

Jurisdiction B, C and D Combined Council Questions

Sorted by A-Team

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Disclaimer: *This Q&A document is not an official publication of the durable medical equipment, Medicare Administrative Contractors (DME MAC). The official guidance documents from the DME MACs are Centers for Medicare & Medicaid Services (CMS) manual instructions, national coverage determinations, local coverage determinations, bulletin articles, and supplier manuals.*

Documentation/Regulatory/Miscellaneous/Education

- 1. Providers are seeing Level 1 and Level 2 claims being denied in error. When calling a representative...the customer service representative (CSR) indicates that they can see that the appropriate documents were supplied, but then they proceed to explain that they cannot fix it...the claim will have to go to the next level. Now that administrative law judge (ALJ) decisions are delayed, it is even more important that Level 1 (redeterminations) and Level 2 (reconsiderations) are reviewed carefully.**

Will the Medicare Administrative Contractors (MACs) reconsider their approach to Level 1 and Level 2 denials and allow for reopening when an oversight has been made by the reviewing analyst?

Response: Reopenings are *not* a substitute for the appeals process. Contractors work to assure that the correct process is used to resolve issues.

- 2. Providers are seeing claims deny in audit for “one or more elements missing from the detailed written order (DWO)” However, upon review, all nine items expected for a DWO were present. For providers to properly respond, it is important that they clearly understand, specifically, what the auditor felt was missing.**

Can the MACs provide specific information on which of the nine elements the auditor feels is missing?

Response: This is a claim specific issue. Refer to the appropriate contractor.

- 3. According to the Comprehensive Error Rate Testing (CERT) review contractor, Advance Med, they have found that 90 percent of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are not compliant with Quality Standards, Section II, A-2: Beneficiary Records states that, “The DMEPOS prescription, any certificates of medical necessity (CMNs), and pertinent documentation from the beneficiary’s prescribing physician shall be kept unaltered in the beneficiary’s record.”**

Based on the MAC’s collaboration with CERT, can the MACs provide information on what Healthcare Procedure Coding System (HCPCS) codes were audited and what documentation was missing or altered?

Response: Individually, a supplier can reach out to the contractors CERT coordinator. Contact information is available on each contractor's website. Consolidated reports can be found on the CMS website which identifies service type denials, provider type and coding errors. Last report released was on January 27, 2014 and was called the Appendices Medicare Fee-for-Service 2013 Improper Payments Report. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/CERT-Reports.html>

4. **Previously, CMS indicated that the Provider Enrollment, Chain and Ownership System (PECOS) edits would not affect payment for equipment in a capped rental period, to allow continued coverage through the capped rental period. The language in the answer is somewhat confusing, because they referenced "13 months from the physician's date of deactivation." Can you please confirm that claims processing logic on capped rental claims (initially dispensed prior to January 06, 2014) where the practitioner is NOT registered in PECOS (regardless of whether the practitioner was deactivated or simply never enrolled)?**

Response: The instructions given were only for physicians whose number was deactivated from PECOS. Beneficiaries with ordering physicians who have never been enrolled in PECOS should consider seeing a different physician and getting a new order.

5. **At times, providers find that a physician may sign and date an order but many assume (especially when completing the order via a pad Rx) that the date the prescription is signed and dated is the effective date of the order. Must providers request that the physician add the start date of the order to the pad Rx in order to meet the minimum written order prior to delivery (WOPD) requirements when an order only lists the signature date; or will the DME MAC consider the start date of the order to be the same as the signature date in instances where a "start date" is not otherwise indicated?**

Response: A start date is only required if different from the date of the order. In other words, if the physician does not want the beneficiary to use the particular device or drug until a specific time, then that date should be included on the order as the start date.

6. **For clarification, we also see desk pad prescriptions where the date is at the top and the prescriber signs below but does not include an additional date next to his/her signature. In those instances, can providers assume that the date on top of the pad Rx (when combined with a signature and all other applicable elements).**

- a. **Would be acceptable in meeting the WOPD date requirements (element #5 of the MLN MM8304)?**

Response: No, there are two separate date requirements. 1) The date of the order. 2) The date the order is signed.

- b. **Also, how about electronically printed physician orders which just list the electronic signature with a date? There are various forms of these electronic documents.**

Response: All standard documentation requirements for detailed written orders (DWO) must be met.

