

Local Coverage Determination (LCD): Power Mobility Devices (L33789)

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Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
CGS Administrators, LLC	DME MAC	17013 -	DME MAC J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia Connecticut District of Columbia Delaware Massachusetts Maryland Maine New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada Oregon
CGS Administrators, LLC	DME MAC	18003 -	DME MAC J-C	
Noridian Healthcare Solutions, LLC	DME MAC	16013 -	DME MAC J-A	
Noridian Healthcare Solutions, LLC	DME MAC	19003 -	DME MAC J-D	

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LCD Information

Document Information

LCD ID L33789	Original Effective Date For services performed on or after 10/01/2015
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Original ICD-9 LCD ID L27239 L23613 L21271 L23598	Revision Effective Date For services performed on or after 01/01/2017
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	Revision Ending Date N/A
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LCD Title Power Mobility Devices	Retirement Date N/A
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	Notice Period Start Date N/A
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	Notice Period End Date N/A
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CMS National Coverage Policy CMS Pub. 100-3, Medicare National Coverage Determinations Manual, Chapter 1, Sections 280.3

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements.

The purpose of a Local Coverage Determination (LCD) is to provide information regarding "reasonable and necessary" criteria based on Social Security Act § 1862(a)(1)(A) provisions.

In addition to the "reasonable and necessary" criteria contained in this LCD there are other payment rules, which are discussed in the following documents, that must also be met prior to Medicare reimbursement:

- The LCD-related Standard Documentation Requirements Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- The LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- Refer to the Supplier Manual for additional information on documentation requirements.
- Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

For the items addressed in this LCD, the "reasonable and necessary" criteria, based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

Power Mobility Device bases require a 7-element order. Refer to this LCD's related Policy Article for this statutory requirement. Other separately billable wheelchair options and accessories require a detailed product description (DPD). Refer to the Standard Documentation Requirements for All Claims Submitted to DME MACs Policy Article for information about the DPD.

Refer to this related Policy Article for information on the face-to-face examination.

The term power mobility device (PMD) includes power operated vehicles (POVs) and power wheelchairs (PWCs).

GENERAL COVERAGE CRITERIA:

All of the following basic criteria (A-C) must be met for a power mobility device (K0800-K0898) or a push-rim activated power assist device (E0986) to be covered. Additional coverage criteria for specific devices are listed below.

- A. The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:
 - Prevents the beneficiary from accomplishing an MRADL entirely, or
 - Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
 - Prevents the beneficiary from completing an MRADL within a reasonable time frame.
- B. The beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.
- C. The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.
 - Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
 - An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.

POWER OPERATED VEHICLES (K0800-K0808, K0812):

A POV is covered if all of the basic coverage criteria (A-C) have been met and if criteria D-I are also met.

- D. The beneficiary is able to:

- Safely transfer to and from a POV, and
 - Operate the tiller steering system, and
 - Maintain postural stability and position while operating the POV in the home.
- E. The beneficiary's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home.
- F. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided.
- G. The beneficiary's weight is less than or equal to the weight capacity of the POV that is provided and greater than or equal to 95% of the weight capacity of the next lower weight class POV – i.e., a Heavy Duty POV is covered for a beneficiary weighing 285 – 450 pounds; a Very Heavy Duty POV is covered for a beneficiary weighing 428 – 600 pounds.
- H. Use of a POV will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it in the home.
- I. The beneficiary has not expressed an unwillingness to use a POV in the home.

If a POV will be used inside the home and coverage criteria A-I are not met, it will be denied as not reasonable and necessary.

Group 2 POVs (K0806-K0808) have added capabilities that are not needed for use in the home. Therefore, if a Group 2 POV is provided it will be denied as not reasonable and necessary.

If a POV will only be used outside the home, see related Policy Article for information concerning noncoverage.

POWER WHEELCHAIRS (K0013, K0813-K0891, K0898):

A power wheelchair is covered if:

- a. All of the basic coverage criteria (A-C) are met; and
 - b. The beneficiary does not meet coverage criterion D, E, or F for a POV; and
 - c. Either criterion J or K is met; and
 - d. Criteria L, M, N, and O are met; and
 - e. Any coverage criteria pertaining to the specific wheelchair type (see below) are met.
- J. The beneficiary has the mental and physical capabilities to safely operate the power wheelchair that is provided; or
- K. If the beneficiary is unable to safely operate the power wheelchair, the beneficiary has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair that is provided; and
- L. The beneficiary's weight is less than or equal to the weight capacity of the power wheelchair that is provided and greater than or equal to 95% of the weight capacity of the next lower weight class PWC – i.e., a Heavy Duty PWC is covered for a beneficiary weighing 285 – 450 pounds; a Very Heavy Duty PWC is covered for a beneficiary weighing 428 – 600 pounds; an Extra Heavy Duty PWC is covered for a beneficiary weighing 570 pounds or more.
- M. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is provided.
- N. Use of a power wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it in the home. For beneficiaries with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver.
- O. The beneficiary has not expressed an unwillingness to use a power wheelchair in the home.

If a PWC will be used inside the home and if coverage criteria (a)-(e) are not met, it will be denied as not reasonable and necessary.

If a PWC will only be used outside the home, see related Policy Article for information concerning noncoverage.

ADDITIONAL CRITERIA FOR SPECIFIC TYPES OF POWER WHEELCHAIRS:

- I. A Group 1 PWC (K0813-K0816) or a Group 2 PWC (K0820-K0829) is covered if all of the coverage criteria (a)-(e) for a PWC are met and the wheelchair is appropriate for the beneficiary's weight.
- II. A Group 2 Single Power Option PWC (K0835 – K0840) is covered if all of the coverage criteria (a)-(e) for a PWC are met and if:
 - A. Criterion 1 or 2 is met; and
 - B. Criteria 3 and 4 are met.
 - 1. The beneficiary requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control).
 - 2. The beneficiary meets coverage criteria for a power tilt or a power recline seating system (see Wheelchair Options and Accessories policy for coverage criteria) and the system is being used on the wheelchair.
 - 3. The beneficiary has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, or practitioner may have no financial relationship with the supplier.
 - 4. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary.

If a Group 2 Single Power Option PWC is provided and if criterion II(A) or II(B) is not met (including but not limited to situations in which it is only provided to accommodate a power seat elevation feature, a power standing feature, or power elevating legrests), it will be denied as not reasonable and necessary.

- III. A Group 2 Multiple Power Option PWC (K0841-K0843) is covered if all of the coverage criteria (a)-(e) for a PWC are met and if:
 - A. Criterion 1 or 2 is met; and
 - B. Criteria 3 and 4 are met.
 - 1. The beneficiary meets coverage criteria for a power tilt and recline seating system (see Wheelchair Options and Accessories policy) and the system is being used on the wheelchair.
 - 2. The beneficiary uses a ventilator which is mounted on the wheelchair.
 - 3. The beneficiary has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, or practitioner may have no financial relationship with the supplier.
 - 4. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary.

If a Group 2 Multiple Power Option PWC is provided and if criterion III(A) or III(B) is not met, it will be denied as not reasonable and necessary.

- IV. A Group 3 PWC with no power options (K0848-K0855) is covered if:

- A. All of the coverage criteria (a)-(e) for a PWC are met; and
- B. The beneficiary's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and
- C. The beneficiary has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The PT, OT, or practitioner may have no financial relationship with the supplier; and
- D. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary.

If a Group 3 PWC is provided and if criteria (IV)(A) – (IV)(D) are not met, it will be denied as not reasonable and necessary.

- V. A Group 3 PWC with Single Power Option (K0856-K0860) or with Multiple Power Options (K0861-K0864) is covered if:
 - A. The Group 3 criteria IV(A) and IV(B) are met; and
 - B. The Group 2 Single Power Option (criteria II[A] and II[B]) or Multiple Power Options (criteria III[A] and III[B]) (respectively) are met.

If a Group 3 Single Power Option or Multiple Power Options PWC is provided and if criterion V(A) or (V)(B) is not met, it will be denied as not reasonable and necessary.

- VI. Group 4 PWCs (K0868-K0886) have added capabilities that are not needed for use in the home. Therefore, if these wheelchairs are provided they will be denied as not reasonable and necessary.
- VII. A Group 5 (Pediatric) PWC with Single Power Option (K0890) or with Multiple Power Options (K0891) is covered if:
 - A. All the coverage criteria (a)-(e) for a PWC are met; and
 - B. The beneficiary is expected to grow in height; and
 - C. The Group 2 Single Power Option (criteria II[A] and II[B]) or Multiple Power Options (criteria III[A] and III[B]) (respectively) are met.

If a Group 5 PWC is provided and if criteria (VII)(A) – (VII)(C) are not met, it will be denied as not reasonable and necessary.

- VIII. A push-rim activated power assist device (E0986) for a manual wheelchair is covered if all of the following criteria are met:
 - A. All of the criteria for a power mobility device listed in the Basic Coverage Criteria section are met; and
 - B. The beneficiary has been self-propelling in a manual wheelchair for at least one year; and
 - C. The beneficiary has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the need for the device in the beneficiary's home. The PT, OT, or practitioner may have no financial relationship with the supplier; and
 - D. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary.

If all of the coverage criteria are not met, it will be denied as not reasonable and necessary.

A custom motorized/power wheelchair base (K0013) will be covered if:

- 1. The beneficiary meets the general coverage criteria for a power wheelchair; and
- 2. The specific configurational needs of the beneficiary are not able to be met using wheelchair cushions, or options or accessories (prefabricated or custom fabricated), which may be added to another power wheelchair base.

If coverage criterion 1 for K0013 is not met, the claim will be denied as not reasonable and necessary.

If coverage criterion 2 for K0013 is not met, the claim will be denied for incorrect coding (see related Policy Article for additional information).

A custom motorized/power wheelchair base is not reasonable and necessary if the expected duration of need for the chair is less than three months (e.g., post-operative recovery).

If the PWC base is not covered, then related accessories will be denied.

MISCELLANEOUS:

A POV or power wheelchair with Captain's Chair is not appropriate for a beneficiary who needs a separate wheelchair seat and/or back cushion. If a skin protection and/or positioning seat or back cushion that meets coverage criteria (see Wheelchair Seating LCD) is provided with a POV or a power wheelchair with Captain's Chair, the POV or PWC will be denied as not reasonable and necessary. (Refer to Wheelchair Seating LCD and Policy Article for information concerning coverage of general use, skin protection, or positioning cushions when they are provided with a POV or power wheelchair with Captain's Chair.)

For beneficiaries who do not have special skin protection or positioning needs, a power wheelchair with Captain's Chair provides appropriate support. Therefore, if a general use cushion is provided with a power wheelchair with a sling/solid seat/back instead of Captain's Chair, the wheelchair and the cushion(s) will be covered only if either criterion 1 or criterion 2 is met:

1. The cushion is provided with a covered power wheelchair base that is not available in a Captain's Chair model – i.e., codes K0839, K0840, K0843, K0860 – K0864, K0890, K0891; or
2. A skin protection and/or positioning seat or back cushion that meets coverage criteria is provided.

