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Medicare Coverage of Power Mobility Devices: Tips and Reminders

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MEDICARE COVERAGE OF POWER MOBILITY DEVICES:
TIPS AND REMINDERS

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Mrs. Carrie is an eighty-two-year-old woman with a degenerative condition that severely compromises her mobility.\footnote{1} She uses a motorized wheelchair, which was purchased through Medicare Part B as a power operated vehicle (POV). Recently, Mrs. Carrie moved to Fort Lauderdale to live with her youngest daughter. Mrs. Carrie’s condition has declined since the move. She now has edema in her right leg and needs a leg-lift for her wheelchair. Mrs. Carrie purchased her current wheelchair six years ago and it has started malfunctioning.\footnote{2} Now she needs a new, customized power chair. Mrs. Carrie and her physician would like to know the likelihood of Medicare coverage of the new chair and leg-lift.

Mrs. Carrie’s issue raises questions about the process by which beneficiaries can learn whether their Durable Medical Equipment (DME) will be covered by Medicare. Prior to October 1, 2001, some items of DME were eligible for prior authorization of coverage before a claim was submitted.\footnote{3}

\begin{enumerate}
\item \textit{Ctr. for Medicare Advocacy, Inc., Medicare Coverage for Power Operated Wheelchairs and Other Power Mobility Devices, 7 Healthcare RTS. Rev. pt. 3, at 1 (2006).}
\item \textit{See Social Security Act § 1834(a)(7)(C)(iii), 42 U.S.C. § 1395m(a)(7)(C)(iii) (2006) (setting out expectation that a piece of durable medical equipment (DME) will last at least five years). For example, Cigna, a Durable Medical Equipment Program Medicare Administrative Contractor (DME MAC), reminds its providers and suppliers that “after the 5 year reasonable use lifetime is met, the beneficiary must meet all of the coverage requirements outlined in the local coverage determination (LCD) for PMDs [Power Mobility Device], including a new 7-element order and face-to-face evaluation.” \textit{Reminder – Replacement of Power Mobility Devices, Cigna Gov’t Servs.} \textit{(Nov. 5, 2009)}, http://www.cignagovernmentservices.com/jc/pubs/news/2009//1109/cope10983.html.}
\end{enumerate}
prior authorization was phased out and replaced with a voluntary process—the Advance Determination of Medical Coverage (ADMC). The ADMC allows beneficiaries to see whether their wheelchair will be covered before they have purchased it from a supplier. This Article seeks to explain the ADMC process and the general process by which wheelchairs and other DME are prescribed, issued, and covered under Medicare. The determination of whether a wheelchair will be covered by Medicare involves detailed analysis of the beneficiary’s condition and mobility in the home.

The Medicare coverage process for a wheelchair or other DME is complicated, like any other Medicare process. A person seeking Medicare coverage for an item of DME must: be enrolled in Medicare Part B; seek coverage for an item of DME that will be used “in the home”; meet other criteria such as mobility limitations; and be willing to and capable of using the item of DME. Several parties, including Mrs. Carrie, her physician, the Durable Medical Equipment Program Medicare Administrative Contractor (DME MAC), and the wheelchair supplier must collaborate and coordinate the completion of required supporting documentation. These requirements are set forth by Medicare

5. See infra notes 95–127 and accompanying text.
6. See infra note 7 and accompanying text.
and the DME MAC.\textsuperscript{9} When it exercises its oversight function, the DME program safeguard contractor (PSC) ultimately determines whether the DME is a reasonable and necessary Medicare purchase, and therefore eligible for Part B coverage.\textsuperscript{10}

I. DURABLE MEDICAL EQUIPMENT (DME)

For an item of medical equipment to qualify as DME, it must meet the following criteria:\textsuperscript{11}

- It can withstand repeated use;
- It is used primarily and customarily to serve a medical purpose;
- Generally, it is not useful to a person in the absence of illness or injury; and


10. Durable Medical Equipment that is medically necessary is covered under Medicare Part B. \textit{CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., MEDICAL COVERAGE OF DURABLE MEDICAL EQUIPMENT AND OTHER DEVICES} 1, 3 (2008), \url{http://www.medicare.gov/Publications/Pubs/pdf/11045.pdf}. For a discussion of DME PSC, see \textit{MEDICARE PROGRAM INTEGRITY MANUAL}, supra note 4. In general, Program Safeguard Contractors (PSCs) represent an additional layer of review of Medicare program expenditures with respect to fraud and overutilization. PSCs are now associated with multiple provider settings. Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (1996). Section 202 of HIPAA, adding section 1893 to the Social Security Act, established the Medicare Integrity Program (MIP) to extend CMS’s contracting authority. This allowed CMS to contract with entities to perform Medicare program integrity activities, including medical, potential fraud, and utilization review; cost report audits; Medicare secondary payer determinations; overpayment recovery; education of providers, suppliers, beneficiaries, and other persons regarding payment integrity and benefit quality assurance issues, including DME as defined in 1834(a)(15) of the Social Security Act. \textit{See} \textit{42 C.F.R. § 431.300} (2009).