7. **Is the National Provider Identifier (NPI) on the WOPD verified? If yes, what happens if there was a typographical error and the number is incorrect?**

Response: If the NPI on the claim is not valid due to a transposition/typographical error, the claim will be dismissed if it's a paper claim and denied CO-16 if it's an electronic claim. The supplier should research, correct, and resubmit.

8. **In reference to face-to-face (F2F) rule, as outlined in Section 6407 of the Affordable Care Act (ACA): Many patients being released from a hospital will have had a proper F2F evaluation completed during the hospital stay by one of the hospital physicians. It is very common for the evaluation to be completed by a different practitioner than the practitioner completing the discharge orders, based upon the rotation and timing of the evaluation and the discharge.**

In the situation of a hospital discharge, is it acceptable for the WOPD to be signed by a different hospital practitioner than the practitioner that completed the F2F evaluation?

Response: The DME MACs are awaiting guidance from CMS on the issue of whether the prescriber must be the provider of the in-person visit.

9. **The *Jurisdiction B DME MAC Supplier Manual* states that the following requirements apply to continued medical need:**

For ongoing supplies and rental DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the date of service under review. Any of the following may serve as documentation justifying continued medical need:

- A recent order by the treating physician for refills
- A recent change in prescription
- A properly completed CMN or Durable Medical Equipment Information Form (DIF) with an appropriate length of need specified
- Timely documentation in the beneficiary's medical record showing usage of the item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified in policy.

When an order, prescription, CMN or DIF is used as proof of continued medical need, how long can those documents show continued need? The medical records support up to 12 months of continued need under the definition of "timely documentation," but there is not any guidance of how long an order, prescription, CMN or DIF can support continued need.

Response: The preceding 12 month rule applies to all documentation to support continued need.

10. **In 2008 Medicare question and answer (Q&A) stated: Does the treating physician who does the initial face-to-face examination have to write the order for the positive airway pressure (PAP) therapy or can it be ordered by the interpreting physician from the sleep lab? Answer: The treating physician that does the initial face-to face exam does not have to be the same physician that orders the PAP.**

Now the update on 11/25/13: Q: If a beneficiary has a F2F prior to their sleep study by their treating physician and then is seen by a specialist after the sleep study, can the DWO for the PAP be signed by the specialist? A: No. The physician who conducts the F2F must sign the DWO.

- a. **Does this mean that the treating physician can no longer do the F2F and then have the specialist interpret the study, order PAP therapy and conduct the follow-up visit to establish compliance and continued need?**

Response: The initial in-person visit is to assess whether sleep testing is justified. The primary care physician (PCP) orders the testing at that time but does not order the equipment, pending the test results. Once testing is done the prescription for the DME may be ordered by a treating physician, which may be the PCP or the sleep doc. This prescription must be ACA compliant.

- b. **Does the specialist need to conduct the F2F prior to the sleep study?**

Response: The current PAP F2F requirements prior to a sleep study apply.

- c. **If the treating physician does the F2F, signs the WOPD/DWO, does that same physician need to conduct and document the follow-up for continued rental after the initial three months?**

Response: It would be acceptable for another physician to complete the evaluation to confirm adherence to therapy, there are multiple treating physicians at times.

11. **For place of service #54—an intermediate care facility/mentally retarded according to the national place of service (POS) code set—the definition is a facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or skilled nursing facility (SNF).**

According to the local coverage determination (LCD) for urological supplies, one of the requirements is the beneficiary resides in a nursing facility. This residence is a facility but is not a skilled nursing facility. Does Medicare cover urological supplies for a Medicare beneficiary in a POS 54 and if so are there any limitations?

Response: Medically necessary urological supplies are covered in POS 54.

12. **Is there any more information regarding CMS's requirement on:**

- a. **The full signature (and date) regarding any changes made on a document versus using initials and date?**

Response: Recordkeeping principles are outlined in the CMS Internet-Only Manual (IOM) Publication 100-08, *Medicare Program Integrity Manual (PIM)*, Chapter 3, Section 3.3.2.5 B:

Paper Medical Records: When correcting a paper medical record, these principles are generally accomplished by using a single line strike through so that the original content is still readable. Further, the author of the alteration must sign and date the revision. Similarly, amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record.

