

# CERT

DME MAC OUTREACH & EDUCATION

Task Force for Error-Free Medicare Claims

## Manual Wheelchairs

**noridian**  
Healthcare Solutions

  
**CGS**<sup>®</sup>  
A CELERIAN GROUP COMPANY

# Disclaimer

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The DME MAC CERT Outreach and Education Task Force consists of representatives from each of the DME MACs and is independent from the CMS CERT Team and CERT Contractors, who are responsible for the calculation of the Medicare Fee-for-Service Improper Payment Rate.

The DME MAC CERT Outreach and Education Task Force has produced this material as an informational reference for providers furnishing services in our contract jurisdictions. The CERT Task Force employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the Centers for Medicare & Medicaid Services (CMS) website at <http://www.cms.gov>.

# Webinar Moderators and Presenters

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- Jurisdiction A and D – Noridian Healthcare Solutions
  - Shelly Carlson
- Jurisdiction B and C – CGS Administrators
  - Judie Roan

# Agenda

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- Comprehensive Error Rate Testing (CERT) Data
- Medical Necessity Requirements
- Wheelchair Bases
- Documentation Requirements
- Resources
- Questions

# Comprehensive Error Rate Testing (CERT) Data



# 2023 Medicare Fee-for-Service Supplemental Improper Payment Data

Service Type	Improper Payment Rate	Projected Improper Payment Amount
Overall	7.4%	\$31.2 B
<b>Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)</b>	<b>22.5%</b>	<b>\$1.9 B</b>
Part B Providers	10.0%	\$11.0 B
Part A Providers (excluding Hospital Inpatient Prospective Payment System (IPPS))	7.8%	\$14.2 B
Hospital IPPS	3.4%	\$4.1 B

*Claims Submitted Dates: July 1, 2021 – June 30, 2022*

<https://www.cms.gov/files/document/2022-medicare-fee-service-supplemental-improper-payment-data.pdf>

# Top DMEPOS Improper Payment Rates by Service Type

Policy Group	Claims Reviewed	Projected Improper Payments	Improper Payment Rate
CPAP	1,034	\$157 M	15.0%
All Policy Groups with Less than 30 Claims	295	\$100.3 M	35.8%
<b>Manual Wheelchairs</b>	<b>264</b>	<b>\$42.8 M</b>	<b>42.6%</b>
Infusion Pumps & Related Supplies	396	\$80.9 M	12.5%
Surgical Dressings	370	\$262.6 M	62.1%
Ventilators	241	\$135.9 M	24.3%
Glucose Monitors	791	\$103.2 M	13.5%
Lower Limb Prostheses	171	\$20.7 M	6.0%
Oxygen Supplies/Equipment	480	\$82.7 M	11.4%
Urological Supplies	255	\$116.6 M	28.1%

# Top Root Causes of Improper Payments for Manual Wheelchairs

## Root Cause Description – Medical Necessity

Documentation does not demonstrate Criterion A – the beneficiary has a mobility limitation which significantly impairs their ability to participate in mobility related activities of daily living (MRADLs) within their home.

Documentation does not demonstrate Criterion B – the beneficiary’s mobility limitation cannot be sufficiently resolved using an appropriately fitted cane or walker.

Documentation does not demonstrate Criterion C – the beneficiary’s home provides adequate access between rooms, maneuvering space and surfaces for use of the manual wheelchair that is provided.

## Root Cause Description – Insufficient Documentation or Status


Documentation to support coverage criteria – Inadequate or Missing

Beneficiary was in an acute care hospital or skilled nursing facility on this date of service.

Order – Missing



# CERT Letter

  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PROVIDER/SUPPLIER NAME  
ADDRESS LINE 1  
ADDRESS LINE 2  
CITY, STATE, ZIPCODE

Date: 4/8/2022  
Reference ID: CID #: 00000000  
NPI/Provider #: 0000000000  
Phone: 000-000-0000  
Fax: 000-000-0000

**Request Type & Purpose: First Letter**  
**Subject: Additional Documentation Required.**

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS), through the Comprehensive Error Rate Testing (CERT) program, carries out the task of requesting, receiving, and reviewing medical records.<sup>1</sup> The CERT program reviews selected Medicare A, B and DME claims and produces annual improper payment rates. For more information regarding the CERT program, please visit [www.cms.gov/CERT](http://www.cms.gov/CERT).

