any type (K0090-K0097, K0099)
- Legrests (K0051, K0052, and E0995). Elevating legrests may be billed separately (E0990, E1010, K0195).
- Fixed/swingaway detachable footrests or platform without angle adjustment (K0037, K0040-K0045, K0052). There is no separate billing for adjustable angle footplates on Group 1 or 2 PWCs. Adjust angle footplates (K0040) may be billed separately on Group 3, 4 or 5 PWCs.
- Armrests (K0015, K0019, K0020). Adjustable height armrests may be billed separately (E0973).
- Upholstery for seat/back of proper strength/type for the weight capacity of the PWC (E0981, E0982)
- Weight specific components per patient weight capacity including: braces, bars, upholstery, brackets, motors, gears, etc.
- Any seat and/or back width and depth. Exception: Group 3 and 4 PWCs with sling/solid seat/back, the following may be billed separately:
  - For standard duty, seat width and/or depth greater than 20 inches (K0108)
  - For heavy duty, seat width and/or depth greater than 22 inches (K0108)
  - For very heavy duty, seat width and/or depth greater than 24 inches (K0108)
  - For extra heavy duty, no separate billing
- Controller and Input Device. An expandable controller, nonstandard joystick or other alternative driver control may be billed separately.

**POV Basic Equipment Package** - Each POV is to include all these items on initial issue (i.e. no separate billing/payment at initial issue):
- Battery or batteries required for operation
- Battery charger, single mode
- Weight appropriate upholstery and seating system
- Tiller steering
- Non-expandable controller with proportional response to input
- Complete set of tires
- All accessories needed for safe operation

**Cross Brace Chair** - A type of construction for a power wheelchair in which opposing rigid braces hinge on pivot points to allow the device to fold.

**Power Options** - Tilt, recline, elevating legrests, seat elevators, or standing systems that may be added to a PWC to accommodate a patient’s specific need for seating assistance.

**No Power Options** – A category of PWCs that is incapable of accommodating a power tilt, recline, seat elevation, or standing system. If a PWC can only accept power elevating legrests, it is considered to be a No Power Option chair.

**Single Power Option** - A category of PWCs with the capability to accept and operate a power tilt or power recline or power standing or, for Groups 3, 4, and 5, a power seat elevation system, but not a combination power tilt and recline seating system. It may be able to accommodate power elevating legrests, seat elevator, and/or standing system in combination with a power tilt or power recline. A PMD does not have to be able to accommodate all features to qualify for this code. For example, a power wheelchair that only accommodates a power tilt could qualify for this code.
Multiple Power Options - A category of PWCs with the capability to accept and operate a combination power tilt and recline seating system. It may also be able to accommodate power elevating legrests, a power seat elevator, and/or a power standing system. A PWC does not have to accommodate all features to qualify for this code.

Actuator – A motor that operates a specific function of a power seating system – i.e., tilt, back recline, power sliding back, elevating legrest(s)

Proportional Control Input Device - A device that transforms a user's drive command (a physical action initiated by the wheelchair user) into a corresponding and comparative movement, both in direction and in speed, of the wheelchair. The input device shall be considered proportional if it allows for both a non-discrete directional command and a non-discrete speed command from a single drive command movement.

Non-Proportional Control Input Device - A device that transforms a user's discrete drive command (a physical action initiated by the wheelchair user, such as activation of a switch) into perceptually discrete changes in the wheelchair's speed, direction, or both.

Alternative Control Device - A device that transforms a user's drive commands by physical actions initiated by the user to input control directions to a PWC that replaces a standard proportional joystick. Includes mini-proportional, compact, or short throw joysticks, head arrays, sip and puff and other types of different input control devices.

Non-Expandable Controller - An electronic system that controls the speed and direction of the power wheelchair drive mechanism. Only a standard proportional joystick can be used as the input device. This system may be in the form of an integral controller or a remotely placed controller. The non-expandable controller:

A. May have the ability to control up to 2 power seating actuators through the drive control (for example, seat elevator and single actuator power elevating legrests). (Note: Control of power seating through the joystick requires the use of an additional component, E2310-E2311.)

B. May allow for the incorporation of an attendant control.

Expandable Controller - An electronic system that is capable of accommodating one or more of the following additional functions:

A. Proportional input devices (e.g., mini, compact, or short throw joysticks, touchpads, chin control, head control, etc.) other than a standard proportional joystick.

B. Non-proportional input devices (e.g., sip and puff, head array, etc.)

C. Operate 3 or more powered seating actuators through the drive control. (Note: Control of the power seating actuators though the Control Input Device would require the use of an additional component, E2310-E2311.)

An expandable controller may also be able to operate one or more of the following:

A. A separate display (i.e., for alternate control devices)

B. Other electronic devices (e.g., control of an augmentative speech device or computer through the chair's drive control)

C. An attendant control

Integral Control System - Non-expandable wheelchair control system where the joystick is housed in the same box as the controller. The entire unit is located and mounted near the hand of the user. A direct electrical connection is made from the Integral Control box to the motors and batteries through a high power wire harness.

Remotely Placed Controller - Non-expandable or expandable wheelchair control system where the joystick (or alternative control device) and the controller box are housed in separate locations. The joystick (or alternative control device) is connected to the controller through a low power wire harness. The separate controller connects directly to the motors and batteries through a high power wire harness.

Sling Seat/Back - Flexible cloth, vinyl, leather or equal material designed to serve as the support for buttocks or back of the user respectively. They may or may not have thin padding but are not intended to provide cushioning or positioning for the user.

Solid Seat/Back - Rigid metal or plastic material usually covered with cloth, vinyl, leather or equal material, with or without some padding material designed to serve as the support for buttocks or back of the user respectively. They may or may not have thin padding but are not intended to provide cushioning or positioning for the user. PWCs with an automotive-style back and a solid seat pan are considered as a solid seat/back system, not a Captain's Chair.

Captain's Chair - A one or two-piece automotive-style seat with rigid frame, cushioning material in both seat and back sections, covered in cloth, vinyl, leather or equal as upholstery, and designed to serve as a complete seating, support, and cushioning system for the user. It may have armrests that can be fixed, swingaway, or detachable. It may or may not have a headrest, either integrated or separate.

Stadium Style Seat - A one or two piece stadium-style seat with rigid frame and cushioning material in both seat and back sections, covered in cloth, vinyl, leather or equal as upholstery, and designed to serve as a complete seating, support, and cushioning system for the user. It may have armrests that can be fixed, swingaway, or detachable. It will not have a headrest. Chairs with stadium style seats are billed as Captain's Chair codes.

Highway Use - Mobility devices that are powered and configured to operate legally on public streets.

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**Push-rim activated power assist** – (E0986) - An option for a MWC in which sensors in specially designed wheels determine the force that is exerted by the patient on the wheel. Additional propulsive and/or braking force is then provided by motors in each wheel. Batteries are included.

**Performance Testing** – Term used to denote the RESNA based test parameters used to test PMDs. The PMD is expected to meet or exceed the listed performance and durability figures for the category in which it is to be used when tested. There is no requirement to test the PMD with all possible accessories.

**Test Standards** – Performance and durability acceptance criteria defined by ANSI/RESNA standard testing protocols.

**Crash Testing** – Successful completion of WC-19 testing.

**Top End Speed** – Minimum speed acceptable for a given category of devices. It is to be determined by the RESNA test for maximum speed on a flat hard surface.

**Range** – Minimum distance acceptable for a given category of devices on a single charge of the batteries. It is to be determined by the appropriate RESNA test for range.

**Obstacle Climb** – Vertical height of a solid obstruction that can be climbed using the standing and/or 0.5 meter run-up RESNA test.

**Dynamic Stability Incline** – The minimum degree of slope at which the PMD in the most common seating and positioning configuration(s) remains stable at the required patient weight capacity. If the PMD is stable at only one configuration, the PMD may have protective mechanisms that prevent climbing inclines in configurations that may be unstable.

**Radius Pivot Turn** – The distance required for the smallest turning radius of the PMD base. This measurement is equivalent to the “minimum turning radius” specified in the ANSI/RESNA bulletins.
Proof of Delivery

Documentation must show that an item or service was actually provided to a specific beneficiary. There are three methods to document proof of delivery based on the three ways items are delivered to beneficiaries.

**Method 1: Direct delivery to the beneficiary by the supplier**

When delivering an item directly to the beneficiary, proof of delivery is documented by a delivery slip, signed and dated by the beneficiary or his or her authorized representative. The slip must be signed on the date the item or service was delivered. The delivery slip must include:

- The beneficiary’s name
- The date the items were delivered
- The quantity of items delivered
- A detailed description of items including brand name and serial number if applicable

**Method 2: Delivery via shipping or delivery service**

When using a commercial delivery service the delivery service’s tracking slip and the shipping invoice are proof of delivery. The invoice must include:

- The beneficiary’s name
- The quantity of items delivered
- A detailed description of the items including brand name and serial number, if applicable
- The package identification number that the delivery service assigned to the package

The delivery service’s tracking slip must include:

- A listing of each of the patient’s packages
- The delivery address
- The package identification number assigned to the package by the delivery service

**Method 3: Delivery to a nursing facility on behalf of a beneficiary**

When a supplier delivers items to a nursing facility the documentation described for Method 1 is required. When a delivery service is used to deliver to a nursing facility, the documentation described for Method 2 is required.

In addition, there must be proof that the items were used by the beneficiary for whom they were delivered. Work with the nursing facility to implement an inventory control system to ensure that:

- The receipt of supplies at the nursing facility is verified
- Supplies are identified and retained for use only by the specific beneficiary for whom they were intended
- Supplies are actually used by the beneficiary for whom they were intended

The medical records at the nursing home must document the use of all items billed to Medicare. That documentation may be in the form of nurse’s notes or a special treatment record or form.

**Date of Service and Date of Delivery**

The date of service on the claim will depend on which method of delivery is used.

- For Method 1, the date of service is the date that the item was delivered
- For Method 2, the date of service is the date that the item was shipped
- For Method 3, the date of service is either the date that a supplier delivered the item to the nursing facility, or the date that the item was shipped, if a delivery service was used

An exception to this occurs when items are delivered in anticipation of discharge from a hospital or nursing facility. If an item is delivered to a beneficiary at the hospital up to two days prior to discharge to home and if it is delivered for the benefit of the patient for the purpose of fitting or training, then the date of service will be the date of discharge to home. Place of service (POS) 12 (home) should be indicated.
Noridian Administrative Services, LLC (NAS) serves as the Pricing, Data Analysis and Coding (PDAC) Contractor, performing the following activities that Palmetto GBA’s Statistical Analysis DME Regional Carrier (SADME MAC) performed prior to August 2008:

- Provide data analysis support to the DME Program Safeguard Contractors (PSCs)
- Guide manufacturers and suppliers on the proper use of the Healthcare Common Procedure Coding System (HCPCS) through product reviews and decisions
- Conduct national pricing functions for DMEPOS services
- Assist CMS with DMEPOS fee schedules

DME Coding System - DMECS
- Provides HCPCS coding assistance and national pricing information via searches for HCPCS Level II codes and modifiers, DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies), and CMS national fee schedules.
- Is designed to assist the public with the coding of DMEPOS for submission to the DME MACs.
- Contains HCPCS codes beginning with the letters A, B, E, J, K, L, Q, and V. Not all of the HCPCS starting with these letters are valid for submission to the DME MACs. Invalid HCPCS are included for convenience. The tracking of coding history and crosswalk information may be incomplete for codes invalid for DME MAC submission.

HCPCS Review
HCPCS review is the process that allows manufacturers, distributors and other parties to request a coding decision on a DMEPOS item. A Coding Verification Request form and supporting documentation is submitted to the PDAC staff for review and a decision.

Resources
Resources to assist manufacturers, distributors and suppliers in coding DMEPOS products and provides information on HCPCS changes. This includes advisory articles, previously published by the Statistical Analysis DME Regional Carrier (PDAC) and those published by the PDAC. In addition, we have provided related DME and HCPCS web sites and information about the Comprehensive Error Rate Testing program to help prevent coding errors.

All PDAC questions should be directed to:

PDAC Contact Center
Toll Free: 877.735.1326
Direct: 701.433.3077
Fax: 866.209.1236
Hours: 8:30 am – 4:00 pm CT

Mailing Address
Pricing, Data Analysis and Coding
PO Box 6757
Fargo ND 58108-6757

Courier Address
Pricing, Data Analysis and Coding
900 42nd Street South
Fargo ND 58108-6757
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Wheelchair Accessories

For an option or accessory for a manual wheelchair to be covered, a written signed and dated order must be received by the supplier before a claim is submitted. If the supplier bills for an item without first receiving the completed order, the item will be denied as not medically necessary.

For an option or accessory for a power wheelchair to be covered by Medicare, a written signed and dated order must be received by the supplier prior to delivery of the item. If the supplier delivers the item prior to the receipt of a written order, it will be denied as non-covered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

Options and accessories for wheelchairs are covered if the patient has a wheelchair that meets Medicare coverage criteria and the option/accessory itself is medically necessary. Coverage criteria for specific items are described below.

If these criteria are not met, the item will be denied as not medically necessary.

The allowance for a power operated vehicle (POV) includes all options and accessories that are provided at the time of initial issue, including but not limited to batteries, battery chargers, seating systems, etc. If a patient-owned POV meets coverage criteria, medically necessary replacement items are covered.

The allowance for a rollabout chair includes all options and accessories that are provided at the time of initial issue. The allowance for a transport chair includes all options and accessories that are provided at the time of initial issue except for elevating legrests (E0990, K0195). If a rollabout chair or transport chair are covered, medically necessary replacement items are covered.

An option/accessory that is beneficial primarily in allowing the patient to perform leisure or recreational activities is non-covered.

If an option or accessory that is included in another code is billed separately, the claim line will be denied as not separately payable.

**HCPCS Modifiers**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>EY</td>
<td>No physician or other licensed health care provider order for this item or service</td>
</tr>
<tr>
<td>GA</td>
<td>Waiver of liability statement issued as required by payer policy, individual case</td>
</tr>
<tr>
<td>GY</td>
<td>Item or service statutorily excluded or does not meet the definition of any Medicare benefit</td>
</tr>
<tr>
<td>GZ</td>
<td>Item or service expected to be denied as not reasonable and necessary</td>
</tr>
<tr>
<td>KC</td>
<td>Replacement of special power wheelchair interface</td>
</tr>
<tr>
<td>KX</td>
<td>Specified required documentation on file</td>
</tr>
<tr>
<td>RB</td>
<td>Replacement of a part of DME furnished as part of a repair</td>
</tr>
</tbody>
</table>

For accessories for a PMD, if the requirements related to a 7-element order and face-to-face examination from the PMD policy have not been met, the **GY** modifier must be added to the codes for all accessories.

For accessories provided with a MWC or PMD, if it is only needed outside the home, the **GY** modifier must be added to the codes for all accessories.

If the conditions for use of the **GY** modifier are not met, the **KX** modifier must be added to the code for the accessory only if (a) the coverage criteria that are specified in the MWC or PMD LCD have been met and (b) any specific coverage criteria for the accessory in this LCD have been met. If the coverage criteria are not met, the **KX** modifier must not be used.

If the conditions for use of the **GY** modifier are not met and if the requirements for use of the **KX** modifier are not met, the **GA** or **GZ** modifier must be added to a claim line for the accessory. When there is an expectation of a medical necessity denial, suppliers must enter the **GA** modifier on the claim line if they have obtained a properly executed ABN or the **GZ** modifier if they have not obtained a valid ABN.

If the **GY** modifier is used, the **KX**, **GA**, and **GZ** modifiers should not be used.

Claim lines billed without a **GA**, **GY**, **GZ**, or **KX** modifier will be rejected as missing information.

If a MWC accessory is billed before a signed and dated order is received by the supplier, it must be submitted with an **EY** modifier after each affected HCPCS code.

If a PWC accessory is delivered before a signed and dated order has been received by the supplier, it must be submitted with an **EY** modifier added to each affected HCPCS code.

For PWC, if the coverage criteria that are specified in the PMD LCD have been met, a **KX** modifier must be added to the codes for all accessories provided at the same time. If the coverage criteria are not met, the **KX** modifier must not be used.
The KC modifier is used in the following situations:
1. Due to a change in the patient's condition an integrated joystick and controller is being replaced by another drive control interface - e.g., remote joystick, head control, sip and puff, etc.; or
2. The patient had a drive control interface described by codes E2321-E2322, E2325, or E2327-E2330 and both the interface (e.g., joystick, head control, sip and puff) and the controller electronics are being replaced due to irreparable damage.

The KC modifier would never be used at the time of initial issue of a wheelchair. The KC modifier specifically states replacement, therefore, the RB modifier is not required.

The RB modifier is used when an option or accessory is provided as a replacement for the same part which has been worn or damaged (e.g., replacing a tire of the same type). The RB modifier must not be used for an upgrade subsequent to providing the wheelchair base (e.g., replacing a standard seat of a power wheelchair with a power seating system). The RB modifier must not be used if the accessory is provided at the same time as the wheelchair base, even if the option/accessory is the same as one that the patient had on a prior wheelchair.

The right (RT) and left (LT) modifiers must be used when appropriate. When the same code for bilateral items are billed on the same date of service, bill both items on the same claim line using the LTRT modifiers and 2 units of service. Exceptions: For options or accessories that are in the capped rental payment category and are not described as a pair, if bilateral items are provided, they need to be billed on two separate claim lines with the RT modifier on one line and the LT modifier on the other.

Arm of Chair:
E0973 WC accessory, adjustable height, detachable armrest, complete assembly, each
E2209 Accessory, arm trough, with or without hand support, each
K0015 Detachable, non-adjustable height armrest, each
K0017 Detachable, adjustable height armrest, base, each
K0018 Detachable, adjustable height armrest, upper portion, each
K0019 Arm pad, each
K0020 Fixed, adjustable height armrest, pair

Adjustable arm height option (E0973, K0017, K0018, K0020) is covered if the patient requires an arm height that is different than that available using nonadjustable arms and the patient spends at least 2 hours per day in the wheelchair.

An arm trough (E2209) is covered if patient has quadriplegia, hemiplegia, or uncontrolled arm movements.

Footrest/Legrest
E0951 Heel loop/holder, any type, with or without ankle strap, each
E0952 Toe loop/holder, any type, each
E0990 WC accessory, elevating leg rest, complete assembly, each
E0995 WC accessory, calf rest/pad, each
E1020 Residual limb support system for wheelchair
K0037 High mount flip-up footrest, each
K0038 Leg strap, each
K0039 Leg strap, H style, each
K0040 Adjustable angle footplate, each
K0041 Large size footplate, each
K0042 Standard size footplate, each
K0043 Footrest, lower extension tube, each
K0044 Footrest, upper hanger bracket, each
K0045 Footrest, complete assembly
K0046 Elevating legrest, lower extension tube, each
K0047 Elevating legrest, upper hanger bracket, each
K0050 Ratchet assembly
K0051 Cam release assembly, footrest or legrest, each
K0052 Swingaway, detachable footrests, each
K0053 Elevating footrests, articulating (telescoping), each
K0195 Elevating leg rests, pair (for use with capped rental wheelchair base)

Elevating legrests that are used with a wheelchair that is purchased or owned by the patient are coded E0990. This code is per legrest. Elevating legrests that are used with a capped rental wheelchair base should be coded K0195. This code is per pair of legrests.