Electronic Health Records (EHR): Medical record keeping within an EHR deserves special considerations; however, the principles wed above remain fundamental and necessary for document submission to MACs, CERT, recovery auditors, and zone program integrity contractors (ZPICs). Records sourced from electronic systems containing amendments, corrections or delayed entries must:

- a. Distinctly identify any amendment, correction or delayed entry, and

- b. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

Corrections to CMNs are outline in the CMS IOM Publication 100-08, *PIM*, Chapter 5, Section 5.3.1: *If there is a change made to any section of the CMN after the physician has signed the CMN, the physician must line through the error, initial and date the correction; or the supplier may choose to have the physician complete a new CMN.*

- b. **How have physicians been educated? (Most do not realize or believe that this is the case.)**

Response: Physicians are educated by the A/B MAC. The above applies to part B physicians.

Enteral/Parenteral/IV Therapy

- 13. **Now that the external infusion pump category is effective for competitive bid Round 1 Recompete, what modifiers will be appropriate for E0781, external infusion pump, as well as for E0776, the IV pole?**

Response: Hospitals in a Round 1 Recompete competitive bidding areas (CBA) bill modifier J4 with E0781 when providing the E0781 to its own patients. Similarly, physicians or treating practitioners who are enrolled as DMEPOS suppliers append modifier KV to E0781 when providing the item to his or her own patients as part of his or her professional service. Detailed information regarding the use of these codes is available within the Fact Sheets located on the [Competitive Bidding Implementation Contractor's \(CBIC\) website](#).

Suppliers should refer to the Single Payment Amount (SPA) Files on the CBIC website to determine modifier requirements for items within the external infusion pump category. Per the SPA files, modifier KG is not required for E0776; however, certain supply codes do require modifier KG.

- 14. **A supplier is furnishing total parenteral nutrition (TPN) therapy to a beneficiary. The supplier is billing for the TPN bag of protein (B4189–B4199), the lipids (B4185), infusion pump, and the items that are included in a daily “kit” code, e.g.: TPN administration kit (B4224) and TPN supply kit (B4220) for each day a bag of TPN is administered.**

For purpose of meeting the request for refill (RFR) requirements, the supplier is contacting the beneficiary prior to the next delivery to determine the amount of TPN bags on hand, continued use of the pump, and when the next delivery will be needed.

Since the parenteral administration “kit” and parenteral supply “kit” are billed as “a daily allowance” for TPN administration, and therefore are not subject to the RFR requirements, could the TPN LCD be revised to include this language? This would be a proactive solution to decrease the number of negative audit decisions for not documenting the remaining supplies on hand, when there is clear documentation of the number of TPN bags remaining.

Language in the enteral LCD was revised 5.1.2013 to include: Supply allowance HCPCS codes (B4034-B4036) are daily allowances, which are considered all inclusive, and therefore refill requirements are not applicable to these HCPCS codes. Refer to the Coding Guidelines section in the Policy Article for further clarification.

Response: The DME MACs do not look for refill requirements on anything coded as a supply allowance regardless if the LCD has been updated or not.

- 15. External Infusion Pump Category: For the external infusion pump (EIP) E0781 and E0791 and the IV pole E0776, we are unclear what modifiers to use when billing for denial (statutorily excluded drug) in a competitive bid area by a noncontracted competitive bid supplier.**

Response: Per the EIP LCD: “Drugs and related supplies and equipment billed by a supplier who does not meet these criteria will be denied as not reasonable and necessary.” If the drug is going through an external infusion pump and does not meet the coverage criteria the supplier should consider executing an advance beneficiary notice of noncoverage (ABN) and submitting the claim with a GA modifier in order to shift liability to the beneficiary. The supplier should also indicate they are a noncontracted supplier within the CBA. The EIP policy article says: “Drugs are only covered as a supply to a covered DME infusion pump. Drugs billed alone (without a covered pump being used) will be denied as statutorily noncovered (no benefit).” In the case of no pump the GY modifier should be used on the drug and related supplies.