• It is appropriate for use in the home.\textsuperscript{12}

Coverage-eligible DME must meet all four of the above-listed elements and must typically be necessary and reasonable for the treatment of an illness or injury or to improve the functioning of a malformed body member.\textsuperscript{15}

The requirement that DME is used primarily for a medical purpose may exclude items that are medically necessary for an individual beneficiary, such as air conditioners.\textsuperscript{14} Commonly known and recognized items of DME include iron lungs, hospital beds, oxygen tents, and wheelchairs (power and manual).\textsuperscript{15} Other items the Secretary of Health and Human Services\textsuperscript{16} has deemed eligible for coverage include: alternating pressure pads, blood glucose monitors, and canes.\textsuperscript{17} A more complete list of items of DME can be found in the Medicare National Coverage Determination Manual, Section 280 (Medical and Surgical Supplies).\textsuperscript{18}

Wheelchairs are covered under the DME benefit as Mobility Assistive Equipment (MAE), which includes other devices, such as scooters, crutches, and walkers, among others.\textsuperscript{19} Currently, CMS\textsuperscript{12}.


\textsuperscript{13} Id.


\textsuperscript{15} PUB. 100-03 MEDICARE NCD, supra note 14.

\textsuperscript{16} See, e.g., 42 U.S.C. § 301 (2009) (defining “Secretary” as the Secretary of Health and Human Services); Social Security Act § 1834m, 42 U.S.C. § 1395m (2006) (describing various responsibilities of the Secretary of Health and Human Services regarding DME).

\textsuperscript{17} PUB. 100-03 MEDICARE NCD, supra note 14 (listing items of DME and their corresponding coverage status). See also Durable Medical Equipment: Scope and Conditions, 42 C.F.R. § 410.38(a), (c) (2009).


\textsuperscript{19} CMS modified its national coverage policy to create a new class of DME identified as Mobility Assistive Equipment (MAE). PUB. 100-03 MEDICARE NCD, supra note 14, § 280.3. MAE is not a modern invention:

[t]he use of assistive technology to aid ambulation goes back into
states that coverage of MAE is “reasonable and necessary” for beneficiaries who have a personal mobility deficit sufficient to impair their participation in Mobility Related Activities of Daily Living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. Medicare will cover eighty percent of the reasonable cost of the covered item, leaving the beneficiary responsible for the remaining twenty percent as coinsurance. Beneficiaries may elect to use Medicare coverage to rent or purchase their equipment.

II. MEDICARE COVERAGE OF POWER MOBILITY DEVICES SUCH AS WHEELCHAIRS

Motorized MAE, such as power wheelchairs, scooters, and other motorized devices, fall under Medicare’s Power Mobility Device (PMD) category. Power wheelchairs are medically necessary for beneficiaries who cannot perform MRADLs using other MAEs such as manual wheelchairs, canes, or scooters. Many
beneficiaries who require power wheelchairs have severe upper body weakness due to a neurological or muscular condition.\textsuperscript{25} In April 2007, CMS issued a detailed treatment of access to PMDs, including power wheelchairs and power operated vehicles (POVs).\textsuperscript{26} It provides the following useful definitions:

**Power Mobility Devices**: PMDs are defined as covered items of Durable Medical Equipment (DME) that are in a class of wheelchairs that includes power wheelchairs (four-wheeled motorized vehicles whose steering is operated by an electronic device or joystick to control direction and turning) or POVs (three- or four-wheeled motorized scooters that are operated by a tiller) that a beneficiary uses in the home.

**Power (Motorized) Wheelchairs**: Most beneficiaries who require power wheelchairs are non-ambulatory and have severe weakness of the upper extremities due to a neurologic or muscular condition. Under the new MAE national coverage policy, power wheelchairs may be medically necessary for beneficiaries who cannot effectively perform Mobility-Related Activities of Daily Living (MRADLs) in the home using a cane, walker, manually operated wheelchair, or a POV/scooter. In addition, the beneficiary must demonstrate the ability to safely and effectively operate the power wheelchair in the home environment.