Elevating legrests (E0990, K0046, K0047, K0053, K0195) are covered if:
1. The patient has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; or
2. The patient has significant edema of the lower extremities that requires having an elevating legrest; or
3. The patient meets the criteria for and has a reclining back on the wheelchair.

Nonstandard Seat Frame Dimensions
E1011 Modification to pediatric size WC, width adjustment package (not to be dispensed with initial chair)
E2201 MWC accessory, nonstandard seat frame, width greater than or equal to 20” and less than 24”
E2202 MWC accessory, nonstandard seat frame width, 24-27”
E2203 MWC accessory, nonstandard seat frame depth, 20 to less than 22”
E2204 MWC accessory, nonstandard seat frame depth, 22 to 25”
K0056 Seat height < 17” or ≥ 21” for a high strength, lightweight, or ultralightweight WC

For all adult MWC (E1161, K0001-K0009), payment for seat widths and/or seat depths of 15-19” are included in the payment for the base code.

These seat dimensions should not be separately billed. Codes E2201-E2204 describe seat widths and/or depths of 20” or more for MWCs.

A nonstandard seat width and/or depth for a manual wheelchair (E2201-E2204) is covered only if the patient’s dimensions justify the need.

For power wheelchairs, there is no separate billing for nonstandard seat frame dimensions (width, depth, or height) with the following exceptions:

For Group 3 and 4 PWCs with a sling/solid seat/back, the following may be billed separately using code K0108:
- For Standard Duty, back width greater than 20 inches;
- For Heavy Duty, back width greater than 22 inches;
- For Very Heavy Duty, back width greater than 24 inches;
- For Extra Heavy Duty, no separate billing.

Wheels/Tires for Manual Wheelchairs
E0961 MWC accessory, wheel lock brake extension (handle), each
E0967 MWC accessory, handrim with projections, any type, each
E2205 MWC accessory, handrim without projections, any type, replacement only, each
E2206 MWC accessory, wheel lock assembly, complete, each
E2211 MWC accessory, pneumatic propulsion tire, any size, each
E2212 MWC accessory, tube for pneumatic propulsion tire, any size, each
E2213 MWC accessory, insert for pneumatic propulsion tire (removable), any type, any size, each
E2214 MWC accessory, pneumatic caster tire, any size, each
E2215 MWC accessory, tube for pneumatic caster tire, any size, each
E2216 MWC accessory, foam filled propulsion tire, any size, each
E2217 MWC accessory, foam filled caster tire, any size, each
E2218 MWC accessory, foam propulsion tire, any size, each
E2219 MWC accessory, foam caster tire, any size, each
E2220 MWC accessory, solid (rubber/plastic) propulsion tire, any size, each
E2221 MWC accessory, solid (rubber/plastic) caster tire (removable), any size, each
E2222 MWC accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, each
E2224 MWC accessory, propulsion wheel excludes tire, any size, each
E2225 MWC accessory, caster wheel excludes tire, any size, replacement only, each
E2226 MWC accessory, caster fork, any size, replacement only, each
E2227 MWC accessory, gear reduction drive wheel, each
E2228 MWC accessory, wheel braking system and lock, complete, each
K0065 Spoke protectors, each
K0069 Rear wheel assembly, complete, with solid tire, spokes or molded, each
K0070 Rear wheel assembly, complete, with pneumatic tire, spokes or molded, each
K0071 Front caster assembly, complete, with pneumatic tire, each
K0072 Front caster assembly, complete, with semi-pneumatic tire, each
K0073 Caster pin lock, each
K0077 Front caster assembly, complete, with solid tire, each

Propulsion Wheel is a large wheel which can be used by a beneficiary to propel the wheelchair with his/her arms.

Caster is a small wheel that is in contact with the ground during normal operation of the wheelchair and which cannot be used for arm propulsion. This includes rear tires on tilt-in-space wheelchairs that are not used for arm propulsion.

Pneumatic Tire - (E2211, E2214) is a rubber tire which is used in conjunction with a separate tube (E2212, E2215) which is filled with air. A valve (E2223) is part of the tire tube and is only separately payable if just the valve is replaced on an existing tire tube.
Flat Free Insert - (E2213) is a removable ring of firm material that is placed inside of a pneumatic tire to allow the wheelchair to continue to move if the pneumatic tire is punctured. This code may not be used for a foam filled tire.

Foam Filled Tire - (E2216, E2217) is one in which a rubber tire shell has been filled with foam which is non-removable.

Foam Tire - (E2218, E2219) is one which is made entirely of self-skinning urethane.

Solid Tire - (E2220, E2221, E2222) is one which is made of hard plastic or rubber.

Gear reduction drive wheel – (E2227) is one that has more than one gear ratio option. Pushing on the rim allows the user to manually shift between the gears in order to provide additional leverage to assist propulsion of a manual wheelchair.

Wheel braking and lock system - (E2228) is a caliper or disc type braking system that permits the controlled slowing of a manual wheelchair or the controlled descent on inclines. It also has full wheel lock capability.

Rear Wheel Assembly - (K0069, K0070) includes a wheel rim plus a tire. For pneumatic tires, it also includes the tire tube, but not a flat free insert.

Caster Assembly - (K0071, K0072, K0077) includes a caster fork, wheel rim, and tire.

Batteries/Chargers:

- E2360 PWC accessory, 22NF non-sealed lead acid battery, each
- E2361 PWC accessory, 22NF sealed lead acid battery, each, (e.g. gel cell, absorbed glassmat)
- E2362 PWC accessory, group 24 non-sealed lead acid battery, each
- E2363 PWC accessory, group 24 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)
- E2364 PWC accessory, U-1 non-sealed lead acid battery, each
- E2365 PWC accessory, U-1 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)
- E2366 PWC accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each
- E2367 PWC accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each
- E2371 PWC accessory, group 27 sealed lead acid battery, (e.g. gel cell, absorbed glassmat), each
- E2372 PWC accessory, group 27 non-sealed lead acid battery, each
- E2397 PWC accessory, lithium based battery, each
- K0733 PWC accessory, 12-24 amp hour sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)

A sealed battery (E2361, E2363, E2365, E2371, K0733) is separately payable from the wheelchair base (K0813-K0886). Up to two batteries (E2361, E2363, E2365, E2371, K0731, K0733) at any one time are allowed if required for a power wheelchair.

A non-sealed battery (E2360, E2362, E2364, E2372) will be denied as not medically necessary.

A single mode battery charger (E2366) is appropriate for charging a sealed lead acid battery. If a dual mode battery charger (E2367) is provided as a replacement, it will be denied as not reasonable and necessary.

Power Seating Systems

- E1002 WC accessory, power seating system, tilt only
- E1003 WC accessory, power seating system, recline only, without shear reduction
- E1004 WC accessory, power seating system, recline only, with mechanical shear reduction
- E1005 WC accessory, power seating system, recline only, with power shear reduction
- E1006 WC accessory, power seating system, combination tilt and recline, without shear reduction
- E1007 WC accessory, power seating system, combination tilt and recline, with mechanical shear reduction
- E1008 WC accessory, power seating system, combination tilt and recline, with power shear reduction
- E1009 WC accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each
- E1010 WC accessory, addition to power seating system, power leg elevation system, including leg rest, pair
- E2300 PWC accessory, power seat elevation system
- E2301 PWC accessory, power standing system
- E2310 PWC accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware
- E2311 PWC accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware

A power seating system – tilt only, recline only, or combination tilt and recline – w/ or w/o power elevating legrests will be covered if criteria 1 and 2 are met and if criterion 3, 4, or 5 is met:

1. The patient meets all the coverage criteria for a PWC described in the Power Mobility Devices LCD; and
2. A specialty evaluation that was performed by a licensed/certified medical professional, such as a PT/OT or physician who has specific training and experience in rehabilitation wheelchair evaluations of the patient's seating and positioning needs. The PT, OT, or physician may have no financial relationship with the supplier; and
3. The patient is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or
4. The patient utilizes intermittent catheterization for bladder management and is unable to independently transfer from wheelchair to bed; or
5. The power seating system is needed to manage increased tone or spasticity.

If these criteria are not met, the power seating component(s) will be denied as not medically necessary.

Code **K0108** may not be used for nonstandard dimensions of a power tilt and/or recline seating system (E1002-E1008). The definition of those codes includes any frame width and depth.

For claims with dates of service on or after April 1, 2008, the specialty evaluation required for patients receiving a power tilt and/or recline seating system must be performed by a RESNA-certified Assistive Technology Professional (ATP) specializing in wheelchairs or a physician who is board-certified in Physical Medicine and Rehabilitation. The ATP or physician may not have any financial relationship with the supplier. In addition, the power seating system must be provided by a RESNA-certified ATP specializing in wheelchairs.

**Power Tilt Seating System (E1002)** includes: a solid seat platform and a solid back; any frame width and depth; detachable or flip-up fixed height or adjustable height armrests; fixed or swingaway detachable legrests; fixed or flip-up footplates; a motor and related electronics with or without variable speed programmability; a switch control which is independent of the power wheelchair drive control interface; any hardware that is needed to attach the seating system to the wheelchair base. It does not include a headrest. It must have the following features: ability to tilt to greater than or equal to 45 degrees from horizontal; back height of at least 20 inches; ability for the supplier to adjust the seat to back angle; ability to support patient weight of at least 250 pounds.

**Power Recline Seating System (E1003-E1005)** includes: a solid seat platform and a solid back; any frame width and depth; detachable or flip-up fixed height or adjustable height armrests; fixed or swingaway detachable legrests; fixed or flip-up footplates; a motor and related electronics with or without variable speed programmability; a switch control which is independent of the power wheelchair drive control interface; any hardware that is needed to attach the seating system to the wheelchair base. It does not include a headrest. It must have the following features: ability to recline to greater than or equal to 150 degrees from horizontal; back height of at least 20 inches; ability to support patient weight of at least 250 pounds.

**Power Tilt and Recline Seating System (E1006-E1008)** includes: a solid seat platform and a solid back; any frame width and depth; detachable or flip-up fixed height or adjustable height armrests; fixed or swingaway detachable legrests; fixed or flip-up footplates; two motors and related electronics with or without variable speed programmability; a switch control which is independent of the power wheelchair drive control interface; any hardware that is needed to attach the seating system to the wheelchair base. It does not include a headrest. It must have the following features: ability to recline to greater than or equal to 150 degrees from horizontal; back height of at least 20 inches; ability to support patient weight of at least 250 pounds.

**Mechanical Shear Reduction** feature (E1004, E1007) consists of two separate back panels. As the posterior back panel reclines or raises there is a mechanical linkage between the two panels which allows the patient's back to stay in contact with the anterior panel without sliding along that panel.

**Power Shear Reduction** feature (E1005/E1008) consists of two separate back panels. As the posterior back panel reclines or raises there is a separate motor which controls the linkage between the two panels and allows the patient's back to stay in contact with the anterior panel without sliding along that panel.

**Mechanically Linked Leg Elevation** feature (E1009) involves a pushrod which connects the legrest to a power recline seating system. With this feature, when the back reclines, the legrest elevates; when the back raises, the legrest lowers.

**Power Leg Elevation** feature (E1010) involves a dedicated motor and related electronics with or without variable speed programmability which allows the legrest to be raised and lowered independently of the recline and/or tilt of the seating system. It includes a switch control which may or may not be integrated with the power tilt and/or recline control(s). It includes either articulating or non-articulating legrests. The unit of service of code E1010 is a pair.

**Power Seat Elevation System (E2300)** includes: a motor and related electronics with or without variable speed programmability; a switch control which is independent of the power wheelchair drive control interface; any hardware that is needed to attach the seating system to the wheelchair base. It must provide a seat elevation of at least 6 inches.

**Power Standing System (E2301)** includes: a solid seat platform and a solid back; detachable or flip-up fixed height armrests; hinged legrests; anterior knee supports; fixed or flip-up footplates; a motor and related electronics with or without variable speed programmability; a basic switch control which is independent of the power wheelchair drive control interface; any hardware that is needed to attach the seating system to the wheelchair base. It does not include a headrest. It must have the following features: ability to move the patient to a standing position; ability to support patient weight of at least 250 pounds.

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A power seat elevation feature (E2300) and power standing feature (E2301) are non-covered because they are not primarily medical in nature. If a wheelchair has an electrical connection device described by code E2310 or E2311 and if the sole function of the connection is for a power seat elevation or power standing feature, it will be denied as non-covered.

Codes E2310 and E2311 describe the electronic components that allow the patient to control two or more of the following motors from a single interface (e.g., proportional joystick, touchpad, or non-proportional interface): power wheelchair drive, power tilt, power recline, power shear reduction, power leg elevation, power seat elevation, power standing. It includes a function selection switch which allows the patient to select the motor that is being controlled and an indicator feature to visually show which function has been selected. When the wheelchair drive function has been selected, the indicator feature may also show the direction that has been selected (forward, reverse, left, right). This indicator feature may be in a separate display box or may be integrated into the wheelchair interface. Payment for the code includes an allowance for fixed mounting hardware for the control box and for the display box (if present).

### Power Wheelchair Drive Control Systems

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2312</td>
<td>PWC accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including fixed mounting hardware</td>
</tr>
<tr>
<td>E2313</td>
<td>PWC accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each</td>
</tr>
<tr>
<td>E2321</td>
<td>PWC accessory, hand control interface, remote joystick, non-proportional, including all related electronics, mechanical stop switch, and fixed mounting hardware</td>
</tr>
<tr>
<td>E2322</td>
<td>PWC accessory, hand control interface, multiple mechanical switches, non-proportional, including all related electronics, mechanical stop switch, and fixed mounting hardware</td>
</tr>
<tr>
<td>E2323</td>
<td>PWC accessory, specialty joystick handle for hand control interface, prefabricated</td>
</tr>
<tr>
<td>E2324</td>
<td>PWC accessory, chin cup for chin control interface</td>
</tr>
<tr>
<td>E2325</td>
<td>PWC accessory, sip and puff interface, non-proportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware</td>
</tr>
<tr>
<td>E2326</td>
<td>PWC accessory, breath tube kit for sip and puff interface</td>
</tr>
<tr>
<td>E2327</td>
<td>PWC accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware</td>
</tr>
<tr>
<td>E2328</td>
<td>PWC accessory, head control interface, mechanical, proportional, including all related electronics, fixed hardware</td>
</tr>
<tr>
<td>E2329</td>
<td>PWC accessory, head control interface, contact switch mechanism, non-proportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware</td>
</tr>
<tr>
<td>E2330</td>
<td>PWC accessory, head control interface, proximity switch mechanism, non-proportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware</td>
</tr>
<tr>
<td>E2331</td>
<td>PWC accessory, attendant control, proportional, including all related electronics and fixed mounting hardware</td>
</tr>
<tr>
<td>E2373</td>
<td>PWC accessory, hand or chin control interface, mini-proportional, compact, or short throw remote joystick or touchpad, proportional, including all related electronics and fixed mounting hardware</td>
</tr>
<tr>
<td>E2374</td>
<td>PWC accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only</td>
</tr>
<tr>
<td>E2375</td>
<td>PWC accessory, non-expandable controller, including all related electronics and mounting hardware, replacement only</td>
</tr>
<tr>
<td>E2376</td>
<td>PWC accessory, expandable controller, including all related electronics and mounting hardware, replacement only</td>
</tr>
<tr>
<td>E2377</td>
<td>PWC accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue</td>
</tr>
</tbody>
</table>

The interfaces described by codes E2312, E2321, E2322, E2325, E2327-E2330, and E2373-E2377 must have programmable control parameters for speed adjustment, tremor dampening, acceleration control, and braking.

Code E2321 is used for a non-proportional remote joystick, regardless of whether it is used for hand or chin control.

A touchpad is an interface similar to the pad-type mouse found on portable computers. It is billed with code K0108.

When code E2321, E2373, or E2374 is used for a chin control interface, the chin cup is billed separately with code E2324.

Code E2322 describes a system of 3-5 mechanical switches which are activated by the patient touching the switch. The switch selected determines the direction of the wheelchair. A mechanical stop switch and direction change switch, if provided, are included in the allowance for the code.

Code E2323 includes prefabricated joystick handles that have shapes other than a straight stick - e.g., U shape or T shape - or that have some other nonstandard feature - e.g., flexible shaft.

Codes E2374-E2376 describe components of drive control systems. They may only be used for replacements other than at the time of initial issue.

Code E2377 is used when an expandable controller is provided at initial for a power wheelchair described by code K0841-K0891.

Code K0108 (not otherwise classified interface) is appropriately used at the time of initial issue only when the drive control interface that is provided is not included in the base code and there is no specific E code which describes it.
Code **K0108** (not otherwise classified interface) is appropriately used at the time of replacement in the following situations:
1. An integrated proportional joystick and controller box are being replaced due to damage; or
2. An interface other than a remote joystick (e.g. sip and puff, head control) is being replaced but the controller is not being replaced; or
3. There is no specific E code which describes the type of drive control interface system which is provided.

The term **Interface** in the code narrative and definitions describes the mechanism for controlling the movement of a power wheelchair. Examples of interfaces include, but are not limited to, joystick, sip and puff, chin control, head control, etc.

**Proportional Interface** is one in which the direction and amount of movement by the patient controls the direction and speed of the wheelchair. One example of a proportional interface is a standard joystick.

**Non-Proportional Interface** is one which involves a number of switches. Selecting a particular switch determines the direction of the wheelchair, but the speed is pre-programmed. One example of a non-proportional interface is a sip-and-puff mechanism.

**Controller** describes the microprocessor and other related electronics that receive and interpret input from the joystick (or other drive control interface) and convert that input into power output which controls speed and direction. A high power wire harness connects the controller to the motor and gears.

A non-expandable controller has the following features:
- May have the ability to control up to 2 power seating actuators through the drive control (for example, seat elevator and single actuator power elevating legrests). (Note: Control of the power seating actuators though the Control Input Device would require the use of an additional component, **E2310-E2311**.)
- May allow for the incorporation of an attendant control.

An expandable controller is capable of accommodating one or more of the following additional functions:
- Other types of proportional input devices (e.g., mini or low-force joysticks, touchpads, chin control, head control, etc.)
- Non-proportional input devices (e.g., sip and puff, head array, etc.)
- Operate 3 or more powered seating actuators through the drive control. (Note: Control of the power seating actuators though the Control InputDevice would require the use of an additional component, **E2310-E2311**.)

An expandable controller may also be able to operate one or more of the following:
- A separate display (i.e., for alternate control devices)
- Other electronic devices (e.g., control of an augmentative speech device or computer through the chair’s drive control)
- An attendant control

For PWC which are capable of being upgraded to an expandable controller (**K0835-K0891**), **E2377** is used if an expandable controller is provided at the time of initial issue.

**Harness** - (**E2313**) describes all of the wires, fuse boxes, fuses, circuits, switches, etc. that are required for the operation of an expandable controller. It also includes all the necessary fasteners, connectors, and mounting hardware. Code **E2313** is separately billable in addition to an expandable controller both at initial issue and with complete replacement of the expandable controller. However, if individual components of the harness are replaced, code **K0108** should be used.