If one of these criteria is not met, both the power wheelchair with a sling/solid seat and the general use cushion will be denied as not reasonable and necessary.

If a heavy duty, very heavy duty, or extra heavy duty PWC or POV is provided and if the beneficiary's weight is outside the range listed in criterion G or L above (i.e., for heavy duty – 285 – 400 pounds, for very heavy duty – 428 – 600 pounds, for extra heavy duty – 570 pounds or more), it will be denied as not reasonable and necessary.

Refer to the related Policy Article for information concerning coverage of Group 2 PWCs with seat elevators (K0830, K0831).

The delivery of the PMD must be within 120 days following completion of the face-to face examination. (Exception: For PWCs that go through Advance Determination of Medicare Coverage (ADMC) or Prior Authorization (PA) and receive an affirmative determination, the delivery must be within 6 months following the determination.)

An add-on to convert a manual wheelchair to a joystick-controlled power mobility device (E0983) or to a tiller-controlled power mobility device (E0984) will be denied as not reasonable and necessary.

Payment is made for only one wheelchair at a time. Backup chairs are denied as not reasonable and necessary.

One month's rental of a PWC or POV (K0462) is covered if a beneficiary-owned wheelchair is being repaired. Payment is based on the type of replacement device that is provided but will not exceed the rental allowance for the power mobility device that is being repaired.

A power mobility device will be denied as not reasonable and necessary if the underlying condition is reversible and the length of need is less than 3 months (e.g., following lower extremity surgery which limits ambulation).

A POV or PWC which has not been reviewed by the Pricing, Data Analysis, and Coding (PDAC) contractor or which has been reviewed by the PDAC and found not to meet the definition of a specific POV/PWC will be denied as not reasonable and necessary and should be coded as K0899.

GENERAL

A Detailed Written Order (DWO) (if applicable) must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving a completed DWO, the claim shall be

denied as not reasonable and necessary.

For Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) base items that require a Written Order Prior to Delivery (WOPD), the supplier must also obtain a DWO before submitting a claim for any associated options, accessories, and/or supplies that are separately billed. In this scenario, if the supplier bills for associated options, accessories, and/or supplies without first receiving a completed DWO, the claim shall be denied as not reasonable and necessary.

A WOPD (if applicable) must be received by the supplier before a DMEPOS item is delivered to a beneficiary. If a supplier delivers a DMEPOS item without first receiving a completed WOPD, the claim shall be statutorily denied. Refer to the LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.

An item/service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, LCD-related Policy Articles, or DME MAC articles. Claims that do not meet coding guidelines shall be denied as not reasonable and necessary/incorrectly coded.

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. Proof of delivery documentation must be made available to the Medicare contractor upon request. All services that do not have appropriate proof of delivery from the supplier shall be denied as not reasonable and necessary.

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Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A

CPT/HCPCS Codes

Group 1 Paragraph: The appearance of a code in this section does not necessarily indicate coverage.

HCPCS MODIFIERS:

EY – No physician or other licensed health care provider order for this item or service

GA - Waiver of liability statement issued as required by payer policy, individual case

GY – Item or service statutorily excluded or doesn't meet the definition of any Medicare benefit category

GZ - Item or service expected to be denied as not reasonable and necessary

KX - Requirements specified in the medical policy have been met

HCPCS CODES:

Group 1 Codes:

- E0983 MANUAL WHEELCHAIR ACCESSORY, POWER ADD-ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, JOYSTICK CONTROL
- E0984 MANUAL WHEELCHAIR ACCESSORY, POWER ADD-ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, TILLER CONTROL
- E0986 MANUAL WHEELCHAIR ACCESSORY, PUSH-RIM ACTIVATED POWER ASSIST SYSTEM
- K0013 CUSTOM MOTORIZED/POWER WHEELCHAIR BASE
- K0800 POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0801 POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0802 POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0806 POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0807 POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0808 POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0812 POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED
- K0813 POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0814 POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0815 POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0816 POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0820 POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0821 POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0822 POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0823 POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0824 POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0825 POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0826 POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0827 POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0828 POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
- K0829 POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT 601 POUNDS OR MORE
- K0830 POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0831 POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0835 POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS

- K0836 POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0837 POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0838 POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0839 POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0840 POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
- K0841 POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0842 POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0843 POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0848 POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0849 POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0850 POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0851 POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0852 POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0853 POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0854 POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
- K0855 POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
- K0856 POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0857 POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0858 POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 301 TO 450 POUNDS
- K0859 POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0860 POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0861 POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0862 POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0863 POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0864 POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
- K0868 POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0869 POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0870 POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0871 POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0877 POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0878 POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0879

- K0880 POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0884 POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
- K0884 POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0885 POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0886 POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
- K0890 POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS
- K0891 POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS
- K0898 POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED
- K0899 POWER MOBILITY DEVICE, NOT CODED BY DME PDAC OR DOES NOT MEET CRITERIA

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph: Not specified

Group 1 Codes: N/A

ICD-10 Codes that DO NOT Support Medical Necessity

Group 1 Paragraph: Not specified

Group 1 Codes: N/A

ICD-10 Additional Information

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General Information

Associated Information

DOCUMENTATION REQUIREMENTS

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records include the treating practitioner's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

GENERAL DOCUMENTATION REQUIREMENTS

In order to justify payment for DMEPOS items, suppliers must meet the following requirements:

- Prescription (orders)
- Medical Record Information (including continued need/use if applicable)

- Correct Coding
- Proof of Delivery

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information regarding these requirements.

Refer to the Supplier Manual for additional information on documentation requirements.

Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

Items covered in this LCD have additional policy-specific requirements that must be met prior to Medicare reimbursement.

Refer to the LCD-related Policy article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information.

PRESCRIPTION (ORDER) REQUIREMENTS

7-ELEMENT ORDERS (PIM 5.9.2)

The order, referred to as the 7-element order, that the supplier must receive within 45 days after completion of the face-to-face examination (see Policy Article) must contain all of the following elements:

1. Beneficiary's name
2. Description of the item that is ordered. This may be general – e.g., "power operated vehicle", "power wheelchair", or "power mobility device"– or may be more specific.
3. Date of the face-to-face examination
4. Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
5. Length of need
6. Practitioner's signature
7. Date of practitioner signature

The Supplier may provide a template order listing the seven required elements but is prohibited from completing any part of it. The treating practitioner completing the face-to-face requirements must write the 7-element order. The 7-element order may only be written after the completion of the face-to-face exam requirements. Refer to the Policy Article NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information regarding the statutory requirements for PMDs.

A date stamp or equivalent must be used to document receipt date.

DETAILED PRODUCT DESCRIPTION

Once the supplier has determined the specific power mobility device that is appropriate for the beneficiary based on the practitioner's 7-element order, the supplier must prepare a written document (termed a detailed product description). This detailed product description (DPD) must comply with the requirements for a detailed written order as outlined in the Supplier Manual and CMS' Program Integrity Manual (Internet-Only Manual, Pub. 100-8), Chapter 5. Regardless of the form of the description, there must be sufficient detail to identify the item(s) in order to determine that the item(s) dispensed is properly coded.

The practitioner must sign and date the detailed product description and the supplier must receive it prior to delivery of the PWC or POV. Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4. A date stamp or equivalent must be used to document the supplier receipt date. The detailed product description must be available on request.

A prescription is not considered as part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record. (PIM 5.7)

FACE-TO-FACE EXAMINATION:

The report of the face-to-face examination (see Policy Article) should provide information relating to the following questions.

For POVs and PWCs	What is this beneficiary's mobility limitation and how does it interfere with the performance of activities of daily living?
For POVs and PWCs	Why can't a cane or walker meet this beneficiary's mobility needs in the home?
For POVs and PWCs	Why can't a manual wheelchair meet this beneficiary's mobility needs in the home?
For POVs	Does this beneficiary have the physical and mental abilities to transfer into a POV and to operate it safely in the home?
For PWCs	Why can't a POV (scooter) meet this beneficiary's mobility needs in the home?
For PWCs	Does this beneficiary have the physical and mental abilities to operate a power wheelchair safely in the home?

The report should provide pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.

- History of the present condition(s) and past medical history that is relevant to mobility needs
 - Symptoms that limit ambulation
 - Diagnoses that are responsible for these symptoms
 - Medications or other treatment for these symptoms
 - Progression of ambulation difficulty over time
 - Other diagnoses that may relate to ambulatory problems
 - How far the beneficiary can walk without stopping
 - Pace of ambulation
 - What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used
 - What has changed to now require use of a power mobility device
 - Ability to stand up from a seated position without assistance
 - Description of the home setting and the ability to perform activities of daily living in the home
- Physical examination that is relevant to mobility needs
 - Weight and height
 - Cardiopulmonary examination
 - Musculoskeletal examination
 - Arm and leg strength and range of motion
 - Neurological examination
 - Gait
 - Balance and coordination

The evaluation should be tailored to the individual beneficiary's conditions. The history should paint a picture of the beneficiary's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the beneficiary's ambulatory difficulty or impact on the beneficiary's ambulatory ability.

A date stamp or equivalent must be used to document the date that the supplier receives the report of the face-to-face examination. The written report of this examination must be available upon request.

Practitioners shall document the examination in a detailed narrative note in their charts in the format that they use for other entries. The note must clearly indicate that a major reason for the visit was a mobility examination.

Many suppliers have created forms which have not been approved by CMS which they send to practitioners and ask them to complete. Even if the practitioner completes this type of form and puts it in his/her chart, this supplier-generated form is not a substitute for the comprehensive medical record as noted above. Suppliers are encouraged to help educate practitioners on the type of information that is needed to document a beneficiary's mobility needs.

Practitioners shall also provide reports of pertinent laboratory tests, x-rays, and/or other diagnostic tests (e.g., pulmonary function tests, cardiac stress test, electromyogram, etc.) performed in the course of management of the beneficiary. Upon request, suppliers shall provide notes from prior visits to give a historical perspective of the progression of disease over time and to corroborate the information in the face-to-face examination.

If the report of a licensed/certified medical professional (LCMP) examination is to be considered as part of the face-to-face examination (see Policy Article), there must be a signed and dated attestation by the supplier or LCMP that the LCMP has no financial relationship with the supplier. (Note: Evaluations performed by an LCMP who has a financial relationship with the supplier may be submitted to provide additional clinical information, but will not be considered as part of the face-to-face examination by the practitioner.)

Although beneficiaries who qualify for coverage of a power mobility device may use that device outside the home, because Medicare’s coverage of a wheelchair or POV is determined solely by the beneficiary’s mobility needs within the home, the examination must clearly distinguish the beneficiary’s abilities and needs within the home from any additional needs for use outside the home.

