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Introduction

In this chapter, you will find information regarding DMEPOS benefit categories, the DME MAC Medical Review Department, medical policies, Advance Determination of Medicare Coverage (ADMC) process, and Prior Authorization. In order for any item to be covered by the DME MAC, it must fall into one of the benefit categories defined below. The medical policies used by the DME MAC to make coverage determinations may be either national or local. The national policies can be found on the CMS website in the *Medicare National Coverage Determinations Manual* and in the *Medicare Benefit Policy Manual*. Both of these manuals can be viewed at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>. The local policies can be found in Local Coverage Determinations (LCDs), which are available at <https://www.cgsmedicare.com/jc/coverage/LCDinfo.html>. See the “Medical Policies” section below for more specific information.

1. DMEPOS Benefit Categories

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §§50.5.1-50.6 &110-140
CMS Manual System, Pub. 100-03, *Medicare National Determinations Manual*, Chapter 1, §180

All Medicare Part B covered services processed by the DME MAC fall into one of the following benefit categories specified in the Social Security Act (§1861(s)):

1. Durable medical equipment (DME)
2. Prosthetic devices (including nutrition)
3. Leg, arm, back, and neck braces (orthoses) and artificial leg, arm, and eyes, including replacement (prostheses)
4. Surgical dressings
5. Immunosuppressive drugs
6. Therapeutic shoes for diabetics
7. Oral anticancer drugs
8. Oral antiemetic drugs (replacement for intravenous antiemetics)
9. Intravenous immune globulin

10. Home Infusion Services Temporary Transitional Payments

General definitions and coverage issues relating to the preceding categories are listed below.

Durable Medical Equipment (DME)

Durable medical equipment is equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an illness or injury, and (d) is appropriate for use in the home.

Supplies and accessories that are necessary for the effective use of medically necessary DME are covered. Supplies may include drugs and biologicals that must be put directly into the equipment in order to achieve the therapeutic benefit of the DME or to assure the proper functioning of the equipment.

Repairs, skilled maintenance, and replacement of medically necessary DME are covered.

Prosthetic Devices

Prosthetic devices are items which replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ. The test of permanence is considered met if the medical record, including the judgment of the treating practitioner, indicates that the condition is of long and indefinite duration.

In addition to artificial arms and legs, coverage under this benefit includes, but is not limited to, breast prostheses, eye prostheses, parenteral and enteral nutrition, ostomy supplies, urological supplies in beneficiaries with permanent urinary incontinence, and glasses or contact lenses in beneficiaries with aphakia or pseudophakia.

Enteral and Parenteral Nutrition therapy is covered under the prosthetic device benefit provision, which requires that the beneficiary must have a permanently inoperative internal body organ or function thereof.

Supplies that are necessary for the effective use of a medically necessary prosthetic device are covered. Equipment, accessories, and supplies (including nutrients) which are used directly with an enteral or parenteral nutrition device to achieve the therapeutic benefit of the prosthesis or to assure the proper functioning of the device are covered.

Repairs, adjustments, and replacement of medically necessary prosthetic devices are covered.

Dental prostheses (i.e., dentures) are excluded from coverage. Claims for internal prostheses (e.g., intraocular lens, joint implants, etc.) are not processed by the DME MAC.

Braces (Orthotics)

A brace is a rigid or semi-rigid device that is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. The orthotic benefit for braces is limited to leg, arm, back, and neck, and used independently, rather than in conjunction with, or as components of, other medical or non-medical equipment. Accessories used in conjunction with, and necessary for the full functioning of, durable medical equipment fall under the durable medical equipment benefit. You must not use L-codes or miscellaneous codes to bill for items that are components of, or used in conjunction with, wheelchairs. These items are correctly billed using the appropriate wheelchair accessory codes.

Repairs, adjustments, and replacement of medically necessary braces are covered.

Surgical Dressings

Surgical dressings are therapeutic and protective coverings applied to surgical wounds or debrided wounds. Surgical dressings include primary and secondary dressings.

Immunosuppressive Drugs

Immunosuppressive drugs used in beneficiaries who have received a Medicare-covered organ transplant are covered. Immunosuppressive drugs used for indications other than transplantation do not fall into the DME MAC's jurisdiction.

Supplies used in conjunction with parenterally administered immunosuppressive drugs are not covered under this benefit category.

Therapeutic Shoes for Diabetics

Custom molded or extra-depth shoes and inserts for use by beneficiaries with diabetes are covered under this benefit.

Oral Anticancer Drugs

Certain oral cancer drugs are covered if they have the same chemical composition and indications as the parenteral form of the drug.

Oral Antiemetics (used as full replacement for IV form)

Certain oral antiemetic drugs are covered when used as full replacement for the intravenous (IV) form of the same drug during chemotherapy treatment.

Intravenous Immune Globulin

Intravenous immune globulin is covered when it is administered in the home to treat primary immunodeficiency. Infusion pumps and other administration supplies are not covered under this benefit.

Home Infusion Temporary Transitional Payments

Effective for claims with dates of service on or after January 1, 2019, Section 50401 of the Bipartisan Budget Act of 2018 (Pub. L 115-123) amended Section 1834(u) of the Social Security Act (the Act) by adding paragraph (7), which requires a temporary, transitional payment be made to eligible home infusion suppliers for home infusion therapy services furnished on or after January 1, 2019 until the implementation of the full home infusion therapy benefit, as required by section 5012(d) of the 21st Century Cures Act (Pub. L. 144-255).

