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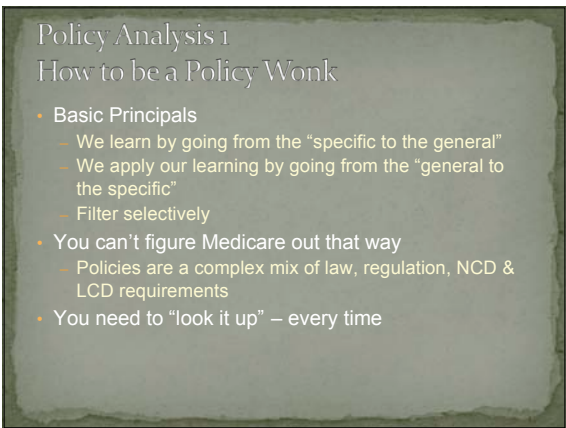
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## Policy Analysis 2

- Core concepts
  - Defined benefit program
    - Benefits are created by congress, e.g. Part D
    - No benefit, no coverage, no appeal, medical condition/needs are not relevant, no exceptions
    - Binding on all
  - R&N
    - "Reasonable and Necessary" AKA medical necessity
    - R&N is defined by Medicare policy NOT by the prescribing physician.

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## Policy Analysis 3

- Coverage Determinations
  - NCDs and LCDs set out the R&N criteria
  - LCDs are your PRIMARY source of guidance.
- Articles, FAQ, etc.
- 3<sup>rd</sup> party sources

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## PMDs 1

- Compliance, are we there yet?
  - Depends on how you look at it.
- For consumer products, high error rates persist
- Not so for rehab community.

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## PMD 2

- Errors fall into 2 broad categories
  - Technical
    - Prescriptions
    - Sequence
    - Timing
  - R&N

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## PMD 3

- Technical review (sequence counts)
  - F2F - 2 elements
    - In person visit to request
    - Medical evaluation
  - 7-element order
  - DPD
  - Home assessment
  - Delivery

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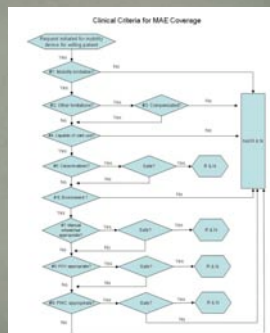
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## PMD 4

- R&N MAE NCD
- LCD criteria



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## Manual Mobility 1

- Do the criteria differ (from PMDs)?
  - Yes – no F2F, 7-element order, DPD, required
  - No – MAE NCD algorithm and usual PIM requirements apply

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## MAE NCD (up to Manual WC)

1. Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs 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 participate in 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 participate in MRADLs at home?
  - a. Some exceptions are significant impairment of cognition or judgment and/or vision.
  - b. For these beneficiaries, the provision of MAE might not enable them to participate in MRADLs if the comorbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with MAE.
3. If those other limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of MAE will be reasonably expected to significantly:
  - a. Improve the beneficiary's ability to perform or obtain assistance to participate in MRADLs in the home?
    - i. 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. The caregiver's mood
    - ii. Use a wheelchair to assist the beneficiary in the MRADLs to be considered in the determination.
    - iii. If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether intentional or inadvertent, can be grounds for denial of MAE coverage. If failure in the beneficiary continues to have a significant limitation, it may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of MAE.
  - b. Does the beneficiary or caregiver demonstrate the capability and the willingness to consistently operate the MAE safely?
    - i. 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.
    - ii. A history of unsafe behavior in other venues may be considered.
4. Can the functional mobility deficit be sufficiently resolved by the provision 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.
5. Does the beneficiary's typical environment support the use of wheelchairs including scooters/power-operated vehicles (POVs)?
  - a. Determine whether the beneficiary's environment will support the use of these types of MAE.
  - b. Items in a room such as floors, physical layout, surfaces, and obstacles, which may render MAE unusable in the beneficiary's home.
6. Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair in the home to participate in MRADLs during a typical day? The manual wheelchair should be optimally configured (seating system, wheelchair, device weight, and other appropriate accessories) for this determination.
  - a. Limitations of strength, endurance, range of motion, coordination, and balance or dexterity 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, i.e. light weight etc. 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. Some power-operated vehicles may require a ramp or lift.

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## Seating and Positioning 1 Dx driven?

- Answer – Sort of but not really.
- A skin protection seat cushion (E2603, E2604, K0734, K0735) is covered for a patient who meets both of the following criteria:
  1. The patient has a manual wheelchair or a power wheelchair with a sling/solid seat/back and the patient meets Medicare coverage criteria for it; and

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## S&P 2

- 2. The patient has either of the following:
  - a. 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

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## S&P 3

- Skin Protection #2 cont'd.
  - b. 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), muscular dystrophy (359.0, 359.1).

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## S&P 4

- 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;

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## S&P 5

- 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 or OT may have no financial relationship with the supplier

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## Repairs FAQ Review

- Q1. Clarify the terms "repair" and "replacement" as used in the September 2003 bulletin on repair/replacement issues. Does the 5-year useful lifetime rule apply to replacement parts used to repair DME (e.g., tires and batteries)?
- A1. Repair means to fix or mend. During the course of a repair, parts or components of a base item may be replaced. The replacement of parts or components that make up a base item is considered a repair. When the base item is completely replaced with a new base item, that is considered a "replacement". The default 5-year reasonable useful lifetime applies to replacement of the base item, not to parts and accessories.