SPECIALTY EVALUATION:

The specialty evaluation that is required for beneficiary's who receive a Group 2 Single Power Option or Multiple Power Options PWC, any Group 3 PWC, or a push-rim activated power assist device is in addition to the requirement for the face-to-face examination. The specialty evaluation provides detailed information explaining why each specific option or accessory – i.e., power seating system, alternate drive control interface, or push-rim activated power assist – is needed to address the beneficiary’s mobility limitation. There must be a written report of this evaluation available on request.

HOME ASSESSMENT:

Prior to or at the time of delivery of a POV or PWC, the supplier or practitioner must perform an on-site evaluation of the beneficiary’s home to verify that the beneficiary can adequately maneuver the device that is provided considering physical layout, doorway width, doorway thresholds, and surfaces. There must be a written report of this evaluation available on request.

Miscellaneous

Appendices

Utilization Guidelines

Refer to Coverage Indications, Limitations, and/or Medical Necessity

Sources of Information and Basis for Decision
 CMS Decision Memorandum on Mobility Assistive Equipment.
 Information received from multiple sources during the comment period.

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Revision History Information

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
01/01/2017	R4	Revision Effective Date: 01/01/2017 COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Updated: Reference for Detailed Product Description Removed: Standard Documentation Language Added: New reference language and directions to Standard Documentation Requirements Added: General Requirements Revised: Delivery requirements for PA eligible bases DOCUMENTATION REQUIREMENTS: Removed: Standard Documentation Language Added: General Documentation Requirements Added: New reference language and directions to Standard Documentation Requirements POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Removed: Standard Documentation Language	<ul style="list-style-type: none"> Provider Education/Guidance

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
07/01/2016	R3	<p>Added: Direction to Standard Documentation Requirements</p> <p>Removed: Information under Miscellaneous</p> <p>Removed: PIM reference under Appendices</p> <p>RELATED LOCAL COVERAGE DOCUMENTS:</p> <p>Added: LCD-related Standard Documentation Requirements article</p> <p>Revision Effective Date 07/01/2016</p> <p>COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:</p> <p>Removed: Group 4 power wheelchair HCPCS Codes from the Miscellaneous section</p> <p>DOCUMENTATION REQUIREMENTS:</p> <p>Revised: Standard documentation language for orders, added New order requirements, and Correct coding instructions; revised Proof of delivery instructions – Effective 04/28/16</p>	<ul style="list-style-type: none"> Provider Education/Guidance
07/01/2016	R2	<p>Effective July 1, 2016 oversight for DME MAC LCDs is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the LCDs.</p> <p>Revision Effective Date: 01/01/2015</p> <p>COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:</p> <p>Revised: Standard Documentation Language to add covered prior to a beneficiary’s Medicare eligibility</p> <p>HCPCS CODES:</p> <p>Revised: HCPCS Narrative for E0986</p> <p>DOCUMENTATION REQUIREMENTS:</p> <p>Revised: Standard Documentation Language to add who can enter date of delivery date on the POD</p> <p>Added: Instructions for equipment retained from a prior payer and repair/replacement verbiage</p>	<ul style="list-style-type: none"> Change in Assigned States or Affiliated Contract Numbers
10/01/2015	R1	<p>Revised: Standard Documentation Language to add covered prior to a beneficiary’s Medicare eligibility</p> <p>HCPCS CODES:</p> <p>Revised: HCPCS Narrative for E0986</p> <p>DOCUMENTATION REQUIREMENTS:</p> <p>Revised: Standard Documentation Language to add who can enter date of delivery date on the POD</p> <p>Added: Instructions for equipment retained from a prior payer and repair/replacement verbiage</p>	<ul style="list-style-type: none"> Provider Education/Guidance Revisions Due To CPT/HCPCS Code Changes

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Associated Documents

Attachments N/A

Related Local Coverage Documents Article(s) [A52498 - Power Mobility Devices - Policy Article A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs](#)

Related National Coverage Documents N/A

Public Version(s) Updated on 04/13/2017 with effective dates 01/01/2017 - N/A [Updated on 08/25/2016 with effective dates 07/01/2016 - 12/31/2016](#) [Updated on 06/07/2016 with effective dates 07/01/2016 - N/A](#) [Updated on 02/19/2015 with effective dates 10/01/2015 - 06/30/2016](#) [Updated on 04/04/2014 with effective dates 10/01/2015 - N/A](#) [Back to Top](#)

Keywords

N/A Read the [LCD Disclaimer](#) [Back to Top](#)

Local Coverage Article: Power Mobility Devices - Policy Article (A52498)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
CGS Administrators, LLC	DME MAC	17013 -	DME MAC J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia Connecticut District of Columbia Delaware Massachusetts Maryland Maine New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada Oregon
CGS Administrators, LLC	DME MAC	18003 -	DME MAC J-C	
Noridian Healthcare Solutions, LLC	DME MAC	16013 -	DME MAC J-A	
Noridian Healthcare Solutions, LLC	DME MAC	19003 -	DME MAC J-D	

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Article Information

General Information

Article ID

A52498

Original Article Effective Date

10/01/2015

Original ICD-9 Article ID

[A47122](#)[A41136](#)[A36239](#)[A41127](#)**Revision Effective Date**

01/01/2017

Revision Ending Date

N/A

Article Title

Power Mobility Devices - Policy Article

Retirement Date

N/A

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Article Guidance

Article Text:

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. "reasonable and necessary").

Power mobility devices are covered under the Durable Medical Equipment benefit (Social Security Act §1861(s)(6)). In order for a beneficiary's equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, added section 1834(a)(1)(E)(iv) which provides that payment may not be made for a motorized or power wheelchair unless the practitioner who has conducted the face-to-face examination him or herself writes the 7-element order. It is a statutory requirement that all items of the 7-element order be entered specifically by and only by the practitioner who has conducted the face-to-face requirements. (See below).

For a power operated vehicle (POV) or power wheelchair (PWC) to be covered, the supplier must receive from the prescribing practitioner a written order, termed the 7-element order, containing all the elements specified in the Documentation Requirements section of the Local Coverage Determination within 45 days after completion of the practitioner's face-to-face examination and prior to delivery of the device. (Exception: If the examination is performed during a hospital or nursing home stay, the supplier must receive the order within 45 days after discharge.) If these requirements are not met, the claim will be denied as noncovered.

If the detailed product description for the specific device is not obtained prior to delivery, payment will not be made for the item even if the documentation is subsequently obtained. If a similar item is provided by an unrelated supplier who has obtained the required documentation prior to delivery, it will be eligible for coverage.

A power mobility device may not be ordered by a podiatrist. If it is, it will be denied as noncovered.

FACE-TO-FACE EXAMINATION:

For a POV or PWC to be covered, the treating practitioner must conduct a face-to-face examination of the beneficiary before writing the order and the supplier must receive a written report of this examination within 45 days after completion of the face-to-face examination and prior to delivery of the device. If this requirement is not met, the claim will be denied as noncovered. (Exceptions: If this examination is performed during a hospital or nursing home stay, the supplier must receive the report of the examination within 45 days after discharge. If the POV or PWC is a replacement during the 5 year useful lifetime of an item in the same performance group that was previously covered by Medicare, a face-to-face examination is not required. Note: Replacement during an item's useful lifetime is limited to situations involving loss or irreparable damage from a specific accident or natural disaster [e.g., fire, flood, etc.].)

The practitioner may refer the beneficiary to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), who has experience and training in mobility evaluations to perform part of the face-to-face examination. This person may have no financial relationship with the supplier. (Exception: If the supplier is owned by a hospital, PT or OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination.)

If the beneficiary was referred before being seen by the practitioner, then once the practitioner has received and reviewed the written report of this examination, the practitioner must see the beneficiary and perform any additional examination that is needed. The report of the practitioner's visit shall state concurrence or any disagreement with the LCMP examination. In this situation, the practitioner must provide the supplier with a copy of both examinations within 45 days after the face-to-face examination with the practitioner.

If the practitioner saw the beneficiary to begin the examination before referring the beneficiary to an LCMP, then if the practitioner sees the beneficiary again in person after receiving the report of the LCMP examination, the 45-day period begins on the date of that second practitioner visit. However, it is also acceptable for the practitioner to review the written report of the LCMP examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the practitioner must send a copy of the note from his/her initial visit to evaluate the beneficiary plus the annotated, signed, and dated copy of the LCMP examination to the supplier. The 45-day period begins when the practitioner signs and dates the LCMP examination.

For an item addressed in this policy to be covered by Medicare, a written signed and dated order must be received by the supplier prior to delivery of the item. If the supplier delivers the item prior to receipt of a written

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order, it will be denied as noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

A custom motorized/power wheelchair base (K0013) must be uniquely constructed or substantially modified for a specific beneficiary according to the description and orders of the beneficiary's treating practitioner. The beneficiary's needs must not be able to be accommodated by any other existing PMD and accessories, including customized seating arrangements. See 42 CFR Section 414.224 and Internet-Only Manual, Publication 100-04, Medicare Claims Processing Manual, Chapter 20, Section 30.3 for more information on customized DME.

MISCELLANEOUS:

A seat elevator is a statutorily noncovered option on a power wheelchair. If a PWC with a seat elevator (K0830, K0831) is provided, it will be denied as noncovered.

If any POV or PWC is only for use outside the home, it will be denied as noncovered.

Reimbursement for the wheelchair codes includes all labor charges involved in the assembly of the wheelchair. Reimbursement also includes support services, such as delivery, set-up, and education about the use of the PMD.

Upgrades that are beneficial primarily in allowing the beneficiary to perform leisure or recreational activities are noncovered.

POLICY SPECIFIC DOCUMENTATION

In addition to policy specific documentation requirements, there are general documentation requirements that are applicable to all DMEPOS policies. These general requirements are located in the DOCUMENTATION REQUIREMENTS section of the LCD.

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this Policy Article under the Related Local Coverage Documents section for additional information regarding GENERAL DOCUMENTATION REQUIREMENTS and the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS discussed below.

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO 42 CFR 410.38(c) and 42 CFR 410.38(g)

42 CFR 410.38(c) requires a face-to-face evaluation and a specific written order prior to delivery for specified PMD codes.

42 CFR 410.38(g) requires a face-to-face evaluation and a specific written order prior to delivery for specified HCPCS codes. CMS provides a list of the specified codes, which is periodically updated, located [here](#).

Claims for the specified items subject to 42 CFR 410.38(c) or 42 CFR 410.38(g) that do not meet the requirements specified in the LCD-related Standard Documentation Requirements Article will be denied as statutorily noncovered – failed to meet statutory requirements.

If the supplier delivers the item prior to receipt of a written order, it will be denied as statutorily noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

For the specified items that must meet this ACA 6407 requirement, the 7-element order with the NPI applied to it will fulfill both the ACA 6407 and the DWO prescription requirements.