2. Medical Review Program

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 1, §1.3.8

The goal of the medical review program is to reduce payment errors by preventing the initial payment of claims that do not comply with Medicare's coverage, coding, payment, and billing policies. The medical review staff at CGS consists of medical directors (physicians), a research team, clinical staff (registered nurses and other allied health professionals), and experienced support personnel.

Medical Review Responsibilities

- Develop Local Coverage Determinations (coverage policies)
- Publish educational articles
- Analyze claim data, identifying and addressing billing errors and take action to correct future billing
- Perform reviews and audits to determine supplier compliance using Targeted Probe & Educate
- Notify suppliers of review findings
- Perform corrective actions to correct the behavior in need of change in order to prevent future inappropriate billing
- Advance Determination of Medicare Coverage (ADMC)
- Condition of Payment Prior Authorization Program
- Develop an annual Medical Review Strategy, based on data analysis, that details the problems and interventions in the jurisdiction
- Partner with the Provider Outreach & Education team to provide education

3. Medical Policies

CMS Manual System, Pub. 100-03, *Medicare National Coverage Determinations Manual*
CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 13

General Information

Medical policies may be either national or local. Local policies are termed Local Coverage Determinations (LCDs) and national policies are National Coverage Determinations (NCDs).

National Coverage Determinations are established by the Centers for Medicare and Medicaid Services (CMS). These policies are found on the CMS website in the *Medicare National Coverage Determinations Manual* and in the *Medicare Benefit Policy Manual*. Both manuals can be viewed at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>. You can search for National Coverage Determinations (NCDs) using the Medicare Coverage Database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. The DME MACs, CERT, and Unified Program Integrity Contractors (UPICs) follow, and Administrative Law Judges (ALJs) are bound by, national policy when it exists.

Local Coverage Determinations are developed jointly by the DME MACs. The DME MACs have the authority and responsibility to establish LCDs when there is no national policy on a subject or when there is a need to further define an NCD. The LCDs are identical for all DME MACs.

Local medical policies consist of three separate, though closely related, documents: an LCD, an LCD-related Policy Article, and the LCD-related Standard Documentation Requirements for All Claims Submitted to DME MACs Article. All LCD-related articles are referenced as links in the Associated Documents section of each LCD. A link to the CMS Medicare Coverage Database and the LCDs can be found on the home page of CGS's DME MAC Jurisdiction C website, listed under Local Coverage Determinations (<https://www.cgsmedicare.com/jc/coverage/LCDinfo.html>).

Major Sections of an LCD*Coverage Indications, Limitations, and/or Medical Necessity*

Defines coverage criteria based on a determination of whether an item is eligible for a defined Medicare benefit category, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and meets all other applicable Medicare statutory and regulatory requirements. Items addressed in this section are based on Social Security Act §1862(a)(1)(A) provisions. When an item does not meet these criteria, it will be denied as “not reasonable and necessary.”

*Summary of the Evidence**

Summary of the evidence used for coverage determinations.

*Analysis of Evidence (Rationale for Determination)**

Explanation of the rationale that supports determination.

HCPCS Codes and Modifiers

Lists the HCPCS codes and modifiers that are applicable to the LCD. The presence of a code in this section does not necessarily indicate coverage.

Documentation Requirements

States the necessary documentation requirements that you must have on file and/or submit with your claim for this specific policy. Refer to the LCD-related Standard Documentation Requirements article for additional information regarding these requirements.

*Bibliography**

List of all evidentiary sources used in determination.

Revision History Information

Explanation of revisions along with an effective date and reason for change are listed here.

Attachments

CMN or DIF (if applicable)

Other suggested forms (if applicable)

Related Local Coverage Documents

A link(s) to other related LCDs and Policy Articles

**For LCDs published for comment and notice on or after June 11, 2017, as required by the 21st Century Cures Act.*

Major Sections of a Policy Article*Non-Medical Necessity Coverage and Payment Rules*

Identifies situations in which an item does not meet the statutory definition of a benefit category (e.g., durable medical equipment, prosthetic devices, etc.) or when it doesn't meet other requirements specified in regulations. It also identifies situations in which an item is statutorily excluded from coverage for reasons other than medical necessity. In these situations, the term used to describe the denial is "noncovered." This section may also include statements defining when an item will be denied as "not separately payable" or situations in which claim processing for the item is not within the DME MAC's jurisdiction.

Requirements for Specific DMEPOS Items Pursuant to Final Rule 1713 (84 Fed. Reg Vol 217)

Provides information regarding the requirement for standard written orders (SWOs), face-to-face encounters and written order prior to delivery (WOPD) for certain HCPCS codes, as specified in CMS' Final Rule CMS-1713-F.

Policy Specific Documentation Requirements

States the necessary documentation requirements that you must have on file and/or submit with your claim for this specific policy. Refer to the LCD-related Standard Documentation Requirements article for additional information regarding these requirements.

Coding Guidelines

Provides detailed information about the characteristics and features of products that qualify for inclusion under specific HCPCS codes.

HCPCS Codes and Modifiers

Lists the HCPCS codes and modifiers that are applicable to the Policy Article. The presence of a code in this section does not necessarily indicate coverage.

ICD-10 Codes that Support Medical Necessity

Diagnosis codes listed in this section relate to: coverage criteria (described in the Coverage Indications, Limitations, and/or Medical Necessity section of the LCD) and/or statutory or regulatory coverage (as described in the Non-Medical Necessity Coverage and Payment Rules section of the LCD-related PA).

ICD-10 Codes that DO NOT Support Medical Necessity

Diagnosis codes listed in this section are not covered as specified.

Revision History Information

Explanation of revisions along with an effective date are listed here.