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## Repair FAQ 2

- Q2. How often can tires, batteries, etc. be replaced? If the claim denies for frequency limitations, does the supplier get a PR (patient responsibility) denial or a CO (contractual obligation) denial?
- A2. No routine or prophylactic replacement is appropriate. Wear items such as batteries and tires are eligible for replacement as a repair to a wheelchair only when they become non-functional. Because the frequency of necessary replacement can vary so much depending on how an individual beneficiary uses his/her wheelchair, it is difficult to set a "usual" replacement frequency. Suppliers are reminded that they should maintain records documenting the need for the repair. Repairs are covered under Medicare only when made to medically necessary equipment. Thus, denials associated with repairs are considered "medical necessity" denials, which get a CO message - unless an ABN has been obtained.

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### Repairs FAQ 3

- Q3. For repairs to equipment not purchased by Medicare, what are the requirements?
- A3. CMS policy is clear. IOM 100-2, Ch. 15, §110.2 states,  
  
*"[P]ayment may be made for repair, maintenance, and replacement of medically required DME, including equipment which had been in use before the user enrolled in Part B of the program."*
- Key to implementing this provision is in understanding the criteria that the equipment is "medically required DME". The criteria means that all of the applicable benefit category and reasonable and necessary requirements for the base item must be met before the item is eligible to have repairs reimbursed. These criteria are generally found in the relevant LCD.

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### Repairs FAQ 4

- Q4. When repairs are made to equipment by a supplier who did not sell the equipment to the client, it is often difficult to get the correct date of purchase and HCPCS code. Although the repair supplier can verify through the IVR if Medicare paid a claim, that supplier does not know if the original supplier had the proper documentation and was paid properly. Is there a way the repair supplier can be protected?
- A4. No. The requirement that repairs are covered for medically necessary equipment applies regardless of who is performing the repair.

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### Repairs FAQ 5

- Q8. If a beneficiary refuses to bring their equipment to the supplier location, can they be charged a fee for this service?
- A8. No. Medicare's payment for repairs, i.e., parts and labor, is all-inclusive. There is no separate payment for travel time, service charges, fuel surcharges, etc. On an assigned claim, suppliers may not charge a beneficiary for these costs. On a nonassigned claim, the beneficiary will be responsible for the difference between the submitted charges for the repairs and the amount Medicare pays.

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## Repairs FAQ 6

- Q9a. The reasonable useful lifetime for durable medical equipment is 5 years. If an item that is less than 5 years old needs to be repaired because of “wear and tear” (rather than a specific incident) and a thorough evaluation reveals that the cost to repair the equipment exceeds the cost to replace the equipment would Medicare consider payment for a replacement piece of equipment?
- Q9b. If the equipment has been repaired on several different occasions, is in need of repair again, and no single repair has exceeded the cost to replace the equipment but the cumulative repair costs will exceed the replacement cost, would Medicare consider payment for a replacement piece of equipment?
- A9a&b. No, according to Medicare statute, during an item’s reasonable useful lifetime, payment can only be made for repairs up to the cost of replacement.

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## “Wear and Tear”

- Routine periodic servicing, such as testing, cleaning, regulating, and checking of the beneficiary’s equipment, is not covered.
- Equipment which the beneficiary owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood). A physician’s order and/or new Certificate of Medical Necessity (CMN), when required, is needed to reaffirm the medical necessity of the item.

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## “Wear and Tear” 2

- Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment. If the item of equipment has been in continuous use by the patient on either a rental or purchase basis for the equipment’s useful lifetime, the beneficiary may elect to obtain a new piece of equipment. Replacement may be reimbursed when a new physician order and/or new CMN, when required, is needed to reaffirm the medical necessity of the item.
- Replacement due to wear is not covered during the reasonable useful lifetime of the equipment. During the reasonable useful lifetime, Medicare does cover repair up to the cost of replacement (but not actual replacement) for medically necessary equipment owned by the beneficiary

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### Repair Billing 1

- K0739 (REPAIR OR NONROUTINE SERVICE FOR DURABLE MEDICAL EQUIPMENT OTHER THAN OXYGEN REQUIRING THE SKILL OF A TECHNICIAN, LABOR COMPONENT, PER 15 MINUTES).
- One unit of service = 15 minutes.
- Code E1340 is no longer valid for repairs for dates of service on or after April 1, 2009.

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### Repair Billing 2

- The table contains repair units of service allowances for commonly repaired items.
- Units of service include basic troubleshooting and problem diagnosis.
- Suppliers are reminded that there is no Medicare payment for travel time or equipment pick-up and/or delivery.

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### Repair Billing 3

- Suppliers may only bill the allowable units of service listed in the above table for each repair, regardless of the actual repair time.
- Claims for repairs must include narrative information itemizing each repair and the time taken for each repair.
- Suppliers are also reminded that Medicare does not pay for repairs to capped rental items during the rental period or items under warranty.

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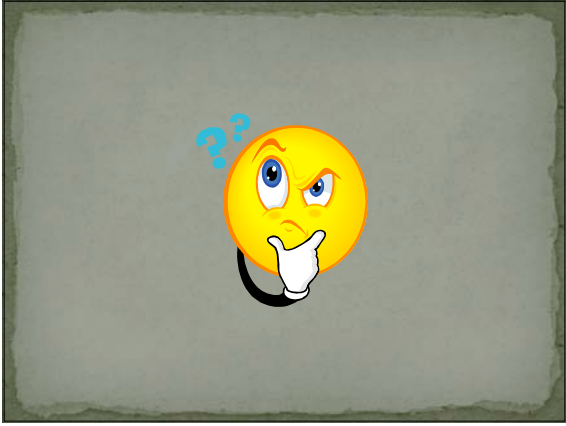
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