If documentation of the medical necessity for a K0013 wheelchair is requested, contractors must be able to determine that the item delivered is a customized item. Documentation must include a description of the beneficiary's unique physical and functional characteristics that require a custom motorized/power wheelchair base. This must include a detailed description of the manufacturing of the wheelchair base, including types of materials used in custom fabricating or substantially modifying it, and the construction process and labor skills required to modify it. The record must document that the needs of the beneficiary cannot be met using another power wheelchair base that incorporates seating modifications or other options or accessories (prefabricated and/or custom). The documentation must demonstrate that the K0013 is so different from another power wheelchair base that the two items cannot be grouped together for pricing purposes

MODIFIERS

KX, GA, GY, AND GZ MODIFIERS:

If the requirements related to a face-to-face examination have not been met, the GY modifier must be added to the codes for the power mobility device and all accessories.

If the power mobility device or push-rim activated power assist device that is provided is only needed for mobility outside the home, the GY modifier must be added to the codes for the item and all accessories.

A KX modifier may be added to the code for a power mobility device and all accessories only if one of the following conditions is met:

1. If all of the coverage criteria specified in the related LCD have been met for the product that is provided;
or
2. If there is an affirmative Advance Determination of Medicare Coverage (ADMC) for the product that is provided.

If the requirements for use of the KX modifier or GY modifier are not met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter GA on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or GZ if they have not obtained a valid ABN.

Claim lines billed without a KX, GA, GY, or GZ modifier will be rejected as missing information.

MISCELLANEOUS:

The following power wheelchairs are eligible for Advance Determination of Medicare Coverage (ADMC):

1. A Group 2, 3 or 5 Single Power Option or Multiple Power Options wheelchair (K0835-K0843, K0856 - K0864, K0890-K0891) – whether or not a power seating system will be provided at the time of initial issue
2. A Group 3 No Power Option wheelchair (K0848-K0855) that will be provided with an alternative drive control interface at the time of initial issue
3. Custom motorized/power wheelchair base (K0013)

Refer to the ADMC section in the Supplier Manual for details concerning the ADMC process.

Refer to the Supplier Manual for additional information on documentation requirements.

CODING GUIDELINES

DEFINITIONS:

Power Mobility Device (PMD) - Base codes include both integral frame and modular construction type power wheelchairs (PWCs) and power operated vehicles (POVs).

Power Wheelchair - Chair-like battery powered mobility device for people with difficulty walking due to illness or disability, with integrated or modular seating system, electronic steering, and four or more wheel non-highway construction.

Power Operated Vehicle - Chair-like battery powered mobility device for people with difficulty walking due to illness or disability, with integrated seating system, tiller steering, and three or four-wheel non-highway construction.

Beneficiary Weight Capacity – The terms Standard Duty, Heavy Duty, etc., refer to weight capacity, not performance. For example, the term Group 3 heavy duty power wheelchair denotes that the PWC has Group 3 performance characteristics and beneficiary weight handling capacity between 301 and 450 pounds. A device is not required to carry all the weight listed in the class of devices, but must have a beneficiary weight capacity within the range to be included. For example, a PMD that has a weight capacity of 400 pounds is coded as a Heavy Duty device.

Portable - A category of devices with lightweight construction or ability to disassemble into lightweight components that allows easy placement into a vehicle for use in a distant location.

Performance Testing - Term used to denote the RESNA based test parameters used to test PMDs. The PMD is expected to meet or exceed the listed performance and durability figures for the category in which it is to be used when tested. There is no requirement to test the PMD with all possible accessories.

Test Standards - Performance and durability acceptance criteria defined by ANSI/RESNA standard testing protocols.

Crash Testing - Successful completion of WC-19 testing.

Top End Speed - Minimum speed acceptable for a given category of devices. It is to be determined by the RESNA test for maximum speed on a flat hard surface.

Range - Minimum distance acceptable for a given category of devices on a single charge of the batteries. It is to be determined by the appropriate RESNA test for range.

Obstacle Climb - Vertical height of a solid obstruction that can be climbed using the standing and/or 0.5 meter run-up RESNA test.

Dynamic Stability Incline - The minimum degree of slope at which the PMD in the most common seating and positioning configuration(s) remains stable at the required beneficiary weight capacity. If the PMD is stable at only one configuration, the PMD may have protective mechanisms that prevent climbing inclines in configurations that may be unstable.

Radius Pivot Turn - The distance required for the smallest turning radius of the PMD base. This measurement is equivalent to the "minimum turning radius" specified in the ANSI/RESNA bulletins.

PWC Basic Equipment Package - Each power wheelchair code is required to include all these items on initial issue (i.e., no separate billing/payment at the time of initial issue, unless otherwise noted). The statement that an item may be separately billed does not necessarily indicate coverage.

- Lap belt or safety belt. Shoulder harness/straps or chest straps/vest may be billed separately.
- Battery charger, single mode
- Complete set of tires and casters, any type
- Legrests. There is no separate billing/payment if fixed, swingaway, or detachable non-elevating legrests with or without calf pad are provided. Elevating legrests may be billed separately.
- Footrests/foot platform. There is no separate billing/payment if fixed, swingaway, or detachable footrests or a foot platform without angle adjustment are provided. There is no separate billing for angle adjustable footplates with Group 1 or 2 PWCs. Angle adjustable footplates may be billed separately with Group 3, 4 and 5 PWCs.
- Armrests. There is no separate billing/ payment if fixed, swingaway, or detachable non-adjustable height armrests with arm pad are provided. Adjustable height armrests may be billed separately.
- Any weight specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by beneficiary weight capacity.
- Any seat width and depth. Exception: For Group 3 and 4 PWCs with a sling/solid seat/back, the following may be billed separately:
 - For Standard Duty, seat width and/or depth greater than 20 inches;
 - For Heavy Duty, seat width and/or depth greater than 22 inches;
 - For Very Heavy Duty, seat width and/or depth greater than 24 inches;
 - For Extra Heavy Duty, no separate billing
- Any back width. Exception: For Group 3 and 4 PWCs with a sling/solid seat/back, the following may be billed separately:

- For Standard Duty, back width greater than 20 inches;
 - For Heavy Duty, back width greater than 22 inches;
 - For Very Heavy Duty, back width greater than 24 inches;
 - For Extra Heavy Duty, no separate billing
- Controller and Input Device

There is no separate billing/payment if a non-expandable controller and a standard proportional joystick (integrated or remote) is provided. An expandable controller, a nonstandard joystick (i.e., nonproportional or mini, compact or short throw proportional), or other alternative control device may be billed separately.

Refer to the bundling table in the Wheelchair Options and Accessories Policy Article for a list of codes that are not separately billable at the time of initial issue of a PWC.

POV Basic Equipment Package - Each POV is to include all these items on initial issue (i.e., no separate billing/payment at the time of initial issue):

- Battery or batteries required for operation
- Battery charger, single mode
- Weight appropriate upholstery and seating system
- Tiller steering
- Non-expandable controller with proportional response to input
- Complete set of tires
- All accessories needed for safe operation

Cross Brace Chair - A type of construction for a power wheelchair in which opposing rigid braces hinge on pivot points to allow the device to fold.

Power Options - Tilt, recline, elevating legrests, seat elevators, or standing systems that may be added to a PWC to accommodate a beneficiary's specific need for seating assistance.

No Power Options - A category of PWCs that is incapable of accommodating a power tilt, recline, seat elevation, or standing system. If a PWC can only accept power elevating legrests, it is considered to be a No Power Option chair.

Single Power Option - A category of PWCs with the capability to accept and operate a power tilt or power recline or power standing or, for Groups 3, 4, and 5, a power seat elevation system, but not a combination power tilt and recline seating system. It may be able to accommodate power elevating legrests, seat elevator, and/or standing system in combination with a power tilt or power recline. A PMD does not have to be able to accommodate all features to qualify for this code. For example, a power wheelchair that can only accommodate a power tilt could qualify for this code.

Multiple Power Options - A category of PWCs with the capability to accept and operate a combination power tilt and recline seating system. It may also be able to accommodate power elevating legrests, a power seat elevator, and/or a power standing system. A PWC does not have to accommodate all features to qualify for this code.

Actuator - A motor that operates a specific function of a power seating system - i.e., tilt, back recline, power sliding back, elevating legrest(s), seat elevation, or standing.

Proportional Control Input Device - A device that transforms a user's drive command (a physical action initiated by the wheelchair user) into a corresponding and comparative movement, both in direction and in speed, of the wheelchair. The input device shall be considered proportional if it allows for both a non-discrete directional command and a non-discrete speed command from a single drive command movement. (Note: In the Wheelchair Options and Accessories policy, the term "interface" is used instead of "control input device".)

Non-Proportional Control Input Device - A device that transforms a user's discrete drive command (a physical action initiated by the wheelchair user, such as activation of a switch) into perceptually discrete changes in the wheelchair's speed, direction, or both.

Alternative Control Device - A device that transforms a user's drive commands by physical actions initiated by the user to input control directions to a power wheelchair that replaces a standard proportional joystick. Includes mini-proportional, compact, or short throw joysticks, head arrays, sip and puff and other types of different input control devices.

Non-Expandable Controller - An electronic system that controls the speed and direction of the power wheelchair drive mechanism. Only a standard proportional joystick (used for hand or chin control) can be used as the input device. This system may be in the form of an integral controller or a remotely placed controller. The non-expandable controller:

- a. May have the ability to control up to 2 power seating actuators through the drive control (for example, seat elevator and single actuator power elevating legrests). (Note: Control of the power seating actuators through the Control Input Device would require the use of an additional component, E2310 or E2311.)
- b. May allow for the incorporation of an attendant control.

Expandable Controller - An electronic system that is capable of accommodating one or more of the following additional functions:

- a. Proportional input devices (e.g., mini, compact, or short throw joysticks, touchpads, chin control, head control, etc.) other than a standard proportional joystick.
- b. Non-proportional input devices (e.g., sip and puff, head array, etc.)
- c. Operate 3 or more powered seating actuators through the drive control. (Note: Control of the power seating actuators through the Control Input Device would require the use of an additional component, E2310 or E2311.)

An expandable controller may also be able to operate one or more of the following:

- d. A separate display (i.e., for alternate control devices)
- e. Other electronic devices (e.g., control of an augmentative speech device or computer through the chair's drive control)
- f. An attendant control

Integral Control System - Non-expandable wheelchair control system where the joystick is housed in the same box as the controller. The entire unit is located and mounted near the hand of the user. A direct electrical connection is made from the Integral Control box to the motors and batteries through a high power wire harness.

Remotely Placed Controller - Non-expandable or expandable wheelchair control system where the joystick (or alternative control device) and the controller box are housed in separate locations. The joystick (or alternative control device) is connected to the controller through a low power wire harness. The separate controller connects directly to the motors and batteries through a high power wire harness.

Sling Seat/Back - Flexible cloth, vinyl, leather or equal material designed to serve as the support for buttocks or back of the user respectively. They may or may not have thin padding but are not intended to provide cushioning or positioning for the user.

