

# Medicare Coverage of Power Mobility Devices (PMDs)

DME MAC A Outreach &  
Education Department

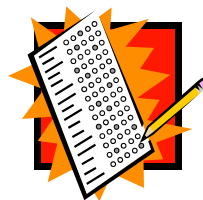
For Training Purposes Only  
April 21, 2008 - June 11, 2008

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A CMS MEDICARE ADMINISTRATIVE CONTRACTOR



## Pre-Test



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## Disclaimer

**Information in this presentation is current as of April 2008. Any additional updates will be provided at the seminar.**

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## Disclaimer

**This seminar handout is meant as only an outline of the full seminar presentation. Additional information and discussion provided during the seminar will accompany these materials for a complete educational session. Use of these materials by entities other than NHIC, Corp. DME MAC Jurisdiction A may not fully reflect the educational intent for which they were developed.**

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# Agenda

- **MAE National Coverage Determination**
- **Coverage Criteria**
  - PMD Basic Coverage Criteria
  - Power Operated Vehicle (POV) Coverage Criteria
  - Power Wheelchair (PWC) Coverage Criteria
  - Least Costly Alternative
  - PMD Non-Coverage
- **Documentation Requirements**
  - Face-to-Face Exam
  - Specialty Evaluation
  - Orders
  - Detailed Product Description
  - Home Assessment
  - Advance Determination of Medicare Coverage (ADMC)
- **PMD Frequently Asked Questions (FAQs)**
- **Open Discussion**

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# MAE National Coverage Determination

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## MAE National Coverage Determination

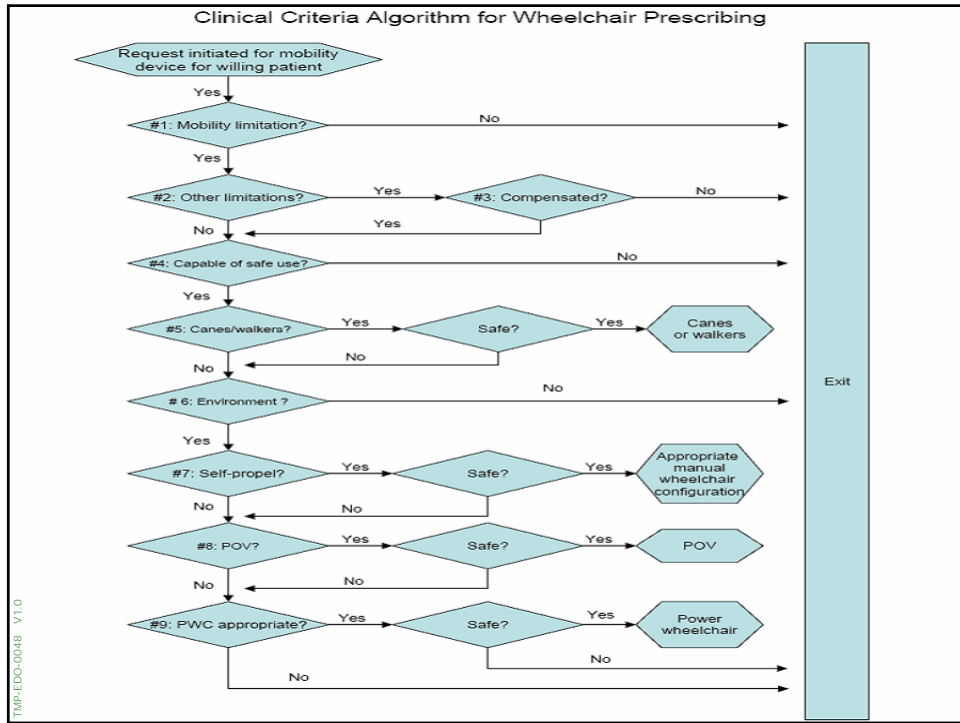
- Mobility Assistive Equipment (MAE)
  - Canes, crutches, walkers, manual/power wheelchairs and scooters
  - Reasonable and necessary if presence of a personal mobility deficit sufficient to impair participation in mobility-related activities of daily living (MRADLs)
    - Toileting, feeding, dressing, grooming, and bathing

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## MAE National Coverage Determination