**Switch** - an electronic device which turns power to a particular function either “on” or “off”. The external component of a switch may be either mechanical or non-mechanical. Mechanical switches involve physical contact in order to be activated. Examples of the external components of mechanical switches include, but are not limited to, toggle, button, ribbon, etc. Examples of the external components of non-mechanical switches include, but are not limited to, proximity, infrared, etc. Some of the codes include multiple switches. In those situations, each functional switch may have its own external component or multiple functional switches may be integrated into a single external switch component or multiple functional switches may be integrated into the wheelchair control interface without having a distinct external switch component.

**Stop Switch** - allows for an emergency stop when a wheelchair with a non-proportional interface is operating in the latched mode. (Latched mode is when the wheelchair continues to move without the patient having to continually activate the interface.) This switch can be referred to as a kill switch.

**Direction Change Switch** - allows the patient to change the direction that is controlled by another separate switch or by a mechanical proportional head control interface. For example, it allows a switch to initiate forward movement one time and backward movement another time.

**Function Selection Switch** - allows the patient to determine what operation is being controlled by the interface at any particular time. Operations may include, but are not limited to, drive forward, drive backward, tilt forward, recline backward, etc.

**Integrated Proportional Joystick and Controller** - an electronics package in which a joystick and controller electronics are in a single box, which is mounted on the arm of the wheelchair.

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Remote Joystick - is one in which the joystick is in one box that is mounted on the arm of the wheelchair and the controller electronics are located in a different box that is typically located under the seat of the wheelchair. The joystick is connected to the controller through a low power wire harness. A remote joystick may be used for either hand control, chin control, or attendant control.

Standard Proportional Remote Joystick - is one which requires approximately 340 grams of force to activate and which has an excursion (length of throw) of approximately 25 mm from neutral position. It can be used with a non-expandable or an expandable controller. There is no separate billing for a standard proportional remote joystick when it is provided at the time of initial issue of a power wheelchair whether it is used for hand or chin control by the patient or whether it is used as an attendant control in place of a patient-operated drive control interface.

Mini-Proportional (Short Throw) Remote Joystick - (E2312) is one which can be activated by a very low force (approximately 25 grams) and which has a very short displacement (a maximum excursion of approximately 5 mm from neutral). It can only be used with an expandable controller. It can be used for hand or chin control or control by other body part (e.g., tongue, lip, finger tip, etc.) There is no separate billing for control buttons, displays, switches, etc. There is no separate billing for fixed mounting hardware, regardless of the body part used to activate the joystick.

Compact Proportional Remote Joystick - (E2373) is one which has a maximum excursion of about 15 mm from neutral position but requires approximately 340 grams of force to activate. It can only be used with an expandable controller. It can be used for hand or chin control or control by other body part (e.g., foot, amputee stump, etc.) There is no separate billing for control buttons, displays, switches, etc. There is no separate billing for fixed mounting hardware, regardless of the body part used to activate the joystick.

Sip and Puff Interface (E2325) - is a non-proportional interface in which the patient holds a tube in their mouth and controls the wheelchair by either sucking in (sip) or blowing out (puff). A mechanical stop switch is included in the allowance for the code. E2325 does not include the breath tube kit which is described by code E2326.

Proportional, Mechanical Head Control Interface (E2327) - is one in which a headrest is attached to a joystick-like device. The direction and amount of movement of the patient's head pressing on the headrest control the direction and speed of the wheelchair. A mechanical direction control switch is included in the code.

Proportional, Electronic Head Control Interface (E2328) - is one in which a patient's head movements are sensed by a box placed behind the patient's head. The direction and amount of movement of the patient's head (which does not come in contact with the box) control the direction and speed of the wheelchair. A proportional, electronic extremity control interface (E2328) is one in which the direction and amount of movement of the patient's arm or leg control the direction and speed of the wheelchair.

Non-Proportional, Contact Switch Head Control Interface (E2329) - is one in which a patient activates one of three mechanical switches placed around the back and sides of their head. These switches are activated by pressure of the head against the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and direction change switch is included in the allowance for the code.

Non-Proportional, Proximity Switch Head Control Interface (E2330) - is one in which a patient activates one of three switches placed around their head. These switches are activated by movement of the head toward the switch, though the head does not touch the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and direction change switch is included in the allowance for the code.

Attendant Control (E2331) - is one which allows a caregiver to drive the wheelchair instead of the patient. The attendant control is usually mounted on one of the rear canes of the wheelchair. This code is limited to proportional control devices, usually a joystick.

Code E2331 is used when an attendant control is provided in addition to a patient-operated drive control interface. If an attendant control (E2331) is provided in addition to a patient-operated drive control system, it will be denied as non-covered.

An attendant control is covered in place of a patient-operated drive control system if the patient meets coverage criteria for a wheelchair, is unable to operate a manual or power wheelchair and has a caregiver who is unable to operate a manual wheelchair but is able to operate a power wheelchair.

Other Power Wheelchair Accessories
E1018 Heavy duty shock absorber for heavy duty or extra heavy duty power wheelchair, each
E2351 PWC accessory, electronic interface to operate speech generating device using power wheelchair control interface
E2366 PWC component, motor, replacement only
E2367 PWC component, gear box, replacement only
E2378 PWC accessory, pneumatic drive wheel tire, any size, replacement only, each
E2380 PWC accessory, insert for pneumatic drive wheel tire (removable), any size, replacement only, each
E2384 PWC accessory, pneumatic caster tire, any size, replacement only, each
E2385 PWC accessory, tube for pneumatic caster tire, any size, replacement only, each
E2386 PWC accessory, foam filled drive wheel tire, any size, replacement only, each

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An electronic interface (E2351) to allow a speech generating device to be operated by the power wheelchair control interface is covered if the patient has a covered speech generating device.

Code E2351 describes an electronic interface used with a speech generating device. An electronic interface that is used to allow lights or other electrical devices to be operated using the power wheelchair control interface must be billed with code A9270 and non-covered because it is not primarily medical in nature.

The following features of a power wheelchair are non-covered: stair climbing (A9270), electronic balance (A9270), ability to elevate the seat by balancing on two wheels (A9270), remote operation (A9270).

Drive Wheel - is directly controlled by the motor of the PWC. It may be either a rear, mid, or front wheel, depending on the model of the PWC.

Caster - is a smaller wheel that is in contact with the ground during normal operation of the wheelchair and is not directly controlled by the motor. It may be in the front and/or rear, depending on the location of the drive wheel.

Pneumatic Tire - (E2381, E2384) - is a rubber tire which is used in conjunction with a separate tube (E2382, E2385) which is filled with air.

Valve - (E2393) - is part of the tire tube and is only separately payable if just the valve is replaced on an existing tire tube.

Flat Free Insert - (E2383) - is a removable ring of firm material that is placed inside of a pneumatic tire to allow the wheelchair to continue to move if the pneumatic tire is punctured. This code may not be used for a foam filled tire.

Foam Filled Tire - (E2386-E2387) - is one in which a rubber tire shell has been filled with foam which is non-removable.

Foam Tire - (E2388-E2389) - is one which is made entirely of self-skinning urethane.

Solid Tire - (E2390-E2392) - is one which is made of hard plastic or rubber.

All types of tires and wheels are included in the code for a power mobility base. Codes E2381-E2396 may only be used for replacements.

Codes E2368-E2370 are for a replacement motor and/or gearbox. These codes are not used at the time of initial issue. If the item is a rebuilt component, the UE (used DME) modifier must be added to the code.

Miscellaneous Accessories

A9270 Non-covered item or service

A9900 Miscellaneous DME supply, accessory, and/or service component of another HCPCS code

E0705 Transfer board or device, any type, each

E0950 WC accessory, tray, each

E0958 MWC accessory, one-arm drive attachment, each

E0959 MWC accessory, adapter for amputee, each

E0971 MWC accessory, anti-tipping device, each

E0974 MWC accessory, anti-rollback device, each

E0978 WC accessory, positioning belt/safety belt/pelvic strap, each

E0981 WC accessory, seat upholstery, replacement only, each

E0982 WC accessory, back upholstery, replacement only, each

E0985 WC accessory, seat lift mechanism

E1014 Reclining back, addition to pediatric size wheelchair

E1015 Shock absorber for manual wheelchair, each

E1017 Heavy duty shock absorber for heavy duty or extra heavy duty MWC, each

E1028 WC accessory, manual swingaway, retractable or removable hardware for joystick, other control interface or positioning accessory

E1029 WC accessory, ventilator tray, fixed
Each PWC code is required to include all these items on initial issue (i.e., no separate Power Wheelchair Basic Equipment Package (E1030) billing/payment at initial issue, unless otherwise noted). The statement that an item may be separately billed does not necessarily indicate coverage allowance for that code.

If billing electronically, details should be notated in the NTE 2400 segment of the electronic claim. For paper claims, details must be provided as an attachment. Claims submitted without this required information will be denied.

Code E1028 is not to be used for swingaway hardware used with a sip and puff interface (E2305) because swingaway hardware is included in the allowance for that code.

One example (not all-inclusive) of a covered indication for swingaway, retractable, or removable hardware (E1029) would be to move the component out of the way so that a patient could perform a slide transfer to a chair or bed.

When submitting a claim for any number of claim lines for code E1028, the following instruction must be applied:

1. Each different item that is billed as an E1028 must be on a separate claim line.
2. Each E1028 claim line must include a narrative description of the item, the brand name, the make/model and the part number.

If billing electronically, details should be notated in the NTE 2400 segment of the electronic claim. For paper claims, details must be provided as an attachment. Claims submitted without this required information will be denied.

Code E1029 describes a ventilator tray which is attached in a fixed position to the wheelchair base or back. Code E1030 describes a ventilator tray which is attached to the seat back and is articulated so that the tray will remain horizontal when the seat back is raised or lowered.

Code E1225 describes a manually operated reclining back that can recline greater than 15 degrees but less than 80 degrees. Code E1226 describes a manually operated reclining back that reclines 80 degrees or greater.

A manual fully reclining back option (E1226) is covered if the patient has one or more of the following conditions:

1. The patient is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or
2. The patient utilizes intermittent catheterization for bladder management and cannot independently transfer from the wheelchair to the bed.

If these criteria are not met, then the manual reclining back will be denied as not medically necessary.

Power Wheelchair Basic Equipment Package - Each PWC code is required to include all these items on initial issue (i.e., no separate billing/payment at initial issue, unless otherwise noted). The statement that an item may be separately billed does not necessarily indicate coverage.

- Lap belt or safety belt (E0970). Shoulder or chest straps may be billed separately (E0960).
- Battery charger single mode (E2366).
- Complete set of tires and casters any type (K0090-K0097, K0099).
- Legrests (K0051, K0052, and E0995). Elevating legrests may be billed separately (E0990, E1010, K0195).
- Fixed/swingaway detachable footrests or platform without angle adjustment (K0037, K0040-K0045, K0052). There is no separate billing for adjustable angle footplates on Group 1 or 2 PWCs. Adjust angle footplates (K0040) may be billed separately on Group 3, 4 or 5 PWCs.
- Armrests (K0015, K0019, K0020). Adjustable height armrests may be billed separately (E0973).
- Upholstery for seat/back of proper strength/type for the weight capacity of the PWC (E0981, E0982).
- Weight specific components per patient weight capacity including: braces, bars, upholstery, brackets, motors, gears, etc.
- Any seat and/or back width and depth. Exception: Group 3 and 4 PWCs with sling/solid seat/back, the following may be billed separately:
  - For standard duty, seat width and/or depth greater than 20 inches (K0108).
  - For heavy duty, seat width and/or depth greater than 22 inches (K0108).

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- For very heavy duty, seat width and/or depth greater than 24 inches (K0108)
- For extra heavy duty, no separate billing

- Controller and Input Device. An expandable controller, nonstandard joystick or other alternative driver control may be billed separately.

POV Basic Equipment Package - Each POV is to include all these items on initial issue (i.e., no separate billing/payment at initial issue):

- Battery or batteries required for operation
- Battery charger, single mode
- Weight appropriate upholstery and seating system
- Tiller steering
- Non-expandable controller with proportional response to input
- Complete set of tires
- All accessories needed for safe operation.

A table at the end of this section defines the bundling guidelines for wheelchair bases and options/accessories. Codes listed in Column II are not separately payable from the wheelchair base and must not be billed separately at the time of initial purchase or rental of the wheelchair.

A replacement option/accessory for a power operated vehicle (POV) is billed using a wheelchair option/accessory code. All options and accessories provided at the time of initial issue of a POV are not separately billable.

Accessories provided at the time of initial issue of a rollabout chair are not separately billable. Accessories provided with the initial issue of a transport chair are not separately billable with the exception of elevating legrests (E0990, K0195). A replacement accessory for a rollabout or transport chair is billed using code E1399.

Miscellaneous options, accessories, or replacement parts for wheelchairs that do not have a specific HCPCS code and are not included in another code should be coded K0108. If multiple miscellaneous accessories are provided, each should be billed on a separate claim line using code K0108.

When billing more than one line item with code K0108, ensure that the additional information can be matched to the appropriate line item on the claim. It is also helpful to reference the line item to the submitted charge. If a supplier chooses to bill separately for a component that is included in another code, code A9900 must be used.

Codes E0969, E0970, E0977, E0980, E0994, E0997-E0999, E1227, E1296-E1298, E2320, E2340-E2343, and K0099 are not valid for claim submission.

Codes E0968 and E1228 should only be used to bill for maintenance and servicing for an item for which the initial claim was paid by the local carrier prior to transition to the DME MAC.

Documentation Requirements
It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request.

For options and accessories provided at the time of initial issue of a power wheelchair, once the supplier has determined the specific power mobility device that is appropriate for the patient based on the physician's order, the supplier must prepare a written document (termed a detailed product description) that lists the specific base (HCPCS code and either a narrative description of the item or the manufacturer name/model) and all options and accessories that will be separately billed. The supplier must list their charge and the Medicare fee schedule allowance for each separately billed item. If there is no fee schedule allowance, the supplier must enter “not applicable”. The physician must sign and date this detailed product description and the supplier must receive it prior to delivery of the PWC. A date stamp or equivalent must be used to document receipt date. The detailed product description must be available on request.

For items provided other than at the time of initial issue of a power wheelchair, there must be a detailed written order which lists each item which will be separately billed and which is signed and dated by the physician. In these situations, the supplier's charges and Medicare allowances do not need to be included. For manual wheelchair accessories, this order must be received by the supplier before the claim is submitted. For power wheelchair accessories, this order must be received prior to delivery.

The medical necessity for all options and accessories must be documented in the patient's medical record and be available on request. This documentation might include information on why the patient needs the item, the patient's diagnosis, the patient's abilities and limitations as they relate to the equipment, the duration of the condition, the expected prognosis, and past experience using similar equipment.

Accessories to the wheelchair base must be billed on the same claim as the wheelchair base itself.
A Column II code is included in the allowance for the corresponding Column I code when provided at the same time. When multiple codes are listed in column I, all the codes in column II relate to each code in column I.

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</table>
Wheelchair Cushions

Coverage And Payment Rules

A general use seat cushion (E2601, E2602) and a general use wheelchair back cushion (E2611-E2612) is covered for a patient who has a manual wheelchair or a power wheelchair with a sling/solid seat/back which meets Medicare coverage criteria. If the patient does not have a covered wheelchair, then the cushion will be denied as not medically necessary. If the patient has a POC or a power wheelchair with a captain's chair seat, the cushion will be denied as not medically necessary.

If a general use seat and/or back cushion is provided with a power wheelchair with a sling/solid seat/back, total payment for those items (cushion(s) plus the wheelchair) will be based on the allowance for the least costly medically appropriate alternative – e.g., the code for the comparable power wheelchair with Captain's Chair, if that code exists.

A skin protection seat cushion (E2603, E2604, K0734, K0735) is covered for a patient who meets both of the following criteria:

a. The patient has a MWC or a PWC with a sling/solid seat/back and the patient meets Medicare coverage criteria for it; and

b. The patient has either of the following:
   1. Current pressure ulcer (707.03, 707.04, 707.05) or past history of a pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface; or
   2. Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1), other spinal cord disease (336.0-336.3), multiple sclerosis (340), other demyelinating disease (341.0-341.9), cerebral palsy (343.0-343.9), anterior horn cell diseases including amyotrophic lateral sclerosis (335.0-335.21, 335.23-335.9), post polio paralysis (138), traumatic brain injury resulting in quadriplegia (344.09), spina bifida (741.00-741.93), childhood cerebral degeneration (330.0-330.9), Alzheimer's disease (331.0), Parkinson's disease (332.0).

A positioning seat cushion (E2605, E2606), positioning back cushion (E2613-E2616, E2620, E2621), and positioning accessory (E0955-E0957, E0960) is covered for a patient who meets both of the following criteria:

a. The patient has a MWC or a PWC with a sling/solid seat/back and the patient meets Medicare coverage criteria for it; and

b. The patient has any significant postural asymmetries that are due to one of the diagnoses listed in criterion 2b above or to one of the following diagnoses: monoplegia of the lower limb (344.30-344.32, 438.40-438.42) or hemiplegia (342.00-342.92, 438.20-438.22) due to stroke, traumatic brain injury, or other etiology, muscular dystrophy (359.0, 359.1), torsion dystonias (333.4, 333.6, 333.71), spinocerebellar disease (334.0-334.9).

A headrest (E0955) is also covered when the patient has a covered manual tilt-in-space, manual semi or fully reclining back on a manual wheelchair, a manual fully reclining back on a PWC, or power tilt and/or recline power seating system. Code E0955 describes any type of cushioned headrest.

A combination skin protection and positioning seat cushion (E2607, E2608, K0736, K0737) is covered for a patient who meets the criteria for both a skin protection seat cushion and a positioning seat cushion.

If a skin protection seat cushion, positioning seat cushion, or combination skin protection and positioning seat cushion is provided for a patient who does not meet the stated coverage criteria, but the criteria for another type of seat cushion are met, payment will be based on the allowance for the least costly medically appropriate alternative; if the criteria for another type of seat cushion are not met, the provided cushion will be denied as not medically necessary.

If a skin protection seat cushion is provided for a patient who does not meet the stated coverage criteria, but the criteria for a general use back cushion are met, payment will be based on the allowance for the least costly medically appropriate alternative, E2611 or E2612; if the criteria for a general use back cushion are not met, the provided cushion will be denied as not medically necessary.

If a positioning accessory is provided and the criteria are not met, the item will be denied as not medically necessary.

A custom fabricated seat cushion (E2609) is covered if criteria (1) and (3) are met. A custom fabricated back cushion (E2617) is covered if criteria (2) and (3) are met:

1. Patient meets all of the criteria for a prefabricated skin protection seat cushion or positioning seat cushion;
2. Patient meets all of the criteria for a prefabricated positioning back cushion;
3. There is a comprehensive written evaluation by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), which clearly explains why a prefabricated seating system is not sufficient to meet the patient's seating and positioning needs. The PT/OT may have no financial relationship with the supplier.

If a custom fabricated cushion is provided for a patient who does not meet the stated coverage criteria, but the coverage criteria for another type of cushion are met, payment will be based on the allowance for the least costly medically appropriate alternative; if the criteria for another type of cushion are not met, the custom fabricated cushion will be denied as not medically necessary.