Related Local Coverage Documents

A link(s) to other related LCDs and Policy Articles.

Posting of new and revised policies will be announced in a ListServ message from CGS and on our website at <https://www.cgsmedicare.com/jc>.

The LCD page on our website includes links to current/active LCDs and Policy Articles, Future LCDs and Policy Articles, Proposed LCDs, Retired LCDs and Policy Articles, and information related to New and Reconsideration LCD requests. This page can be viewed here:

<https://www.cgsmedicare.com/jc/coverage/LCDinfo.html>.

New LCD Request Process

The New LCD Request process is a mechanism by which interested parties within a contractor's jurisdiction can request the development of a new LCD. This process is different from the LCD Reconsideration Process.

Informal Meeting (Optional):

The process for requesting a New LCD may begin with an informal meeting in which interested parties (in the DME MAC's jurisdiction) can request to informally discuss potential New LCD Requests. These meetings are permitted but **not** required, are for educational purposes only, and allow requestors the opportunity to communicate with the DME MACs via conference call before submitting a formal LCD request. During these meetings, the requirements for valid LCD requests are reviewed. Requests for these optional, informal meetings may be submitted via email to LCDReconJC@cgsadmin.com. In the request for an informal discussion, requestors should include the following information:

1. Include the following in the subject line of the email: "Request for New LCD Call – [Topic for New LCD]"
2. Several options for dates and times for a one (1) hour conference call
3. Teleconference number with enough lines to accommodate 15 participants
4. Agenda for the call, including requestor participants and titles
5. Summary information (1-2 paragraphs, maximum) for the LCD request

Request Submission Criteria (Required):

Following the voluntary informal discussion, should the requestor wish to continue with submission of a formal new LCD request, a valid request must include all of the following:

1. Be submitted by one of the following:
 - Beneficiaries residing or receiving care in a contractor's jurisdiction;
 - Health care professionals doing business in a contractor's jurisdiction; and
 - Any interested party doing business in a contractor's jurisdiction.
2. Clearly identify the statutorily-defined Medicare benefit category to which the requestor believes the item or service falls under;
3. Provide a rationale justifying the proposed assignment of Medicare benefit category;
4. Identify the language that the requestor wants in a new LCD;
5. All available evidence, as well as all related FDA approval correspondence, marketing designations, decision summaries pertinent to the product or service, 510(k)/PMA/De Novo notifications, SSED data sheet, FDA Panel Minutes and Post-Approval Study Result/Outcome Submissions.

Submitted literature and references should be limited to published, full-text, peer-reviewed evidence, indexed in PubMed of the US National Library of Medicine, National

- Institutes of Health. The failure to include the specific literature with the request will render the LCD request incomplete;
6. The request must include information that addresses the relevance, usefulness, clinical health outcomes, or the medical benefits of the item or service in the Medicare-eligible population; and,
 7. The request must include information that fully explains the design, purpose, and/or method, as appropriate, of using the item or service for which the request is made.

The level of evidence required for LCD development may be found in the *CMS Program Integrity Manual*, Chapter 13.

The DME MAC has the discretion to consolidate valid requests if similar requests are received. Any request for a new LCD that, in the judgment of the contractor, does not meet these criteria is invalid.

How to Submit New LCD Requests:

New LCD requests may be sent via one of three methods: email (preferred), fax, or hard copy by mail. Below lists pertinent information for each of the three methods:

1. **Email (Preferred Method):** LCDReconJC@cgsadmin.com
 - Electronic requests should be sent with "New LCD Request – [Topic for New LCD]" in the subject line.
 - If the attachment size for clinical citations exceeds 15 MB, the requestor must send the articles and supporting documents via multiple, smaller emails.
 - Please contact LCDReconJC@cgsadmin.com for alternative methods for submitting large electronic files or if you have difficulty submitting a new LCD request.
2. **Fax:** 615.664.5955
 - Please address your fax cover sheet to DME New LCD – [Topic for New LCD] – Attn: Dr. Robert Hoover

3. Mail:

CGS Administrators, LLC
Attn: Robert D. Hoover, Jr., MD, MPH
DME LCD Reconsiderations
Suite ST610
26 Century Blvd
Nashville, TN 37214

Next Steps:

The DME MAC will review materials received to determine whether the request is valid. A valid request must meet criteria 1-7 listed above. CGS will respond to the request within 60 calendar days upon receipt.

If the DME MAC determines that the request is not valid, the requestor will be notified in writing that the request is not valid and the rationale for this decision will be provided.

If the request is valid, the DME MAC will begin the LCD development process outlined in the *Program Integrity Manual*, Chapter 13 (Internet-only Manual Pub.100-08). The response to the requestor that the request is valid is simply an acknowledgement to the requestor of the receipt of a complete, valid request. The DME MAC's request response does not convey that a determination has been made or the likelihood of coverage, or non-coverage, within a defined period of time under 1862 (a)(1)(A) of the Act, but is confirmation that CGS plans to proceed with development of a new LCD or place the requested LCD on the wait-list for development at a later time.

If the request is valid and a new LCD is developed, the DME MAC will follow the process outlined in the *Program Integrity Manual*, Chapter 13. This involves:

1. Consultation with the requestor or subject matter experts (if necessary);
2. Contractor Advisory Committee (CAC) meeting (if necessary);
3. Publication of a proposed LCD;
4. Open meeting to solicit comments from the public on the proposed LCD;
5. Opportunity for public comment in writing (minimum of 45 days following posting of proposed LCD);
6. Publication of a final LCD, including:
 - a. A response to public comments received;
 - b. Notice to public of new policy at least 45 days in advance of the effective date.