**Power Operated Vehicles (POVs or scooters)**: These vehicles have been appropriately used in the home environment to improve the ability of chronically disabled persons to cope with normal domestic, vocational, and social activities. Under the new MAE national coverage policy, POVs may be medically necessary for beneficiaries who cannot effectively perform MRADLs in the home using a cane, walker, or manually operated wheelchair. In addition, the beneficiary must demonstrate sufficient strength and postural stability to safely and effectively operate the POV in the home environment.\textsuperscript{27}

\textsuperscript{25} See id.
\textsuperscript{26} PMD FACT SHEET, supra note 7, at 2. Advocates should check this fact sheet frequently for updates.
\textsuperscript{27} Id. See also 42 C.F.R. § 410.38(c) (2009) (defining “Power Mobility Devices”).
III. CHANGES TO COMBAT FRAUD & ABUSE

Over the last few years, CMS has modified MAE coverage under Medicare Part B.\textsuperscript{28} These changes were motivated, in part, by an increase in fraud cases related to power wheelchairs and scooters.\textsuperscript{29} Medicare spending on power wheelchairs has decreased in recent years. In 2003, spending peaked at $1.2 billion.\textsuperscript{30} Expenditures decreased to $850 million in 2004.\textsuperscript{31} However, in 2005 and 2006, Medicare and its beneficiaries spent more than $900 million per year on power wheelchairs.\textsuperscript{32} In 2007, Medicare and its beneficiaries spent $686 million to cover power wheelchairs for approximately 173,300 Medicare beneficiaries.\textsuperscript{33} The escalation of the cost of PMDs in comparison to general increases in Medicare spending led to the current system that requires CMS to set DME payment rates based on competitive bids from suppliers.\textsuperscript{34}


\textsuperscript{31} Id.

\textsuperscript{32} Id.


Recently, CMS has addressed fraud and abuse by requiring physicians to enroll in the Provider Enrollment, Chain and Ownership System (PECOS).\textsuperscript{35} DMEPOS suppliers will be added to PECOS later in 2010.\textsuperscript{36} PECOS is the standardized, national electronic system implemented in 2003 to enable physicians and other eligible professionals to enroll into Medicare.\textsuperscript{37} The standardized system “speeds up the application process, reduces paperwork, and helps cut down on fraud and abuse.”\textsuperscript{38} Provider information entered into the system is available to all Medicare Administrative Contractors (MACs).\textsuperscript{39} PECOS can be used to submit and track an initial Medicare enrollment application; view or change existing enrollment information; add or change a reassignment of benefits; reactivate an existing enrollment record; and withdraw from the Medicare program.\textsuperscript{40}

\textsuperscript{35} Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements, 75 Fed. Reg. 24,437, 24,440 (proposed May 5, 2010) (to be codified at 42 C.F.R. pts. 424 & 451) (requiring providers and eligible suppliers to register their National Provider Identifier (NPI) with their enrollment information on PECOS). For detailed information on how providers enroll in PECOS online, see Ctrs. for Medicare & Medicaid Servs., U.S. Dep’t of Health & Human Servs., Internet-Based Provider Enrollment, Chain and Ownership System for Physicians and Non-Physician Practitioners (2010), available at https://www.cms.gov/MedicareProviderSupEnroll/downloads/GettingStarted.pdf.

\textsuperscript{36} Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements, 75 Fed. Reg. at 24,440.


\textsuperscript{38} Chris Silva, Medicare PECOS Deadline Extended Again, AM. MED. NEWS (Mar. 8, 2010), http://www.ama-assn.org/amednews/2010/03/08/gs0308.htm. Accord Jorgenson, supra note 37 (stating that CMS hopes to reduce enrollment paperwork with PECOS because practitioners will not have to enroll separately with “fiscal intermediaries, carriers and MACs”).

\textsuperscript{39} Jorgenson, supra note 37.

\textsuperscript{40} Internet-Based PECOS, Ctrs. for Medicare & Medicaid Servs., U.S. Dep’t of Health & Human Servs., http://www.cms.gov/MedicareProviderSupEnroll/04 _InternetbasedPECOS.asp#TopOfPage (last updated June 30, 2010).
Mandatory physician enrollment in PECOS will also ensure compliance with provisions of the Patient Protection and Affordable Care Act of 2010\(^{41}\) that are meant to prevent fraud and are effective for orders on or after July 1, 2010.\(^{42}\) These provisions permit only a Medicare enrolled physician or eligible professional to “certify or order home health services, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and certain items and services” covered under Medicare Part B.\(^{43}\) The Affordable Care Act defines an “enrolled physician” as one who has enrolled in Medicare according to the rules established by the Secretary.\(^{44}\) An “eligible professional” is one who has enrolled under Medicare’s Quality Care Reporting System for providers.\(^{45}\)