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A seat or back cushion that is provided for use with a transport chair (E1037, E1038) will be denied as not medically necessary.

The effectiveness of a powered seat cushion (E2610) has not been established, therefore, it will be denied as not medically necessary.

A prefabricated seat cushion, a prefabricated positioning back cushion, or a brand name custom fabricated seat or back cushion which has not received a written coding verification from the PDAC or which does not meet the criteria stated in the Coding Guidelines section will be denied as not medically necessary.

There is separate payment for a seat cushion solid support base (E2618) with mounting hardware when it is used on an adult manual wheelchair (K0001-K0009, E1161). Code E2618 will be denied as not medically necessary when it is used with a POV or power wheelchair.

**HCPCS Modifiers**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>EY</td>
<td>No physician or other licensed healthcare provider order for this item or service</td>
</tr>
<tr>
<td>KX</td>
<td>Specific required documentation on file</td>
</tr>
</tbody>
</table>

**Seat Cushions**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2601</td>
<td>General use wheelchair seat cushion, width less than 22&quot;, any depth</td>
</tr>
<tr>
<td>E2602</td>
<td>General use wheelchair seat cushion, width 22&quot; or greater, any depth</td>
</tr>
<tr>
<td>E2603</td>
<td>Skin protection wheelchair seat cushion, width less than 22&quot;, any depth</td>
</tr>
<tr>
<td>E2604</td>
<td>Skin protection wheelchair seat cushion, width 22&quot; or greater, any depth</td>
</tr>
<tr>
<td>E2605</td>
<td>Positioning wheelchair seat cushion, width less than 22&quot;, any depth</td>
</tr>
<tr>
<td>E2606</td>
<td>Positioning wheelchair seat cushion, width 22&quot; or greater, any depth</td>
</tr>
<tr>
<td>E2607</td>
<td>Skin protection and positioning wheelchair seat cushion, width less than 22&quot;, any depth</td>
</tr>
<tr>
<td>E2608</td>
<td>Skin protection and positioning wheelchair seat cushion, width 22&quot; or greater, any depth</td>
</tr>
<tr>
<td>E2609</td>
<td>Custom fabricated wheelchair seat cushion, any size</td>
</tr>
<tr>
<td>E2610</td>
<td>Wheelchair seat cushion, powered</td>
</tr>
<tr>
<td>K0734</td>
<td>Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth</td>
</tr>
<tr>
<td>K0735</td>
<td>Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth</td>
</tr>
<tr>
<td>K0736</td>
<td>Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth</td>
</tr>
<tr>
<td>K0737</td>
<td>Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth</td>
</tr>
</tbody>
</table>

**Back Cushions**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2611</td>
<td>General use wheelchair back cushion, width less than 22&quot;, any height, including any type mounting hardware</td>
</tr>
<tr>
<td>E2612</td>
<td>General use wheelchair back cushion, width 22&quot; or greater, any height, including any type mounting hardware</td>
</tr>
<tr>
<td>E2613</td>
<td>Positioning wheelchair back cushion, posterior, width less than 22&quot;, any height, including any type mounting hardware</td>
</tr>
<tr>
<td>E2614</td>
<td>Positioning wheelchair back cushion, posterior, width 22&quot; or greater, any height, including any type mounting hardware</td>
</tr>
<tr>
<td>E2615</td>
<td>Positioning wheelchair back cushion, posterior-lateral, width less than 22&quot;, any height, including any type mounting hardware</td>
</tr>
<tr>
<td>E2616</td>
<td>Positioning wheelchair back cushion, posterior-lateral, width 22&quot; or greater, any height, including any type mounting hardware</td>
</tr>
<tr>
<td>E2617</td>
<td>Custom fabricated wheelchair back cushion, any size, including any type mounting hardware</td>
</tr>
<tr>
<td>E2620</td>
<td>Positioning wheelchair back cushion, planar back w/lateral supports, width &lt; 22&quot;, any height, including any type mounting hardware</td>
</tr>
<tr>
<td>E2621</td>
<td>Positioning wheelchair back cushion, planar back w/lateral supports, width &gt;= 22&quot;, any height, including any type mounting hardware</td>
</tr>
</tbody>
</table>

**Positioning Accessories**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0955</td>
<td>WC accessory, headrest, cushioned, any type, including fixed mounting hardware, each</td>
</tr>
<tr>
<td>E0956</td>
<td>WC accessory, lateral trunk/hip support, any type, including fixed mounting hardware, each</td>
</tr>
<tr>
<td>E0957</td>
<td>WC accessory, medial thigh support, any type, including fixed mounting hardware, each</td>
</tr>
<tr>
<td>E0960</td>
<td>WC accessory, shoulder harness/straps/chest strap, including any type mounting hardware</td>
</tr>
<tr>
<td>E0966</td>
<td>Manual wheelchair accessory, headrest extension, each</td>
</tr>
<tr>
<td>E1028</td>
<td>WC accessory, manual swingaway, retractable/removable mounting hardware for joystick, other control interface/positioning accessory</td>
</tr>
</tbody>
</table>

**Miscellaneous**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9900</td>
<td>Miscellaneous DME supply, accessory, and/or service component of another HCPCS code</td>
</tr>
<tr>
<td>E0992</td>
<td>MWC accessory, solid seat insert</td>
</tr>
<tr>
<td>E2231</td>
<td>MWC accessory, solid seat support base (replaces sling seat), includes any type mounting hardware</td>
</tr>
<tr>
<td>E2291</td>
<td>Back, planar, for pediatric size wheelchair including fixed attaching hardware</td>
</tr>
<tr>
<td>E2292</td>
<td>Seat, planar, for pediatric size wheelchair including fixed attaching hardware</td>
</tr>
<tr>
<td>E2293</td>
<td>Back, contoured, for pediatric size wheelchair including fixed attaching hardware</td>
</tr>
<tr>
<td>E2294</td>
<td>Seat, contoured, for pediatric size wheelchair including fixed attaching hardware</td>
</tr>
<tr>
<td>E2618</td>
<td>WC accessory, solid seat support base (replaces sling seat), for use with MWC or lightweight PWC, includes any type mounting hardware</td>
</tr>
<tr>
<td>E2619</td>
<td>Replacement cover for wheelchair seat cushion or back cushion, each</td>
</tr>
<tr>
<td>K0669</td>
<td>WC accessory, wheelchair seat or back cushion, does not meet specific code criteria or no written coding verification from PDAC</td>
</tr>
</tbody>
</table>
There is no separate payment for a solid insert (E0992) that is used with a seat or back cushion because a solid base is included in the allowance for a wheelchair seat or back cushion.

**ICD-9 Codes that Support Medical Necessity**

The presence of an ICD-9 code listed in this section is not sufficient by itself to assure coverage. Refer to the section on Indications and Limitation of Coverage and/or Medical Necessity for other coverage criteria and payment information.

For HCPCS codes **E2603-E2604, K0734-K0735**:

138 Late Effects of Acute Poliomyelitis
330.0 - 330.9 Leukodystrophy - Unspecified Cerebral Degeneration In Childhood
331.0 Alzheimer's Disease
332.0 Paralysis Agitans (Parkinson's Disease)
335.0 - 335.21 Werdnig-Hoffmann Disease - Progressive Muscular Atrophy
335.23 - 335.9 Pseudobulbar Palsy - Anterior Horn Cell Disease Unspecified
336.0 - 336.3 Syringomyelia And Syringobulbia - Myelopathy In Other Diseases Classified Elsewhere
340 Multiple Sclerosis
341.0 - 341.9 Neuromyelitis Optica - Demyelinating Disease Of Central Nervous System Unspecified
343.0 - 343.9 Congenital Diplegia - Infantile Cerebral Palsy Unspecified
344.00 - 344.4 Quadriplegia Unspecified - Paraplegia
707.03 Decubitus Ulcer, Lower Back
707.04 Decubitus Ulcer, Hip
707.05 Decubitus Ulcer, Buttock
741.00 - 741.93 Spina Bifida Unspecified Region with Hydrocephalus - Spina Bifida Lumbar Region without Hydrocephalus

For HCPCS codes **E0955-E0957, E0960, E2605-E2606, E2613-E2617** and **E2620-E2621**:

138 Late Effects Of Acute Poliomyelitis
330.0 - 330.9 Leukodystrophy - Unspecified Cerebral Degeneration in Childhood
331.0 Alzheimer's Disease
332.0 Paralysis Agitans (Parkinson's Disease)
333.4 Huntington's Chorea
333.6 Idiopathic Torsion Dystonia
333.7 - 333.71 Symptomatic Torsion Dystonia – Athetoid Cerebral Palsy
334.0 - 334.9 Friedreich's Ataxia - Spinocerebellar Disease Unspecified
335.0 - 335.21 Werdnig-Hoffmann Disease - Progressive Muscular Atrophy
335.23 - 335.9 Pseudobulbar Palsy - Anterior Horn Cell Disease Unspecified
336.0 - 336.3 Syringomyelia And Syringobulbia - Myelopathy In Other Diseases Classified Elsewhere
340 Multiple Sclerosis
341.0 - 341.9 Neuromyelitis Optica - Demyelinating Disease Of Central Nervous System Unspecified
342.00 - 342.92 Flaccid Hemiplegia/Hemiparesis, Unspecified Side - Unspecified Hemiplegia/Hemiparesis, Non-dominant Side
343.0 - 343.9 Congenital Diplegia - Infantile Cerebral Palsy Unspecified
344.00 - 344.1 Quadriplegia Unspecified - Paraplegia
344.30 - 344.32 Monoplegia of Lower Limb Affecting Unspecified Side - Monoplegia Of Lower Limb Affecting Non-dominant Side
359.0 Congenital Hereditary Muscular Dystrophy
359.1 Hereditary Progressive Muscular Dystrophy
438.20 - 438.22 Hemiplegia Affecting Unspecified Side - Hemiplegia Affecting Non-dominant Side
438.40 - 438.42 Monoplegia of Lower Limb Affecting Unspecified Side - Monoplegia of Lower Limb Affecting Non-dominant Side
741.00 - 741.93 Spina Bifida Unspecified Region with Hydrocephalus - Spina Bifida Lumbar Region without Hydrocephalus

For HCPCS codes **E2607, E2608, K0736-K0737**

1) One of the following ICD-9 codes:

138 Late Effects of Acute Poliomyelitis
330.0 - 330.9 Leukodystrophy - Unspecified Cerebral Degeneration in Childhood
331.0 Alzheimer's Disease
332.0 Paralysis Agitans (Parkinson's Disease)
335.0 - 335.21 Werdnig-Hoffmann Disease - Progressive Muscular Atrophy
335.23 - 335.9 Pseudobulbar Palsy - Anterior Horn Cell Disease Unspecified
336.0 - 336.3 Syringomyelia And Syringobulbia - Myelopathy In Other Diseases Classified Elsewhere
340 Multiple Sclerosis
341.0 - 341.9 Neuromyelitis Optica - Demyelinating Disease Of Central Nervous System Unspecified
343.0 - 343.9 Congenital Diplegia - Infantile Cerebral Palsy Unspecified
344.00 - 344.1 Quadriplegia Unspecified - Paraplegia
741.00 - 741.93 Spina Bifida Unspecified Region with Hydrocephalus - Spina Bifida Lumbar Region without Hydrocephalus

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2) A combination of ICD-9 code 707.03, 707.04, or 707.05 AND one of the following ICD-9 codes:

- 333.4: Huntington's Chorea
- 333.6: Idiopathic Torsion Dystonia
- 333.7: Symptomatic Torsion Dystonia
- 334.0 - 334.9: Friedreich's Ataxia - Spinocerebellar Disease Unspecified
- 342.00 - 342.92: Flaccid Hemiplegia/Hemiparesis, Unspecified Side - Unspecified Hemiplegia/Hemiparesis Non-dominant Side
- 344.30 - 344.32: Monoplegia of Lower Limb Affecting Unspecified Side - Monoplegia of Lower Limb Affecting Non-dominant Side
- 359.0: Congenital Hereditary Muscular Dystrophy
- 359.1: Hereditary Progressive Muscular Dystrophy
- 438.40 - 438.42: Monoplegia of Lower Limb Affecting Unspecified Side - Monoplegia of Lower Limb Affecting Non-dominant Side

For HCPCS code **E2609**:

- 138: Late Effects Of Acute Poliomyelitis
- 330.0 - 330.9: Leukodystrophy - Unspecified Cerebral Degeneration In Childhood
- 331.0: Alzheimer's Disease
- 332.0: Paralysis Agitans (Parkinson's Disease)
- 333.4: Huntington's Chorea
- 333.6: Idiopathic Torsion Dystonia
- 333.7: Symptomatic Torsion Dystonia
- 334.0 - 334.9: Friedreich's Ataxia - Spinocerebellar Disease Unspecified
- 335.0 - 335.21: Werdnig-Hoffmann Disease - Progressive Muscular Atrophy
- 335.23 - 335.9: Pseudobulbar Palsy - Anterior Horn Cell Disease Unspecified
- 336.0 - 336.3: Syringomyelia And Syringobulbia - Myelopathy In Other Diseases Classified Elsewhere
- 340: Multiple Sclerosis
- 341.0 - 341.9: Neuromyelitis Optica - Demyelinating Disease Of Central Nervous System Unspecified
- 342.00 - 342.92: Flaccid Hemiplegia/Hemiparesis, Unspecified Side - Unspecified Hemiplegia/Hemiparesis, Non-dominant Side
- 343.0 - 343.9: Congenital Diplegia - Infantile Cerebral Palsy Unspecified
- 344.00 - 344.1: Quadriplegia Unspecified - Paraplegia
- 344.30 - 344.32: Monoplegia of Lower Limb Affecting Unspecified Side - Monoplegia of Lower Limb Affecting Non-dominant Side
- 359.0: Congenital Hereditary Muscular Dystrophy
- 359.1: Hereditary Progressive Muscular Dystrophy
- 438.40 - 438.42: Monoplegia of Lower Limb Affecting Unspecified Side - Monoplegia of Lower Limb Affecting Non-dominant Side
- 707.03: Decubitus Ulcer, Lower Back
- 707.04: Decubitus Ulcer, Hip
- 707.05: Decubitus Ulcer, Buttock
- 741.00 - 741.93: Spina Bifida Unspecified Region with Hydrocephalus - Spina Bifida Lumbar Region without Hydrocephalus

For HCPCS codes **E2601, E2602, E2611, E2612, E2618,** and **E2619:** Not Specified

For codes **A9900, E2610,** and **E2619:** None

**Diagnoses that DO NOT Support Medical Necessity**

For the specific HCPCS codes indicated above, all diagnoses that are not specified in the previous section. For HCPCS codes **E2610** and **E2619,** all diagnoses.

**Documentation Requirements**

It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available to the DME MAC upon request.

An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request.

For cushions and positioning accessories provided at the time of initial issue of a power wheelchair, once the supplier has determined the specific power mobility device that is appropriate for the patient based on the physician's order, the supplier must prepare a written document (termed a detailed product description) that lists the specific base (HCPCS code and either a narrative description of the item or the manufacturer name/model) and all options and accessories that will be separately billed. The supplier must list their charge and the Medicare fee schedule allowance for each separately billed item. If there is no fee schedule allowance, the supplier must enter “not applicable”. The physician must sign and date this detailed product description and the supplier must receive it prior to delivery of the PWC. A date stamp or equivalent must be used to document receipt date.
The detailed product description must be available on request.

For items provided other than at the time of initial issue of a power wheelchair, there must be a detailed written order which lists each item which will be separately billed and which is signed and dated by the physician. In these situations, the supplier’s charges and Medicare allowances do not need to be included. This order must be received prior to delivery of cushion.

Items delivered before a signed written order has been received by the supplier must be submitted with an **EY** modifier added to each affected HCPCS code.

The ICD-9 code which justifies the need for these items must be included on the claim.

For a skin protection seat cushion (E2603, E2604, K0734, K0735), a **KX** modifier should be added to the code if either criterion (a), (b), or (c) is met:

a. If there is a past history of or current pressure ulcer in the area of contact with the seating surface; or
b. If there is absent or impaired sensation in the area of contact with the seating surface due to one of the diagnoses listed as a covered diagnosis; or
c. If there is an inability to carry out a functional weight shift due to one of the diagnoses listed as a covered diagnosis.

For a positioning seat cushion (E2613-E2616, E2620, E2621), or positioning accessory (E0956-E0957, E0960), a **KX** modifier should be added to the code if the patient has significant postural asymmetries due to one of the diagnoses listed as a covered diagnosis.

For a headrest (E0955), a **KX** modifier should be added to the code if one of the coverage criteria specified in the Indications and Limitations of Coverage section has been met.

For a combination skin protection and positioning seat cushion (E2607, E2608, K0736, K0737), a **KX** modifier should be added to the code if criterion (a) or (b) or (c) is met and criterion (d) is met:

a. If there is a past history or current pressure ulcer in the area of contact with the seating surface; or
b. If there is absent or impaired sensation in the area of contact with the seating surface due one of the diagnoses listed as a covered diagnosis for skin protection cushions (except 707.03, 707.04, 707.05); or
c. If there is an inability to carry out a functional weight shift due one of the diagnoses listed as a covered diagnosis for skin protection cushions (except 707.03, 707.04, 707.05); and
d. If the patient has significant postural asymmetries due to one of the diagnoses listed as a covered diagnosis for positioning cushions.

For a custom fabricated seat or back cushion (E2609, E2617), a **KX** modifier should be added to the code if criterion (a) is met and criterion (b), (c), or (d) is met:

a. For E2609 or E2617, there is a comprehensive written evaluation by a licensed/certified medical professional, such as a PT or OT (who has no financial relationship with the supplier) which explains why a prefabricated seating system is not sufficient to meet the patient’s seating and positioning needs; and
b. For E2609, there is a past history of or current pressure ulcer in the area of contact with the seating surface; or
c. For E2609, there is absent or impaired sensation in the area of contact with the seating surface or an inability to carry out a functional weight shift due to one of the diagnoses listed as a covered diagnosis for skin protection cushions; or
d. For E2609 or E2617, the patient has significant postural asymmetries due to one of the diagnoses listed for positioning cushions.

When billing for a custom fabricated cushion (E2609, E2617), the claim must include the manufacturer and model name/number of the product (if applicable), or if not, a detailed description of the product that was provided.

**Non-Medical Necessity Coverage And Payment Rules**

For an item addressed in this policy to be covered by Medicare, a written signed and dated order must be received by the supplier prior to delivery of the item. If the supplier delivers the item prior to the receipt of a written order, it will be denied as non-covered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

There is no separate payment for mounting hardware for a seat or back cushion.

There is no separate payment for a wheelchair seat or back cushion when it is used with a rollabout chair (**E1031**).

If foam-in-place or other material is used to fit a substantially prefabricated cushion to an individual patient, the cushion must be billed as a prefabricated cushion, not custom fabricated.

A powered wheelchair seat cushion (**E2610**) is a battery-powered, prefabricated cushion in which an air pump provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the cushion. One type of powered seat cushion is an alternating pressure cushion.
Pediatric seating system codes E2291-E2294 may only be billed with pediatric wheelchair base codes.

