



<p>If a company has a ATP on staff and need a Group 3 w/c in 2008 they have a different ATP do the evaluation that has no \$\$\$ with the other ATP's company. The company has the ATP on staff but not a ATS, do they need a ATS too? Or will the ATP on staff take care of the ATS issue in 2008?</p>	<p>CMS has indicated that the supplier "ATS" role can be fulfilled by either an ATP or ATS. Be aware that the clinical reviewer would have to have an ATP and have no financial ties to the supplier</p>
<p>When they say optimally configured W/C does that mean they will cover aK0005 or K0009 wheelchair if this will prevent them from going to a power wheelchair?</p>	<p>Yes</p>
<p>Strength measurements are not in my opinion very good because they are stagnant and not functional. They may have a 3/5 or 4/4 upper but when they have to hold this or do this a few times they drop fast. If I as an ATS state they have no endurance will that take care of it or do I need the DR to say it.</p>	<p>A full functional evaluation of strength, ROM and/or endurance as it pertains to wheeled mobility needs to be part of the medical record. This would need to be documented by a physician or OT/PT, preferably in quantifiable terms.</p>
<p>What if a client meets all the requirements for a PWC with the exception of bathroom access which is not possible with or without a PWC? Client uses a commode and is given periodic shower/baths when additional help is available. Client has an HH aide and cannot independently transfer, and is functionally non ambulatory.</p>	<p>It would be necessary to document MRADL's that the PWC does ameliorate – dressing, grooming, meal prep activities and that the home is accessible for these activities. The modification utilizing equipment to substitute for entry into the bathroom is fine.</p>
<p>Can someone who qualifies for a Group 3 power wheelchair get a Group 2 wheelchair?</p>	<p>Yes, but remember that this piece of equipment must meet the needs of the client for > 5 years. You must take into consideration the durability of the product as well as the possibility of client function/need changes Will a group 2 product be able to meet the clients functional needs for 5+ years?</p>
<p>Why is it that the Golden Compass power wheelchair is coded as a group 1 and a Group 2 power wheelchair? I know that you don't make this chair but when I called them they said the Group 1 power compass and group 2 are the same chair nothing is different. How can this be? I encourage you to call Golden and ask, I have 3 times and get the same answer</p>	<p>The product has to meet these minimal performance requirements. However, the chair can exceed them. As a result, some manufacturers have products that meet the requirements for multiple groups.</p>
<p>For providing equipment that meets future needs for someone with a progressive diagnosis such as MS or ALS, must the supplier submit this to ADMC? Also, is there any future need consideration for tilt or just the base?</p>	<p>Yes – if you are requesting a power wheelchair based on its ability to meet the "near-future" needs of the client, it must be submitted through ADMC</p>



<p>How do I distinguish between Grp 3 and Grp 4 when many of the products are the same?</p>	<p>The 2 products differ in the minimal performance characteristics The order forms will designate the wheelchair's code(s) so you can seek correct funding. Group 3 product parameters Speed: 4.5 mph Battery range: 12 miles Min Obstacle climb: 60 mm Min Dynamic stability incline: 7.5 degrees Group 4 product parameters Speed: 6 mph Battery range: 16 miles Min Obstacle climb: 75 mm Min Dynamic stability incline: 9 degrees</p> <p>Gp 4 is considered complex, high activity and this may be what is most necessary for your client. A range of 12 miles most likely is not enough for someone using the power chair on a college campus or working. Also allows better terrain navigation 3" versus 2" curb. A slide has been included in the presentation that describes the performance characteristics for all 5 groups.</p>
<p>Why is the Z500 not considered a K0890?</p>	<p>This code incorporates chairs with highly specialized functions such as power standing feature and or power seat lowering functionality. The z500 does not offer these functions and is therefore a group 3 product. In addition, Group 5 products have a 125 lbs maximum weight capacity</p>
<p>For the power option what physicians, PT/OT's are qualified to do the evals?</p>	<p>Evaluation performed by PT, OT, Physician with specific training and experience in rehabilitation wheelchair evaluations. This person can have no financial obligation to the supplier. Beginning April 1 2008 - will have to be performed by an ATP with no financial ties or a board certified physical medicine and rehabilitation physician</p>
<p>What is the new K0108 code?</p>	<p>This remains a miscellaneous code. Expandable electronics have a current code of E2399. It will transition to an E2377 code January 1 2007</p>