Initially, CMS required that all providers be enrolled in PECOS by April 5, 2010; otherwise any orders, certifications, or referrals would face automatic rejection.\(^{46}\) However, practitioners protested that automatic rejection was unfair because claims from enrolled treating physicians would be denied even if only the referring or ordering physician had failed to enroll.\(^{47}\) In a statement released on June 30, 2010, CMS stated that the regulation would be effective July 6, 2010, but that it would not implement automatic rejection of claims at that time, citing problems that some providers had encountered attempting to enroll through PECOS.\(^{48}\)

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\(^{42}\) PECOS, \textit{supra} note 37. The interim final rule with comment period implementing these provisions was effective on July 6, 2010. 75 Fed. Reg. 24,437 (May 5, 2010) (to be codified at 42 C.F.R pts. 424, 431).


\(^{44}\) Id. (referencing Social Security Act § 1866(j), 42 U.S.C. § 1395cc(j) (2006)).

\(^{45}\) Id. (referencing Social Security Act § 1848(k)(3)(B), 42 U.S.C. § 1395w-4 (2006)).

\(^{46}\) Silva, \textit{supra} note 38.

\(^{47}\) Id.

\(^{48}\) PECOS, \textit{supra} note 36, at 2.
In May 2005, CMS issued a new function-based assessment tool for POVs and other MAE through its National Coverage Determination (NCD) process. The function-based assessment tool employs an algorithmic process called the “Clinical Criteria for MAE Coverage.” It replaced the prior “bed- or chair-confined” standard. Under the old standard, wheelchairs were only covered if:

- the patient’s condition such that without the use of a wheelchair he would otherwise be bed or chair confined. An individual may qualify for a wheelchair and still be considered bed confined. Wheelchairs (power operated) and wheelchairs with other special features were covered if the patient’s condition is such that a wheelchair was medically necessary and the patient was unable to operate the wheelchair manually.

This strict standard was criticized by commentators who observed that the policy created obstacles to beneficiary independence, confused beneficiaries, physicians, and suppliers, and led to unwarranted denials of the benefit due to inconsistent interpretations by providers.


51. PMD Fact Sheet, supra note 7, at 1.


53. Id. at 7.
In June of 2004, CMS formed a group called the Interagency Wheelchair Work Group (IWWG) to review the bed or chair confined standard, and to analyze the published scientific literature on the use of wheelchairs. The IWWG was comprised of:

- clinicians, including physicians, occupational therapists, and physical therapists, researchers, and policy specialists who have practical experience with mobility equipment utilization issues from different federal agencies including the Veterans Administration (VA), National Institutes of Health (NIH), Food and Drug Administration (FDA), Department of Education (ED), as well as different areas within CMS, including the Office of Clinical Standards and Quality (OCSQ), Center for Medicare Management (CMM), Office of Financial Management (OFM), Office of External Affairs (OEA), and Center for Medicaid and State Operations (CMSO).

In its report, the IWWG stated that its members were “committed to preserving the dignity and independence of those who must face lost or limited mobility.”

The IWWG recommended that CMS adopt a function-based determination of medical necessity. Such a determination would consider the beneficiary’s ability to perform activities of daily living (ADLs), such as grooming, dressing, feeding, toileting, and bathing. The beneficiary’s performance would be considered with and without the use of MAE. CMS chose to use the ADLs recommended by the IWWG because they serve a medical purpose in the home, and were renamed “mobility related activities of daily living” (MRADLs).

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54. Id. at 2.
56. Id. The function-based assessment is described in detail under the heading “Functional Criteria.” Id. at 2.
57. Id. at 2.
58. Id. Although some members of the panel noted that “extending the coverage criteria to explicitly include mobility related tasks performed outside of the home (for example, shopping for food) would facilitate greater functional independence,” Medicare continues to restrict coverage to those who require wheelchairs in the home. Id.
59. Id.
60. Decision Memo for Mobility Assistive Equipment, supra note 52.
CMS has also clarified, in a local coverage determination (LCD), the process that carriers (DME MACs) should use to select a PMD suitable for the particular beneficiary. The emphasis is on ensuring the use of appropriate mobility technology and avoiding a rigid approach to Medicare policy interpretation. Now, coverage determinations take into account a particular beneficiary’s ability to perform MRADLS, such as toileting, feeding, and bathing in the home. Where such criteria are met and properly documented, CMS will consider the item of DME at issue reasonable and necessary.

