



CMA Weekly Alert – October 12, 2006

MEDICARE AGENCY CLARIFIES LOCAL COVERAGE DETERMINATION FOR POWER MOBILITY DEVICES

On September 20, 2006, the Centers for Medicare & Medicaid Services (CMS) issued a Fact Sheet announcing its clarification of a Local Coverage Determination (LCD) outlining the process that Medicare Carriers are to use in determining the appropriate power mobility device (PMD) for use in the home by a Medicare beneficiary. PMDs include power wheelchairs and scooters. The clarified LCD and 2006 PMD fee schedule ceiling and floor amounts will be effective on November 15, 2006. (See, <http://www.cms.hhs.gov/apps/mediapress/release.asp?Counter=1966>).

Background

CMS determined that a clarification regarding PMDs was necessary to address concerns of suppliers, clinicians, and manufacturers who felt that CMS' policy lacked the appropriate flexibility to assure that a beneficiary received a PMD appropriate to his or her needs, often due to the fact that CMS' "least costly alternative" language had been interpreted as requiring a blanket down-coding from general use (group 2) to light weight (group 1) power wheelchairs. The new LCD thus lays out the basic coverage criteria for a PMD, and includes a revision of language providing for a "least costly alternative" determination.

The clarified LCD has been issued by the durable medical equipment (DME) Program Safeguard Contractor (PSC) Medical Directors and adopted by the DME Medicare Administrative Contractors (MACs), and is available at the following three websites: <http://www.tricenturion.com>; http://www.trustsolutionsllc.com/DRAFT_LCD_Status/asp; and <http://www.edssafeguardservices.edsgov.com/providers/dme/lcd/asp>.

Coverage Criteria

CMS' national coverage policy on PMDs is defined in CMS Pub. 100-3, Medicare National Coverage Determinations Manual, Chapter 1, Sections 280.3. The LCD outlines coverage criteria for a PMD which include:

- A. A mobility limitation that significantly impairs the individual's 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;
- B. The individual's mobility limitation cannot be sufficiently and safely resolved by use of an appropriately fitted cane or walker; and
- C. The individual 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.
- D. The individual is able to:
 - Safely transfer to and from a power operated vehicle (POV), and
 - Operate the POV's tiller steering system, and
 - Maintain postural stability and position while operating the POV in the home.

- E. The individual's mental capabilities and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home.
- F. The individual's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided.
- G. The individual's weight is less than or equal to the weight capacity of the POV that is provided
- H. Use of a POV will significantly improve the individual's ability to participate in MRADLs and the individual will use it in the home.
- I. The individual has not expressed an unwillingness to use a POV in the home.
- J. The individual has the mental and physical capabilities to safely operate the power wheelchair that is provided; or
- K. If the individual is unable to safely operate the power wheelchair, the individual 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 individual's weight is less than or equal to the weight capacity of the power wheelchair that is provided.
- M. The individual's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is provided.
- N. Use of a power wheelchair will significantly improve the individual's ability to participate in MRADLs and the individual will use it in the home. For individuals with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver.
- O. The individual has not expressed an unwillingness to use a power wheelchair in the home.

Power Operated Vehicles (POV)

A power operated vehicle, including a scooter, used as a power wheelchair, is covered by Medicare if the coverage criteria A-I, above, are met.

If a POV will be used inside the home and coverage criteria A-I have not been met, it will be denied as not medically necessary, at which point consideration of a least costly medically appropriate alternative PMD commences (see below). If the POV is to be used only outside the home, it will simply not be covered.

Power Wheelchairs (K0813-K0891, K0898)*

A power wheelchair is covered if:

- All of the basic coverage criteria (A-C) are met; and
- The individual 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.

Least Costly Alternative

The least costly alternative language has been widely misinterpreted by clinicians, suppliers, and manufacturers who interpreted it to require a blanket down-coding of Group 2 POVs (general use) to Group 1 POVs (light weight). CMS notes that Group 2 POVs have added capabilities that are not needed

* Check the LCD Coding Information section for the specific Healthcare Common Procedure Coding System Code (HCPCS), identifying specific wheelchair types. See, websites identified above.

for use in the home. Medicare thus bases its payment for a Group 2 POV on the allowance for the least costly medically appropriate alternative. This determination is to take into account the individual's weight, seating needs, and needs for other special features (i.e., power seating systems, alternative drive controls, ventilators).

The LCD clarifies that based on the CMS policy, some types of PMD will never be paid in full but will always be either paid at a least costly alternative (if coverage criteria are met) or denied (if coverage criteria for a PMD are not met). According to the LCD, where coverage is appropriate, the first level least costly alternative determination will be made by an automated system edit. It notes, too, that in many situations, the final determination of a least costly alternative can only be made at the time of manual review of a claim during medical review or a fraud investigation and that subsequent review may result in further adjustments in payment or denial.

Miscellaneous

- The LCD clarifies that a POV or power wheelchair with Captain's Chair is not appropriate for a individual who needs a separate wheelchair seat and/or back cushion. It also notes that if a skin protection and/or positioning seat or back cushion that meets coverage criteria (wheelchair seating LCD, see websites listed above) is provided with a POV or a power wheelchair with Captain's Chair, the POV or PWC will be denied as not medically necessary.
- The LCD also notes that if a individual 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 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.
- If a individual'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. If a Group 2 Seat Elevator is provided and if all of the criteria A-E for a PWC are met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 PWC without seat elevator.
- The delivery of the PMD must be within 120 days following completion of the face-to-face examination. An exception is made for PWCs that go through the Advance Determination of Medicare Coverage (ADMC) process and receive an affirmative determination. In this situation, delivery must be within 6 months following the determination.
- An add-on to convert a manual wheelchair to a joystick-controlled power mobility device or to a tiller-controlled power mobility device will be denied as not medically necessary.

Conclusion

The policy clarified in the LCD remains problematic, particularly in interpreting whether and to what extent a final, least costly alternative determination might have a negative impact on Medicare coverage for power mobility devices. The rule is likely to result in on-going provider, manufacturer, and clinician confusion, and in overly conservative judgments about coverage with respect to whether a beneficiary's PMD falls within in Group 2 or Group 1. Hopefully it will not also serve as a major barrier to access to necessary equipment for people with Medicare.

For further discussion, please contact Alfred J. Chiplin, Jr., Esq. (achiplin@medicareadvocacy.org), in the Center for Medicare Advocacy's Washington, DC office at 202-216-0028.