A headrest extension (E0966) is a sling support for the head. The code for a seat or back cushion includes any rigid or semi-rigid base or posterior panel, respectively that is an integral part of the cushion.

A solid insert is a separate rigid piece of wood or plastic which is inserted in the cover of a cushion to provide additional support. If a supplier chooses to bill separately for a solid insert used with a seat cushion use code E0992 whether it is a manual or a power wheelchair. Code A9900 must be used for a solid insert used with a back cushion.

A solid support base for a seat cushion is a rigid piece of plastic or other material which is attached with hardware to the seat frame of a wheelchair in place of a sling seat. A cushion is placed on top of the support base. Use code E2231 for a solid support base that is used with a manual wheelchair. A solid support base is included in the allowance for the power wheelchair codes. There should be no separate billing with power wheelchairs.

If a supplier chooses to bill separately for mounting hardware, either nonadjustable or adjustable, for a seat or back cushion or solid support base, code A9900 must be used.

The only products which may be billed using codes E2601-E2608, E2611-E2616, E2620, E2621, and K0734-K0737 and the only brand name products that may be billed using codes E2609 or E2617 are those products for which a written coding verification has been made by PDAC. Information concerning the documentation that must be submitted to the PDAC for a Coding Verification Request can be found on the PDAC web site or by contacting the PDAC. A Product Classification List with products which have received a coding verification can be found on the PDAC web site.

If a non-powered, prefabricated seat cushion, a prefabricated back cushion, or a brand name custom fabricated seat or back cushion has not received a written coding verification from the PDAC or if it is determined that the cushion does not meet the criteria for the code, it must be billed with code K0669.

Pediatric size positioning accessories are billed with the codes described in this policy. Codes E1025-E1027 (lateral thoracic and lateral/anterior supports) are invalid for claim submission.

Code E1028 (swingaway or removable mounting hardware upgrade) may be billed in addition to codes E0955-E0957. It must not be billed in addition to code E0960. It must not be used for mounting hardware related to a wheelchair seat cushion or back cushion code.
Common Abbreviations and Acronyms

/ Or
< Less Than
≤ Less Than or Equal To
> Greater Than
≥ Greater Than or Equal To
ABN Advance Beneficiary Notice
ADMC Advance Determination of Medicare Coverage
ALJ Administrative Law Judge
ANSI American National Standards Institute
AOB Assignment of Benefits
BBA Balanced Budget Act
CIM Coverage Issue Manual
CMN Certificate of Medical Necessity
CMR Comprehensive Medical Review
CMS Centers for Medicare and Medicaid Services
COB Coordination of Benefits
CWF Common Working File
DHHS Department of Health and Human Services
DME Durable Medical Equipment
DMEPOS Durable Medical Equipment, Prosthetics, Orthotics and Supplies
DME MAC Durable Medical Equipment Medicare Administrative Contractor
DO Doctor of Osteopathy
DPM Doctor of Podiatric Medicine
DRG Diagnosis Related Groups
DX Diagnosis
ECF Extended Care Facility
EDI Electronic Data Interchange
EFT Electronic Funds Transfer
Ein Employer Identification Number
EOB Explanation of Benefits
EOMB Explanation of Medicare Benefits
ERN Electronic Remittance Notice
ESRD End Stage Renal Disease
FDA Food and Drug Administration
HCPCS Healthcare Common Procedure Coding System
HHA Home Health Agency
HHS Health and Human Services
HICN Health Insurance Claim Number
HIPAA Health Insurance Portability and Accountability Act
HMO Health Maintenance organization
HO Hearing Office
HPSA Health Professional Shortage Area
ICD-9-CM International Classification of Diseases, Clinical Modification, 9th Revision
ICF Intermediate Care Facility
ICN Internal Claim Number
ICU Intensive Care Unit
IRP Inexpensive or Routinely Purchased
L Left
Lbs Pounds
LMRP Local Medical Review Policies
LPN Licensed Practical Nurse
MCM Medicare Carriers Manual
MedPAC Medicare Payment Advisory Commission
MSN Medicare Summary Notice
MSP Medicare Secondary Payor
NCI National Cancer Institute
NEC Not Elsewhere Classified
NF Nursing Facility
NH Nursing Home
NOC Not Otherwise Classified
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>NON-PAR</td>
<td>Non-Participating Provider</td>
</tr>
<tr>
<td>NOS</td>
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</tr>
<tr>
<td>NSC</td>
<td>National Supplier Clearinghouse</td>
</tr>
<tr>
<td>NSF</td>
<td>National Standard Format</td>
</tr>
<tr>
<td>OBRA</td>
<td>Omnibus Budget Reconciliation Act</td>
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<tr>
<td>OIG</td>
<td>Office of the Inspector General</td>
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<tr>
<td>OPPS</td>
<td>Outpatient Prospective Payment System</td>
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<td>PA</td>
<td>Prior Authorization</td>
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<td>Physician's Assistant</td>
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<td>Remittance Advice</td>
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<td>Regional Medical Review Policies</td>
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<tr>
<td>PDAC</td>
<td>Pricing, Data Analysis and Coding Contractor</td>
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<tr>
<td>SGD</td>
<td>Speech Generated Device</td>
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<tr>
<td>SNF</td>
<td>Skilled Nursing Facility</td>
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<td>SSA</td>
<td>Social Security Administration</td>
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<td>Social Security Number</td>
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<td>UPIN</td>
<td>Unique Provider Identification Number</td>
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<td>VA</td>
<td>Veteran's Affairs</td>
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<td>WC</td>
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<td>Without</td>
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<tr>
<td>WOPD</td>
<td>Written Order Prior to Delivery</td>
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Dear Physician,

In order for Medicare to provide reimbursement for a power wheelchair (PWC) or power operated vehicle (POV) (scooter), there are several statutory requirements that must be met:

1. There must be an in-person visit with a physician specifically addressing the patient’s mobility needs.
2. There must be a history and physical examination by the physician or other medical professional (see below) focusing on an assessment of the patient's mobility limitation and needs. The results of this evaluation must be recorded in the patient's medical record.
3. A prescription must be written AFTER the in-person visit has occurred and the medical evaluation is completed. This prescription has seven required elements (see below).
4. The prescription and medical records documenting the in-person visit and evaluation must be sent to the equipment supplier within 45 days after the completion of the evaluation.

The in-person visit and mobility evaluation together are often referred to as the “face-to-face examination.”

The complete history and physical examination typically includes:

History of the present condition(s) and past medical history that are relevant to the patient’s mobility needs in the home:

- Symptoms that limit ambulation
- Diagnoses that are responsible for these symptoms
- Medications or other treatment for these symptoms
- Progression of ambulation difficulty over time
- Other diagnoses that may relate to ambulatory problems
- How far the patient can walk without stopping and with what assistive device, such as a cane or walker
- Pace of ambulation
- History of falls, including frequency, circumstances leading to falls, and why a walker isn’t sufficient
- What ambulatory assistance (cane, walker, wheelchair) is currently used and why it isn’t sufficient
- What has changed to now require use of a power mobility device
- Ability to use a manual wheelchair
- Reasons why a power operated vehicle (scooter) would not be sufficient for this patient’s needs in the home
- Description of the home setting and the ability to perform activities of daily living in the home
- Physical examination that is relevant to the patient's mobility needs
  - Weight and height
  - Cardiopulmonary examination
  - Musculoskeletal examination
    - Arm and leg strength and range of motion
  - Neurological examination
    - Gait
    - Balance and coordination
  - If the patient is capable of walking, the report should include documented observation of ambulation (with use of a cane or walker, if appropriate)

Examples of vague or subjective descriptions of the patient’s mobility limitations include:

- upper extremity weakness
- poor endurance
- gait instability
- weakness
- abnormality of gait
- difficulty walking
- SOB on exertion
- pain
- fatigue
- deconditioned

These types of statements are insufficient and do not objectively address the mobility limitation or provide a clear picture of the patient's mobility deficits. Objective measurements should be provided.

The evaluation should be tailored to the individual patient's conditions. The history should paint a picture of your 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.
It is important to keep in mind that because of the way that the Social Security Act defines durable medical equipment, a power mobility device is covered by Medicare only if the beneficiary has a mobility limitation that significantly impairs his/her ability to perform activities of daily living within the home. If the wheelchair/POV is needed in the home, the beneficiary may also use it outside the home. However, in your evaluation you must clearly distinguish your patient's mobility needs within the home from their needs outside the home.

You may elect to refer the patient to another medical professional, such as a physical therapist or occupational therapist, to perform part of the evaluation – as long as that individual has no financial relationship with the wheelchair supplier. However, you do have to personally see the patient before or after the PT/OT evaluation. You must review the report, indicate your agreement in writing on the report, and sign and date the report. If you do not see the patient after the PT/OT evaluation, the date that you sign the report is considered to be the date of completion of the face-to-face examination.

You should record the visit and mobility evaluation in your usual medical record-keeping format. Many suppliers provide forms for you to complete. Suppliers often try to create the impression that these documents are a sufficient record of the in-person visit and medical evaluation. Based upon our auditing experience, most of them are not. That is because they typically contain check-off boxes or space for only brief answers and thus do not provide enough detailed information about the patient's ambulatory abilities and limitations to allow the Medicare contractor to determine if coverage criteria have been met. Forms such as those developed by the Texas or Florida Academy of Family Physicians are designed to gather selected bits of information and are almost always insufficient. What is required is a thorough narrative description of your patient's current condition, past history, and pertinent physical examination that clearly describes their mobility needs in the home and why a cane, walker, or optimally configured manual wheelchair is not sufficient to meet those needs.

You may write a prescription for a power mobility device ONLY after the visit and examination are complete. This prescription must contain the following seven elements:

1. Beneficiary's name
2. Description of the item that is ordered. This may be general – e.g., “POV”, “PWC”, or “PMD”– or may be more specific.
3. Date of completion of the face-to-face examination
4. Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
5. Length of need
6. Physician's signature
7. Date of physician signature

You must forward a copy of the face-to-face evaluation and your seven-element prescription to the supplier within 45 days from the completion of the face-to-face mobility exam. You should also include copies of previous notes, consultations with other physicians, and reports of pertinent laboratory, x-ray, or other diagnostic tests if they will help to document the severity of your patient's ambulatory problems.

After the supplier receives your order and the face-to-face information, they will prepare a detailed product description that describes the item(s) being provided including all options and accessories. You should review it and, if you agree with what is being provided, sign, date and return it to the supplier. If you do not agree with any part of the detailed product description, you should contact the supplier to clarify what you want the beneficiary to receive.

This information is not intended to serve as a substitute for the complete DME MAC local coverage determination on Power Mobility Devices. It is only a synopsis detailing the highlights of documentation. Refer to the complete LCD and Policy Article on the CMS Web site at http://www.cms.gov/mcd/overview.asp?from2=overview.asp& for additional information.

Medicare does provide you additional reimbursement (HCPCS code G0372) to recognize the additional time and effort that are required to provide this documentation to the supplier. This code is payable in addition to the reimbursement for your E&M visit code.

Your participation in this process and cooperation with the supplier will allow your patient to receive the most appropriate type of mobility equipment. We appreciate all your efforts in providing quality services to your Medicare patients.

Sincerely,

Paul J. Hughes, M.D. Medical Director, DME MAC, Jurisdiction A
Adrian M. Oleck, M.D. Medical Director, DME MAC, Jurisdiction B
Robert D. Hoover, Jr., MD, MPH, FACP Medical Director, DME MAC, Jurisdiction C
Richard W. Whitten, MD, MBA, FACP Medical Director, DME MAC, Jurisdiction D
DME Terminology

**ABN (Advanced Beneficiary Notice)** - a document indicating that the supplier has reason to believe that Medicare will not cover the piece of equipment or supply being given to a patient. It must list the item(s) and the reason(s) it will not be covered and be signed and dated by the patient (or a representative) before delivery of the item.

**ANSI (American National Standards Institute)** – responsible for the standard remark codes that are used on all Medicare Explanations of Benefits.

**AOB (Assignment of Benefits)** - a document that must be signed and dated by a patient before a supplier can bill Medicare for an assigned claim. It allows Medicare to pay the supplier directly and indicates that the supplier will not bill any more to the patient than his/her deductible and/or copay.

**Appeal** – request to Medicare to reconsider their decision on a particular claim.

**ARU (Automated Response Unit)** – automated telephone system used by DME MAC's to help the caller obtain claim status information.

**Assigned** - the supplier agrees to accept Medicare's allowable.

**Beneficiary** - a patient receiving Medicare benefits.

**Capped Rental** - type of rental specific to Medicare.

**CMN (Certificate of Medical Necessity)** - a document required by Medicare for certain items. It is signed by the patient's physician and indicates what the item(s) is/are and has questions that the doctor answers about the patient's medical condition and need for the item.

**COB (Coordination of Benefits)** – CMS' program to help correctly determine what each patient's insurers are in order to avoid incorrect payments by Medicare.

**Cover Letter** – a letter written by a supplier describing the attached CMN or doctor's order.

**CSI (Claims Status Inquiry)** – on online system provided by the DME MAC where suppliers can check the status of claims that they have billed.

**CWF (Common Working File)** – CMS' database of information on their beneficiaries, including insurance specifics, date of death and CMNs.

**DCN (Document Control Number)** – a reference number assigned to each claim by the DME MAC. This should be included in all correspondence about each particular claim.

**DME (Durable Medical Equipment)** – the DME MAC has certain criteria for what DME (or HME) is: it must be able to be used repeatedly; it must be used for a medical purpose, and is something that is not usually used if the patient is not sick or injured; and it must be used in the home.

**DME MAC (Durable Medical Equipment Regional Carrier)** – one of four different insurance companies that has contracted with HCFA to process claims for durable medical equipment.

**Doctor's Order** – a prescription written (or signed) by a physician.

**EDI (Electronic Data Interchange)** – system through which claims can be submitted electronically to DME MAC's.

**EFT (Electronic Funds Transfer)** – payments from the DME MAC are automatically transferred to the supplier's bank account.

**EGHP (Employer Group Health Plan)** – health insurance coverage through the patient's employer or the patient's spouse's employer.

**EOMB (Explanation of Medicare Benefits)** – a report of claims that have processed by the DME MAC, including payment amounts and denial codes.

**ERN (Electronic Remittance Notice)** – a report of processed claims that can be downloaded electronically to your software system, eliminating manual posting of payments.

**Fair Hearing** – the second step in the DME MAC appeals process. Claims must total more than $100 and must have already gone to review before a fair hearing can take place. Can be held in person, on the telephone or based on what's in the patient's file.

**HCPCS (Healthcare Common Procedure Coding System)** – developed by HCFA to standardize the codes used for processing Medicare claims. Each piece of equipment or supply is to be billed with a specific code that must be used when billing the DME MAC.
**HME (Home Medical Equipment)** – see durable medical equipment (DME).

**Medicare HMO** – a contracted health maintenance organization that enrolls Medicare patients and provides benefits to them, instead of traditional Medicare. Patient may enroll and withdraw from HMO’s at any time. The HMO and not the DME MAC processes claims.

**Medigap** – insurance secondary to Medicare that covers the patient’s Medicare copay and/or deductible.

**MOA (Medicare Outpatient Adjudication)** – “M” codes listed on EOMBs - represent general Medicare remark codes and are defined at the end of each EOMB.

**Modifier** – two letter code that indicates something specific about a code to the DME MAC.

**MSN (Medicare Summary Notice)** – report sent to beneficiaries indicating what claims have been submitted and how these claims were processed.

**MSP (Medicare as Secondary Payer)** – type of processing done when the patient has other insurance primary to Medicare. HCFA is responsible for determining when Medicare is primary or secondary.

**Non-Assigned** – the supplier has not agreed to accept Medicare’s allowable and patient is responsible for payment to the supplier.

**Nonparticipating Provider/Supplier** – provider that has not signed a contract with the NCS to accept assignment on all claims. This provider may choose whether to accept assignment on a claim-by-claim basis.

**NSC (National Supplier Clearinghouse)** – the HCFA division that assigns supplier numbers to DME suppliers so that they may bill DME MAC’s. Also responsible for maintaining data on suppliers, reenrolling providers and helping with the investigation of fraud and abuse.

**OIG (Office of Inspector General)** – part of the Department of Health and Human Services responsible for working with Medicare’s fraud units to investigate fraud and abuse of the Medicare system.

**Participating Provider/Supplier** – provider that has signed an agreement with the NSC indicating that he will accept assignment on all claims that he bills for that particular year.

**Prior Authorization** – Medicare will authorize the payment on certain items based on a completed CMN and medical necessity.

**Review** – the first step in the appeals process; a written request for a second examination of a denied claim.

**PDAC (Pricing and Data Analysis Contractor)** – performs data analysis on Medicare claims and helps suppliers in using the HCPCS system. It is the place to call when you do not know the correct code to use for a product.


**UPIN (Unique Physician Identification Number)** – individual number assigned to each provider for billing Medicare.
# Home Accessibility Assessment

*(NOTE: Supplier or practitioner MUST perform in-home assessment for power mobility device.)*

<table>
<thead>
<tr>
<th>Patient Name: ________________________________</th>
<th>Date of Assessment: ________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Address: ______________________________</td>
<td></td>
</tr>
</tbody>
</table>

Describe outside accessibility (paved, gravel, dirt):
____________________________________________________________________________________________________________________________________________________

Describe the type of environment in which the patient resides (ranch, apartment, assisted living). Be sure to give descriptive details:
____________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________

Provide details regarding floor surfaces, accessibility and maneuvering space for each of the following:

<table>
<thead>
<tr>
<th>AREA</th>
<th>ACCESSIBLE</th>
<th>DOORWAY MEASUREMENTS</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Room</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Bedroom</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Hallways</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Kitchen</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Bathroom</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Entrance</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

If an area is not accessible, how will the patient/caregiver offset the lack of access (i.e. cannot get into bathroom, but there is a bedside commode in bedroom)? Please describe in detail:
____________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________

Recommendations:
____________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________

Patient is able to enter and exit the home safely?  
Yes   No

Patient and/or caregiver are willing and able to use the mobility device safely and adequately to assist with MRADLs in the home?  
Yes   No

Patient and/or caregiver were educated on care and safety with use of the proposed equipment?  
Yes   No

Print Name of Person Completing Assessment Title
________________________________________________________________________
<table>
<thead>
<tr>
<th>Signature of Person Completing Assessment</th>
<th>Date completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Patient/Caregiver</td>
<td>Date</td>
</tr>
</tbody>
</table>
Manual Wheelchair Documentation Checklist

Required Documentation in Supplier’s File

Claims for All Manual Wheelchairs
Documentation of Verbal Order (if item is dispensed based on a verbal order) that Contains:

☐ Description of the item
☐ Name of the beneficiary
☐ Name of the physician
☐ Start date of the order

Valid Written Order That Contains:

☐ Beneficiary’s name
☐ Detailed description of the item(s) to be dispensed
☐ The treating physician’s signature
☐ The date the treating physician signed the order
☐ The start date of the order - only required if the start date is different than the signature date

NOTE: Suppliers should not submit claims to the DME MAC prior to obtaining a valid written order. Items billed to the DME MAC before a signed and dated order has been received must be submitted with modifier EY.