- 16. Parenteral Nutrition Category: For IV Pole, E0776, used with either parenteral nutrition or enteral nutrition therapy;**

- a. Please clarify when a supplier should use the KG modifier?**

Response: The KG (and BA) modifier is used on the IV pole for beneficiary’s who reside in CBA when enteral is billed. For beneficiaries who do not reside within a CBA, the KE modifier is required for the IV Pole when billing parenteral nutrition. The KG modifier is not used for IV poles billed with parenteral nutrition.

- b. Please clarify what modifiers noncontracted, CBA providers should use when billing for denial (does not meet benefit requirements).**

Response: GY as well as any payment category modifiers, i.e. NU, RR, UE

Oxygen

- 17. With regard to the WOPD for F2F items, some of these items (such as gaseous contents (E0443)) are billed following the ending of the oxygen rental cycle. The oxygen policy article states: “When billing oxygen contents (refer to the policy article, non-medical necessity coverage and payment rules section), suppliers should use a date of service (DOS) that is the anniversary date of the equipment whose rental period has ended. The billed DOS will usually not be the actual delivery date. The supplier must have a delivery slip for the actual delivery date.”**

- a. Would the F2F visit be required, six months prior to which date...the actual delivery date of the contents or the date of service that is billed to Medicare?**

Response: In the first 36 month there is no separate billing for contents. Contents are considered included in the monthly payment for the stationary item. From months 37 to 60 contents are separately billable with a unique HCPCS code. If that code is on the original (premonth one DWO), then no additional prescription is necessary in order to correctly bill for contents. However, if the correct HCPCS code for contents is not specifically listed on the original DWO, a prescription will be needed. For prescriptions obtained after 07/01/13 the ACA requirements apply.

- b. Would the face to face WOPD need to be received prior to the anniversary date (the DOS) or the actual delivery date?**

Response: The WOPD is required prior to dispensing a gas or liquid oxygen system which includes the contents. If the content was not on the original WOPD, a new WOPD would be required prior to delivery.

PAP/Other Respiratory Care Equipment

18. If a patient has had a sleep study and qualified for therapy but refused treatment at that time, is there a time limit on how long the first sleep study is valid? For example, if a patient had a sleep study in January 2012, qualified for PAP therapy but refused treatment and in January 2014 has decided to start therapy, can the sleep study from 2012 be used if the patient has a face to face visit completed by the physician and documentation stating the need for therapy?

Response: No.

19. Regarding [LCD for Respiratory Assist Devices \(L27228\)](#) chronic sleep apnea (CSA) definition:

a. One requirement is stated “Central apneas/hypopneas greater than 50 percent of the total apneas/hypopneas.”

i. Is this to be interpreted as central apneas and/or central hypopneas greater than 50 percent of the total apneas/hypopneas?

Response: Yes.

ii. Or can undefined hypopneas (hypopneas not scored as central, obstructive, or mixed) be included with central apneas to qualify a patient for an E0471?

Response: No. Undefined means not defined and thus are not relevant to the determination.

b. Another requirement is stated “Central apneas or hypopneas greater than or equal to five times per hour.”

i. Is this to be interpreted as central apneas and/or central hypopneas greater than or equal to five times per hour?

Response: Yes.

ii. Or can undefined hypopneas (hypopneas not scored as central, obstructive, or mixed) be included with central apneas to qualify a patient for an E0471?

Response: No, see above.

c. Could a patient qualify for an E0471 if a sleep study with an apnea-hypopnea index (AHI) greater than or equal to five, didn't show any apneas, and showed only undefined hypopneas (hypopneas not scored as central, obstructive, or mixed)?

Response: No, the diagnosis of CSA must be established.

d. Could a patient qualify for an E0471 if a sleep study with an AHI greater than or equal to five, didn't show any apneas, and showed only undefined hypopneas (hypopneas not scored as central, obstructive, or mixed) and the physician interpreting the sleep study notes they are central events and/or interprets it as CSA?

Response: No, same as above

Prosthetics/Orthotics

20. There have been reports of denials for L5940 and L5950 (Ultra-light material) when providing a replacement socket for a definitive prosthesis. The [lower limb prosthesis LCD](#) is clear that these codes are used to describe materials used in the fabrication of an endoskeletal socket. Are these codes eligible for coverage subject to medical necessity criteria when provided as part of a socket replacement?

Response: These codes were designed as add-on codes to metal components that were redesigned with lightweight material. Socket construction materials are already defined and these codes are not add-ons to sockets.