**Reason for Selection**  
The CMS' CERT program has randomly selected one or more of your Medicare claims for review.

**Action: Medical Records Required**  
Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providers/suppliers are required to send supporting medical records to the CERT program. **Providing medical records of Medicare patients to the CERT program does not violate the Health Insurance Portability and Accountability Act (HIPAA).** Patient authorization is not required to respond to this request. Providers/suppliers are responsible for obtaining and providing the documentation as identified on the attached Bar Coded Cover Sheet. The CMS is not authorized to reimburse providers/suppliers for the cost of medical record duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT program.

**When: 5/23/2022**  
Please provide the requested documentation by 5/23/2022. A response is still required by 5/23/2022 even if you are unable to locate the requested information.

**Consequences**  
If the provider/supplier fails to send the requested documentation or contact CMS by 5/23/2022, the provider's/supplier's Medicare contractor will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

<sup>1</sup>Social Security Act Sections 1833 [42 USC §1395l(e)] and 1815 [42 USC §1395g(a)]; 42 CFR 405.980-986

CENTERS FOR MEDICARE AND MEDICAID SERVICES  
CERT DOCUMENTATION CENTER  
8701 Park Central Drive  
Suite 400-A  
Richmond, VA 23227

**Important Dated Information Enclosed**

**Immediate Response Required**  
**Medicare Record Request**

If no addressee name is shown, forward to Medical Records Department.

# CERT Documentation Requests

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- The CERT Review Contractor (CERT RC) requests and receives all medical records
- Use the barcoded coversheet as your documentation coversheet
- Documentation may be submitted via:
  - Mail or Fax
  - Electronic Submission of Medical Documentation (esMD)
    - Include a CID number or claim number and the barcoded cover sheet in your file transmission
    - Information on esMD can be found at <https://www.cms.gov/esMD>
  - CD or email attachment
    - Encrypted per HIPAA security rules
- Check the current status of a claim under CERT review by using the CERT C3HUB Claim Status Search <https://c3hub.certrc.cms.gov/>
  - If CERT shows the review has been completed – refer to DME MAC CERT resources

# CERT Contact Information

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## CERT Contractor Resources and Contacts

- Phone: 1.888.779.7477 or 1.443.663.2699
- E-mail: <mailto:certprovider@empower.ai>
- Website: C3HUB (<https://c3hub.certrc.cms.gov/>)

## DME MAC CERT Resource Locations

- JA: <https://med.noridianmedicare.com/web/jadme/cert-reviews/cert>
- JB: <https://www.cgsmedicare.com/jb/claims/cert/index.html>
- JC: <https://www.cgsmedicare.com/jc/claims/cert/index.html>
- JD: <https://med.noridianmedicare.com/web/jddme/cert-reviews/cert>

# Appeal Rights from CERT Audits

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- If the CERT contractor finds errors with the claim in question, the supplier will receive an Overpayment Demand Letter and a revised Medicare Remittance Advice (MRA)
- If the supplier does not agree with the outcome of the CERT review, they should file an appeal to the Redeterminations department of their DME MAC within 120 days of the date on the demand letter or MRA
  - If a Redetermination is filed to the appropriate DME MAC within 30 days of the letter/MRA, all recoupment activities will cease until the redetermination decision is made

# Medical Necessity Requirements



# General Coverage Criteria

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Covered for home use if criteria A-E, and F or G met

- A. Mobility limitation significantly impairs participation in Mobility Related Activities of Daily Living (MRADLs), **and**
- Toileting, feeding, dressing, grooming, bathing
    1. Prevents beneficiary from accomplishing MRADL entirely, or
    2. Possible morbidity or mortality when performing MRADL, or
    3. Prevents completing MRADL within reasonable time frame

## General Coverage Criteria <sup>2</sup>

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- B. Limitation not sufficiently resolved with cane/walker, **and**
- C. There is adequate access between rooms, **and**
- D. Manual wheelchair (MWC) will improve MRADLs, **and**
  - With regular use in home
- E. Beneficiary has not expressed unwillingness to use MWC, **and**

## General Coverage Criteria <sup>3</sup>

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### F. Physical and mental capabilities to safely self-propel

- Beneficiary has sufficient upper extremity function
  - Medical records should indicate limitations of strength, endurance, range of motion, coordination, presence of pain, deformity or absence of one or both upper extremities
- Beneficiary has mental capabilities to safely self-propel MWC in home, or

### G. Caregiver available to assist with MWC

If MWC only for use outside home, denied as noncovered



# Home Assessment – Criterion C

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Documented in medical record or elsewhere by supplier