Medical Records documenting that all of the following criteria are met:

☐ The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs in the home; AND
☐ The mobility deficit cannot be sufficiently resolved by using a cane, crutches or walker; AND
☐ The patient is able to safely use the manual wheelchair; AND
☐ The functional mobility deficit can be sufficiently resolved by use of a manual wheelchair.

Note: It is expected that the patient’s medical records will reflect the need for the care provided. These records are not routinely submitted to the DME MAC but must be available upon request. Therefore, while it is not a requirement, it is a recommendation that suppliers obtain and review the appropriate medical records and maintain a copy in the beneficiary’s file.

The patient’s file must also include documentation of the following:

☐ Beneficiary Authorization
☐ Proof of Delivery

Claims for a Standard Hemi-Wheelchair (K0002)
The patient's medical record* supports that the patient requires a lower seat height (17” to 18”) because of:

☐ Short Stature, OR
☐ Need to place his/her feet on the ground for propulsion.

Claims for a Lightweight Wheelchair (K0003)
The patient's medical record* supports that the patient:

☐ Cannot self-propel in a standard wheelchair using arms and/or legs; AND
☐ Can and does self-propel in a lightweight wheelchair.
Claims for a High Strength Lightweight Wheelchair (K0004)
The patient’s medical record* supports that the patient:

☐ Self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair; AND/OR
☐ Requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair and spends at least two hours per day in the wheelchair.

Claims for an Ultralightweight Wheelchair (K0005)
Payment is determined on an individual consideration basis. If the DME MAC requests documentation of the medical necessity for a K0005, the documentation must include all of the following:

☐ A description of the patient’s routine activities,
☐ The types of activities the patient frequently encounters,
☐ Information concerning whether or not the patient is fully independent in the use of the wheelchair, and
☐ A description of the features of the K0005 base which are needed compared to the K0004 base.

Claims for a Heavy Duty Wheelchair (K0006)
The patient’s medical record* supports that the patient:

☐ Weighs more than 250 pounds; OR
☐ Has severe spasticity.

Claims for an Extra Heavy Duty Wheelchair (K0007)
The patient’s medical record* supports that the patient:

☐ Weighs more than 300 pounds.

Claims for a K0009 (Other Manual Wheelchair Base)
Payment is determined on an individual consideration basis. The claim must include:

☐ Manufacturer,
☐ The product name/number, and
☐ Information justifying the medical necessity for the item. (This documentation might include the patient’s diagnosis, the patient’s abilities and limitations as they relate to the equipment, the duration of the condition, the expected prognosis and past experience using similar equipment.

Billing Reminders
Manual wheelchairs described by codes E1161, E1231 – E1234, K0005 and K0009 are eligible for Advance Determination of Medicare Coverage (ADMC).
### HCPCS Modifiers for DME

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BP</strong></td>
<td>Purchase option, beneficiary decided to purchase capped rental item. The beneficiary has been informed of the purchase and rental options and has elected to purchase the item. Used with the first month claim for an electric wheelchair and the 10th, 11th, or 12th capped rental claim to indicate that the beneficiary has accepted the purchase of the equipment. Rental will continue until the 13th month. At the onset of the 13th month, the supplier will transfer ownership to the beneficiary.</td>
</tr>
<tr>
<td><strong>BU</strong></td>
<td>Purchase option, beneficiary did not respond. The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision. Used with the 10th, 11th, or 12th capped rental claim to indicate that the supplier has notified the beneficiary of the option to purchase the equipment, however, the beneficiary has failed to respond.</td>
</tr>
<tr>
<td><strong>BR</strong></td>
<td>Purchase option, beneficiary elected to rent. The beneficiary has been informed of the purchase and rental options and has elected to rent the item. Used with the 10th, 11th, or 12th capped rental claim to indicate that the beneficiary has declined the purchase option. The capped rental payment will continue until the 15th month.</td>
</tr>
<tr>
<td><strong>CC</strong></td>
<td>Procedure code change. Used by the carrier when the procedure code submitted was changed either for administrative reasons or because an incorrect procedure code was filed.</td>
</tr>
<tr>
<td><strong>EY</strong></td>
<td>No physician or other licensed health care provider order for this item or service</td>
</tr>
<tr>
<td><strong>GA</strong></td>
<td>A waiver of liability statement is on file. Used when an item or service is expected to be denied as not reasonable and necessary, and an ABN is on file.</td>
</tr>
<tr>
<td><strong>GK</strong></td>
<td>Indicates that the item was ordered by the physician, and is used in upgrade situations when an ABN may be applicable.</td>
</tr>
<tr>
<td><strong>GL</strong></td>
<td>Medically unnecessary upgrade provided instead of standard item, no charge, no ABN</td>
</tr>
<tr>
<td><strong>GY</strong></td>
<td>Item or service statutorily excluded or does not meet the definition of any Medicare benefit.</td>
</tr>
<tr>
<td><strong>GZ</strong></td>
<td>Item or service expected to be denied as not reasonable and necessary. Used when an Advance Beneficiary Notice is not on file.</td>
</tr>
<tr>
<td><strong>KA</strong></td>
<td>Add-on option to be used with wheelchair codes</td>
</tr>
<tr>
<td><strong>KC</strong></td>
<td>Replacement of special power wheelchair interface</td>
</tr>
<tr>
<td><strong>KH</strong></td>
<td>Initial claim, purchase (electric wheelchair) or first month capped rental and/or PEN pumps</td>
</tr>
<tr>
<td><strong>KI</strong></td>
<td>Second or third month rental, capped rental items and/or PEN pumps</td>
</tr>
<tr>
<td><strong>KJ</strong></td>
<td>Months four to fifteen, capped rental items and/or PEN pumps</td>
</tr>
<tr>
<td><strong>KR</strong></td>
<td>Rental item – billing for partial month.</td>
</tr>
<tr>
<td><strong>KS</strong></td>
<td>Used when filing diabetic supplies for non-insulin treated diabetes. Indicates that the supplier has an order on file.</td>
</tr>
<tr>
<td><strong>KX</strong></td>
<td>Specific requirements found in the Documentation section of the Medical Policy have been met, and are available in the supplier's record.</td>
</tr>
<tr>
<td><strong>NU</strong></td>
<td>New equipment purchase. Used when purchasing new equipment.</td>
</tr>
<tr>
<td><strong>RA</strong></td>
<td>Replacement of a DME item</td>
</tr>
<tr>
<td><strong>RB</strong></td>
<td>Replacement of a part of DME furnished as part of a repair</td>
</tr>
<tr>
<td><strong>RR</strong></td>
<td>Initial rental. Use the -RR modifier when DME is to be rented.</td>
</tr>
<tr>
<td><strong>UE</strong></td>
<td>Used equipment purchase. Used for purchase of used equipment and for any purchase on ASSIGNED claims when no indication of new or used equipment is submitted with the claim.</td>
</tr>
</tbody>
</table>

**Note:** Pricing modifiers are to be listed first after the HCPCS code on the CMS-1500 form in Item 24D.
Group 1 Power Operated Vehicle

K0800
Lynx L-3
Lynx L-3X
Lynx L-4

Basic Coverage Criteria
- Patient has a mobility limitation that impairs his/her ability to perform 1 or more MRADLs
- The limitation cannot be resolved with a cane or walker
- Patient doesn’t have sufficient UE function to operate a MWC in the home

POV Coverage Criteria
- The patient is able to:
  - Safely transfer to and from a POV, and
  - Operate the tiller steering system, and
  - Maintain postural stability and position while operating the POV in the home.
- The patient’s mental capabilities (e.g., cognition) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home.
- The patient’s home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided.
- The patient’s weight is less than or equal to the weight capacity of the POV that is provided.
- Use of a POV will significantly improve the patient’s ability to participate in MRADLs and the patient will use it in the home.
- The patient has not expressed an unwillingness to use a POV in the home.

Documentation Requirements
- Written order from physician or treating practitioner (including all 7 elements)
- Face-to-Face exam documentation from ordering physician or treating practitioner
- Detailed product description signed by ordering physician or treating practitioner
- Home assessment by supplier (there must be a document showing this was completed)
- Signed attestation stating there is no financial interest between supplier and therapist, if PT/OT participation in the face-to-face exam documentation is to be considered.

Miscellaneous
- Written order and face-to-face documentation must be received within 45 days of the F2F exam
- Written order, face-to-face documentation and signed detailed product description must be received prior to delivering the power wheelchair
- All information received from the physician or treating practitioner must be date stamped
- Delivery of the power wheelchair must take place within 120 days of the face-to-face exam
- Use KX modifier when all coverage criteria has been met.

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Group 2 No Power Options

K0822  K0823  K0825
Nutron R51  Pronto M41  TDXSIV-HD
Nutron R51LXP  Pronto M51-P
P9000XDT  TDXSCV
Pronto M41R  TDXSIV-2
Pronto M51-PR  TDXSIV-2-S
TDXSI-2
TDXSI-2-S  K0824  TDXSI-HD
K0830  K0831
Nutron R51LXP  Pronto M51-P
P9000XDT  TDXSCV
Pronto M41R  TDXSIV-2
Pronto M51-PR  TDXSIV-2-S
TDXSI-2
TDXSI-2-S
M61-R
M61

Basic Coverage Criteria
• Patient has a mobility limitation that impairs his/her ability to perform 1 or more MRADLs
• The limitation cannot be resolved with a cane or walker
• Patient doesn't have sufficient UE function to operate a MWC in the home

Rule Out Scooter/POV
• The patient cannot transfer to and from a POV, operate the tiller on a POV or maintain stability and position while operating a POV; or
• The patient’s mental and physical capabilities are insufficient to operate a POV in the home; or
• The patient’s home does not provide adequate access, space or surfaces to operate a POV in the home

Power Wheelchair Coverage Criteria
• The patient has the mental/physical capabilities to safely operate the power wheelchair provided; or
• The patient has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair provided; and
• The patient’s weight is less than or equal to the weight capacity of the power wheelchair that is provided; and
• The patient’s home provides adequate access, maneuvering space, and surfaces for the operation of the power wheelchair that is provided; and
• Use of a power wheelchair will significantly improve the patient’s ability to participate in MRADLs and the patient will use it in the home; and
• The patient has not expressed an unwillingness to use a power wheelchair in the home

Documentation Requirements
• Written order from physician or treating practitioner (including all 7 elements)
• Face-to-Face exam documentation from ordering physician or treating practitioner
• Detailed product description signed by ordering physician or treating practitioner
• Home assessment by supplier (there must be a document showing this was completed)
• Signed attestation stating there is no financial interest between supplier and therapist, if PT/OT participation in the face-to-face exam documentation is to be considered

Miscellaneous
• Written order and face-to-face documentation must be received within 45 days of the F2F exam
• Written order, face-to-face documentation and signed detailed product description must be received prior to delivering the power wheelchair
• All information received from the physician or treating practitioner must be date stamped
• Delivery of the power wheelchair must take place within 120 days of the face-to-face exam
• Use KX modifier on the wheelchair base and accessories when all coverage criteria has been met.
Basic Coverage Criteria
- Patient has a mobility limitation that impairs his/her ability to perform 1 or more MRADLs
- The limitation cannot be resolved with a cane or walker
- Patient doesn’t have sufficient UE function to operate a MWC in the home

Rule Out Scooter/POV
- The patient cannot transfer to and from a POV, operate the tiller on a POV or maintain stability and position while operating a POV; or
- The patient’s mental and physical capabilities are insufficient to operate a POV in the home; or
- The patient’s home does not provide adequate access, space or surfaces to operate a POV in the home

Power Wheelchair Coverage Criteria
- The patient has the mental/physical capabilities to safely operate the power wheelchair provided; or
- The patient has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair provided; and
- The patient’s weight is less than or equal to the weight capacity of the power wheelchair that is provided; and
- The patient’s home provides adequate access, maneuvering space, and surfaces for the operation of the power wheelchair that is provided; and
- Use of a power wheelchair will significantly improve the patient’s ability to participate in MRADLs and the patient will use it in the home; and
- The patient has not expressed an unwillingness to use a power wheelchair in the home

Additional Coverage Criteria
- The patient requires a drive control interface other than a hand or chin-operated standard proportional joystick; or
- The patient meets coverage criteria for a power tilt or recline seating system and the system is being used on the wheelchair; and
- The patient has had a specialty evaluation performed by a PT/OT, or physician who documents the medical necessity for the wheelchair and its special features.

Documentation Requirements
- Written order from physician or treating practitioner (including all 7 elements)
- Face-to-Face exam documentation from ordering physician or treating practitioner
- Detailed product description signed by ordering physician or treating practitioner
- Specialty evaluation by PT/OT which provides medical justification for separately billable accessories
- Home assessment by supplier (there must be a document showing this was completed)
- Signed attestation stating there is no financial interest between supplier and therapist, if PT/OT participation in the face-to-face exam documentation is to be considered
- Documentation that a supplier employed ATS/ATP was directly involved in the wheelchair selection

Miscellaneous
- Written order and face-to-face documentation must be received within 45 days of the F2F exam
- Written order, face-to-face documentation and signed detailed product description must be received prior to delivering the power wheelchair
- All information received from the physician or treating practitioner must be date stamped
- Delivery of the power wheelchair must take place within 120 days of the face-to-face exam
- Use KX modifier on the wheelchair base and accessories when all coverage criteria has been met.
Group 3 No Power Options

<table>
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<td>TDXSI</td>
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</table>

Basic Coverage Criteria
- Patient has a mobility limitation that impairs his/her ability to perform 1 or more MRADLs
- The limitation cannot be resolved with a cane or walker
- Patient doesn't have sufficient UE function to operate a MWC in the home

Rule Out Scooter/POV
- The patient cannot transfer to and from a POV, operate the tiller on a POV or maintain stability and position while operating a POV; or
- The patient's mental and physical capabilities are insufficient to operate a POV in the home; or
- The patient's home does not provide adequate access, space or surfaces to operate a POV in the home

Power Wheelchair Coverage Criteria
- The patient has the mental/physical capabilities to safely operate the power wheelchair provided; or
- The patient has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair provided; and
- The patient's weight is less than or equal to the weight capacity of the power wheelchair that is provided; and
- The patient's home provides adequate access, maneuvering space, and surfaces for the operation of the power wheelchair that is provided; and
- Use of a power wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it in the home; and
- The patient has not expressed an unwillingness to use a power wheelchair in the home

Additional Coverage Criteria
- The patient's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and
- The patient has had a specialty evaluation performed by a PT/OT, or physician who documents the medical necessity for the wheelchair and its special features.

Documentation Requirements
- Written order from physician or treating practitioner (including all 7 elements)
- Face-to-Face exam documentation from ordering physician or treating practitioner
- Detailed product description signed by ordering physician or treating practitioner
- Specialty evaluation by PT/OT which provides medical justification for separately billable accessories
- Home assessment by supplier (there must be a document showing this was completed)
- Signed attestation stating there is no financial interest between supplier and therapist, if PT/OT participation in the face-to-face exam documentation is to be considered
- Documentation that a supplier employed ATS/ATP was directly involved in the wheelchair selection

Miscellaneous
- Written order and face-to-face documentation must be received within 45 days of the F2F exam
- Written order, face-to-face documentation and signed detailed product description must be received prior to delivering the power wheelchair
- All information received from the physician or treating practitioner must be date stamped
- Delivery of the power wheelchair must take place within 120 days of the face-to-face exam
- Use KX modifier on the wheelchair base and accessories when all coverage criteria has been met.
Group 3 Single Power Option

K0856
Pronto M91-TS TDXSPREE-CG
TDXSI-CG 3G Torque 3 (3GTQ3-CG)
TDXSP-CG FDX-CG
TDXSP-CG-GT

K0858
Pronto M91-M HD
Pronto M91-TS HD
TDXSP-CG HD

Basic Coverage Criteria
• Patient has a mobility limitation that impairs his/her ability to perform 1 or more MRADLs
• The limitation cannot be resolved with a cane or walker
• Patient doesn’t have sufficient UE function to operate a MWC in the home

Rule Out Scooter/POV
• The patient cannot transfer to and from a POV, operate the tiller on a POV or maintain stability and position while operating a POV; or
• The patient’s mental and physical capabilities are insufficient to operate a POV in the home; or
• The patient’s home does not provide adequate access, space or surfaces to operate a POV in the home

Power Wheelchair Coverage Criteria
• The patient has the mental/physical capabilities to safely operate the power wheelchair provided; or
• The patient has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair provided; and
• The patient’s weight is less than or equal to the weight capacity of the power wheelchair that is provided; and
• The patient’s home provides adequate access, maneuvering space, and surfaces for the operation of the power wheelchair that is provided; and
• Use of a power wheelchair will significantly improve the patient’s ability to participate in MRADLs and the patient will use it in the home; and
• The patient has not expressed an unwillingness to use a power wheelchair in the home

Additional Coverage Criteria
• The patient’s mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and
• The patient requires a drive control interface other than a hand or chin-operated standard proportional joystick; or
• The patient meets coverage criteria for a power tilt or recline seating system and it is being used on the wheelchair; and
• The patient has had a specialty evaluation performed by a PT/OT, or physician who documents the medical necessity for the wheelchair and its special features

Documentation Requirements
• Written order from physician or treating practitioner (including all 7 elements)
• Face-to-Face exam documentation from ordering physician or treating practitioner
• Detailed product description signed by ordering physician or treating practitioner
• Specialty evaluation by PT/OT which provides medical justification for separately billable accessories
• Home assessment by supplier (there must be a document showing this was completed)
• Signed attestation stating there is no financial interest between supplier and therapist, if PT/OT participation in the face-to-face exam documentation is to be considered
• Documentation that a supplier employed ATS/ATP was directly involved in the wheelchair selection

Miscellaneous
• Written order and face-to-face documentation must be received within 45 days of the F2F exam
• Written order, face-to-face documentation and signed detailed product description must be received prior to delivering the power wheelchair
• All information received from the physician or treating practitioner must be date stamped
• Delivery of the power wheelchair must take place within 120 days of the face-to-face exam
• Use KX modifier on the wheelchair base and accessories when all coverage criteria has been met.
Group 3 Multiple Power Options

K0861
TDXSP-MCG
3G Ranger X (3GRX-CG)
3G Torque 3 (3GTQ3-MCG)
FDX-MCG

K0862
TDXSP-MCG HD

Basic Coverage Criteria
- Patient has a mobility limitation that impairs his/her ability to perform 1 or more MRADLs
- The limitation cannot be resolved with a cane or walker
- Patient doesn’t have sufficient UE function to operate a MWC in the home

Rule Out Scooter/POV
- The patient cannot transfer to and from a POV, operate the tiller on a POV or maintain stability and position while operating a POV; or
- The patient’s mental and physical capabilities are insufficient to operate a POV in the home; or
- The patient’s home does not provide adequate access, space or surfaces to operate a POV in the home

Power Wheelchair Coverage Criteria
- The patient has the mental/physical capabilities to safely operate the power wheelchair provided; or
- The patient has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair provided; and
- The patient’s weight is less than or equal to the weight capacity of the power wheelchair that is provided; and
- The patient’s home provides adequate access, maneuvering space, and surfaces for the operation of the power wheelchair that is provided; and
- Use of a power wheelchair will significantly improve the patient’s ability to participate in MRADLs and the patient will use it in the home; and
- The patient has not expressed an unwillingness to use a power wheelchair in the home

Additional Coverage Criteria
- The patient’s mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and
- The patient meets coverage criteria for a power tilt and recline seating system and the system is being used on the wheelchair; or
- The patient uses a ventilator mounted on the wheelchair; and
- The patient has had a specialty evaluation performed by a PT/OT, or physician who documents the medical necessity for the wheelchair and its special features

Documentation Requirements
- Written order from physician or treating practitioner (including all 7 elements)
- Face-to-Face exam documentation from ordering physician or treating practitioner
- Detailed product description signed by ordering physician or treating practitioner
- Specialty evaluation by PT/OT which provides medical justification for separately billable accessories
- Home assessment by supplier (there must be a document showing this was completed)
- Signed attestation stating there is no financial interest between supplier and therapist, if PT/OT participation in the face-to-face exam documentation is to be considered
- Documentation that a supplier employed ATS/ATP was directly involved in the wheelchair selection

Miscellaneous
- Written order and face-to-face documentation must be received within 45 days of the F2F exam
- Written order, face-to-face documentation and signed detailed product description must be received prior to delivering the power wheelchair
- All information received from the physician or treating practitioner must be date stamped
- Delivery of the power wheelchair must take place within 120 days of the face-to-face exam
- Use KX modifier on the wheelchair base and accessories when all coverage criteria has been met.
**Group 4 No Power Options**

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<tr>
<td>3G Torque SP (3GTQSP)</td>
<td>TDXSR</td>
<td>TDXSR HD</td>
</tr>
</tbody>
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**Basic Coverage Criteria**
- Patient has a mobility limitation that impairs his/her ability to perform 1 or more MRADLs
- The limitation cannot be resolved with a cane or walker
- Patient doesn’t have sufficient UE function to operate a MWC in the home

**Rule Out Scooter/POV**
- The patient cannot transfer to and from a POV, operate the tiller on a POV or maintain stability and position while operating a POV; or
- The patient’s mental and physical capabilities are insufficient to operate a POV in the home; or
- The patient’s home does not provide adequate access, space or surfaces to operate a POV in the home

**Power Wheelchair Coverage Criteria**
- The patient has the mental/physical capabilities to safely operate the power wheelchair provided; or
- The patient has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair provided; and
- The patient’s weight is less than or equal to the weight capacity of the power wheelchair that is provided; and
- The patient’s home provides adequate access, maneuvering space, and surfaces for the operation of the power wheelchair that is provided; and
- Use of a power wheelchair will significantly improve the patient’s ability to participate in MRADLs and the patient will use it in the home; and
- The patient has not expressed an unwillingness to use a power wheelchair in the home

**Additional Coverage Criteria**
- The patient’s mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and
- The patient has had a specialty evaluation performed by a PT/OT, or physician who documents the medical necessity for the wheelchair and its special features.