Proposed LCDs will be finalized or retired within a rolling calendar year of publication date on the Medicare Coverage Database (365 days).

For additional information on the New LCD Request process, please see CGS' Request New LCD Process webpage at https://cgsmedicare.com/jc/coverage/lcd_request_process.html.

LCD Reconsideration Process

The LCD Reconsideration process is a method by which interested parties can request a revision to an active LCD. The reconsideration process is available for final, effective LCDs only. The entire LCD or any part of it is subject to reconsideration.

Informal Meeting (Optional):

Prior to submitting a formal request for LCD Reconsideration, interested parties are encouraged to schedule an informal conference call to review the requirements for a valid LCD Reconsideration request. Request for a conference call may be submitted via email to LCDReconJC@cgsadmin.com. In the request for an informal discussion, requestors should include the following information:

1. Include in the subject line of the email: "Request for LCD Reconsideration Call – [Title of LCD]"
2. Several options for dates and times for a one (1) hour conference call
3. Teleconference number with enough lines to accommodate 15 participants
4. Agenda for the call, including requestor participants and titles

5. Summary information (1-2 paragraphs, maximum) for the reconsideration request.

Request Submission Criteria (Required):

Following the informal discussion, should the requestor wish to continue with a formal LCD Reconsideration request, a valid request must meet all of the following requirements:

1. Be submitted by one of the following:
 - Beneficiaries residing or receiving care in a contractor's jurisdiction;
 - Health care professionals doing business in a contractor's jurisdiction; and
 - Any interested party doing business in a contractor's jurisdiction.
2. Include the specific language that the requestor proposes be added to or deleted from an LCD.
3. Submission of all available evidence, as well as all related FDA approval correspondence, marketing designations, decision summaries pertinent to the product or service, 510(k)/PMA/De Novo notifications, SSED data sheet, FDA Panel Minutes and Post-Approval Study Result/Outcome Submissions.

Submitted literature and references should be limited to published, full-text, peer-reviewed evidence, indexed in PubMed of the US National Library of Medicine, National Institutes of Health. The failure to include the specific literature with the request will render the LCD request invalid.

4. Only request reconsideration of an LCD published in final form. Requests will not be accepted for other documents including:
 - National Coverage Determinations (NCDs);
 - Coverage provisions in interpretive manuals;
 - Proposed LCDs;
 - Template LCDs, unless or until they are adopted by the contractor;
 - Retired LCDs;
 - Individual claim determinations;
 - Bulletins, articles, training materials; and
 - Any instance in which no LCD exists, i.e., requests for development of an LCD.

The level of evidence required for LCD reconsideration is the same as that required for new/revised LCD development (see *Program Integrity Manual*, Chapter 13).

The DME MAC has the discretion to consolidate valid requests if similar requests are received.

Any request for LCD reconsideration that, in the judgment of the contractor, does not meet these criteria is invalid.

The DME MAC may revise or retire their LCDs at any time on their own initiatives.

If modification of the final LCD would conflict with an NCD, the request will not be valid.

For information about the NCD reconsideration process, reference Medicare Coverage Determination Process at http://www.cms.gov/DeterminationProcess/01_overview.asp. Information about requesting an NCD or an NCD revision is found under "How to Request an NCD" in the Coverage Process section.

How to Submit LCD Reconsideration Requests:

LCD Reconsideration requests may be sent via one of three methods: email (preferred), fax, or hard copy by mail. Below lists pertinent information for each of the three methods:

1. **Email (Preferred Method):** LCDReconJC@cgsadmin.com
 - Electronic requests should be sent with "LCD Reconsideration Request – **[Name of LCD]**" in the subject line.
 - If the attachment size for clinical citations exceeds 15 MB, the requestor must send the articles and supporting documents via multiple, smaller emails.
 - Please contact LCDReconJC@cgsadmin.com for alternative methods for submitting large electronic files or if you have difficulty submitting an LCD Reconsideration request.

2. **Fax:** 615.664.5955
 - Please address your fax cover sheet to DME LCD Reconsideration – Attn: Dr. Robert Hoover.
 - Note: This fax line is for the LCD reconsideration process described above. This is not the fax line for appealing individual claims (Redeterminations).

3. **Mail:**

CGS Administrators, LLC
Attn: Robert D. Hoover, Jr., MD, MPH
DME LCD Reconsiderations
Suite ST610
26 Century Blvd
Nashville, TN 37214

Next Steps

The DME MAC will review materials received to determine whether the request is valid. A valid request must meet criteria 1-4 listed above. CGS will respond to the request within 60 calendar days upon receipt.

If the DME MAC determines that the request is not valid, the requestor will be notified in writing that the request is not valid and the rationale for this decision will be provided.

If the request is valid, the DME MAC will begin the LCD development process outlined in the *Program Integrity Manual* Chapter 13 (Internet-only Manual Pub.100-08). The response to the requestor that the request is valid is simply an acknowledgement to the requestor of the receipt of a complete, valid request. The DME MAC's request response does not convey that a determination has been made or the likelihood of coverage, or non-coverage, within a defined period of time under

1862 (a)(1)(A) of the Act, but is confirmation that CGS plans to proceed with reconsidering the LCD or place the requested LCD reconsideration on the wait-list for development at a later time

If the request is valid and the LCD is accepted for reconsideration, the DME MACs will follow the process detailed in the Centers for Medicare & Medicaid Services (CMS) *Program Integrity Manual* (Internet-only manual 100-08), Chapter 13. This involves:

1. Consultation with the requestor or subject matter experts (if necessary);
2. Contractor Advisory Committee (CAC) meeting (if necessary);
3. Publication of a proposed LCD;
4. Open meeting to solicit comments from the public on the proposed LCD;
5. Opportunity for public comment in writing (minimum of 45 days following posting of proposed LCD);
6. Publication of a final LCD, including:
 - a. A response to public comments received;
 - b. Notice to public of new policy at least 45 days in advance of the effective date.