- Conducted by supplier or beneficiary
- Can home accommodate wheelchair
  - Physical layout of home
    - Adequate access between rooms
  - Obstacles
  - Surfaces

# Wheelchair Bases

# Manual Wheelchair Base

Complete manual wheelchair base includes:

- Complete frame
- Propulsion wheels
- Casters
- Brakes
- Seat
- Back
- Standard leg and footrests
- Armrests
- Safety accessories



# Standard Wheelchairs

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K0001

General coverage criteria must be met

Specific criteria

- Weight capacity ≤ 250 lbs
- Seat height
  - 19 inches or greater
- Transport chair alternative
  - Record must show why manual wheelchair doesn't meet need
  - E1037, E1038, E1039
  - Criteria A-E and G must be met
  - Caregiver must be available

# Standard Hemi Wheelchair

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K0002

General coverage criteria must be met

Specific criteria

- Weight capacity  $\leq$  250 lbs
- Beneficiary requires lower seat height (17" to 18")
  - I.e., short stature, OR
  - To place feet on ground for propulsion

# Light-Weight Wheelchair

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K0003

General coverage criteria must be met

Specific criteria

- Weight capacity  $\leq$  250 lbs
- Cannot self-propel in standard wheelchair; AND
- Can self-propel in lightweight wheelchair

# High Strength, Lightweight

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K0004

General coverage criteria must be met

Specific criteria

- Self-propels wheelchair
  - Engages in frequent activities in home
  - Cannot be performed in standard/lightweight wheelchair; **and/or**
- Seat width, depth, or height needs
  - Standard/lightweight/hemi-wheelchair unaccommodating
  - Usage minimum two hours per day

# Ultra Lightweight Wheelchair

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K0005

General coverage criteria must be met

Meet specific criteria 1 or 2, and 3-4

1. Full-time manual wheelchair user, **or**
  2. Requires individualized fitting and adjustments, **and**
  3. Has licensed/certified medical professional (LCMP) specialty evaluation, **and**
  4. Equipment provided by Rehabilitative Technology Supplier (RTS)
- Supplier employs Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified Assistive Technology Professional (ATP)



# K0005 - Medical Documentation

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Description of routine home activities

- Types of activities
- Beneficiary is fully independent in use of wheelchair

Description of features needed

- K0005 needs vs K0004 capabilities

# Heavy Duty Wheelchair

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K0006

General coverage criteria must be met

Specific criteria

- Weight > 250 pounds, or
- Beneficiary has severe spasticity

# Extra Heavy-Duty Wheelchair

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K0007

General coverage criteria must be met

Specific criteria

- Weight > 300 pounds

# Custom Manual Wheelchair Base

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K0008

General coverage criteria must be met

Specific configuration

- Not met by standard MWC bases
- Unique construction required
- No other code can be used

Duration of need

- Greater than three months or denies

Lifetime warranty on side frames and cross braces

See Coding Guidelines section in Policy Article for additional information

# Adult Tilt-In-Space Wheelchair

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E1161

General coverage criteria must be met

Specific criteria

- Tilt frame more than 20 degrees
- Specialty evaluation by LCMP, and
- Wheelchair provided by RTS
  - Employs RESNA-certified ATP
  - Specializes in wheelchairs
  - Direct, in-person involvement in selection

Lifetime warranty on side frames and cross braces required

# Pediatric Wheelchairs

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E1229, E1231-E1238

General coverage criteria must be met

- Coverage determined by beneficiary size/stature, no age factor
  - Seat width and/or depth 14” or less

# Indications of Noncoverage

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If used only outside home - noncovered

- Append GY modifier to claim line
  - Statutorily excluded
  - Does not meet Medicare benefit definition
- Advance Beneficiary Notice of Noncoverage (ABN) not required

Backup wheelchair

- Not considered reasonable and necessary
  - Obtain ABN
  - Append GA modifier to claim line
    - Keep Waiver of Liability statement on file

# Documentation Requirements





# Signature Requirements

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- Services provided/ordered/certified should be authenticated by the author
- If signature is missing from an order, MACs and CERT may disregard the order during review of claim (e.g., reviewer may proceed as if order was not received)
- If signature is missing from any other medical documentation (other than order), MACs and CERT may accept a signature attestation from author of medical record entry
- CMS Program Integrity Manual 100-8, Chapter 3, Section 3.3.2.4:  
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>