- Mobility Assistive Equipment (MAE)
  - Algorithmic approach determines if MAE is reasonable and necessary
- National Coverage Determination (NCD) Manual
  - Publication 100-03, Chapter 1, Part 4, Section 280.3
  - Effective May 5, 2005
  - Implemented July 5, 2005

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# PMD Payment Categories

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## PMD Payment Categories

- Inexpensive or Routinely Purchased
  - Items can be rented or purchased
  - **NU, UE** or **RR** modifier
  - Rentals are payable for 10 months
  - Repairs and replacements are billable on patient owned equipment
- Capped Rental Items
  - Rented for 13 months and then converted to a purchase (effective 01/01/06)
  - **RR** and **KH, KI**, or **KJ** modifiers
  - Repairs and replacements are billable after purchase conversion

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## Capped Rental Modifiers

- **KH** - Initial claim, first month rental
- **KI** - Second or third month rental
- **KJ** - Months four through thirteen of rental
- **BP** - The beneficiary has been informed of the purchase and rental options and has elected to purchase the item
- **BR** - The beneficiary has been informed of the purchase and rental options and has elected to rent the item

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## Capped Rental Billing Examples - PWC

- Initial Rental Example
  - K0813RRKHBRKX - Month 1
  - K0813RRKIBRKX - Months 2 - 3
  - K0813RRKJBRKX - Months 4 - 13
- Initial Purchase Example
  - K0813NUKHBPKX

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## Inexpensive or Routinely Purchased Billing Examples - POV

- Initial Rental Example
  - K0800RRKX - Month 1 - Month 10
- Initial Purchase Example
  - K0800NUKX, K0800UEKX

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## Coverage Criteria

- **Basic Criteria**
- **POV Criteria**
- **PWC Criteria**

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## Basic Coverage Criteria for All PMDs

Three basic criteria must be met for PMD or push-rim power assist device to be covered

- Presence of mobility limitation impairing mobility-related activities of daily living (MRADLs)
  - MRADL: toileting, feeding, dressing, grooming, and bathing in customary locations in the home
- Mobility limitation cannot be resolved by the use of an appropriately fitted cane or walker
- Unable to self-propel an optimally-configured manual wheelchair
  - Limited upper extremity strength, deformity, absence of arms, etc.

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## POV Coverage Criteria

Covered if all of the basic coverage criteria have been met and the following six criteria

- D. Patient is able to:
  - Safely transfer to and from a POV, and
  - Operate the steering system, and
  - Maintain postural stability and position while operating the POV in the home
- E. Sufficient mental and physical capabilities
  - **Mental capabilities:** cognition, judgment
  - **Physical capabilities:** vision
- F. Home provides adequate access between rooms, maneuvering space, and surfaces

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## POV Coverage Criteria

- G. Patient's weight  $\leq$  the weight capacity of the POV
- H. Use of a POV will significantly improve patient's ability to participate in MRADLs in the home
- I. The patient has not expressed an unwillingness to use a POV in the home

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

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## POV Coverage Criteria

### Group 1 (K0800 – K0802)

- Length - less than or equal to 48 inches
- Width - less than or equal to 28 inches
- Minimum Top End Speed - 3 MPH
- Minimum Range - 5 miles
- Minimum Obstacle Climb - 20 mm
- Radius Pivot Turn - less than or equal to 54 inches
- Dynamic Stability Incline - 6 degrees

### Group 2 (K0806 – K0808)

- Length - less than or equal to 48 inches
- Minimum Top End Speed - 4 MPH
- Minimum Range - 10 miles
- Minimum Obstacle Climb - 50 mm
- Radius Pivot Turn - less than or equal to 54 inches
- Dynamic Stability Incline - 7.5 degrees

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## PWC Coverage Criteria

**Covered if all of the basic coverage criteria have been met and all of the following:**

- The patient does not meet coverage criterion D, E, or F for a POV; **and**
- Either criterion J **or** K is met; **and**
- Criterion L, M, N, and O are met; **and**
- Any coverage criteria pertaining to the “specific wheelchair type” are met

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## PWC Coverage Criteria

- J. Patient has mental/physical capabilities to safely operate the PWC
- K. Patient has caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the PWC
- L. Patient's weight is  $\leq$  to weight capacity of the PWC
- M. Home provides adequate access between rooms, maneuvering space, and surfaces
- N. Use of PWC will significantly improve patient's ability to participate in MRADLs in the home
- O. The patient has not expressed an unwillingness to use a POV in the home