Proposed LCDs will be finalized or retired within a rolling calendar year of publication date on the Medicare Coverage Database (365 days).

For additional information on the LCD Reconsideration process, please see CGS' LCD Reconsideration Process webpage at <https://cgsmedicare.com/jc/coverage/reconsideration.html>.

LCD Tracking

When the DME MACs receive a valid request to revise an existing LCD, or to develop a new LCD, the DME MACs follow the LCD development process outlined in the CMS *Program Integrity Manual* (Internet-only Manual 100-08) Chapter 13.

For up-to-date information on LCDs under reconsideration or development, please see CGS' LCD Tracking webpage at <https://www.cgsmedicare.com/jc/coverage/tracking.html>.

Claim Determination in the Absence of Medical Policy

The DME MACs and UPICs have the authority to review any claim even if there is no formal national or local policy. In those situations, the contractor first determines whether the item falls within a statutory benefit category that is within its jurisdiction. If it is, then the reviewer determines whether the item is reasonable and necessary for the individual beneficiary. This may include a review of pertinent medical literature. It also includes review of detailed documentation from the treating practitioner and supplier supporting the medical necessity of the item.

4. Advance Determination of Medicare Coverage (ADMC) for Wheelchairs

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5, §5.16

Advance Determination of Medicare Coverage (ADMC) is an optional process by which the DME MAC provides you and the beneficiary with a coverage decision prior to delivery of an item.

An ADMC is available only for the following wheelchair base HCPCS codes and related options and accessories:

Manual Wheelchairs

E1161

E1231–E1234

K0005

K0008

K0009

Power Wheelchairs

Group 5: K0890–K0891

Custom Motorized/Power Wheelchair: K0013

When a particular wheelchair base is eligible for ADMC, all wheelchair options and accessories ordered by the treating practitioner for that beneficiary along with the base HCPCS code will be eligible for ADMC.

The ADMC request should include the wheelchair base and each option and accessory that is to be provided. Do not submit an ADMC request for options and/or accessories without a wheelchair base.

All requests for Advance Determination of Medicare Coverage should be submitted to CGS. **Clearly indicate “ADMC” on the first page of all requests.** For your convenience, an ADMC request form is provided on the DME MAC Jurisdiction C website. You can access and fill out the form online at https://www.cgsmedicare.com/jc/forms/pdf/JC_ADMC_request_form.pdf.

ADMC requests may be faxed to 615.782.4647 or mailed to the following address. ADMC requests can be submitted electronically. You can also submit ADMC requests via the myCGS Web Portal.

CGS – Jurisdiction C
Attn: ADMC
P.O. Box 20010
Nashville, TN 37202

The first page of the ADMC request must contain all of the following demographic information:

- **Beneficiary information**
 - Name
 - Medicare Number

- Address
- Date of birth
- Diagnosis code (narrative description is not sufficient)
- Place of Service
- **Supplier information**
 - Company Name with a contact name
 - PTAN
 - Address
 - Phone number
- **Physician's information**
 - Name
 - NPI
 - Address
 - Phone number

If the information listed above is not present, the request will be rejected. You will receive written notification of the rejection.

Rejections

ADMC requests are reviewed to determine whether or not they meet the requirements for ADMC requests. **Reasons to reject an ADMC request include:**

1. The item being submitted is not one of the ADMC eligible wheelchair bases.
2. The request exceeds the limit of two within six months.
3. The beneficiary does not live in Jurisdiction C.
4. **The request does not include the item codes (HCPCS) and/or item descriptions.**
5. The request is missing demographic information (i.e., beneficiary's name, current address, date of birth, Medicare identification number, the supplier's PTAN and/or the provider's National Provider Identification [NPI] number).
6. It is the 2nd request, but no new information was submitted.
7. The place of service is a hospital or skilled nursing facility.
8. Two different wheelchair base item codes (HCPCS) are listed on the request and it cannot be determined which base is to be reviewed for medical necessity.

9. A faxing error has occurred which resulted in missing, blackened, partial and/or incomplete documentation.
10. A duplicate request is submitted.
11. A request is submitted for an advance determination on previously denied accessories and/or additional accessories when the base was previously approved.
12. The item that is being submitted for advanced determination is NOT a wheelchair.
13. The base is covered under the Condition of Payment Required Prior Authorization Program for PMDs (see section 5 below).

Power Wheelchair Documentation

Include **all** of the following items with the ADMC request:

1. The **written order** (also referred to as the Standard Written Order [SWO]). The SWO must contain the following elements:
 - i. Beneficiary's name or Medicare Beneficiary Identifier (MBI)
 - ii. Order date
 - iii. General description of the item
 - The description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number
 - For equipment—in addition to the description of the base item, the SWO may include all concurrently ordered options, accessories or additional features that are separately billed or require an upgraded code (list each separately)
 - iv. Quantity to be dispensed, if applicable
 - v. Treating practitioner name or NPI
 - vi. Treating practitioner's signature

You may provide a template **to the treating practitioner for their use in creating the order for the base item. The template may list the elements of an order**, but you are prohibited from **filling in or completing any of these elements**. It is a statutory requirement that the treating practitioner who conducted the face-to-face requirements write the SWO for the power mobility device (**base item**). The SWO for the power mobility device must be written within six months of the face-to-face encounter and be received by you, the supplier, prior to delivery of the power mobility device.