Solid Seat/Back - Rigid metal or plastic material usually covered with cloth, vinyl, leather or equal material, with or without some padding material designed to serve as the support for the buttocks or back of the user respectively. They may or may not have thin padding but are not intended to provide cushioning or positioning for the user. PWCs with an automotive-style back and a solid seat pan are considered as a solid seat/back system, not a Captains Chair.

Captains Chair - A one or two-piece automotive-style seat with rigid frame, cushioning material in both seat and back sections, covered in cloth, vinyl, leather or equal as upholstery, and designed to serve as a complete seating, support, and cushioning system for the user. It may have armrests that can be fixed, swingaway, or detachable. It may or may not have a headrest, either integrated or separate.

Stadium Style Seat - A one or two piece stadium-style seat with rigid frame and cushioning material in both seat and back sections, covered in cloth, vinyl, leather or equal as upholstery, and designed to serve as a complete

seating, support, and cushioning system for the user. It may have armrests that can be fixed, swingaway, or detachable. It will not have a headrest. Chairs with stadium style seats are billed using the Captains Chair codes.

Highway Use - Mobility devices that are powered and configured to operate legally on public streets.

Push-rim activated power assist (E0986) – An option for a manual wheelchair in which sensors in specially designed wheels determines the force that is exerted by the beneficiary upon the wheel. Additional propulsive and/or braking force is then provided by motors in each wheel. E0986 is all-inclusive. All components, e.g., drive wheels, batteries, chargers, controls, mounting hardware, etc, for a manual wheel chair conversion are considered as included in 1 UOS of the code.

CODE-SPECIFIC REQUIREMENTS:

There are five PWC Groups and two POV Groups. Groups are divided based on performance. Each group of PMDs has subdivisions based on beneficiary weight capacity, seat type, portability, and/or power seating system capability.

All POVs (K0800 – K0808, K0812) must have the specified components and meet the following requirements:

- Have all components in the POV Basic Equipment Package
- Seat Width: Any width appropriate to weight group
- Seat Depth: Any depth appropriate to weight group
- Seat Height: Any height (adjustment requirements-none)
- Back Height: Any height (minimum back height requirement-none)
- Seat to Back Angle: Fixed or adjustable (adjustment requirements – none)
- Meet the following testing requirements:
 - Fatigue test – 200, 000 cycles
 - Drop test – 6,666 cycles

Group 1 POVs (K0800 – K0802) must meet the following requirements:

- Length - less than or equal to 48 inches
- Width - less than or equal to 28 inches
- Minimum Top End Speed - 3 MPH
- Minimum Range - 5 miles
- Minimum Obstacle Climb - 20 mm
- Radius Pivot Turn - less than or equal to 54 inches
- Dynamic Stability Incline - 6 degrees

Group 2 POVs (K0806 – K0808) must meet the following requirements:

- Length - less than or equal to 48 inches
- Width - less than or equal to 28 inches
- Minimum Top End Speed - 4 MPH
- Minimum Range - 10 miles
- Minimum Obstacle Climb - 50 mm
- Radius Pivot Turn - less than or equal to 54 inches
- Dynamic Stability Incline - 7.5 degrees

The following requirements describe the configurations of power wheelchairs as they are coded by the Pricing, Data Analysis, and Coding (PDAC) contractor. Items provided to the beneficiary may include upgraded components which are substituted for the basic component and are billed separately. One example is a power seating system. When this is provided, the base code used should be that with a sling/solid seat/back. Another example is the provision of an expandable controller when the base code includes a non-expandable controller but is capable of an upgrade.

All PWCs (K0813 – K0891, K0898) must have the specified components and meet the following requirements:

- Have all components in the PWC Basic Equipment Package

- Have the seat option listed in the code descriptor
- Seat Width: Any width appropriate to weight group
- Seat Depth: Any depth appropriate to weight group
- Seat Height: Any height (adjustment requirements-none)
- Back Height: Any height (minimum back height requirement-none)
- Seat to Back Angle: Fixed or adjustable (adjustment requirements – none)
- May include semi-reclining back
- Meet the following testing requirements:
 - Fatigue test – 200, 000 cycles
 - Drop test – 6,666 cycles

All Group 1 PWCs (K0813 – K0816) must have the specified components and meet the following requirements:

- Standard integrated or remote proportional joystick
- Non-expandable controller
- Incapable of upgrade to expandable controller
- Incapable of upgrade to alternative control devices
- May have crossbrace construction
- Accommodates non-powered options and seating systems (e.g., recline-only backs, manually elevating legrests) (except captains chairs)
- Length - less than or equal to 40 inches
- Width - less than or equal to 24 inches
- Minimum Top End Speed - 3 MPH
- Minimum Range - 5 miles
- Minimum Obstacle Climb - 20 mm
- Dynamic Stability Incline - 6 degrees

For Group 1 portable wheelchairs (K0813, K0814), the largest single component may not exceed 55 pounds.

All Group 2 PWCs (K0820 – K0843) must have the specified components and meet the following requirements:

- Standard integrated or remote proportional joystick
- May have crossbrace construction
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports) (except captains chairs)
- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum Top End Speed - 3 MPH
- Minimum Range - 7 miles
- Minimum Obstacle Climb - 40 mm
- Dynamic Stability Incline - 6 degrees

For Group 2 portable PWCs (K0820, K0821), the largest single component may not exceed 55 pounds.

Group 2 no power option PWCs (K0820 – K0829) must have the specified components and meet the following requirements:

- Non-expandable controller

- Incapable upgrade to expandable controller
- Incapable of upgrade to alternative control devices
- Incapable of accommodating a power tilt, recline, seat elevation, standing system
- Accommodates non-powered options and seating systems (e.g., recline-only backs, manually elevating legrests) (except captains chairs)

Group 2 seat elevator PWCs (K0830, K0831) must have the specified components and meet the following requirements:

- Non-expandable controller
- Incapable of upgrade to expandable controller
- Incapable of upgrade to alternative control devices
- Accommodates only a power seat elevating system

Group 2 single power option PWCs (K0835 – K0840) must have the specified components and meet the following requirements:

- Non-expandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- See Single Power Option definition for seating system capability

Group 2 multiple power option PWCs (K0841 – K0843) must have the specified components and meet the following requirements:

- Non-expandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- See Multiple Power Options definition for seating system capability
- Accommodates a ventilator

All Group 3 PWCs (K0848 – K0864) must have the specified components and meet the following requirements:

- Standard integrated or remote proportional joystick
- Non-expandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- May not have crossbrace construction
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports) (except captains chairs)
- Drive wheel suspension to reduce vibration
- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum Top End Speed - 4.5 MPH
- Minimum Range - 12 miles
- Minimum Obstacle Climb - 60 mm
- Dynamic Stability Incline - 7.5 degrees

All Group 4 PWCs (K0868 – K0886) must have the specified components and meet the following requirements:

- Standard integrated or remote proportional joystick
- Non-expandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- May not have crossbrace construction
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports) (except captains chairs)
- Drive wheel suspension to reduce vibration
- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum Top End Speed - 6 MPH
- Minimum Range - 16 miles
- Minimum Obstacle Climb - 75 mm
- Dynamic Stability Incline - 9 degrees

Group 3 and 4 no power option PWCs (K0848 – K0855, K0868 – K0871) must have the specified components and meet the following requirements:

- Incapable of accommodating a power tilt, recline, seat elevation, standing system
- Accommodates non-powered options and seating systems (e.g., recline-only backs, manually elevating legrests)

Group 3 and 4 single power option PWCs (K0856 – K0860, K0877 – K0880) must have the specified components and meet the following requirements:

- See Single Power Option definition for seating system capability

Group 3 and 4 multiple power option PWCs (K0861 – K0864, K0884 – K0886) must have the specified components and meet the following requirements:

- See Multiple Power Options definition for seating system capability
- Accommodates a ventilator

All Group 5 PWCs (K0890, K0891) must have the specified components and meet the following requirements:

- Standard integrated or remote proportional joystick
- Non-expandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- Seat Width: minimum of 5 one-inch options
- Seat Depth: minimum of 3 one-inch options
- Seat Height: adjustment requirements- \geq 3 inches
- Back Height: adjustment requirements minimum of 3 options
- Seat to Back Angle: range of adjustment-minimum of 12 degrees
- Accommodates non-powered options and seating systems
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports)
- Adjustability for growth (minimum of 3 inches for width, depth and back height adjustment)
- Special developmental capability (i.e., seat to floor, standing, etc.)
- Drive wheel suspension to reduce vibration
- Length - less than or equal to 48 inches
- Width - less than or equal to 34 inches
- Minimum Top End Speed - 4 MPH
- Minimum Range - 12 miles
- Minimum Obstacle Climb - 60 mm
- Dynamic Stability Incline - 9 degrees
- Crash testing - Passed

Group 5 single power option PWC (K0890) must have the specified components and meet the following requirements:

- See Single Power Option definition for seating system capability

Group 5 multiple power option PWC (K0891) must have the specified components and meet the following requirements:

- See Multiple Power Options definition for seating system capability
- Accommodates a ventilator

MISCELLANEOUS:

The only products that may be billed using codes K0800-K0898 are those products for which a written coding verification determination has been made by the Pricing, Data Analysis, and Coding (PDAC) contractor. Information concerning the documentation that must be submitted to the PDAC for a Coding Verification Review can be found on the PDAC web site or by contacting the PDAC. A Product Classification List with devices which have received a coding verification determination can be found on the PDAC web site. Note that code K0013 is not included in the list of products requiring Coding Verification Review.

Manufacturers and suppliers should refer to the PDAC web site or contact the PDAC for information concerning testing requirements.

If a power mobility device has not received a written coding verification determination from the PDAC or if the PDAC determines that the product does not meet the requirements of any code, it must be billed with code K0899.