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## PWC Coverage Criteria

- If PWC will be used inside home and PWC coverage criteria are not met, **but the criteria for a POV are met**, payment will be based on allowance for least costly medically appropriate alternative
- If PWC will be used inside home and **PWC coverage criteria are not met, and the criteria for a POV are not met**, it will be denied as not medically necessary

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## PWC Coverage Criteria

### Specific Types of Power Wheelchairs Five (5) Groups

1. Group 1 (K0813 - K0816)
2. Group 2 (K0820 - K0843)
3. Group 3 (K0848 - K0864)
4. Group 4 (K0868 - K0886)
5. Group 5 (K0890, K0891)

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## Least Costly Alternative

- Coverage criteria for PMDs based on stepwise progression of medical necessity
- Criteria not met, but another device meets patient's needs, payment based on allowance for least costly medically appropriate alternative
- Determinations taken into account:
  - Patient's weight
  - Seating needs
  - Need for other features
    - Power seating systems, alternative drive controls, ventilators

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## Least Costly Alternative

- **Examples of least costly alternative**

- **PWC**

- Patient's weight can be accommodated by a PWC with lower weight capacity than the wheelchair provided
    - PWC used inside the home and coverage criteria are not met but the criteria for a POV are met

- **POV**

- Group 2 POV is provided and coverage criteria for a POV are met
      - Group 2 have added capabilities that are not needed for use in the home
    - Patient's weight can be accommodated by POV with lower weight capacity than POV provided

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## Not Medically Necessary

- PMD used inside the home but appropriate coverage criteria not met
- Add-on to convert a manual wheelchair to a joystick-controlled power mobility device or to a tiller-controlled power mobility device
- Backup chairs
- If underlying condition is reversible and length of need is < 3 months
- PMD not reviewed by the SADMERC or reviewed by SADMERC and found not to meet the definition of a specific POV/PWC (**K0899**)

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## PMD Non-Coverage

- Only for use outside the home
- Requirements related to a face-to-face examination have not been met
- Upgrades that are beneficial primarily in allowing the patient to perform leisure or recreational activities
- When ordered by a Podiatrist

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## Replacements

- Replacement **during useful lifetime**
  - Loss or irreparable damage
    - Fire, flood, hurricane, etc.
  - Irreparable wear
    - Not covered
- Replacement **after useful lifetime**
  - Loss or irreparable damage
    - Fire, flood, hurricane, etc.
  - Irreparable wear
    - Covered
- Order **is** needed

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## Repairs

- Repairs during useful lifetime
  - Covered up to cost of replacement for medically necessary owned equipment
  - Necessary to make equipment serviceable
- Charges for repair of rented equipment are included in rental charge
- New order not needed

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## Documentation Requirements

- Face-to-Face Exam
- Specialty Evaluation
- PMD Orders
- Detailed Product Description
- Home Assessment
- ADMC
- Documentation Reminders

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## Medical Record

- Medical record must reflect need for care provided
- Medical record includes:
  - Physician office records
  - Hospital records
  - Nursing home records
  - Home health agency records
  - Records from other healthcare professionals
- Must be available upon request

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## Face-to-Face Examination

- Treating physician must conduct for POV or PWC to be covered
- Must be done prior to writing the order and prior to delivery
- Supplier must receive written report within 45 days after exam is complete
- Claim will be denied as non-covered if requirements not met
- Not required if the PMD is replacement during five years useful lifetime of an item in same performance group previously covered by Medicare

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## Face-to-Face Examination

- Physician may refer patient to licensed/certified medical professional for part of face-to-face exam
  - Physical therapist (PT) or occupational therapist (OT) with experience and training in mobility evaluations
    - No financial relationship with the supplier
      - Exception: Supplier is owned by a hospital

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## Face-to-Face Examination

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

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

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## Face-to-Face Examination

- The report of the face-to-face examination should provide information about the following elements
  - Symptoms
  - Related diagnoses
  - History
  - Physical exam
  - Functional assessment

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## Face-to-Face Examination

- Physicians shall document the examination in a detailed narrative note in their charts
- Physician must provide pertinent reports for tests performed
- Supplier created forms not a substitute for medical record
- Suppliers encouraged to help educate physician