Refer to the Power Mobility Devices (PMD) LCD (<https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?lcdid=33789>) and Policy Article (PA) (<https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52498>) for information regarding the **reasonable and necessary and** statutory requirements for PMDs.

If you do not receive a written order containing all of these required elements prior to delivery, an EY modifier must be added to the HCPCS codes for the PMD and all accessories. The order must be available on request.

2. An SWO for related options and accessories (if not included on the SWO for the base item). Refer to the PMD Local Coverage Determination (LCD) and related Policy Article for additional information.
3. A report of the **in-person examination**. The treating practitioner must conduct an in-person examination of the beneficiary before writing the order. Refer to the PMD LCD and related Policy Article for guidance about the type of information to be included in the in-person examination and specialty evaluation.
4. **Attestation of “no financial involvement.”** The PMD LCD requires a signed and dated affirmation from the supplier that the licensed/certified medical professional (LCMP) performing the specialty evaluation has no financial relationship with the supplier. CGS will also accept an attestation of no financial relationship from the LCMP conducting the specialty evaluation.
5. **Evidence of RESNA certification by the supplier’s Assistive Technology Professional (ATP).** A copy of a RESNA certificate or screen print from the RESNA website is acceptable proof, but other documentation to show the supplier employs an ATP is acceptable. Examples of acceptable documentation include, but are not limited to, beneficiary evaluation and/or home assessment signed by the supplier’s ATP (must be able to identify supplier); signed statement from the supplier that they employ the specific ATP involved in the in-person wheelchair selection process; narrative statement in the licensed/certified medical professional’s (LCMP’s) evaluation identifying the ATP and his/her employer. The RESNA website is www.resna.org.
6. **Evidence of “direct, in-person involvement” in the selection of the product.** Documentation of direct in-person interaction with the beneficiary by the ATP in the wheelchair selection process must be complete and detailed enough so a third party can understand the nature of the ATP involvement. A home assessment completed by a supplier-employed ATP does not meet the requirement unless the documentation shows how the ATP applied the assessments and measurements to the wheelchair selection process.
7. A report of the **on-site home assessment** which establishes that the beneficiary is able to use the wheelchair ordered to assist with Activities of Daily Living (ADLs) in the home.

Manual Wheelchair Documentation

Include **all** of the following items with the ADMC request:

1. An SWO for the manual wheelchair base and related options/accessories.
2. Information from the beneficiary’s medical record that documents that the coverage criteria defined in the Manual Wheelchair Bases LCD have been met.
3. A home assessment which establishes that the beneficiary or caregiver is able to use the wheelchair ordered to assist with ADLs in the home.

Refer to the **Manual Wheelchair Bases LCD** (<https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?lcdid=33788>) and related **Policy Article** (<https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleid=52497>) for information regarding the reasonable and necessary and statutory requirements for manual wheelchairs.

Additional Guidance on Documentation

Any information that is provided that explains the medical necessity for separately-billed options and accessories must use the same short description for the item that is used in the standard written order.

Even if the majority of the in-person examination for a power wheelchair (PWC) is performed by an LCMP, the ADMC request must also include the report of the in-person examination with the treating practitioner.

For wheelchair cushions, include the manufacturer, product name, model number, and the width of the wheelchair cushion(s) that is provided. Make certain that the product is listed on the Pricing, Data Analysis and Coding (PDAC) Contractor Product Classification List and that the HCPCS code on the ADMC is the one specified by the PDAC (consult the PDAC website at <https://www.dmepdac.com/>). See Chapter 16 of this manual for information about the PDAC.

If the beneficiary currently has a wheelchair or a power operated vehicle (POV), the ADMC request must indicate the reason why it is being replaced.

ADMC Process

Upon receipt of an ADMC request, the DME MAC will make a determination within 30 calendar days. The DME MAC will provide you and the beneficiary with its determination, either affirmative or negative, in writing. If it is a negative determination, the letter will indicate why the request was denied - e.g., not medically necessary, insufficient information submitted to determine coverage, statutorily non-covered.

If a wheelchair base receives a negative determination, all accessories will also receive a negative determination. If a wheelchair base receives an affirmative determination, each accessory will receive an individual determination.

An affirmative determination only relates to whether the item is reasonable and necessary based on the information submitted. An affirmative determination does not provide assurance that the beneficiary meets Medicare eligibility requirements nor does it provide assurance that any other Medicare requirements (e.g., place of service, Medicare Secondary Payer) have been met. Only upon submission of a complete claim can the DME MAC make a full and complete determination. An affirmative determination does not extend to the price that Medicare will pay for the item.

An affirmative ADMC is only valid for items delivered within six months following the date of the determination. If the wheelchair is not delivered within that time, you have the option of either submitting a new ADMC request (prior to providing the item) or filing a claim (after providing the item).

When submitting a claim with HCPCS code K0108 for the ADMC approved options/accessories, the narrative description on the claim must be the same description used in the ADMC request.

A negative ADMC may not be appealed because it does not meet the regulatory definition of an initial determination since no request for payment is being made. However, if the ADMC request for the wheelchair base is denied and if you obtain additional medical documentation, an ADMC request may be resubmitted. ADMC requests may only be resubmitted once during the six-month period following a negative determination. If the wheelchair base is approved, but one or more accessories are denied, an ADMC request may not be resubmitted for those accessories. If you provide a wheelchair and/or accessories following a negative determination, a claim for the item should be submitted. If new information is provided with the claim, coverage will be considered. If the claim is

denied, it may be appealed through the usual process (see Chapter 13 of this manual for information about appeals).