Suppliers should contact the Pricing, Data Analysis, and Coding (PDAC) contractor for guidance on the correct coding of these items. [Back to Top](#)

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

CPT/HCPCS Codes N/A

ICD-10 Codes that are Covered N/A

ICD-10 Codes that are Not Covered N/A

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Revision History Information

Revision History Date	Revision History Number	Revision History Explanation
01/01/2017	R5	Revision Effective Date: 01/01/2017 POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: 42 CFR 410.38(c) and 42 CFR 410.38(g) language, K0013 billing instructions, Modifier instructions and ADMC eligible codes

Revision History Date	Revision History Number	Revision History Explanation
07/01/2016	R4	<p>RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements Language Article Revision Effective Date: 07/01/2016</p> <p>NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Revised Standard Language to add Statutory Prescription (Order) Requirements, revised Face to Face and ACA requirements - Effective 04/28/2016</p> <p>Effective July 1, 2016 oversight for DME MAC Articles is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the Articles.</p> <p>Revision Effective Date: 10/01/2015</p> <p>NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Revised: HCPCS Narrative for E0986 and updated standard language documentation</p> <p>Revision Effective Date: 10/01/2014</p> <p>NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Clarification: The face to face treating physician and prescribing physician requirements under ACA 6407 (Requirements effective 07/01/2013)</p> <p>CODING GUIDELINES: Clarification: E0986 is all inclusive</p>
07/01/2016	R3	
10/01/2015	R2	
10/01/2015	R1	

[Back to Top](#) **Related Local Coverage Document(s)** Article(s) [A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs](#) LCD(s) [L33789 - Power Mobility Devices](#)

Related National Coverage Document(s) N/A

Statutory Requirements URL(s) N/A

Rules and Regulations URL(s) N/A

CMS Manual Explanations URL(s) N/A

Other URL(s) N/A

Public Version(s) Updated on 04/13/2017 with effective dates 01/01/2017 - N/A [Updated on 08/25/2016 with effective dates 07/01/2016 - N/A](#) [Updated on 06/07/2016 with effective dates 07/01/2016 - N/A](#) [Updated on 02/19/2015 with effective dates 10/01/2015 - N/A](#) [Updated on 06/12/2014 with effective dates 10/01/2015 - N/A](#) [Updated on 04/04/2014 with effective dates 10/01/2015 - N/A](#) [Back to Top](#)

[Keywords](#)

N/A Read the [Article Disclaimer](#) [Back to Top](#)

Local Coverage Article: Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)

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Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
CGS Administrators, LLC	DME MAC	17013 -	DME MAC J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia Connecticut District of Columbia Delaware Massachusetts Maryland Maine New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada
CGS Administrators, LLC	DME MAC	18003 -	DME MAC J-C	
Noridian Healthcare Solutions, LLC	DME MAC	16013 -	DME MAC J-A	
Noridian Healthcare Solutions, LLC	DME MAC	19003 -	DME MAC J-D	

Article Information

General Information

Article ID

A55426

Original Article Effective Date

01/01/2017

Article Title

Standard Documentation Requirements for All Claims Submitted to DME MACs

Revision Effective Date

04/20/2017

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Revision Ending Date

N/A

Retirement Date

N/A

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Article Guidance

Article Text:

Many errors reported in Medicare audits are due to claims submitted with incomplete or missing requisite documentation. Consequently, the Durable Medical Equipment Medicare Administrative Contracts (DME MACs) have created standardized language to assist Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers in understanding the information necessary to justify payment.

The documentation requirements are compiled from Statutes, Code of Federal Regulations, Centers for Medicare and Medicaid Services (CMS) manuals, and DME MAC publications. This article sets out the general requirements that are applicable to all DMEPOS claims submitted to the DME MACs.

Documentation must be maintained in the supplier's files for seven (7) years from date of service.

*****IMPORTANT*****

Historically, general documentation requirements have appeared within individual policies (LCDs). Such information will be removed from all DME MAC LCDs whose effective date is on or after Jan 01, 2017. All general documentation requirements will thereafter be located in this Standard Documentation Requirements (SDR) article, which will be linked to all DME MAC LCDs.

Local Coverage Determinations (LCDs) often contain documentation requirements that are unique to that specific policy. These requirements are termed "Policy Specific Documentation Requirements". Historically, these requirements have appeared within individual policies (LCDs). Such information will be removed from all DME MAC LCDs whose effective date is on or after Jan 01, 2017. All Policy Specific Documentation Requirements will thereafter be located in the LCD-related Policy Article, which will be linked to the applicable LCD.

It is important that suppliers review the actual LCD, the related Policy Article, and the SDR article to be sure to have all of the relevant information necessary and applicable to the item(s) provided.

PRESCRIPTION (ORDER) REQUIREMENTS

GENERAL

All claims for items billed to Medicare require a prescription (order). "All claims" refers to all claims submitted for payment of purchases and initial rentals by Medicare Part B.

The legal name and National Provider Identifier (NPI) of the treating practitioner on the order for the item or service shall be used on the claim submitted to the DME MAC. The order shall be kept on file and made available upon request.

An order for each item billed must be signed and dated by the prescribing physician. Items dispensed and/or billed that do not meet these prescription requirements and those below must be submitted with an EY modifier added to each affected HCPCS code.

The term "physician" is used throughout this document and except where specifically noted, refers to Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Optometry (OD), Doctor of Medical Dentistry (DMD), Doctor of Dental Surgery (DDS), Doctor of Podiatric Medicine (DPM), physician assistants (PA), nurse physicians (NP) and clinical nurse specialists (CNS). Prescribing of DMEPOS is limited by Medicare regulations and by the treating physician's respective scope of practice as determined by the state wherein they practice. Chiropractors are not permitted to prescribe DMEPOS items.

The term "treating physician" is defined as the one who is directly providing care to the beneficiary for the condition(s) related to the DMEPOS ordered.

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

NEW ORDER REQUIREMENTS

A new prescription (order) is required:

- For all claims for purchases or initial rentals
- If there is a change in the order for the accessory, supply, drug, etc.
- On a regular basis (even if there is no change in the order) only if it is so specified in the documentation section of a particular medical policy

- When an item is replaced
- When there is a change in the supplier, and the new supplier is unable to obtain a copy of a valid order and documentation from the original supplier.

DISPENSING ORDERS

Most equipment and supplies may be delivered upon receipt of a dispensing order. A dispensing order may be verbal or written. The dispensing order must contain:

- Description of the item
- Beneficiary's name
- Prescribing physician's name
- Date of the order
- Prescribing physician's signature (if a written order) or supplier signature (if verbal order)

For the "Date of the order" described above, use the date the supplier is contacted by the prescribing physician for verbal orders or the date entered by the prescribing physician for written dispensing orders.

In some cases, the prescribing physician may specify a future start date for therapy that is different from the date of the order. This start date does not impact the date of the order, date of service (DOS) entered on the claim, Medicare-required forms (e.g., Certificate of Medical Necessity (CMN), DME Information Form (DIF)) or refill/delivery timelines. As long as the supplier has a properly completed dispensing order with a correctly determined prescription date, an item may be shipped or delivered on or after the date of the dispensing order (except for items that require written orders prior to delivery).

Some dispensing orders are required by statute and/or CMS regulations, to have specific elements and other requirements, which are described in subsequent sections below.

For items that are delivered based on a dispensing order, the supplier must obtain a detailed written order (DWO) before submitting a claim.

DETAILED WRITTEN ORDERS (DWO)

A DWO is required before billing. Someone other than the physician may complete the DWO of the item unless statute, manual instructions, the contractor's LCD or policy articles specify otherwise. However, the prescribing physician must review the content and sign and date the document. It must contain:

- Beneficiary's name
- Prescribing physician's name
- Date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items)
- Prescribing physician's signature
- Signature date, if applicable (see below)

For items provided on a periodic basis, including drugs, the written order must include:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration, if applicable
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills

For the "Date of the order" described above, use the dispensing order date i.e., the date the supplier was contacted by the prescribing physician (for verbal orders) or the date entered by the prescribing physician (for written dispensing orders).

Additional order date instructions:

- If the prescriber creates the DWO, only a single date - the "order date" - is required. This order date may be the date that the prescriber signs the document.
- If someone other than the prescriber (e.g., DME supplier) creates the DWO then the prescription must be reviewed and, "...personally signed and dated..." by the prescriber. In this scenario, two dates are required: an "order date" and a prescriber-entered "signature date".

In some cases, the prescribing physician may specify a future start date for therapy that is different from the date of the order. This start date does not impact the date of the order, DOS entered on the claim, Medicare-required forms (e.g., CMN, DIF) or refill/delivery timelines. As long as the supplier has a properly completed dispensing order with a correctly determined prescription date, an item may be shipped or delivered on or after the date of the dispensing order (except for items that require written order prior to delivery).

Frequency of use information on orders must contain detailed instructions for use and specific amounts to be dispensed. Reimbursement shall be based on the specific utilization amount only. Orders that only state "PRN" or "as needed" utilization estimates for replacement frequency, use, or consumption are not sufficient to justify payment.

The detailed description in the written order may be either a narrative description or a brand name/model number.

WRITTEN ORDERS PRIOR TO DELIVERY (WOPD)

GENERAL

Someone other than the prescribing physician may complete the WOPD of the item unless statute, manual instructions, the contractor's LCD or policy articles specify otherwise. However, the WOPD must be both signed and dated by the prescribing physician before the item is dispensed. The supplier must have received the WOPD before dispensing the item. The date of the written order shall be on or before the date of delivery. The DMEPOS supplier shall have on file the completed written order prior to the delivery of these items.

For base items that require a WOPD, the supplier must also obtain a DWO before submitting a claim for any associated options, accessories, and/or supplies that are separately billed.

There are three categories of DMEPOS items that require a WOPD:

- A standard WOPD is required for specific items identified by CMS or DME MACs such as Negative Pressure Wound Therapy (NPWT).
- As a condition of payment pursuant to 42 CFR 410.38(c), Power Mobility Devices (PMDs) require a 7 Element Order (7EO). A separate Detailed Product Description (DPD) is also required for any associated options and accessories. Please review the PMD policy for additional information.
- As a condition of payment pursuant to 42 CFR 410.38(g), certain specified covered items of DME require a written order prior to delivery of the item (5 Element Order or 5EO).

STANDARD WOPD

A WOPD must meet the requirements described above for a DWO. The WOPD must be both signed and dated by the prescribing physician before the item is dispensed. The supplier must have received the WOPD before dispensing the item. A date stamp or equivalent must be used by the supplier to document receipt date.

For base items that require a WOPD, the supplier must also obtain a DWO before submitting a claim for any associated options, accessories, and/or supplies that are separately billed.

POWER MOBILITY DEVICES WOPD (7 ELEMENT ORDER)

42 CFR 410.38(c) requires a specific WOPD of PMDs for the HCPCS codes specified in the table contained in the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS section of the LCD related Policy Article. The required prescription has seven (7) mandatory elements. For the purposes of this document, the 42 CFR 410.38(c) required order is referred to as a 7EO.

The 7EO must be received by the supplier within 45 days after the completion of the face-to-face examination.

The 7EO must meet all of the requirements below:

- Beneficiary's name
- Description of the item that is ordered. This may be general – e.g., "power operated vehicle", "power wheelchair", or "power mobility device"– or may be more specific.
- Date of the face-to-face examination
- Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
- Length of need
- Prescribing physician's signature
- Date of prescribing physician's signature

The Supplier may provide a template order listing the seven required elements but is prohibited from completing any part of it. The treating physician completing the face-to-face requirements must write the 7EO. The 7EO may only be written after the completion of the face-to-face exam requirements.

The DMEPOS supplier shall have on file the 7EO prior to the delivery of these items. A date stamp or equivalent must be used by the supplier to document receipt date.

POWER MOBILITY DEVICES DETAILED PRODUCT DESCRIPTION

Once the supplier has determined the specific power mobility device that is appropriate for the beneficiary based on the physician's 7EO, the supplier must prepare a written document (termed a DPD). This DPD must comply with the requirements for a DWO (See section above).