**Documentation Requirements**
- Written order from physician or treating practitioner (including all 7 elements)
- Face-to-Face exam documentation from ordering physician or treating practitioner
- Detailed product description signed by ordering physician or treating practitioner
- Specialty evaluation by PT/OT which provides medical justification for separately billable accessories
- Home assessment by supplier (there must be a document showing this was completed)
- Signed attestation stating there is no financial interest between supplier and therapist, if PT/OT participation in the face-to-face exam documentation is to be considered
- Documentation that a supplier employed ATS was directly involved in the wheelchair selection

**Miscellaneous**
- Written order and face-to-face documentation must be received within 45 days of the F2F exam
- Written order, face-to-face documentation and signed detailed product description must be received prior to delivering the power wheelchair
- All information received from the physician or treating practitioner must be date stamped
- Delivery of the power wheelchair must take place within 120 days of the face-to-face exam
Group 4 Single Power Option

K0877  K0879
3G Torque SP (3GTQ-CG)  XSR-CG HD
TDXSR-CG

Basic Coverage Criteria
- Patient has a mobility limitation that impairs his/her ability to perform 1 or more MRADLs
- The limitation cannot be resolved with a cane or walker
- Patient doesn't have sufficient UE function to operate a MWC in the home

Rule Out Scooter/POV
- The patient cannot transfer to and from a POV, operate the tiller on a POV or maintain stability and position while operating a POV; or
- The patient's mental and physical capabilities are insufficient to operate a POV in the home; or
- The patient's home does not provide adequate access, space or surfaces to operate a POV in the home

Power Wheelchair Coverage Criteria
- The patient has the mental/physical capabilities to safely operate the power wheelchair provided; or
- The patient has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair provided; and
- The patient's weight is less than or equal to the weight capacity of the power wheelchair that is provided; and
- The patient's home provides adequate access, maneuvering space, and surfaces for the operation of the power wheelchair that is provided; and
- Use of a power wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it in the home; and
- The patient has not expressed an unwillingness to use a power wheelchair in the home

Additional Coverage Criteria
- The patient's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and
- The patient has had a specialty evaluation performed by a PT/OT, or physician who documents the medical necessity for the wheelchair and its special features.

Documentation Requirements
- Written order from physician or treating practitioner (including all 7 elements)
- Face-to-Face exam documentation from ordering physician or treating practitioner
- Detailed product description signed by ordering physician or treating practitioner
- Specialty evaluation by PT/OT which provides medical justification for separately billable accessories
- Home assessment by supplier (there must be a document showing this was completed)
- Signed attestation stating there is no financial interest between supplier and therapist, if PT/OT participation in the face-to-face exam documentation is to be considered
- Documentation that a supplier employed ATS/ATP was directly involved in the wheelchair selection

Miscellaneous
- Written order and face-to-face documentation must be received within 45 days of the F2F exam
- Written order, face-to-face documentation and signed detailed product description must be received prior to delivering the power wheelchair
- All information received from the physician or treating practitioner must be date stamped
- Delivery of the power wheelchair must take place within 120 days of the face-to-face exam
Group 4 Multiple Power Options

K0884
3G Arrow (3GAR-CG)  
3G Torque SP (3GTQ-MCG)  
TDXSR-MCG

K0886
3G Arrow (3GAR-CG HD)  
TDXSR-MCG HD

Basic Coverage Criteria
- Patient has a mobility limitation that impairs his/her ability to perform 1 or more MRADLs
- The limitation cannot be resolved with a cane or walker
- Patient doesn’t have sufficient UE function to operate a MWC in the home

Rule Out Scooter/POV
- The patient cannot transfer to and from a POV, operate the tiller on a POV or maintain stability and position while operating a POV; or
- The patient’s mental and physical capabilities are insufficient to operate a POV in the home; or
- The patient’s home does not provide adequate access, space or surfaces to operate a POV in the home

Power Wheelchair Coverage Criteria
- The patient has the mental/physical capabilities to safely operate the power wheelchair provided or
- The patient has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair provided; and
- The patient’s weight is less than or equal to the weight capacity of the power wheelchair that is provided; and
- The patient’s home provides adequate access, maneuvering space, and surfaces for the operation of the power wheelchair that is provided; and
- Use of a power wheelchair will significantly improve the patient’s ability to participate in MRADLs and the patient will use it in the home; and
- The patient has not expressed an unwillingness to use a power wheelchair in the home

Additional Coverage Criteria
- The patient’s mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and
- The patient has had a specialty evaluation performed by a PT/OT, or physician who documents the medical necessity for the wheelchair and its special features.

Documentation Requirements
- Written order from physician or treating practitioner (including all 7 elements)
- Face-to-Face exam documentation from ordering physician or treating practitioner
- Detailed product description signed by ordering physician or treating practitioner
- Specialty evaluation by PT/OT which provides medical justification for separately billable accessories
- Home assessment by supplier (there must be a document showing this was completed)
- Signed attestation stating there is no financial interest between supplier and therapist, if PT/OT participation in the face-to-face exam documentation is to be considered
- Documentation that a supplier employed ATS/ATP was directly involved in the wheelchair selection

Miscellaneous
- Written order and face-to-face documentation must be received within 45 days of the F2F exam
- Written order, face-to-face documentation and signed detailed product description must be received prior to delivering the power wheelchair
- All information received from the physician or treating practitioner must be date stamped
- Delivery of the power wheelchair must take place within 120 days of the face-to-face exam
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PMD DOCUMENTATION CHECKLIST

Patient: _____________________________ Tentative Delivery Date: ______________________________

The following is on file PRIOR TO delivery of PMD:

Face -to-Face Date: _____________________________

☐ Detailed Prescription with seven mandated elements
The patient name, item, date of F2F, dx/conditions, length of need, physician signature and date must be documented on the detailed prescription. The order MUST be written AFTER the MD completes assessment/physical exam or if an LCMP clinical assessment is ordered, the MD signs concurrence. The supplier MAY NOT complete the information on a seven element Initial Order and send to the physician for signature.

☐ Physician Chart Notes/Progress Notes/Discharge Summary and PT/OT Assessment (if ordered by physician)
The physician chart note must indicate there was a face-to-face meeting between the patient and physician for the purpose of a mobility evaluation. The face-to-face meeting may take place prior to or after a PT/OT Assessment. A detailed summary should include, among other facts, the patient diagnostic history, strength assessment, range of motion, previous MAE use, and why existing MAE is no longer suitable or safe for use.

☐ The chart notes/assessment indicates patient's ability (or with caretaker's assistance) to complete one or more MRADL's with the MAE ordered. An Algorithmic approach to specifying the required product is evident.
The Medical Record shows patient has one or more mobility-related limitations for which the MAE ordered will alleviate within the home. Lower level MAE have been disqualified or the DX precludes use of a lower end product (e.g. C-3 quadriplegia)

☐ Physician Signature and Date illustrates concurrence with the outcomes of the LCMP Assessment
The LCMP assessment must be sent to the physician for a signed/dated statement of concurrence (or disagreement) after completion. If the physician disagrees with any portion of the assessment, it must be documented prior to signing.

☐ Documentation was received within 45 days of the Face-To-Face Date. The Face-To-Face date is defined as:
  • Date of Patient Examination and Functional Assessment by a Physician (without use of clinician) OR
  • Date the Physician signs and dates his concurrence with the LCMP Assessment report if pt. has been seen OR
  • Date physician saw patient following receipt of the LCMP Assessment OR
  • Date patient was seen in a clinical setting by LCMP and Physician; clinic physician is prescriber
  • Date of Discharge from a Hospital or Nursing Home Stay

☐ Documentation received is clearly date stamped (all documents) and was received 45 days from F-T-F date
A Date Stamp or Fax Imprint is acceptable.

☐ An ATS or ATP employed by the supplier and who specializes in wheelchairs had direct in-person involvement in the wheelchair selection for the patient. (Required for Gp2 SPO/MPO; Gp3; Gp4; or Push Rim Activated Power Assist for manual chairs)
Information is on file documenting the services provided by the ATS or ATP; HR Dept. maintains credential on file.

☐ Detailed Product Description, listing all billable options is signed and dated by the physician/practitioner
This form MUST be completed by Supplier and must contain all items billable to Medicare indicating: HCPC, Description/MFG, Model, Supplier Retail Charge and Medicare Allowable. For K0108 items, indicate N/A as Allowable. The supplier formats this document once the assessment is completed and all specifications have been determined.

☐ Delivery to take place within 120 days of the Face-to-Face date or within 6 months following ADMC determination

☐ An IN-Home Assessment has been completed or will be completed upon Delivery
The home assessment may be completed by the Supplier or practitioner and must demonstrate that the PMD can be adequately maneuvered inside the home considering the physical layout, doorway widths, thresholds and surfaces.

☐ An Attestation, signed and dated by the supplier, signifies there is no financial arrangement between LCMP and the supplier.
Supplier must sign and date the attestation; the LCMP is not required to sign.

Date Reviewed: ______________________________ Signature: ______________________________

☐ PMD may be delivered and claim filed
☐ Do Not Deliver/omissions exist: ________________________________________________________
Elimination of First Month Payment Option for Standard Power Wheelchairs

- Called for in the Patient Protection and Affordable Care Act of 2010 (PPACA)
- Effective for dates of service on or after January 1, 2011, first-month purchase option for standard power wheelchairs (PWC) coded as K0813–K0831, K0898 is eliminated
- Standard PWC furnished in the 9 competitive bid areas maintain the first month payment option
- Complex rehab PWC maintain the first month payment option

Capped Rental Rules
Medicare reimburses on a monthly basis for up to 13 months of continuous use as long as

- The equipment remains medically necessary and
- The beneficiary remains in an eligible place of service
- Standard PWC bases must be billed as a capped rental
  - Most separately billable options/accessories can still be billed as an upfront purchase (i.e., batteries, adjustable height arms, O2 holders, swingaway hardware, cushions/backs and positioning accessories) on the same claim. **Exception:** manual elevating legrests must be billed as a rental under HCPCS code K0195
  
  **Note:** Items provided as a purchase belong to the beneficiary so in the event of a pickup all items provided as a purchase would need to be left with the patient

Documentation Requirements
All documentation requirements PWC remain the same

- Face-to-face exam must be completed and received by the supplier within 45 days
- 7-element order, must be written after the face to face is completed and received by the supplier within 45 days
- Detailed product description must be completed by the supplier and signed by the ordering physician
- Home evaluation must be done in the home

Miscellaneous Capped Rental Details

- Monthly phone calls should be made to verify each patient’s continued necessity, use and eligibility
- Monthly billing/collections process to Medicare and beneficiary versus one time upfront
- Maintenance, repair/replacement expenses are non-covered during the rental period
- Supplier is responsible for equipment pick up and upkeeps (clean-up, refurbishment) prior to re-issue
- If the beneficiary changes suppliers during the rental period, the new rental period does not begin
- The supplier providing the item in the 13th month of continuous use is responsible for supplying the equipment and transferring ownership of the item to the beneficiary
- The transfer of ownership must occur on the first day after the last rental month or the beginning of the 14th month
- After 13 months payments and transfer of ownership, a supplier can bill Medicare for necessary repairs
- 5-year useful lifetime of the equipment begins when the beneficiary receives the unit, NOT the age of the equipment
- The supplier must pick up the rental equipment when no longer needed or not used in a covered place of service
- Continuous use means using the equipment month after month without a break in service
- A break in medical necessity for greater than 60 consecutive days does not constitute a new capped rental period for PWC as use for reversible conditions is denied as not medically necessary
- A new capped rental period would begin if there is a substantive change in the beneficiary’s condition that necessitates a significantly different product described by a different code
- A break in service can occur without a change in the patient’s medical condition or need for the equipment. This can happen when the patient is admitted to a hospital, nursing home, hospice or Medicare HMO and the DME MAC was not being billed during this time. This scenario constitutes a break in billing and a new rental period will not begin regardless of the length of the break.

Capped Rental Modifiers

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<th>Description</th>
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<td>KH</td>
<td>Month 1 billing of a capped rental item</td>
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<td>KI</td>
<td>Months 2-3 billing of a capped rental item</td>
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<td>KJ</td>
<td>Months 4-13 billing of a capped rental item</td>
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Informational Modifier

<table>
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<tr>
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<td>Specified required documentation is on file</td>
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Capped Rental Base/Accessories Modifiers

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<td>Months 4-13</td>
<td>K0823 RR KJ KX</td>
<td>(i.e. K0823 RR KJ KX)</td>
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Purchased Accessories Modifiers
Month 1 New  Accessory code with NU KX (i.e. E2208 NU KX)
Month 1 Used  Accessory code with UE KX (i.e. E2208 UE KX)

Note: Bilateral accessories billed as a purchase and the HCPCS code is defined as “each” requires billing one claim line with RT and LT and 2 units of service. (i.e. NU RT LT KX)

Allowable Calculations
- **Power Wheelchair Capped Rental Base**
  - Months 1 to 3 – rates published in Medicare fee schedule
  - Months 4 to 13 - 40% of rates published in Medicare fee schedule
- **Capped Rental Options/Accessories**
  - Months 1 to 3 – rental rates published in Medicare fee schedule
  - Months 4 to 13 – 75% of rental rates published in Medicare fee schedule
- **Purchased Options/Accessories**
  - Month 1 lump sum payment based on NU rate published in Medicare fee schedule

### Power Wheelchair Capped Rental Allowable Chart - Effective 01/01/2011

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<th>HCPCS</th>
<th>Month 1</th>
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IC = Individual Consideration (Typically a percentage of MSRP)

Capped rental reimbursement is 5% more than first month purchase option when reimbursed for the entire 13 month rental period
1. **When standard power wheelchairs (PWCs) are provided on a rental basis, can they be covered for short term indications?**
   No. The change in the payment policy status for power wheelchair does not change the policy statement that PWCs are not covered for patients with short term, reversible conditions.

2. **How will the “look back” period affect the review of PWCs?**
   There is a general policy that coverage of items that are provided on an ongoing basis, including rented DME, is dependent on their being continued need for the item and continued use by the beneficiary. CMS and the DME Medicare administrative contractors (MACs) have not published any information regarding the look back period.

3. **A PWC is being rented and the beneficiary goes into a hospital and nursing home for an extended stay. The supplier elects to pick up the wheelchair. When the beneficiary is ready to go back home, would there be a problem with providing a different model wheelchair within the same Healthcare Common Procedure Coding System (HCPCS) code?**
   If the supplier chooses to deliver a different model of PWC within the same code, a new detailed product description must be obtained. A new face-to-face (FTF) examination or 7-element order is not needed.

4. **If a patient who is renting a PWC moves, is a new in-home assessment required?**
   No.

5. **If a patient with a PWC moves and their new home will no longer accommodate the PWC they have, will Medicare pay for a new PWC?**
   No. Medicare covers a replacement only if an item is lost, stolen, irreparably damaged, or reaches the 5 year reasonable useful lifetime. Medicare covers a different item only if there is a change in the beneficiary’s medical condition.

6. **If a patient who is renting a PWC goes into a hospital/nursing home for a extended time and the supplier picks up the wheelchair and the beneficiary is discharged to home, would a new capped rental period start and what documentation would be required?**
   Standard capped rental rules for beginning a new rental period will apply to power wheelchairs. That policy states that a new capped rental period will begin only if there has been a break in medical necessity of at least 60 days plus the days remaining in the last paid rental month. In the situation that is described, “medical necessity” would continue while the patient was in a facility. If the patient is receiving the same type of PWC (same code) on discharge that they previously had, then the rental period resumes where it left off and no additional documentation is needed (other than a new detailed product description if the make/model of the wheelchair has changed). If the patient needs a different type of PWC on discharge because of a change in their medical condition, all the requirements for a new PWC must be met (i.e., FTF exam, 7-element order, etc.).

7. **If, during a capped rental period, a PWC is lost, stolen, or irreparably damaged and a new PWC is provided, does a new CR period start?**
   Yes. Replacement of power wheelchairs will follow the same rules as any other rented DME item.

8. **Is there any situation in which a supplier can be paid for repair to a PWC during a capped period, e.g., if the supplier has information to indicate that the repair is required due to “malicious damage” or “culpable neglect” by the beneficiary?**
   There can be no payment for the repair of rented items under any circumstances. Reimbursement for repairs is included in the rental payments. If the supplier believes that a wheelchair repair is required because of malicious damage or culpable neglect by the beneficiary, the supplier can present the information to the DME MAC for investigation. If the DME MAC, in consultation with CMS, agrees that the beneficiary is responsible for the damage, the supplier can charge the beneficiary.