A. Assessment Tool for Determining Eligibility for PMDs

The new assessment tool takes a variety of factors into consideration when determining if a PMD (or any MAE) is appropriate for a beneficiary. An appropriate MAE may improve the health of the beneficiary by allowing him or her to perform MRADLS on his or her own or with some assistance. Assessments should only be conducted for beneficiaries willing to use MAE. This tool accounts for the individual needs of the beneficiary better than an earlier, more restrictive tool, which was often referred to as the “bed or chair-confined” standard because the beneficiary had to show that he or she would be confined to a bed or chair without the MAE.


65. Pub. 100-03 MEDICARE NCD, supra note 14, § 280.3(B) (setting out algorithmic process to provide appropriate MAE to correct mobility limitation of individual Medicare beneficiary).

66. Id.

67. DECISION MEMO FOR MOBILITY ASSISTIVE EQUIPMENT, supra note 52, at pt. VII(B)(7) (describing beneficiary’s willingness to use equipment routinely as one component of MAE coverage).

68. See id. at pt. III (comparing prior standard to new standard).
CMS intended to give greater consideration to the individual beneficiary’s ability to engage in mobility-related activities within the home with this approach. However, it is important to note that the new standard does not preclude use of the PMD outside the home. The chief concerns are as follows: establishing that the beneficiary’s mobility is sufficiently limited to make a PMD medically necessary; confirming that the beneficiary has the physical and mental ability to use the equipment in the home; and confirming that he or she is willing to do so. When these factors are appropriately documented by physicians or treating practitioners, or both, the beneficiary is free to use the MAE outside the home. However, Medicare will not cover the cost of a PMD primarily used to benefit the beneficiary in the pursuit of leisure or recreational activities.

The assessment tool includes nine questions and a flow chart that can help practitioners determine the best MAE for the beneficiary. The questions focus on a determination for coverage of a PMD. When possible, the answers to each question should be supported by documentation. The questions are as follows:

1. **Does the beneficiary have a mobility limitation that significantly impairs his or her ability to participate in one or more of the MRADLs in the home?**

This includes assessing ability to perform tasks, as well as risk of injury in attempting to perform them. In some cases, the amount of time it takes the beneficiary to

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69. Pub. 100-03 Medicare NCD, supra note 14.
70. Decision Memo for Mobility Assistive Equipment, supra note 52, at pt. VII(B)(8) (describing confusion over the “in the home” standard, and assuring beneficiaries that wheelchairs can be used for activities outside of the home). See also infra notes 168–177 and accompanying text for a discussion of the “in the home” standard.
71. Pub. 100-03 Medicare NCD, supra note 14, § 280.3(B).
72. Decision Memo for Mobility Assistive Equipment, supra note 52, at pt. VII(B)(8).
73. PMD Fact Sheet, supra note 7, at 5.
74. Pub. 100-03 Medicare NCD, supra note 14 (setting out nine-question algorithmic assessment and accompanying flowchart to determine appropriate MAE for beneficiary).
75. See id.
76. See id. § 280.3(C).
successfully perform a task can also lead to a favorable determination.

2. **Are there other conditions that limit the beneficiary’s ability to participate in MRADLs at home?**

   This includes vision or cognition problems which would not be helped by a PMD, and may in fact limit the beneficiary’s ability to use a PMD safely.

3. **If these limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of MAE will be reasonably expected to significantly improve the beneficiary’s ability to perform or obtain assistance to participate in MRADLs in the home?**

   This includes caregiver assistance in use of the PMDs. In addition, if there is a way to minimize conditions identified in Question 2 that require the beneficiary to comply with treatment, coverage could still be denied if the condition is not improved enough to allow the beneficiary to use the PMD safely, or if the help of the caregiver does not minimize the effects of the condition.

4. **Does the beneficiary or caregiver demonstrate the capability and the willingness to consistently operate the MAE safely?**

   This is not just a determination of the beneficiary’s safety while using the PMD, but also that of people around them. Any prior history of unsafe behavior is also considered. This may be assessed by having the beneficiary use a variety of other devices that may help improve their independence.

5. **Can the functional mobility deficit be sufficiently resolved by the prescription of a cane or walker?**

   These criteria will help assess the best device for the beneficiary, balancing health outcome and safety
6. **Does the beneficiary’s typical environment support the use of wheelchairs, including scooters or power-operated vehicles (POVs)?**

The living environment will be assessed including physical layout, surfaces, and obstacles that may make using the PMD harder. Changes and improvements to the beneficiary’s home may be necessary.