Finally, the DME MAC may review selected claims on a pre-payment or post-payment basis and may deny a claim or request an overpayment if it determines that an affirmative determination was made based on incorrect information.

5. Condition of Payment Required Prior Authorization Program

Power Mobility Devices (PMDs)

As a condition of payment, the following PMD HCPCS codes are subject to the Required Prior Authorization program:

HCPCS Code	Type of Base
K0813-K0816	Group 1 Power Wheelchair
K0820-K0829	Group 2 Power Wheelchair
K0835-K0840	Group 2 Single Power Option Power Wheelchair
K0841-K0843	Group 2 Multiple Power Option Power Wheelchair
K0848-K0855	Group 3 Power Wheelchair, No Power Option
K0856-K0860	Group 3 Single Power Option Power Wheelchair
K0861-K0864	Group 3 Multiple Power Option Power Wheelchair

Lack of a provisionally affirmed prior authorization request for any of the HCPCS codes subject to the Prior Authorization program will result in a claim denial. All US states and territories are included in this mandatory program.

NOTE: This review is for the wheelchair base only. Accessories will not be reviewed.

- All documentation to support a prior authorization request must meet all applicable rules, policy, and NCD/LCD requirements.
- The LCD states that for these bases, the coverage criteria for certain accessories/options must be met to meet coverage criteria for the base. Therefore, the appropriate supporting documentation, as outlined in the LCD to support the base, should also be submitted as part of the prior authorization request.

- Requesters/ submitters have the option to submit a prior authorization request via esMD (content type 8.4), fax, myCGS web portal, or U.S. mail. The receipt date will be applied to all documents submitted using a Julian date format.

Requests may be submitted by either the beneficiary or the supplier. The submitter is encouraged to complete, and include with their request, a Condition of Payment Prior Authorization Request Coversheet, which is available here:

https://cgsmedicare.com/jc/mr/pdf/condition_of_payment_prior_auth.pdf.

The Condition of Payment Prior Authorization Request must include the following documentation:

- Standard Written Order (SWO)—received prior to delivery—for the power mobility device
- SWO for related options/accessories, if applicable
- Treating practitioner’s face-to-face evaluation
- Specialty evaluation performed by Licensed/Certified Medical Professional (LCMP) for Group 2 and Group 3 bases
- **Attestation of “no financial involvement” if the specialty evaluation, performed by the LCMP, is to be considered part of the face-to-face encounter**
- ATP in person assessment for Group 2 and Group 3 bases
- RESNA certification for Group 2 and Group 3 bases
- Other relevant medical documentation

NOTE: Claims for HCPCS codes, subject to the required prior authorization, submitted without a prior authorization determination and a corresponding unique tracking number (UTN) will be automatically denied.

When faxing or mailing the request:

Fax the Condition of Payment Prior Authorization Request Coversheet to:

615-664-5960

Mail the Condition of Payment Prior Authorization Request Coversheet to:

CGS – **JUR C** DME Medical Review – Condition of Payment Program
PO Box 24890
Nashville, TN 37202-4890

For the initial submission of the prior authorization request(s), the DME MAC will be required to make the decision(s) and notify each requester within 10 business days (excluding federal holidays). The requesters will be notified of the decision, which will include specific reasons for the decision. The DME MAC will notify the beneficiary of the decision if the beneficiary was the prior authorization requester or if the beneficiary asked to be notified. If the DME MAC exceeds the 10-business day (postmarked) requirement of the initial submission, the request is not automatically affirmed.

A claim which has received an affirmed prior authorization decision will be paid so long as all other technical and Medicare requirements are met upon claim submission. If a prior authorization request receives a non-affirmed decision, the DME MAC will make the requester(s) aware that one or more

Medicare requirements have not been met and provide a detailed explanation of which requirements have not been met. Upon receipt of a non-affirmed decision, the requester(s) may make changes and resubmit the prior authorization request. The DME MAC will have an additional 10 business days (excluding federal holidays) to conduct the medical review, make the decision(s), and notify the requester(s) of the decision(s). An unlimited number of resubmissions are allowed.

You, the supplier, may request an expedited review process where applying the standard timeframe for making a prior authorization decision could jeopardize the life or health of the beneficiary. In these situations the DME MAC will communicate the decisions within two business days (excluding federal holidays) of receipt of all applicable Medicare required documentation.

For more information, please visit the Condition of Payment Prior Authorization page on our website at: https://cgsmedicare.com/jc/mr/condition_of_payment_prior_auth.html.

Group 2 Pressure Reducing Support Surfaces (PRSS)

As a condition of payment, Medicare requires a prior authorization for Group 2 Pressure Reducing Support Surfaces (PRSS) for all states and territories.

As a condition of payment, the following Group 2 PRSS HCPCS codes are subject to the Required Prior Authorization program:

HCPCS Code	Code Description
E0193	Powered Air Flotation Bed (Low Air Loss Therapy)
E0277	Powered Pressure-Reducing Air Mattress
E0371	Nonpowered Advanced Pressure Reducing Overlay For Mattress, Standard Mattress Length and Width
E0372	Powered Air Overlay For Mattress, Standard Mattress Length and Width
E0373	Nonpowered Advanced Pressure Reducing Mattress

Claims to Medicare for a Group 2 PRSS, for which the required Prior Authorization applies, must be associated with a prior authorization request as a condition of payment. Lack of an affirmed prior authorization request will result in the supplier of the support surface receiving a claim denial.