# Signature Attestation Statement

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- Must be signed and dated by author of medical record entry
- Must contain sufficient information to identify beneficiary
- CMS currently neither requires nor instructs providers to use a certain form or format
- Only considered when there is an associated medical record entry
- Attestation statements from someone other than author of medical record entry in question are not considered

# Standard Documentation Requirements

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- Standard Written Order (SWO)
- Medical records
- Proof of delivery (POD)
- Continued use/continued need (if applicable)
- Refill requirements (if applicable)
  - Items dispensed on periodic basis
- Beneficiary authorization

<https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=55426>

# SWO Elements

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Beneficiary's name or Medicare Beneficiary Identifier (MBI)

Order date

- Date request communicated to supplier

General description of item

Quantity to be dispensed, if applicable

Treating practitioner name or National Provider Identifier (NPI)

Treating practitioner's signature

# SWO

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## Date of SWO

- On or prior to date of claim submission

## Exception to SWO

- Prescribing practitioners who are also suppliers
  - No separate order required
  - All SWO elements must be in the medical record
- Signature and date stamps remain not allowed

# Authorized to Order

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Treating Practitioner, Doctor of Medicine (MD), or Doctor of Osteopathy (DO)

- Doctor of Podiatric Medicine (DPM)
- Nurse Practitioner (NP)
- Clinical Nurse Specialist (CNS)
- Physician Assistant (PA)

# Authorized to Order: NP/CNS vs PA

## Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS)

- Treating beneficiary for condition for which item is needed
- Practicing independently of practitioners
- Bill Medicare for other covered services using own National Provider Identifier (NPI)
- Permitted to do so in state where services rendered

## Physician Assistant (PA)

- Meet definition of physician assistant found in Section 1861(aa)(5)(A) of Social Security Act
- Treating beneficiary for condition for which item is needed
- Practice under supervision of MD or DO
- Have own NPI
- Permitted to perform services in accordance with state law

# When is a New Order Required?

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For all claims for purchase or initial rentals

Change in order

When indicated in medical policy

Replacement

Change in supplier

- New supplier unable to obtain valid order/documentation from original supplier



# Medical Records

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Treating practitioner's office records

Hospital records

Nursing home records

Home health agency records

Healthcare professional records

Test reports

Must be available upon request

# Medical Records <sub>2</sub>

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Document need for manual wheelchair

Medical history

Physical/neurological examination relevant to mobility needs

- I.e., arm/leg strength, range of motion
- Gait, balance, coordination

# Medical Record Elements

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## Medical history

- Mobility limitation
  - Not resolved by use of cane or walker
- MRADL abilities in home
  - Manual wheelchair will significantly improve MRADLS
- Sufficient upper extremity function
- Physical and mental capabilities to safely self-propel manual wheelchair

# Proof of Delivery

Method 1: Direct Delivery to Beneficiary	Method 2: Shipping/Delivery Service	Method 3: Delivery to Skilled Nursing Facility
<ul style="list-style-type: none"> <li>▪ Beneficiary's name</li> <li>▪ Delivery address</li> <li>▪ A description of the item(s) being delivered                             <ul style="list-style-type: none"> <li>• Narrative description (e.g., frames and lenses), <b>or</b></li> <li>• HCPCS code, <b>or</b></li> <li>• Long description of HCPCS code, <b>or</b></li> <li>• Brand name/model number</li> </ul> </li> <li>▪ Quantity delivered</li> <li>▪ Date delivered</li> <li>▪ Beneficiary (or designee) signature</li> </ul>	<ul style="list-style-type: none"> <li>▪ Beneficiary's name</li> <li>▪ Delivery address</li> <li>▪ A description of the item(s) being delivered                             <ul style="list-style-type: none"> <li>• Narrative description (e.g., frames and lenses), <b>or</b></li> <li>• HCPCS code, <b>or</b></li> <li>• Long description of HCPCS code, <b>or</b></li> <li>• Brand name/model number</li> </ul> </li> <li>▪ Quantity delivered</li> <li>▪ Delivery service's package ID number, supplier invoice number or alternative method which links supplier's delivery documents with delivery services' records</li> <li>▪ Date delivered</li> <li>▪ Evidence of delivery</li> </ul>	<ul style="list-style-type: none"> <li>▪ Documentation demonstrating delivery of the item(s) to the facility by the supplier or delivery entity; <b>and</b></li> <li>▪ Documentation from the nursing facility demonstrating receipt and/or usage of the item(s) by the beneficiary</li> <li>▪ The quantities delivered and used by the beneficiary must justify the quantity billed</li> </ul>
<p style="text-align: center;"><b><i>Date of Service = Date of Delivery</i></b></p>	<p style="text-align: center;"><b><i>Date of Service = Shipping Date or Date of Delivery</i></b></p>	<p style="text-align: center;"><b><i>Date of Service = Shipping Date or Date of Delivery</i></b></p>