7. **Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair in the home to participate in MRADLs during a typical day?**

The manual wheelchair should be configured to best suit the beneficiary (seating options, wheelbase, device weight, and other appropriate accessories). This will include an assessment of the beneficiary’s upper body strength, endurance, and range of motion. In addition, a care giver who is able to help propel the manual wheelchair will also be considered. Ability to use the chair safely and the layout of the home environment will also be taken into consideration in this assessment question.

8. **Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?**

Beneficiaries have to show they can maintain the stability required to adequately operate a scooter. A joystick-operated PMD will require less upper body strength.

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77. CMS points out in the preamble to its final rule on PMDs that the consideration of the beneficiary’s home environment in which the PMD will be used does not require that the treating physician or a third party perform a home visit. Medicare Program; Conditions for Payment of Power Mobility Devices, Including Power Wheelchairs and Power-Operated Vehicles, 71 Fed. Reg. 17,021 (Apr. 5, 2006) (codified at 42 C.F.R. § 410), available at http://edocket.access.gpo.gov/2006/06-3271.htm. However, the supporting documentation must “show that the beneficiary lives in an environment that supports the use of the PMD.” Id. at 17,025.
9. Are the additional features provided by a power wheelchair needed to allow the beneficiary to participate in one or more MRADLs?\(^\text{9a}\)

PMDs are useful to beneficiaries who need assistance making transfers, as well as special seating accommodations. Features such as these are important to the determination of whether the PMD will improve the beneficiary’s mobility.

Clinical Criteria for MAE Coverage

Request initiated for mobility device for eligible patient?

Yes

- #1: Mobility limitation?
  
  Yes

  - #2: Other limitations?
    
    Yes

    - #3: Compensated?
      
      No

    No

  
  No

- #4: Capable of safe use?

  Yes

  - #5: Cerebrovascular?
    
    Yes

    - #6: Environment?
      
      No

    No

  
  No

- #7: Manual wheelchair appropriate?

  Yes

  - #8: P.O.V. appropriate?
    
    No

  
  No

- #9: P.W.C. appropriate?

  Yes

  - #10: Environment?
    
    No

  
  No

No R & N

B. Face-to-Face Examination and Prescription Required

The MAE coverage process often begins with the beneficiary’s physician. 79 Under the Affordable Care Act, the treating practitioner must conduct a face-to-face examination before writing a prescription for any item of DME. 80 It is the physician who determines via face-to-face evaluation whether the POV is appropriate for the beneficiary; that the beneficiary would benefit from the POV; and that the beneficiary has the required physical and mental capacity to operate the POV safely. 81 The practitioner must then write, sign, and date a prescription that must be received by a supplier within forty-five days of the examination. 82 If the beneficiary was recently discharged from the hospital, and a face-to-face examination was done during the hospital stay, there is no need for an additional examination as long as the documentation and the prescription are received by the PMD supplier within forty-five days of the date of discharge. 83

The prescribing physician will also have to provide additional documentation, including medical records or any other documentation that will help show the history of the beneficiary’s need for the device. 84 Documentation should also show that the PMD will improve the beneficiary’s mobility and that the beneficiary can use the PMD safely. 85 Medicare covers payment for the cost of the face-to-face examination as well, as the cost of collecting the additional documentation. 86

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79. Pub. 100-03 Medicare NCD, supra note 14, § 280.3(B) (setting out coverage process for items of MAE).
80. Affordable Care Act of 2010, § 6407(b), Pub. L. No. 111-148, 124 Stat. 119 (codified in scattered sections of 42 U.S.C.). This provision is effective for DME ordered after January 1, 2010. Id. The Secretary has also been given the authority to apply the face-to-face requirement to other areas of Medicare and Medicaid to reduce waste, fraud, and abuse as he or she deems appropriate. Id. § 6407(c)–(d).
81. See PMD Fact Sheet, supra note 7, at 5.
82. 42 C.F.R. § 410.38(c)(2)(ii) (2009); PMD Fact Sheet, supra note 7, at 5 (setting out physician and treating practitioner requirements for prescription of PMD).
83. PMD Fact Sheet, supra note 7, at 5.
84. Id.
85. Id.
Other supporting information that the physician or treating practitioner must provide the supplier of the PMD includes: 87

- The medical necessity for the use of the PMD in the home;
- Relevant information from the beneficiary’s medical record; and
- Information establishing that the beneficiary or caregiver is capable of operating the PMD.

CMS has clarified that the information in the medical record from the face-to-face evaluation is typically sufficient to support a claim of medical necessity. 88 However, prior documentation may be necessary when the information from the face-to-face examination refers to previous notes in the medical record, 89 such as the medical necessity stemming from a condition that the prescribing physician has treated and entered into the beneficiary’s medical record before.