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## Specialty Evaluations

- Required for 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 for a manual wheelchair
- Performed by licensed/certified medical professional such as:
  - PT/OT
  - Physician having specific training and experience in rehabilitation wheelchair evaluations
- Provides detailed information explaining why each specific option or accessory is needed
- Written report must be available upon request
- In addition to the requirement for the face-to-face examination

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## RESNA Certified

- Effective April 1, 2008
- Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair
  - Must be **provided by a supplier that employs** a RESNA-certified Assistive Technology Supplier (ATS) or Assistive Technology Practitioner (ATP) specializing in wheelchairs who is directly involved in the wheelchair selection for the patient

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## PMD Orders

Must be received by supplier within 45 days after completion of face-to-face exam

- Must include all of the following:
  - Beneficiary's name
  - Description of ordered item
  - Date of face-to-face exam
  - Pertinent diagnoses/condition
  - Length of need
  - Physician's signature
  - Date of physician signature
- Date stamp or equivalent must be used to document receipt

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## PMD Orders

- **EY Modifier**
  - No physician or other licensed health care provider order for this item or service
  - Add to each HCPCS code if order not received by supplier within 45 days of face-to-face exam
  - Obtain Advance Beneficiary Notice (ABN)

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## Detailed Product Description

- Prepared by supplier based on physician's order
- Lists specific base
  - HCPCS code, and either
    - Narrative description of item, or
    - Manufacturer name/model
- All options and accessories
- Supplier charge and Medicare Fee Schedule allowance
- Signed/dated by physician and received by supplier prior to delivery
- Date stamp or equivalent must be used to document receipt

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## Home Assessment

- Performed by supplier or practitioner
- Prior to or at time of delivery
- To verify patient can adequately maneuver the device provided considering:
  - Physical layout
  - Doorway width
  - Doorway thresholds
  - Surfaces
- Must be a written report of this assessment

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## Delivery

- Must be within 120 days of the face-to-face completion date
  - Exception: Approved ADCM
    - Must be delivered within 6 months following the determination
- Date of signature on delivery slip must be date the PMD was received by beneficiary or designee
- Suppliers required to maintain proof of delivery
  - Must be available upon request

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## Advance Determination of Medicare Coverage (ADMC)

- May be done if all following situations are met:
  - Customized item
  - Request made by beneficiary/supplier
  - Item not classified as inexpensive
- PMD Codes eligible for ADCM
  - Group 2, 3, 4 or 5 - “Single Power Option” or “Multiple Power Options” wheelchair, whether or not a power seating system will be provided at the time of initial issue
    - K0835 - K0843
    - K0856 - K0864
    - K0877 - K0891
  - Group 3 or 4 - “No Power Option” wheelchair that will be provided with an alternative drive control interface at the time of initial issue
    - K0848 - K0855
    - K0868 - K0871

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## Advance Determination of Medicare Coverage (ADMC)

- **How to request:**

- Must use ADCM cover sheet
  - Must provide specific supporting medical documentation
  - Mail/Fax to NHIC, Corp.
  - [www.medicarenhic.com/dme/forms/ADMC\\_Request\\_Fax\\_Cover.pdf](http://www.medicarenhic.com/dme/forms/ADMC_Request_Fax_Cover.pdf)

- **July 2006 Bulletin**

- Advance Determination of Medicare Coverage - Wheelchairs

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## Miscellaneous - Modifiers

- Add **KX** modifier to PMD and accessory codes if one of the following conditions is met:
  - If all of the coverage criteria have been met for the product that is provided; or
  - If there is an affirmative Advance Determination of Medicare Coverage (ADMC) for the product that is provided; or
  - If a Group 4 PWC is provided and if all of the coverage criteria for a comparable Group 3 PWC have been met
- Add **GY** modifier to PMD and accessory codes:
  - If face-to-face requirements are not met
  - If power mobility device or push-rim activated power assist device is only needed for outside the home

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## Documentation Reminders

- Date of the face-to-face must be documented by the physician
- Date stamp or equivalent by the supplier to verify receipt of the face-to-face within 45 days
- If a written order containing all of the required elements is not received within 45 days after completion of the face-to-face the **EY** modifier must be added to the HCPCS codes for the PMD and all accessories
- The detailed product description must be signed and dated by the physician and received and date stamped or equivalent by the supplier prior to delivery of the PMD

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## Frequently Asked Questions (FAQs)