<p>If a physician orders a PT evaluation for a wheelchair and evaluation is completed, can the PT detailed Evaluation report serve as MD notes if MD indicates he has reviewed and concurs with findings?</p>	<p>MD would need to document in progress notes the review and agreement with evaluation findings. A face to face evaluation by the physician has to occur as well. A common scenario would be a face to face visit with the doctor creating a referral to a LCMP, review, agreement and LCMP documentation. 45 day clock would begin with the doctor's signature of the documentation.</p>
<p>For someone with a progressive condition, will future needs be considered for the base only or for base and a tilt? Must the client qualify for a tilt per the requirements at the time a tilt is provided?</p>	<p>Medicare will consider the near-future needs of the client – both base and power seating. If the client does not currently qualify for a tilt, documentation of a progressive diagnosis as well as a downward slope of function would have to provide. This would require use of the ADMC –advanced determination of medical coverage</p>
<p>So any company that has a ATP on staff has to get them recertified as a ATS because a ATP is no good as a employee, that is what I understood you to say</p>	<p>No - upon further discussion with CMS, they have agreed that an ATP employed by the supplier will fill the role of an ATS</p>
<p>What if a company does not have an ATP or ATS on staff BUT sub contracts an ATP or ATS? is that good or do they have to be full time employee</p>	<p>This question was asked of the DME PSC medical directors after the webinars. Their response was "The 4/1/08 requirement for provision of rehab power wheelchair by a supplier who employs an ATS could be met if the supplier subcontracted with an ATP or ATS and that person was directly (i.e., in person) involved in the wheelchair selection for the patient."</p>



<p>Can you bill separately for batteries, seat belts and flat free tires? How many batteries can you bill in a year?</p>	<p>Batteries are separately billable for power wheelchairs; however, they are included in the basic equipment package for power operated vehicles (POV). The complete list of items that are included in the basic equipment package for both power wheelchairs and POVs is included in the slide presentation. Medicare does not have a specific utilization parameter for batteries. Frequent replacement will require justification.</p>
<p>Please clarify the 45 day requirement from the order / face to face date</p>	<p>The basic rule to remember is the 45 day clock starts with the last date the physician either 1) sees the patient; or 2) signs off on supporting documentation. Several common scenarios are included in the slide presentation.</p>
<p>What can we realistically expect in 2008 regarding the ATP requirement...</p>	<p>At the present time, the policy is specifying ATP, ATS and Board-certified physiatrist for evaluations on or after April 1, 2008. CMS and the medical directors are aware that the numbers of these practitioners are limited; however, they expect the numbers to increase with the inclusion of this requirement in the policy. Sunrise Medical and others in the disability community will be closely monitoring the numbers and will work with CMS and the medical directors to modify this requirement if sufficient numbers are not achieved by April 2008.</p>
<p>What is the difference in the new K codes?</p>	<p>Previously, there were a limited number of healthcare common procedure coding system (HCPCS) codes to describe power wheelchairs and POVs. CMS, in conjunction with a technical panel of mobility engineering experts, developed the new HCPCS code set that defines products according to performance characteristics. The result was 64 codes - two groups for POVs, five groups for power wheelchairs. The performance characteristics for each group are included in the slide presentation.</p>
<p>What is adequate justification for E1010?</p>	<p>HCPCS code E1010 describes power elevating legrests. Coverage criteria for elevating footrests are found in the Wheelchair Options and Accessories Policy. For Medicare coverage, the patient must: 1) have a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; or 2) have significant edema of the lower extremities that requires having an elevating legrest; or 3) meet the criteria for and have a reclining back on the wheelchair. Although there is no policy statement about power elevating legrests, additional justification in addition to the above criteria would include a description of why the patient could not utilize manual elevating legrests (e.g., strength, coordination and dexterity issues, inability to bend over and adjust legrests)</p>
<p>What information is being distributed directly to physicians?</p>	<p>CMS has created several documents that were distributed to physicians through the Medicare Part B local carrier contractor bulletins. In addition Sunrise Medical, other mobility manufacturers and DME providers are conducting educational seminars for clinicians.</p>