9. **Does the patient have to receive a new PWC at the beginning of the rental period?**
   No. Used equipment can be provided but the supplier is financially responsible for any and all repairs to the base equipment during the capped rental period.

10. **Are scooters included in the first month purchase option elimination?**
    Scooters identified by HCPCS codes K0800-K0812 will not be capped rental and will maintain the first month purchase option.

11. **Can a supplier collect the patient’s 20% copay in a lump sum upfront?**
    No, as with billing the Medicare program the patient’s 20% copay must also be collected on a monthly basis.

12. **If accessories are billed as a purchase, is the supplier required to leave those items with the patient in the event the rented PWC must be picked up?**
    If the accessories are purchased they are the property of the beneficiary. If the beneficiary requests that the supplier pick up the purchased accessories, it is recommended the request be documented stating which items are picked up.

13. **What is the required documentation for transferring PWC ownership to the patient?**
    Medicare has no specific requirement, ownership transfers are governed by each state so the requirements may vary. It is suggested to inquire about these requirements through the appropriate agency in your state.
Invacare Matrx Personal Back™ 10/10+ (E2615/E2616) Contoura Back (E2620/E2621) Matrix VI Base (E2605)
Ulti-Mate® Cushion (E2605/E2606) Invacare Matrx Stabilite Max Contour (E2605) Invacare Matrx Stabilite OM (E2605/E2606)
Invacare Matrx PB/PB Deep Back (E2615/E2616) Invacare Matrx Elite/Elite Deep (E2620) Invacare Matrx PCS Back (E2620/E2621)

E2605 POSITIONING WC SEAT CUSHION, WIDTH LESS THAN 22" , ANY DEPTH
E2606 POSITIONING WC SEAT CUSHION, WIDTH 22" OR GREATER, ANY DEPTH
E2613 POSITIONING WC BACK CUSHION, POSTERIOR, WIDTH < 22", ANY HEIGHT, ANY TYPE HARDWARE
E2614 POSITIONING WC BACK CUSHION, POSTERIOR, WIDTH > 22", ANY HEIGHT, ANY TYPE HARDWARE
E2615 POSITIONING WC BACK CUSHION, POSTLAT, WIDTH < 22", ANY HEIGHT, ANY TYPE HARDWARE
E2616 POSITIONING WC BACK CUSHION, POSTLAT, WIDTH > 22", ANY HEIGHT, ANY TYPE HARDWARE
E2617 CUSTOM FABRICATED WC BACK CUSHION, ANY SIZE, INCLUDING ANY TYPE MOUNTING HARDWARE
E2620 POSITIONING WC BACK CUSHION, PLANAR WLAT SUPPORTS, WIDTH < 22", ANY HT , ANY TYPE HARDWARE
E2621 POSITIONING WC BACK CUSHION, PLANAR WLAT SUPPORTS, WIDTH > 22", ANY HT, ANY TYPE HARDWARE
E0955 WC ACCESSORY, HEADREST, CUSHIONED, ANY TYPE, INCLUDING FIXED MOUNTING HARDWARE, EACH
E0956 WC ACCESSORY, LATERAL TRUNK OR HIP SUPPORT, ANY TYPE, INCLUDING FIXED HARDWARE, EACH
E0957 WC ACCESSORY, MEDIAL THIGH SUPPORT, ANY TYPE, INCLUDING FIXED HARDWARE, EACH
E0960 WC ACCESSORY, SHOULDER HARNESS/STRAPS OR CHEST STRAP, ANY TYPE HARDWARE


QUALIFYING DIAGNOSIS CODES
138 LATE EFFECT ACUTE POLIO 335.8 ANT HORN CELL DIS NEC 343.00 QUADRIPLEGIA, UNSPECIFIED
330 LEUKODYSTROPHY 335.9 ANT HORN CELL DIS NOS 344.01 QUADRPLG C1-C4, COMPLETE
330.1 CEREBRAL LIPIDOSES 336.0 SYRINGOMYELIA 344.00 QUADRIPLEGIA, UNSPECIFIED
330.2 CEREB DEGEN IN LIPIDOSIS 336.1 VASCULAR MYELOPATHIES 344.01 QUADRPLG C1-C4, COMPLETE
330.3 CERB DEG CHD IN OTH DIS 336.2 COMB DEG CORD IN OTH DIS 344.02 QUADRPLG C5-C7, INCOMPLT
330.8 CEREB DEGEN IN CHILD NEC 336.3 MYELOPATHY IN OTH DIS 344.09 QUADRPLG C5-C7, COMPLETE
330.9 CEREB DEGEN IN CHILD NOS 340 MULTIPLE SCLEROSIS 344.1 PARAPLEGIA NOS
331.0 ALZHEIMER'S DISEASE 341.0 NEUROMYELITIS OPTICA 707.03 DECUBITUS ULCER, LOW BACK
332.0 PARALYSIS AGITANS 341.1 SCHILDER'S DISEASE 707.04 DECUBITUS ULCER, HIP
335.0 WERDING-HOFFMANN DISEASE 341.8 CNS DEMYELINATION NEC 707.05 DECUBITUS ULCER, BUTTOCK
335.10 SPINAL MUSCULAR ATROPHY 341.9 CNS DEMYELINATION NOS 741.00 SPIN BIF-W HYDROCEPH NOS
335.11 KUGELBERG-WELANDER DIS 343.0 CONGENITAL DIPLEGIA 741.01 SPIN BIF-W HYDROCEPH-CERV
335.19 SPINAL MUSCULAR ATROPHY NEC 343.1 CONGENITAL HEMIPLEGIA 741.02 SPIN BIF-W HYDRECP-DORS
335.20 AMYOTROPHIC LATERAL SCLEROSIS 343.2 CONGENITAL QUADRIPLEGIA 741.03 SPIN BIF-W HYDROCEPH-LUMB
335.21 PROG MUSCULAR ATROPHY 343.3 CONGENITAL MONOPLUGEA 741.90 SPINA BIFIDA
335.23 PSEUDOBULBAR PALSY 343.4 INFANTILE HEMIPLEGIA 741.91 SPINA BIFIDA-CERV
335.24 PRIM LATERAL SCLEROSIS 343.8 CEREBRAL PALSY NEC 741.92 SPINA BIFIDA-DORSAL
335.29 MOTOR NEURON DISEASE NEC 343.9 CEREBRAL PALSY NOS 741.93 SPINA BIFIDA-LUMBAR

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Quality Standards for Suppliers of DMEPOS

I. Business Services

Administration

The supplier shall govern its business so that it obtains and provides appropriate quality equipment, items, and services to beneficiaries.

1. The supplier shall have one or more individuals who perform leadership functions, with the authority, responsibility, and accountability to direct the organization and its key activities and operations. (The term “leadership” does not necessarily imply that there must be a formal group or committee. The supplier can meet this requirement through various means as long as essential leadership functions occur. An owner can lead an owner-operated business, such as a physician’s office. The supplier may use any form of organization, such as a partnership, sole proprietorship, or corporation. Depending on the organization’s structure, examples of leadership positions may include the owners, governing body, chief executive officer, and other individuals responsible for managing services provided by the organization).

2. The supplier shall have a physical location and display all licenses/certificates/permits to operate. The licenses/certificates must be displayed in an area accessible to customers/patients. The supplier shall provide copies, upon request, to government officials or their authorized agents.

3. The supplier shall provide only DMEPOS and other items that meet applicable FDA regulations and medical device effectiveness and safety standards. The supplier shall obtain from the manufacturer copies of the features, warranties, and instructions for each type of non-custom-fabricated item.

4. The supplier shall:
   • Comply with Medicare coverage, claim processing, and payment policies; and
   • Comply with the Medicare disclosure of ownership and control information requirements at 42 CFR 420.201 through 420.206.

5. The supplier shall implement business practices to prevent and control fraud, waste, and abuse by:
   • Using procedures that articulate standards of conduct to ensure the organization’s compliance with applicable laws/regulations; and
   • Designating one or more individuals in leadership positions to address compliance issues.

Financial Management

The supplier shall implement financial management practices that ensure accurate accounting and billing to beneficiaries and the Medicare program. Financial records shall be accurate, complete, current, and reflect cash or accrual base accounting practices. The supplier shall maintain accounts that link equipment and items to the beneficiary and manage revenues and expenses on an ongoing basis, as they relate to beneficiary services, including the following:

   • Reconciling charges to beneficiaries for equipment, supplies, and services with invoices, receipts, and deposits;
   • Planning to meet the needs of beneficiaries and maintain business operations by having an operating budget, as appropriate to the business’s size and scope of services; and
   • Having a mechanism to track actual revenues and expenses.

Human Resource Management

The supplier shall implement policies to specify personnel qualifications, training, experience, and continuing education requirements consistent with the specialized equipment, items, and services it provides to beneficiaries. The supplier shall provide copies, upon request, to accreditation organizations and government officials or their authorized agents.

Technical personnel shall be competent to deliver and set-up equipment and items and train beneficiaries. Professional personnel shall be licensed, certified, or registered and function within their scope of practice as required by the State standard under which the professional is licensed. The supplier shall maintain copies or other verification of licenses/registrations/certifications, and competency assessments for personnel who provide beneficiary services.

Consumer Services

1. When providing equipment, items, and services to beneficiaries, the supplier shall ensure that it:
   • Provides clear instructions related to the use, maintenance, and potential hazards of equipment and items;
   • Provides beneficiaries with information regarding expected time frames for receipt of delivered items;
   • Verifies that the beneficiary has received equipment, items, and services;
   • Provides beneficiaries essential contact information for rental equipment and options for beneficiaries to rent or purchase equipment and items, when applicable; and
   • Provides the beneficiary with information and telephone numbers for customer service assistance regarding regular business hours, after-hours access, item repair, and emergency coverage.

2. The supplier shall notify the prescribing physician (for purposes of these standards, we are using this term to include other practitioners who can prescribe DMEPOS under Medicare laws and regulations) or other healthcare team member promptly, but in no case more than five (5) calendar days, if it cannot provide the equipment, items or services that are prescribed for a beneficiary.

3. Within five (5) calendar days of receiving a beneficiary’s complaint, the supplier shall notify the beneficiary, using either oral, telephone, e-mail, fax, or letter format, that it has received the complaint and that it is investigating. Within 14 calendar days, the supplier shall provide written notification to the beneficiary of the results of its investigation and response. The supplier shall maintain documentation of all complaints that it receives copies of the investigations, and responses to beneficiaries.
Performance Management
The supplier shall implement a performance management plan that measures the outcomes of consumer services, billing practices, and adverse events. The data collection may target certain aspects of services that have a potential to cause harm or injury; occur frequently, creating a greater than expected number of adjustments, repairs, or replacement; or require significant instruction to assure safe use and benefit of items.

At a minimum, each supplier shall measure:
- Beneficiary satisfaction with and complaints about product(s) and service(s);
- Timeliness of response to beneficiary questions, problems, and concerns;
- Impact of the supplier’s business practices on the adequacy of beneficiary access to equipment, items, services, and information;
- Frequency of billing and coding errors (e.g. number of Medicare claims denied, errors the supplier finds in its own records after it has been notified of a claims denial); and
- Adverse events to beneficiaries due to inadequate or malfunctioning equipment, items, or services. This may be identified through follow-up with the prescribing physician, other healthcare team members, or the beneficiary or caregiver.

Product Safety
The supplier shall implement an equipment and item management program that promotes the safe use of equipment and items and minimizes safety risks and hazards both for its staff and for beneficiaries.

1. The supplier shall implement and maintain a plan for identifying, monitoring, and reporting (where indicated) equipment and item failure, repair, and preventive maintenance, for equipment and items provided to beneficiaries.
2. The supplier shall investigate any incident /injury in which DMEPOS may have contributed to the injury/incident, when the supplier becomes aware. The investigation should be initiated within 24 hours after becoming aware of an injury/incident resulting in a beneficiary's hospitalization/death. For other occurrences, the supplier shall investigate within 72 hours after being made aware of the incident /injury. The investigation includes all necessary information, pertinent conclusions about what happened, and whether changes in systems or processes are needed. The supplier should consider possible links between the items and services furnished and the adverse event.
3. The supplier shall have a contingency plan that enables it to respond to emergencies and disasters or to have arrangements with alternative suppliers in the event that the supplier cannot service its own customers as the result of an emergency or disaster.

Information Management
The supplier shall maintain accurate, pertinent, accessible, confidential, and secure beneficiary records, in accordance with privacy and security standards of the Health Insurance Portability and Accountability Act (HIPAA) and other applicable State standards.

II. General Product-Specific Service Standards
All DMEPOS must serve a medical purpose to be covered under the Medicare program and may require the physician to collaborate and coordinate clinical services with other healthcare professionals (e.g., orthotists; prosthetists; occupational, physical, and respiratory therapists; pedorthists; etc.). In addition to the general product specific services, a supplier shall implement the supplemental product specific standards in Appendices A through C, as applicable to its business.

Intake
The supplier shall:
- Comply with CMS regulations, policies, and Medicare contractor policies and articles;
- Consult with the prescribing physician as needed to confirm the order and to recommend any necessary changes or refinements or additional evaluations to the prescribed items and services; and
- Assure that the item delivered to the beneficiary is consistent with the prescribing physician's order and other identified beneficiary needs, risks, and limitations of which the supplier is aware.

Beneficiary Record
The supplier shall:
- As appropriate, review the beneficiary's record and incorporate any necessary revisions, related to the beneficiary’s conditions, which affect the provision of the DMEPOS and related services or to the actual items/services provided, in collaboration with the prescribing MD.

Delivery and Setup
The supplier shall:
- Deliver and set up, or coordinate set up with another supplier, all equipment and items in a timely manner as agreed upon by the beneficiary/caregiver, supplier, and prescribing physician;
- Provide all items that are necessary to operate the equipment or item and perform any further adjustments as applicable; and
- Provide, or arrange for, loaner equipment equivalent to the original equipment during any repair period.

Training/Instruction to Beneficiary and Caregiver
The supplier shall, as applicable:
- Provide, or coordinate the provision of, appropriate information related to the setup (including preparation of formulas), features, routine use, troubleshooting, cleaning, and maintenance of the items provided;
- Advise the beneficiary and caregiver about appropriate safety considerations;
• Provide relevant information and/or instructions about infection control issues related to the use of the equipment and items;
• Verify the beneficiary has received training and instructions on the use of items at the time of initial mail order delivery of items; and
• Record in the beneficiary's record that such instruction was provided.

Beneficiary training and instructions shall be commensurate with the risks, complexity, and manufacturer's instructions and/or specifications for items. The supplier shall tailor training and instruction materials and approaches to the needs, abilities, learning preferences, language, and readiness to learn of individual beneficiaries or caregivers.

Follow-up
The supplier shall provide follow-up services to the beneficiary, consistent with the types of equipment, items and service(s) provided, and recommendations from the prescribing physician or healthcare team members.

Manual Wheelchairs and Power Mobility Devices and Complex Rehab Wheelchairs and Assistive Technology
This standard applies to manual wheelchairs, power mobility devices (PMDs), including Complex Rehab and Assistive Technology. PMDs include power wheelchairs and power operated vehicles (POVs) and accessories. Manual wheelchairs include standard recliners, heavy-duty wheelchairs, standard lightweight wheelchairs, and hemi wheelchairs, armrests, leg rests/footplates, anti-tipping devices, and other Medicare-approved accessories. PMDs include power wheelchairs and power operated vehicles (POVs) and accessories. Complex Rehabilitative Wheelchairs are Group 2 power wheelchairs with power options, Group 3 and higher power wheelchairs and manual wheelchairs that can accommodate rehabilitative accessories and features (e.g., tilt in space).

Intake and Assessment
In addition to Section II: Supplier Product-Specific Service Requirements, the supplier shall verify that seating, positioning and specialty assistive technology have been evaluated and documented in the beneficiary’s record.

Delivery/Setup
See General Product-Specific Service Standards

Training/Instruction to Beneficiary and Caregiver(s) and Follow-Up
See General Product-Specific Service Standards

B. Complex Rehab and Assistive Technology

1. The supplier shall employ (W-2 employee) at least one qualified individual as a Rehab Technology Supplier (RTS) per location. A qualified RTS is an individual that is or has one of the following credentials:
   • Certified Rehab Technology Supplier (CRTS);
   • Assistive Technology Supplier (ATS) (discontinued 12/31/2008)
   • Assistive Technology Practitioner (ATP) (discontinued 12/31/2008)
   • Assistive Technology Professional (AT) (effective 01/01/2009)

2. The Rehab Technology Supplier (RTS) shall have at least one or more trained technicians available to service each location appropriately depending on the size and scope of its business. A trained technician is identified by the following:
   • Factory trained by manufacturers of the products supplied by the company;
   • Experienced in the field of Rehab Technology, e.g. on the job training, familiarity with Rehab clients, products and services;
   • Completed at least ten hours annually of continuing education specific to Rehab Technology; and
   • Able to program/repair sophisticated electronics associated with PWCs, alternative drive controls, and power seating systems.

3. The Rehab Technology Supplier (RTS) shall:
   • Coordinate services with the prescribing physician to conduct face-to-face evaluations of the beneficiary in an appropriate setting and includes input from other members of the health care team (i.e. PT, OT, prescribing physician etc.);
   • Provide the beneficiary with appropriate equipment for trial and simulation, when necessary;
   • Maintain in the beneficiary’s record all of the information obtained during the assessment; and
   • Implement procedures for assembly and set-up of equipment as well as a process to verify that the final product meets the specifications of the original product recommendation approved by the prescribing physician.

4. If beneficiaries are evaluated in the supplier’s facility, the supplier shall:
   • Provide the beneficiary private, clean, and safe rooms appropriate for fittings and evaluations; and
   • Maintain a repair shop located in the facility or in close proximity or easily accessible from another location of the supplier as well as an area appropriate for assembly and modification of products.
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Helpful Reimbursement Websites

Invacare Corporation - Policy and Funding
http://www.invacare.com

Region A MAC – National Heritage
http://www.medicarenhic.com/dme/index.shtml

Region B MAC – Adminastar Federal

Region C MAC – Cigna Medicare
http://www.cignagovernmentservices.com/jc/index.html

Region D MAC – Noridian Administrative Services
https://www.noridianmedicare.com/dme/index.html

CMS Durable Medical Equipment Center
http://www.cms.hhs.gov/center/dme.asp

State Medicaid Webpage Links
http://64.82.65.67/medicaid/states.html

DMEPOS Quality Standards
http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/04_New_Quality_Standards.asp

Approved Accreditation Agency Contact List
http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/

Competitive Bidding Implementation Contractor (CBIC)
http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home

DMEPOS Competitive Bidding Overview
http://www.cms.hhs.gov/DMEPOSCompetitiveBid/

Durable Medical Equipment Code System – DMECS
https://www.dmepdac.com/

DMEPOS Fee Schedule
http://www.cms.hhs.gov/DMEPOSFeeSched/LSDMEPOSFee/list.asp#TopOfPage

National Institute of Neurological Disorders and Stroke
http://www.ninds.nih.gov/disorders/disorder_index.htm

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