Rehab Equipment

21. Providers are having increased difficulty getting ordering practitioners to list the date they co-sign the licensed/certified medical practitioner (LCMP) evaluation as the date of the completion of the F2F on the seven-element order (7EO) when the patient was previously seen by the ordering practitioner for the F2F mobility exam. Is it acceptable to have the ordering practitioner list two dates on the 7EO?

a. The date the ordering practitioner signs the LCMP evaluation and

Response: One date should be listed on the 7EO per the policy article.

b. The date the patient was seen in the office for the mobility exam.

Not all DME MACs apply the “two date format” equally. DME MAC C is the only one we are aware of that will not allow two dates.

Response: One date should be listed on the 7EO per the policy article.

22. Regarding information provided on December 12, 2013 Status Report for Quarter 3 - 2013
HCPCS CODE K0823 SERVICE-SPECIFIC PREPAYMENT REVIEW
<http://cgsmedicare.com/jc/pubs/news/2013/1213/cope24043.html>

The F2F date information in the December article example does not match the [power mobility device \(PMD\) LCD](#).

Case study from December article:

- Mobility evaluation was conducted by a physical therapist on 07/31/2013
- The ordering physician concurred with, signed and dated the evaluation on 10/03/2013
- The ordering practitioner performed a F2F mobility exam on 09/26/2013

According to the article, the F2F date listed on the 7EO should be 09/26/13 because there was a F2F encounter between the physician and beneficiary AFTER the LCMP visit.

For power wheelchairs (PWC) that require a LCMP specialty evaluation per the LCD, the specialty evaluation is part of the F2F process (the file is incomplete without it). How can the ordering practitioner write the 7EO without reviewing, concurring with and signing the specialty evaluation?

Response: The scenario presented in the article provides an incorrect response and will be revised. The dispensing of power mobility devices has two requirements:

1. In-person visit with the treating physician – For the purpose of requesting a PMD AND
2. Mobility Examination – By either the treating physician or another healthcare practitioner (LCMP)

Both of these requirements must be met in order for coverage to be met. In other words, the face-to-face exam is defined as complete when:

The physician has had an in-person (face-to-face) visit with the patient;

AND EITHER

1. The physician completed a comprehensive functional assessment to determine the medical need for the wheelchair base; **or**,
2. The physician has done a partial assessment and referred the beneficiary to another medical professional to complete the exam; **or**,
3. The physician has done no assessment but instead has referred the beneficiary to another medical professional to complete the exam.

In the scenario presented in the article, the correct date to list as the F2F date on the 7EO is the 10/03/13 date. This is when the F2F process was completed by the physician (i.e., when he indicated concurrence/disagreement, signed and dated the LCMP examination).

23. Are there any updates on the appropriate processing of claims with of the KY modifier as it relates to Competitive Bidding Round 2?

Response: No. Items billed with the KY modifier for beneficiaries who permanently reside in a CBA should receive the fee schedule amount which includes the 9.5 percent reduction. Any inappropriate denials/payments should be submitted to the Supplier Contact Center within the appropriate jurisdiction.

24. Are there any updates on the instructions on modifiers for the Round 1 recomplete?

Response: No additional instructions at this time.

25. A beneficiary owns a motorized wheelchair that was funded by Medicare, and the new servicing provider has obtained the original documentation from the patient's medical record regarding the motorized wheelchair. The beneficiary has not received any other equipment subsequent to this motorized wheelchair. Would an order (DWO) be required to repair, including replacement component parts, the patient owned equipment that was funded by Medicare?

Response: An order is not required for repairs or items necessary for the repair. Major components that have their own coverage criteria (i.e. items found in the [Wheelchair Options and Accessories](#) or [Wheelchair Seating LCD](#)) that are replaced are not considered a repair, but a replacement. Replacement order and documentation requirements would be required.

26. There appears to be a conflict between the new WOPD/F2F regulations and the language in the PIM that states that a new prescription is not required in order to provide a repair (including replacement parts) to beneficiary owned equipment. Would you please clarify these requirements?

Response: Vague question – please provide additional information.

27. For wheelchair accessory codes (e.g. E1002 Power Tilt), classified as of 04/01/14, under the capped rental DME payment category and furnished for use with a complex rehabilitative power wheelchair (that is, furnished to be used as part of the complex rehabilitative power wheelchair), we are aware that the supplier must give the beneficiary the option of purchasing these accessories at the time they are furnished.