After the beneficiary obtains a prescription, the beneficiary takes the prescription to a DME supplier, who then recommends a specific power wheelchair, and the physician then approves the supplier’s recommendation. 90 All of the required documentation should be submitted to the supplier before the supplier submits the claim to CMS. 91 Suppliers must maintain this documentation for seven years. 92

Note, however, that the physician’s medical opinion is not necessarily dispositive. It is ultimately the DME MAC or DME PSC that is charged with making the actual coverage determination. 93 Thus, before beginning the process toward an initial determination

87. PMD FACT SHEET, supra note 7, at 5.
88. Id.
89. Id.
90. OFFICE OF INSPECTOR GEN., U.S. DEP’T OF HEALTH & HUMAN SERVS., OEI-04-07-00400, POWER WHEELCHAIRS IN THE MEDICARE PROGRAM: SUPPLIER ACQUISITION COSTS AND SERVICES 10 (2009), available at http://oig.hhs.gov/oei/reports/oei-04-07-00400.pdf. The press release provides the additional clarification that Medicare no longer restricts the type of physician able to prescribe a PMD. PMD Regulation and Payment Press Release, supra note 86. Also, a physician assistant, a nurse practitioner, or a clinical nurse specialist may prescribe a PMD. Id.
91. PMD FACT SHEET, supra note 7, at 6.
93. See MEDICARE PROGRAM INTEGRITY MANUAL, supra note 4, § 5.9 (stating that the DME MAC, DME PSC, or Zoned Program Integrity Contractor (ZPIC) must resolve any questions about whether an item of DME is medically necessary for a beneficiary).
of coverage, Mrs. Carrie and her physician may decide to initiate the Advance Determination of Medical Coverage (ADMC) process to learn the likelihood that the DME MAC will find her items medically necessary and thus eligible for coverage.

There are exceptions to the face-to-face examination requirement when: (1) the physician or practitioner who treated the beneficiary in the hospital and conducted a face-to-face examination during the hospital stay issues the PMD prescription and supporting documentation to the supplier within forty-five days of the beneficiary’s discharge; or (2) only accessories for PMDs are being ordered.\footnote{42 C.F.R. § 410.38(c)(3) (2009).}

IV. ADVANCE DETERMINATION OF MEDICAL COVERAGE (ADMC)

Although it is not a requirement, it is best practice for beneficiaries to obtain an Advance Determination of Medical Coverage (ADMC) of a PMD from their DME MAC before purchasing an item of DME and asking for Medicare coverage.\footnote{See Medicare Program Integrity Manual, supra note 4, § 5.16.}

The ADMC may alert the beneficiary of possible issues that may impede Medicare coverage of her PMD. Obtaining an ADMC does not require the same level of documentation that is necessary for a determination of Medicare coverage. This section of the article will describe the application process and identify potential issues likely to occur early on in the process, in order to increase the likelihood of a favorable ADMC for beneficiaries like Mrs. Carrie. It is important to note that although a favorable ADMC indicates greater likelihood of Medicare coverage, it does not guarantee that Medicare will cover the item.

Before delivery of the item, the Secretary, through the DME MACs, determines whether payment for the item may be denied because the item is not one selected to be covered or the item is not medically necessary.\footnote{Social Security Act § 1834(a)(15)(C), 42 U.S.C. § 1395m (2006). See id. § 1862(a)(1) (regarding the item that needs to be medically necessary). The DME MACs are delegated the task of reviewing Medicare claims for durable medical equipment, orthotics, and prosthetics. See Ctrs. for Medicare & Medicaid Servs., U.S. Dep’t of Health & Human Servs., Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Award General Fact Sheet, 3 (2007), available at http://www.cms.gov/MedicareContractingReform/Downloads/DME_MAC_Awards_General_Fact_Sheet.pdf. However, the DME MACs do not conduct any actual “medical review, benefit integrity, or fraud work investigation}
ADMC may proceed, there are a few preliminary requirements:

- the item in question must be included on the list developed by the Secretary under subparagraph (A); and either
- the item is furnished by a supplier that is included on the list developed by the Secretary under subparagraph (B); or
- the item is a customized item (other than inexpensive items specified by the Secretary); and
- if the patient to whom the item is to be furnished, or the supplier requests that such advance determination be made.