The physician must sign and date the DPD, and the supplier must receive it prior to delivery of the PMD.

Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4. Signature and date stamps are not allowed.

A date stamp or equivalent must be used to document the supplier receipt date of the DPD.

WOPD FOR SPECIFICIED DMEPOS ITEMS (5 ELEMENT ORDER)

42 CFR 410.38(g) requires a specific written order prior to delivery for specified HCPCS codes. CMS provides a list of the specified codes, which is periodically updated, and located [here](#) on CMS's website.

The required prescription has five (5) mandatory elements. For the purposes of this document, the 42 CFR 410.38(g) required order is referred to as a 5EO. The 5EO must meet all of the requirements below:

- The 5EO must include all of the following elements:
 - Beneficiary's name
 - Item of DME ordered - this may be general – e.g., "hospital bed"– or may be more specific.
 - Signature of the prescribing practitioner
 - Prescribing practitioner's NPI
 - The date of the order
- The 5EO must be completed within six (6) months after the required face-to-face examination
- The date of the written order shall be on or before the date of delivery

The DMEPOS supplier shall have on file the 5EO prior to the delivery of these items.

Note that the 5EO for these specified DME items require the NPI to be included on the prescription. Prescriptions for other DME items do not have this NPI requirement. Suppliers should pay particular attention to orders that include a mix of items, some of which are subject to these new order requirements. For example, oxygen concentrators (E1390) are often ordered in conjunction with portable oxygen (E0431). Orders for code E0431 require inclusion of the NPI while orders for E1390 do not.

Suppliers should pay particular attention to orders that include a mix of items to which 42 CFR 410.38(g) does and does not apply, to assure that these 42 CFR 410.38(g) order requirements are met.

All other date and timing requirements specified in the CMS PIM regarding specific items or services remain unchanged.

Upon request by a contractor, all DMEPOS suppliers must provide documentation of the completed 5EO.

For items that are provided based on a 5EO, the supplier must obtain a detailed written order (see DETAILED WRITTEN ORDER section above) before submitting a claim for any associated options, accessories and/or supplies that are separately billed.

DOCUMENTATION REQUIREMENTS

GENERAL

There are numerous CMS manual requirements, reasonable and necessary (R&N) requirements, benefit category, and other statutory and regulatory requirements that must be met in order for payment to be justified. In the event of a claim review, a DMEPOS supplier must provide sufficient information to demonstrate that the applicable criteria have been met thus justifying payment.

Before submitting a claim to Medicare, the DME MAC supplier must have on file a dispensing order (if applicable), a DWO, a WOPD (if applicable), a CMN (if applicable), a DIF (if applicable), information from the treating physician concerning the patient's diagnosis, and any information required for the use of specific modifiers or attestation statements as defined in certain DME MAC policies. The supplier should also obtain as much documentation from the patient's medical record in order to assure themselves that coverage criteria for an item have been met. If the information in the patient's medical record does not adequately support the medical necessity for the item, the supplier is liable for the dollar amount involved unless a properly executed Advance Beneficiary Notice of Noncoverage (ABN) of possible denial has been obtained.

REASONABLE AND NECESSARY CRITERIA (R&N)

CMS NCD and contractor LCD describe the requirements that must be met for an item to be considered R&N. These R&N criteria are often referred to as medical necessity.

MEDICAL RECORD DOCUMENTATION

In the event of a claim review, information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs. The medical record is not limited to treating physician's office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for determining that an item is reasonable and necessary. DMEPOS suppliers are reminded that:

- Supplier-produced records, even if signed by the prescribing physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.
- Templates and forms, including CMS CMNs, are subject to corroboration with information in the medical record.
- A prescription is not considered to be part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record.

In addition to the general requirements discussed above, certain DMEPOS items may have specific documentation requirements. Details regarding these policy specific requirements are contained in the applicable LCD-related Policy Article.

CONTINUED MEDICAL NEED

For all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this timeframe. Entries in the beneficiary's medical record must have been created prior to, or at the time of, the initial DOS to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

For ongoing supplies and rented DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to remain reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review. Any of the following may serve as documentation justifying continued medical need:

- A recent order by the treating physician for refills
- A recent change in prescription
- A properly completed CMN or DIF with an appropriate length of need specified
- Timely documentation in the beneficiary's medical record showing usage of the item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy.

CONTINUED USE

Continued use describes the ongoing utilization of supplies or a rented item by a beneficiary.

Suppliers are responsible for monitoring utilization of DMEPOS rental items and supplies. No monitoring of purchased items or capped rental items that have converted to a purchase is required. Suppliers must discontinue billing Medicare when rental items or ongoing supply items are no longer being used by the beneficiary.

Beneficiary medical records or supplier records may be used to confirm that a DMEPOS item continues to be used by the beneficiary. Any of the following may serve as documentation that an item submitted for reimbursement continues to be used by the beneficiary:

- Timely documentation in the beneficiary's medical record showing usage of the item, related option/accessories and supplies.
- Supplier records documenting the request for refill/replacement of supplies in compliance with the REFILL DOCUMENTATION REQUIREMENTS section. This is deemed sufficient to document continued use for the base item, as well.
- Supplier records documenting beneficiary confirmation of continued use of a rental item.

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in this policy.

REFILL DOCUMENTATION

A routine prescription for refills is not needed.

For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. Suppliers must have documentation, available upon request, to demonstrate contact with the beneficiary to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order prior to delivery or shipment of the product. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. DME MACs shall allow for the processing of claims for refills delivered/shipped prior to the beneficiary exhausting his/her supply.

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the prescribing physician that any changed or atypical utilization is warranted.

Refill intervals are noted in the applicable policies. Regardless of utilization, a supplier must adhere to the refill interval(s) noted in the applicable policy.

Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.

For items that the beneficiary obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of a request for refill.

For items that are delivered to the beneficiary, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary. The refill request must occur and be documented before shipment. A retrospective attestation statement by the supplier or beneficiary is not sufficient.

The refill record must include:

- Beneficiary's name or authorized representative if different from the beneficiary
- A description of each item that is being requested
- Date of refill request
- For consumable supplies i.e., those that are used up (e.g., ostomy or urological supplies, surgical dressings, etc.) the supplier must assess the quantity of each item that the beneficiary still has remaining to document that the amount remaining will be nearly exhausted on or about the supply anniversary date.
- For non-consumable supplies i.e., those more durable items that are not used up but may need periodic replacement (e.g., PAP and RAD supplies) the supplier must assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) is no longer able to function. The supplier must document the functional condition of the item(s) being refilled in sufficient detail to demonstrate the cause of the dysfunction that necessitates replacement (refill).

This information must be kept on file and be available upon request.

PROOF OF DELIVERY (POD)

42 CFR 424.57(c)(12) requires suppliers to maintain proof of delivery documentation in their files.

POD documentation, as well as claims documentation, must be maintained in the supplier's files for 7 years (starting from the date of service).

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item(s) are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The relationship of the designee to the beneficiary should be noted on the delivery slip obtained by the supplier (i.e., spouse, neighbor). The signature of the designee should be legible. If the signature of the designee is not legible, the supplier/shipping service should note the name of the designee on the delivery slip.

For the purpose of the delivery methods noted below, designee is defined as any person who can sign and accept the delivery of DMEPOS on behalf of the beneficiary.

The supplier should also have on file any documentation containing a description of the item delivered to the beneficiary to determine the accuracy of claims coding including, but not limited to, a voucher, invoice or statement in the supplier records. There must be a sufficient level of detail in the item description to definitively determine the appropriate HCPCS to be appended to the claim. The long description of the HCPCS code, may be used as a means to provide a detailed description of the item being delivered.

Proof of delivery documentation must be available to the Medicare contractor on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently fail to provide documentation to support their services may be referred to the Office of Inspector General (OIG) or the National Supplier Clearinghouse for investigation and/or imposition of sanctions.

There are three methods of delivery. Regardless of the method of delivery, the contractor must be able to determine that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) were received by a specific beneficiary:

- Delivery directly to the beneficiary or authorized representative
- Delivery via shipping or delivery service
- Delivery of items to a nursing facility on behalf of the beneficiary

Method 1—Direct Delivery to the Beneficiary by the Supplier

Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery document. The POD document must include:

- Beneficiary's name

- Delivery address
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description). The long description of the HCPCS code, may be used as a means to provide a detailed description of the item being delivered
- Quantity delivered
- Date delivered
- Beneficiary (or designee) signature

The date delivered on the POD must be the date that the DMEPOS item was received by the beneficiary or designee. The date of delivery may be entered by the beneficiary, designee, or the supplier. When the supplier's delivery documents have both a supplier-entered date and a beneficiary or beneficiary's designee signature date on the POD document, the beneficiary (or designee) entered date is the date of service.

In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

Method 2—Delivery via Shipping or Delivery Service Directly to a Beneficiary

If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable POD would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD document must include:

- Beneficiary's name
- Delivery address
- Delivery service's package identification number, supplier invoice number, or alternative method that links the supplier's delivery documents with the delivery service's records
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description). The long description of the HCPCS code, may be used as a means to provide a detailed description of the item being delivered
- Quantity delivered
- Date delivered
- Evidence of delivery

If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim.

Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD document must contain the information specified above.

Method 3—Delivery to Nursing Facility on Behalf of a Beneficiary

For items directly delivered by the supplier to a nursing facility or when a delivery service or mail order is used to deliver the item(s) to a nursing facility, the supplier must have:

- Documentation demonstrating delivery of the item(s) to the facility by the supplier or delivery entity; and,

- Documentation from the nursing facility demonstrating receipt and/or usage of the item(s) by the beneficiary. The quantities delivered and used by the beneficiary must justify the quantity billed.

For any method of delivery, suppliers may also document in their records that a supplier staff member called the beneficiary; and the beneficiary, designee or a family member indicated the date on which the item was delivered. The supplier's record must document the following information:

- Beneficiary's name
- Delivery address
- Sufficiently detailed description to identify the item(s) delivered (e.g., brand name, serial number, narrative description). The long description of the HCPCS code, may be used as a means to provide a detailed description of the item being delivered
- Quantity delivered
- Date delivered
- Name of beneficiary, beneficiary designee or family member contacted

CORRECT CODING

Healthcare Common Procedure Coding System (HCPCS) CODING

The CMS Internet Only Manual (IOM), Publication 100-08, PIM, Chapter 3, Sections 3.3.B and 3.6.2.4 specify that for Medicare claims, only CMS and the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have the authority to establish HCPCS Level II Coding Guidelines. Pursuant to 42 CFR §§ 414.40 and 162.1002, CMS has the authority to assign and manage HCPCS codes (create, delete, change code narrative etc.). The DME MACs have the authority to evaluate products to make benefit category and coding determinations for any DME item that does not logically fall into any of the generic categories listed in NCD 280.1.

Correct HCPCS coding is a determination that the item provided to a beneficiary is billed using the appropriate HCPCS code for that item. Suppliers are required to correctly code for the item billed. An item/service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, LCD-related Policy Articles, or DME MAC articles.