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## PMD FAQs

**Q: Can a form that is developed by an entity other than the supplier and that is completed and signed by the physician and included in the patient's chart be considered sufficient documentation of the required face-to-face examination for PMDs?**

**A:** No. As stated in the Documentation Requirements section of the PMD Local Coverage Determination (LCD), physicians must document the face-to-face examination "in a detailed narrative note in their charts in the format that they use for other entries." Forms that are developed by other entities including but not limited to a supplier or professional association do not meet this requirement. Therefore, they are not sufficient by themselves to document that coverage criteria have been met. If a form is used, there must be documentation in the patient's medical record that corroborates the information on the form and verifies that coverage criteria have been met.

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## PMD FAQs

**Q: Can the detailed product description be on the same form as the written order for a PMD if all the information needed is available?**

**A:** No. The seven element order and the detailed product description must always be two separate pieces of paper.

The **seven element** order is a document that is written by the physician after completion of the face-to-face examination.

The **detailed product description** is a document that is prepared by the supplier and sent to the physician after the supplier receives the seven element order and the report of the face-to-face examination from the physician.

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## PMD FAQs

**Q: A supplier pays a physical therapist (PT) or occupational therapist (OT) to do wheelchair evaluations of non-Medicare patients (e.g., Medicaid only, commercial insurance). The PT or OT performs an evaluation on a Medicare patient and the supplier does not pay the PT/OT for that evaluation. Does Medicare consider that therapist to have a “financial relationship” with the supplier in the context of the Power Mobility Devices policy?**

**A:** Yes. In the situation that is described, the PT/OT is considered to have a financial relationship with the supplier. Therefore, even though the supplier does not pay the therapist for the evaluation of the Medicare patient, the evaluation of that patient cannot be considered part of the required face-to-face examination for all PMDs or the required specialty evaluation for rehab PMDs (Group 2 single and multiple power options power wheelchairs [PWCs], all Group 3 and Group 4 PWCs, and push-rim activated power assist devices for manual wheelchairs).

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## PMD FAQs

**Q: Is a face-to-face exam required for a PMD that is a replacement within the five year useful lifetime?**

**A:** If the PMD is a replacement during the 5 year useful lifetime of an item in the same performance group that was previously covered by Medicare and the original item had a qualifying face-to-face then a face-to-face examination is not required for the replacement.

If the original item qualified prior to the face-to-face requirement, a face-to-face is required when replacing it.

**Note:** *Replacement during an item’s useful lifetime is limited to situations involving loss or irreparable damage from a specific accident or natural disaster.*

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## PMD FAQs

**Q: Sometimes a physician refuses to give medical records when asked for them. Is there a regulation that requires a physician to provide these records?**

**A:** Section 1842 (p)(4) of the Social Security Act states: In the case of an item or service defined in paragraph (3), (6), (8), or (9) of subsection 1861(s) ordered by a physician or a practitioner specified in subsection (b)(18)(C), but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.

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## PMD FAQs

**Q: Is the face-to-face examination required for all wheelchairs?**

**A:** The face-to-face examination is required for all power mobility devices (PMDs). It is not required for manual wheelchairs.

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## DME MAC Resources



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## DME MAC A Resources

- **Customer Service**

- Provider IVR: **866-419-9458**

- Claim information
- Patient eligibility
- CMN status information
- Financial information
- Pricing and Appeals information
- General information

- Provider CSR: **866-590-6731**

- Beneficiary: **1-800-MEDICARE (1-800-633-4227)**



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## DME MAC A Resources

- **Provider Outreach & Education**
  - Outreach Specialists: **781-741-3950**
- **DME MAC A Web site**
  - [www.medicarenhic.com/dme](http://www.medicarenhic.com/dme)



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## DME MAC A ListServes

- **What is a ListServe?**
  - Email service that provides an opportunity for subscribers to receive reminders and announcements
  - Benefits of a ListServe - Be the first to:
    - Know important and time-sensitive Medicare program information and other important or urgent DME MAC A announcements
    - Learn about upcoming educational opportunities and training events
    - Know when our quarterly bulletins become available

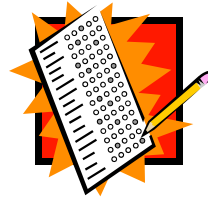
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## Open Discussion



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## Post-Test



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# Evaluations



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