- a. Would the language used in the rent/purchase option template letter for complex rehab PWC bases be acceptable to use to indicate the beneficiary's purchase selection of these accessories?

Response: Yes.

- b. Many wheelchair accessory codes (e.g. E1002 Power Tilt) changed to capped rental as of 04/01/14. Beneficiaries receiving these items will then need to be offered a purchase option. Will one purchase option letter be sufficient for both the base and any capped rent accessories/options?

Response: Yes. Recommend adding base and accessories to your option letter.

- c. Must all options be listed specifically, or can the letter cover "power wheelchair with all options/accessories"?

Response: Yes. The supplier can list "power wheelchair and all options/accessories".

28. Assume a beneficiary began a K0823 rental in May. Beneficiary is now transferring to a contract supplier. The original supplier has provided the contract supplier with all the documentation. Since it is a change in supplier, a new order and detailed product description (DPD) are needed. The F2F is greater than 45 days old.

- a. Is a new F2F for the PMD required since the contract supplier will be starting from month one and the F2F was conducted greater than 45 days ago?

Response: Yes

- b. This is not a PA demo state. Is there any difference in the way things work if the original supplier did not choose to grandfather, or if the original supplier grandfathered and the beneficiary chooses to move to a CB supplier?

Response: No

- c. If the new supplier's first month claim is more than 120 days (4 months) after the original rental date, would that mean that a new F2F visit must take place?

Response: Yes

29. Providers have been getting claims denied for replacement of an integral controller for incorrect code when billed with K0108 (per policy). Since this does not meet the definition of any other type of controller wouldn't this be the correct code to use?

Response: If there is no other HCPCS code yes the K0108 may be used. The narrative must have a complete description. Refer to the PDAC for correct coding of specific products.

30. There is a line in the PMD policy that states (under “Specific Types of Power Wheelchairs”): “If a Group 2 Single Power Option PWC is provided and if criterion II(A) or II(B) is 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 power elevating leg rests), it will be denied as not reasonable and necessary.” However, the policy article also states: “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 leg rests, 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 can only accommodate a power tilt could qualify for this code.” When LCA and K0830/K0832s were removed as viable options, Group 2 chairs were not accounted for in the policy.

a. What is the DME MAC’s suggestion here?

Response: Suppliers should consider submitting the claim as an upgrade if the power option is not for a covered item. The supplier would follow the upgrade guidelines. Refer to the PDAC for any coding questions regarding specific products. Remember that the reasonable and necessary criteria are based upon codes and code groups, not upon the individual characteristics of specific products.

b. There is definitely a hole in the policy; if a PWC is provided with a seat elevator as the only power option, should they bill as a single power (SP) unit (as an upgrade) and if they did would the chair still need to go through prior authorization (PA) since it is an SP base according to policy even though the power function is not a covered one or would it bill as a no-power base?

Response: The PA would need to go through for the no-power base and then bill as an upgrade.

31. Jurisdictions A, B and D wheelchair accessory policies all state the following: Revision Effective Date: 01/01/2006

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added requirement for a written order prior to delivery for power wheelchair accessories.

Added statement concerning accessories for roll-about chair and transport chair.

Revised the types of batteries that are separately payable with power wheelchairs.

Revised non-coverage statement concerning attendant control for power wheelchairs.

Updated section with HCPCS code changes.

CODING GUIDELINES:

Updated section with HCPCS code changes.

Added guidelines for accessories for roll-about and transport chairs.

Added definitions for tires and wheels for manual wheelchairs.

Added roll-about chairs and transport chairs to the correct coding table.

Added E2212 and E2215 to the correct coding table as column I codes.

Revised the Column II codes in the correct coding table for Column I codes for Manual Wheelchairs, Power Wheelchairs, K0069, K0070, K0071, K0072, K0077.

C states:

Revision Effective Date: 01/01/2006

HCPCS CODES AND MODIFIERS:

Added: E0705, E2207-E2226, E2371, E2372

Revised: E0971

Discontinued: E0972, K0064, K0066-K0068, K0074-K0076, K0077, K0078, K0102, K0104, K0106, K0452

PDAC has it as an active code.