# POD Exception: Anticipation of Discharge

## Delivery to facility

- Delivered for purpose of fitting/training
- Two days prior to discharge from hospital or nursing facility
- Date of service (DOS) equals discharge date
- Place of service (POS) 12
  - Beneficiary's home

## Delivery to home

- Two days prior to discharge from hospital or nursing facility
- DOS equals discharge date
- POS 12
  - Beneficiary's home

# Advance Determination of Medicare Coverage (ADMC)

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Voluntary program

Not an initial determination

Eligible manual wheelchairs

- E1161, E1231, E1232, E1233, E1234
- K0005
- K0008
- K0009

# Documentation Checklists

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Noridian:

<https://med.noridianmedicare.com/documents/2230715/26734435/Documentation+Checklist+-+Manual+Wheelchairs+%28MWC%29.pdf>

CGS:

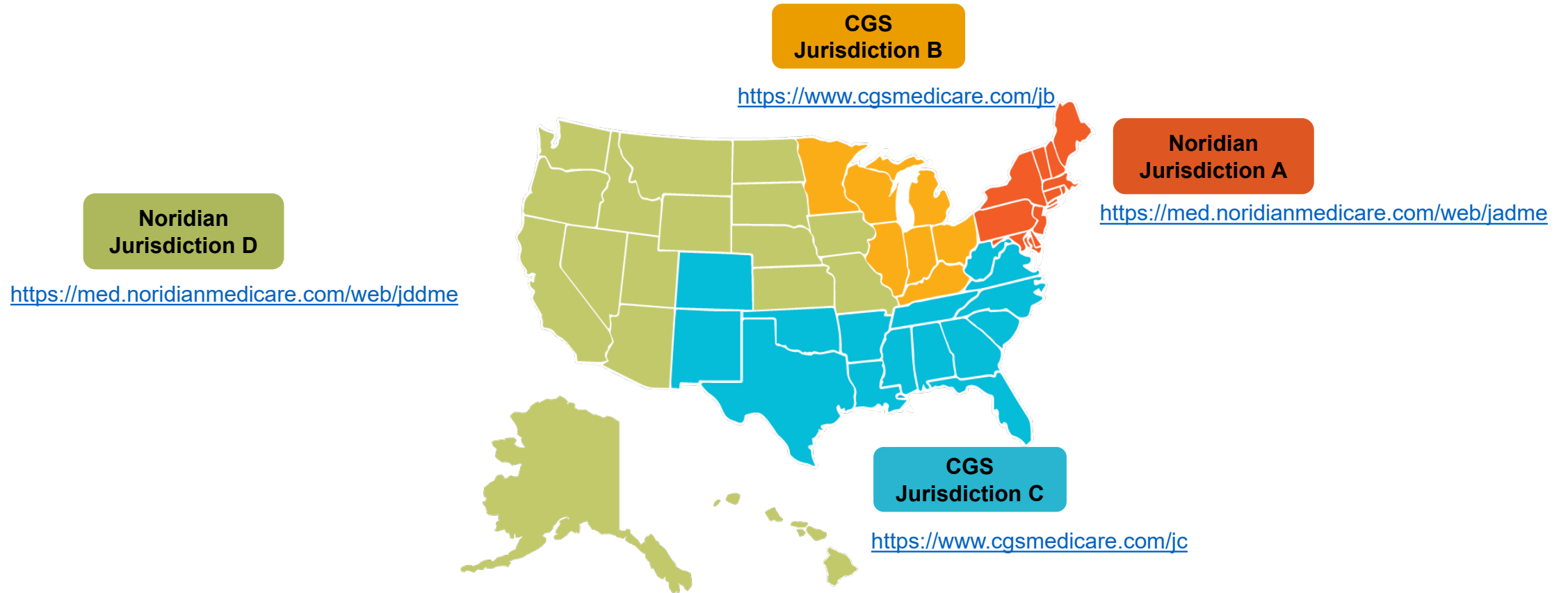
<https://cgsmedicare.com/jb/checklists/mwc.pdf>

# Resources





# DME MAC Jurisdictions



# Questions



**Thank You!**