The Pricing, Data Analysis, and Coding (PDAC) contractor maintains product listings for many HCPCS codes on their [website](#) (Select, "Durable Medical Equipment Coding System (DMECS)" to search for HCPCS codes and associated product lists). Not every HCPCS code has a product classification list; but, reviewed products are added to the listings for each code as coding determinations are completed. For Medicare claim purposes, this product classification listing is accepted as evidence of correct coding.

Each supplier is ultimately responsible for the HCPCS code they select to bill for the item provided. Resources such as LCDs, LCD-related Policy Articles, DME MAC articles, code determinations letters and DMECS are useful; but many products currently on the market have not been reviewed. For these un-reviewed products, each supplier must use their best judgment in selecting HCPCS codes for billing, and are encouraged to check with The PDAC Contact Center, which can provide information that will assist in correct code selection.

Information that is sufficiently detailed to unambiguously identify the specific product delivered to the beneficiary and the HCPCS code used to bill for that item must be maintained by the supplier and be available upon request.

Not Otherwise Classified (NOC) BILLING INFORMATION

Items billed with any HCPCS code with a narrative description that indicates miscellaneous, NOC, unlisted, or non-specified, must also include the following information in loop 2400 (line note), segment NTE02 (NTE01=ADD) of the ANSI X12N, version 5010A1 professional electronic claim format or on Item 19 of the paper claim form:

- Description of the item or service
- Manufacturer name
- Product name and number
- Supplier Price List (PL) amount
- HCPCS code of related item (if applicable)

Miscellaneous HCPCS codes billed without this information will be rejected and will need to be resubmitted with the missing information included.

For questions about correct coding, contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC [Contact Form](#) located on the PDAC [website](#).

EQUIPMENT RETAINED FROM A PRIOR PAYER

When a beneficiary receiving a DMEPOS item from another payer (including a Medicare Advantage plan) becomes eligible for the Medicare Fee For Service (FFS) program, the first Medicare claim for that item or service is considered a new initial Medicare claim. Medicare does not automatically continue coverage for any item obtained from another payer when a beneficiary transitions to Medicare coverage.

For Medicare to provide payment, the beneficiary must meet all Medicare coverage, coding, and documentation requirements for the DMEPOS items in effect on the date of service of the initial Medicare claim.

A POD is required for all items, even those in the beneficiary's possession provided by another insurer prior to Medicare eligibility.

PROOF OF DELIVERY REQUIREMENTS FOR RECENTLY ELIGIBLE MEDICARE FFS

The supplier record must document:

- A statement, signed and dated by the beneficiary (or beneficiary's designee), that the supplier has examined the item; or
- Notation in the supplier's records that a supplier staff member examined the item in the beneficiary's possession and confirmed it is in good working order.

For the purposes of reasonable useful lifetime and calculation of continuous use, the first day of the first rental month in which Medicare payments are made for the item (i.e., date of service) serves as the start date of the reasonable useful lifetime and period of continuous use. In these cases, the proof of delivery documentation serves as evidence that the beneficiary is already in possession of the item.

FACE-TO-FACE EXAMINATION FOR SPECIFIED DMEPOS ITEMS

42 CFR 410.38(g) contains provisions that are applicable to certain specified DMEPOS items. CMS provides a list of the specified items, which is periodically updated, and located [here](#) on CMS' website.

These items require an in-person, face-to-face interaction between the beneficiary and their treating physician prior to prescribing the item. This face-to-face requirement includes examinations conducted via the CMS-approved use of telehealth examinations (as described in Chapter 15 of the Medicare Benefit Policy Manual and Chapter 12 of the Medicare Claims Processing Manual - CMS Internet-Only Manuals, Publ. 100-02 and 100-04, respectively). This face-to-face evaluation must specifically document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered. A dispensing order is not sufficient to provide these items. A 5EO (see 5EO section above) must be received prior to delivery. Refer to the applicable LCD-related Policy Article NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information about these statutory requirements.

FACE-TO-FACE REQUIREMENTS

As a condition for payment, 42 CFR 410.38(g) requires that a treating physician has had a face-to-face examination with a beneficiary within the six (6) months prior to the written order for certain items of DME.

For the treating physician prescribing a specified DME item:

- The face-to-face examination with the beneficiary must be conducted within the six (6) months prior to the date of the prescription.
- The face-to-face examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.

Remember that all other Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient medical information included in the medical record to demonstrate that all other applicable coverage criteria are met. Refer to the applicable Local Coverage Determination for information about the medical necessity criteria for the item(s) being ordered.

The treating physician that conducted the face-to-face examination does not need to be the prescriber for the DME item; however, the prescriber must:

- Verify that the qualifying in-person visit occurred within the 6-months prior to the date of their prescription; and,
- Have documentation of the qualifying face-to-face examination that was conducted.

A new face-to-face examination is required each time a new prescription for one of the specified items is ordered (see GENERAL PRESCRIPTION REQUIREMENTS section above for new prescription requirements).

Upon request by a contractor, all DMEPOS suppliers must provide documentation of the face-to-face examination.

CERTIFICATE OF MEDICAL NECESSITY (CMN) & DME INFORMATION FORM (DIF)

A CMN, which has been completed, signed, and dated by the treating physician, must be kept on file by the supplier and made available upon request. The CMN may act as a substitute for the detailed written order if it contains the same information as required in a detailed written order. The CMN for XXX is CMS Form ### (DME form ###). In addition to the order information that the treating physician enters in Section B, the supplier can use the space in Section C for a written confirmation of other details of the order or the treating physician can enter the other details directly.

A new CMN is not required just because the supplier changes assignment status on the submitted claim.

DME INFORMATION FORM (PIM 5.3)

A DIF, which has been completed, signed, and dated by the supplier, must be kept on file and made available upon request. The DIF for XXX is CMS Form ### (DME form ###).

REPAIRS/REPLACEMENT

GENERAL

For the purposes of Medicare reimbursement, repairs are not synonymous with replacements. Repairs (parts and labor) of DMEPOS items are performed on the base item. The replacement of parts or components that make up the base item is considered to be a repair. Conversely, the furnishing of new separately payable accessories that were not part of the initial base item is considered to be replacement, which is addressed in the section below.

Replacement of a beneficiary owned DMEPOS item typically involves providing an identical or nearly identical item.

REPAIRS

The definition of a repair is found in the CMS Benefit Policy Manual (Internet-only manual 100-02), Chapter 15, Section 110.2.A. That section generally defines repair as to fix or mend and to put the item back in good condition after damage or wear.

Repairs to items which a beneficiary owns are covered when necessary to make the items serviceable. However, "routine periodic maintenance", such as testing, cleaning, regulating, and checking is not covered.

Medicare does not separately reimburse for repairs of:

- Items in the frequent and substantial servicing payment category; or,
- Oxygen equipment; or,
- Items in the capped rental payment category during the capped rental period; or,
- Items covered under a manufacturer's or supplier's warranty; or,
- Previously denied items.

A new CMN and/or treating physician's order is not needed for repairs.

In the case of repairs to a beneficiary-owned DMEPOS item, if Medicare paid for the base item initially, medical necessity for the base item has been established. With respect to Medicare reimbursement for the repair, there are two documentation requirements:

- The treating physician must document that the DMEPOS item being repaired continues to be reasonable and necessary (see Continued Medical Need section above); and,
- Either the treating physician or the supplier must document that the repair itself is reasonable and necessary.

The supplier must maintain detailed records describing the need for and nature of all repairs including a detailed explanation of the justification for any component or part replaced as well as the labor time to restore the item to its functionality.

REPLACEMENT

The definition of replacement is found in the CMS Benefit Policy Manual (Internet-only manual 100-02), Chapter 15, Section 110.2.C. That section generally defines replacement as the provision of an entire identical or nearly identical item when it is lost, stolen or irreparably damaged.

Beneficiary owned items or a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage may be due to a specific accident or to a natural disaster (e.g., fire, flood). Contractors may request documentation confirming details of the incident (e.g., police report, insurance claim report).

Replacement of items due to irreparable wear takes into consideration the Reasonable Useful Lifetime (RUL) of the item. The RUL of DME is determined through program instructions. In the absence of program instructions, carriers may determine the RUL, but in no cases can it be less than 5 years. If the item has been in continuous use by the beneficiary on either rental or purchase basis for its RUL, the beneficiary may elect to obtain a replacement.

Medicare does not cover replacement for items in the frequent and substantial servicing payment category, oxygen equipment, or inexpensive or routinely purchased rental items.

A treating physician's order and/or new CMN, when required, is needed to reaffirm the medical necessity of the item for replacement of an item.

There are special rules for the replacement of artificial arms, legs and eyes.

Adjustments and repairs of prostheses and prosthetic components are covered under the original order for the prosthetic device.

Medicare payment may be made for the replacement of prosthetic devices, which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if a treating physician determines that the replacement device, or replacement part of such a device, is necessary.

Claims involving the replacement of a prosthesis or major component (foot, ankle, knee, socket etc.) must be supported by a new treating physician's order and documentation supporting the reason for the replacement. The reason for replacement must be documented by the treating physician, either on the order or in the medical record, and must fall under one of the following:

- A change in the physiological condition of the patient resulting in the need for a replacement. Examples include but are not limited to, changes in beneficiary weight, changes in the residual limb, beneficiary functional need changes; or,
- An irreparable change in the condition of the device, or in a part of the device resulting in the need for a replacement; or,
- The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

The prosthetist must retain documentation of the prosthesis or prosthetic component replaced, the reason for replacement, and a description of the labor involved irrespective of the time since the prosthesis was provided to the beneficiary. This information must be available upon request. It is recognized that there are situations where the reason for replacement includes but is not limited to changes in the residual limb; functional need changes; or irreparable damage or wear/tear due to excessive beneficiary weight or prosthetic demands of very active amputees.

SIGNATURE REQUIREMENTS

All signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

Note: This is a revision to the previous article published in April 2016 under the title "Standard Documentation Language for Local Coverage Determinations and Related Policy Articles – Revised". The information in this document supersedes the material currently contained in the LCDs and related policy articles. Where there are differences between the policies and this article, this document shall take precedence.

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Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report

this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

CPT/HCPCS Codes N/A

ICD-10 Codes that are Covered N/A

ICD-10 Codes that are Not Covered N/A

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[Revision History Information](#)

Revision History Date	Revision History Number	Revision History Explanation
04/20/2017	R1	Revision Effective Date: 04/20/17 NEW ORDER REQUIREMENTS Revised: Change in supplier direction PROOF OF DELIVERY Revised: Proof of Delivery requirements and use of long description of the HCPCS code Previous Revisions 10/31/14; 11/05/15; 04/28/16; 01/01/17 Originally published 02/17/12

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Related National Coverage Document(s) N/A

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Rules and Regulations URL(s) N/A

CMS Manual Explanations URL(s) N/A

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