C is the only Jurisdiction listing K0077 as discontinued. Can this be revised to match the other Jurisdictions?

Response: JC has updated this document.

32. There is a discrepancy between the requirements necessary for code verification of PWC bases as No Power Option, Single Power Option or Multiple Power Option through the PDAC and the description of these same “options” through the DME MACs.

c. Into what power options base category (no power option, single power option or multiple power option) would each of the following configurations fall based on coding guidelines published by the PDAC and the DME MAC? Note the PDAC and DME coding guidelines differ (see below).

i. Power elevating foot platform (1 actuator)

Response: No power option

ii. Power elevating legrests (2 actuators)

Response: No power option

iii. Power tilt (1 actuator) and a power elevating foot platform (1 actuator)

Response: Single power option

iv. Power recline (1 actuator) and power elevating legrests (2 actuators)

Response: Single power option

v. Power seat elevation (1 actuator), non-covered

Response: Noncovered single power option. Recommend upgrade guidelines

vi. Power standing system (1 actuator), non-covered

Response: Noncovered single power option. Recommend upgrade guidelines

Power Options Definition

PMD LCD Policy Article (PA): Tilt, recline, elevating legrests, seat elevators, or standing systems that may be added to a PWC to accommodate a beneficiary’s specific need for seating assistance.

PDAC Coding: 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 Option Definition

PMD LCD PA: 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.

PDAC Coding: A category of PWCs that is incapable of accommodating any power options.

Single Power Option Definition

PMD LCD PA: 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 can only accommodate a power tilt could qualify for this code.

PDAC Coding: A category of PWCs with the capability to accept and operate only one power option at a time on the base. A PMD does not have to be able to accommodate all features to qualify for this code. For example, a power wheelchair that can only accommodate a power tilt could qualify for this code.

Multiple Power Option Definition

PMD LCD PA: 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 leg-rests, a power seat elevator, and/or a power standing system. A PWC does not have to accommodate all features to qualify for this code.

PDAC Coding: A category of PWC with the capability to accept and operate more than one power option at a time on the base. A PWC does not have to accommodate all features from the defined list of power options to qualify for this code, but must be capable of having more than one power feature present and operational on the PWC at the same time.

We would like to work with the DME MACs to revise the policy language such that it accurately defines “power options” and power seating technology; accurately reflects the electrical connections and components to operate power options; and, redefines the application of non-covered power options. Would the DME MACs support a revision of the PMD LCD and Policy Article? If so, do the councils need to follow the LCD reconsideration process to accomplish this?

Response: Follow the LCD reconsideration process.

- 33. In regard to the changes in pricing category from inexpensive, routinely purchased (IRP) to Capped Rental, what are the actual modifier instructions? For example, if someone was to receive a power tilt (E1002) on a complex power rehab base and the beneficiary selected to purchase the tilt, should providers use the KHBP modifier—effective April 7th?**

Response: Yes. The KHBP in addition to NU and either the KX, GA or GY.

- 34. If a beneficiary has a complex rehab power base from a year ago, and now a power tilt is being added due to a condition change,**

a. Are they able to still select to purchase the tilt (through a purchase option letter)?

Response: Yes

b. What are the modifiers required?

Response: For a purchase the modifiers would be KHBPNU and either the KX, GA or GY.

c. Will the Medicare system be able to recognize this since it will not be on a full wheelchair base order?

Response: The complex rehab chair should be in history or the beneficiary owned information must be indicated within the narrative section of the claim.

d. A beneficiary received a K0848 (Group 3 No Power Option) 2 years ago, and their condition has changed which now requires the use of a power tilt system. The manufacturer of the K0848 has a retrofit kit that allows the tilt system to be added to the existing no power option base at a significantly lesser cost than providing an entire new chair. The Medicare Recovery Auditor (MRC) has recently denied K0848 bases, retroactively, when power seating is added at a later date (EXAMPLE 1: CCNs Removed XXXX). Can this powered seating be billed on a no power base?

Response: Yes, may have to go through appeals to show the conversion was added to retrofit.

e. How would the MAC instruct for this to be billed?

Response: E1002

f. There would be a code for the power tilt system itself (i.e. E1002) and the retrofit kit (possibly K0108?).

Response: This depends on what items fall within the retrofit kit.