Requesters/submitters have the option to submit a prior authorization request via esMD (content type 8.4), fax, myCGS web portal, or U.S. mail. The receipt day will be applied to all documents submitted using a Julian date format.

Requests may be submitted by either the beneficiary or the supplier. The submitter is encouraged to complete, and include with their request, a Condition of Payment Prior Authorization Request Coversheet which is available here: https://cgsmedicare.com/jc/mr/pdf/condition_of_payment_prior_auth.pdf.

The Condition of Payment Prior Authorization Request must include the following documentation:

- A Standard Written Order (SWO)
- Documentation from the medical record to support the medical necessity

NOTE: Claims for HCPCS code subject to required prior authorization submitted without a prior authorization determination and a corresponding unique tracking number (UTN) will be automatically denied.

When faxing or mailing the request:

Fax the Condition of Payment Prior Authorization Request Coversheet to:

615-664-5960

Mail the Condition of Payment Prior Authorization Request Coversheet to:

CGS – **JUR C** DME Medical Review – Condition of Payment Program
PO Box 24890
Nashville, TN 37202-4890

For initial submissions the DME MAC will complete its complex medical review and ensure that the written decision is faxed, postmarked, or delivered electronically by the fifth business day following the DME MAC's receipt of the initial request.

For a resubmitted PAR, the DME MAC will ensure that the written decision is faxed, postmarked, or delivered electronically by the fifth business day of the resubmitted request to the supplier and/or the beneficiary (if specifically requested by the beneficiary) within five business days of receipt of the resubmission.

You, the supplier, may request an expedited review process where applying the standard timeframe for making a prior authorization decision could jeopardize the life or health of the beneficiary. In these situations, the DME MAC will communicate the decisions within two business days (excluding federal holidays) of receipt of all applicable Medicare required documentation. For expedited review requests, you should use fax, esMD, or the myCGS Web Portal to avoid delays with mailing.

6. Denial Categories

The Medicare Program provides coverage for a wide range of services that improve the health of the elderly and disabled. Medicare, however, does not cover every service that is related to the health care of its beneficiaries. Coverage and exclusion of services are defined in the Social Security Act, which in turn are implemented through federal regulations, Medicare manuals, instructions from CMS, and decisions by the individual DME MACs.

This section provides an overview of the denial categories for services billed to Medicare. It is important to understand the basic concepts for proper submission, as well as supplier and beneficiary liability issues. This section is a general summary; there are occasional exceptions to some of the statements made below. Specific coverage guidelines are published in the individual medical policies on our website.

Benefit Denials

Section 1861(s) of the Social Security Act defines the medical and other health services that are covered by Medicare. Items or services that are not included in the benefit category definitions are considered benefit category denials. While these services may be reasonable and important health care services, they are just not included in the benefit package specified by the law.

Examples (not all-inclusive) of items in this category include:

1. Disposable supplies other than surgical dressings or supplies required for the effective use of DME or prosthetic devices
2. Equipment that does not serve an exclusively medically therapeutic function
3. Most oral and injectable medications

Medical Necessity Denials

Section 1862(a)(1) of the Social Security Act excludes services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” CMS issues NCDs that are binding on all Medicare jurisdictions. In addition, the DME MAC has the authority and responsibility to make medical necessity determinations on all aspects of medical practice not defined nationally.

Services that are considered investigational or experimental are denied under this exclusion. Preventive services are excluded from coverage under this section of the Act because they do not diagnose or treat an established condition (not because they are inherently unreasonable or unnecessary).

Other Statutory Exclusion Denials

Sections 1862(a)(2)–1862(a)(16) of the Social Security Act list other categories of services that are excluded from coverage by Medicare. Those that may be related to DMEPOS items are as follows:

1. Routine services and appliances (Section 1862[a][7]). Some examples of items excluded from coverage under this section are:
 - a. Eyeglasses and contact lenses except in those beneficiaries who have had cataract extraction or have had their lens removed for other indications
 - b. Hearing aids
2. Orthopedic shoes or other supportive devices for the feet. An exception is a shoe that is an integral part of a leg brace. Another exception is a special shoe and inserts used for the prevention or management of foot ulcers in diabetics.
3. Personal comfort items.
4. Services received outside of the United States.
5. Services for which another government program is primary (e.g., Veteran’s Administration).
6. Services provided to an immediate relative or members of the household.
7. Services relating to war injuries received after the beneficiary is eligible for Medicare coverage.
8. Services for which the beneficiary has no legal obligation to pay.

9. Services paid under Workers' Compensation.

Fragmented Coding

The Medicare allowance for an individual HCPCS code often includes several component items. An individual HCPCS code will be denied if it is determined that the item described by that code is included in the allowance for another code that has also been billed. In this case, even though the item provided may be covered—the payment for the code is being denied.

Duplicate Claims

If a claim is received for a service that has been previously processed, and a Medicare allowed amount has been established, the second claim will be denied as a duplicate.

When a second supplier submits a diabetic test strip claim for a span date already approved for the same beneficiary for a different supplier, the DME MAC will deny the second supplier's claim as a duplicate claim, when the following conditions are met:

- Same beneficiary Medicare ID;
- Overlapping span DOS (From DOS and through DOS);
- Same HCPCS code;
- Same type of service on the incoming claim matches a previously approved claim in history; and
- The item is a diabetic testing supply.

Incomplete Claims

You are required to submit complete claims for items provided to Medicare beneficiaries. Claims lacking beneficiary information, diagnosis codes, procedure codes, ordering practitioner's name/NPI, or billing supplier information will be denied as incomplete claims. These claims will be considered for payment when the missing information is supplied on a resubmitted claim.