<p>Does the KX modifier need to be attached to every code on the claim?</p>	<p>According to the policy, the KX modifier may be added to the code for the power mobility device AND all accessories if one of the following conditions is met: 1) If all of the coverage criteria specified in the policy have been met for the product that is provided; or, 2) If there is an Advance Determination of Medicare Coverage (ADMC) for the product that is provided; or, 3) If a Group 4 power wheelchair is provided and all of the coverage criteria for a comparable Group 3 power wheelchair have been met.</p>
<p>Is CVA not considered a neuro diagnosis?</p>	<p>Cerebrovascular Accident (CVA) is a neurologic disorder; however, it can take many forms in terms of mobility impairment. Clinicians should carefully document the impairment resulting from the CVA that either: 1) prevents the patient from accomplishing their mobility-related activities of daily living (MRADLs) entirely; or, 2) places the patient at a heightened safety risk in performing their MRADLs; or, 3) prevents the patient from accomplishing their MRADLs in a reasonable time frame.</p>
<p>When is the accreditation deadline?</p>	<p>CMS has not announced the deadline for accreditation.</p>



<p>What is the LCD?</p>	<p>LCD stands for Local Coverage Determination. This is the local coverage policy that is developed by the Durable Medical Equipment Program Safeguard Contractors or DME PSCs. It builds on the NCD or National Coverage Determination and details the specific coverage, coding and documentation requirements for power mobility devices.</p>
<p>Is Medicare restricting PWC as rental only or can we still purchase these?</p>	<p>Power wheelchairs, by law, can either be rented or purchased. Rental payments "cap" at 13 months. For purchase, the decision must be made at the time of initial purchase.</p>
<p>Does the ATP have to be an OT/PT or could there be a PT and an assistive technology spec.?</p>	<p>According to the policy, until April 1, 2008, there must be an evaluation by a PT, OT or physician with training and experience in wheelchair rehabilitation evaluations for Group 2 single power option and above. On or after April 1, 2008, the wheelchair evaluation must be performed by a RESNA-certified assistive technology practitioner (ATP) or board-certified physiatrist (physician with specific training in physical medicine and rehabilitation) and the equipment supplied by a RESNA-certified assistive technology supplier (ATS).</p>
<p>Should the provider order and bill powered seating components upfront or one by one?</p>	<p>The provider should bill for the items that are medically necessary at the time the evaluation is performed. The exception is for patients with progressive disorders. For those patients, the provider may utilize the Advance Determination of Medicare Coverage (ADMC) process to justify and seek a coverage decision for a more advanced wheelchair base that may be necessary in the future to accommodate additional accessories.</p>
<p>Is my understanding that an OT/PT report is only needed when the Doctor is not trained w/ mobility devices?</p>	<p>At the present time, the policy specifies that there must be a face-to-face evaluation by a physician. Some physicians may be uncomfortable with their knowledge of power mobility devices and evaluations and choose to enlist the aide of a PT or OT. When ordering a product in Group 2 single power option or above, the physician must have "training and experience" in wheelchair rehabilitation evaluations. The policy did not specify what that training and experience must include or how it is documented. On or after April 1, 2008, the physician must be board-certified in physical medicine and rehabilitation. In order to become board-certified in that field, the physician must complete a residency program in physical medicine and rehabilitation.</p>
<p>Medicare says CMN still has to be on file?</p>	<p>For claims for power mobility devices with dates of service before May 5, 2005, a certificate of medical necessity must be completed and signed by the physician. For claims for power mobility devices with dates of service on or after May 5, 2005, a CMN is not required and should not be submitted with the claim.</p>
<p>Will the dealer be able to bill for both the base and power seating system for a chair?</p>	<p>Yes, power wheelchair bases and power seating systems are separately billable.</p>
<p>What happens if I have someone who has been in a chair for years (Medicaid). Could they get down coded?</p>	<p>If the primary payer is Medicare and the patient would otherwise qualify medically for a Group 4 power wheelchair, Medicare will downcode the chair to payment at the "least costly medically appropriate alternative." In other words, if the patient meets criteria for a Group 3 chair, Medicare will reimburse at the level of the Group 3 product even though the product billed was a Group 4 chair.</p>
<p>We have a rehab tech that does the eval and has the dr. sign off, is that legal?</p>	<p>The process described would not meet the requirements for an evaluation in the new policy. Medicare law now states that there must be a face-to-face evaluation by either a physician (MD or DO), physicians assistant, nurse practitioner or clinical nurse specialist for all power mobility devices.</p>