Each regional DME MAC will determine which DME items are eligible for ADMC review pursuant to the above considerations. The public is deemed to have notice of what items are eligible because DME MACs are required to provide examples, which are published annually in the DME MAC’s Supplier Manual or in the DME MAC’s Supplier Bulletin.

on DME claims. Id. Instead, these tasks are given to the functional contractors known as the program (or payment) safeguard contractors (PSC) who work in conjunction with MACs. Id.

Subparagraph A states:

Construction and maintenance of a list of items by secretary.—The Secretary may develop and periodically update a list of items for which payment may be made under this subsection that the Secretary determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization throughout a carrier’s entire service area or a portion of such area.


Subparagraph B states:

Construction and maintenance of a list of suppliers by secretary.—The Secretary may develop and periodically update a list of suppliers of items for which payment may be made under this subsection with respect to whom—(i) the Secretary has found that a substantial number of claims for payment under this part for items furnished by the supplier have been denied on the basis of the application of section 1862(a)(1); or (ii) the Secretary has identified a pattern of overutilization resulting from the business practice of the supplier.

Id. § 1834(a)(15)(B).

Subparagraph C states:

Development of list of items by secretary.—The Secretary may develop and periodically update a list of items for which payment may be made under this subsection that the Secretary determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization throughout a carrier’s entire service area or a portion of such area.


Adams v. Sec'y of HHS, 597 F.3d 13, 21 (D.C. Cir. 2010) (affirming the district court's grant of summary judgment for the Secretary).

MEDICARE PROGRAM INTEGRITY MANUAL, supra note 4, § 5.16.1.
There are four regional DME MACs. Each one works with a regional DME Program Safeguard Contractor (DME PSC) in reviewing fraud and abuse of Medicare claims. Although the Secretary has an interest in preventing and eradicating fraud and abuse in the health care system, the ADMC cannot be used as a method to deliberately seek and uncover fraud since it is a voluntary process. Therefore, the DME PSC may not require an ADMC request as a prerequisite for submitting a claim in furtherance of the anti-fraud and abuse goals.

In the instant case, Mrs. Carrie resides in Region C; the current DME MAC for Region C is CIGNA Government Services. CIGNA has published a list of eligible items in a chapter as part of its supplier manual. The eligible items are organized by billing code, which can be confusing to beneficiaries not familiar with the Healthcare Common Procedure Coding System. Although the

101. The fifty states and United States territories are divided into four regions and have one assigned DME MAC. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., DURABLE MEDICAL EQUIPMENT (DME) MEDICARE ADMINISTRATIVE CONTRACTOR (MAC) AWARD GENERAL FACT SHEET 4–5 (2007), available at http://www.cms.gov/MedicareContractingReform/Downloads/DME_MAC_Awards_General_Fact_Sheet.pdf. The MAC in Region A is the National Heritage Insurance Company; in Region B, it is National Government Services; in Region C, it is CIGNA Government; and in Region D, it is Noridian Administrative Services. Id.

102. CMS created the PSC under the authority of the Medicare Integrity Program (MIP), which was a creation of the Health Insurance Portability and Accountability Act (HIPPA) of 1996. This authority allows CMS to enter into contracts with PSC to promote the integrity of the medical program against fraud and abuse. See CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., CMS DURABLE MEDICAL EQUIPMENT MEDICARE ADMINISTRATIVE CONTRACTOR: WORKLOAD IMPLEMENTATION HANDBOOK § 7-2 (March 1, 2007), available at http://www.cms.gov/MedicareContractingReform/Downloads/DME_MAC_Implementation_Handbook.pdf.

103. See MEDICARE PROGRAM INTEGRITY MANUAL, supra note 4, § 5.16.

104. Id.

105. See MEDICARE PROGRAM INTEGRITY MANUAL, supra note 4, § 5.16.


107. CIGNA has provided an appendix to its Supplier Manual to decode the HCPCS. Id. at app. A. The appendix offers a description of the item and its corresponding HCPCS number. Id.
regions have similar policies and practices, there are some significant differences.\textsuperscript{108} Advocates should be sure to review their specific region’s policies.\textsuperscript{109}

Once a request is received, the DME MAC must provide the ADMC with a written decision—positive or negative—within thirty calendar days.\textsuperscript{110} A request for a medically inappropriate item or a request lacking sufficient documentation to support coverage will be denied for not meeting medical necessity requirements.\textsuperscript{111}

Generally, all ADMC requests must contain adequate information about the beneficiary and the requested item, such as the beneficiary’s identity, the intended use of the item, and the medical record and condition of the patient that necessitates the use of a customized item.\textsuperscript{112} The DME MAC will review and determine if the request is accompanied by sufficient medical documentation to support the “reasonable and necessary” standard.\textsuperscript{113} The DME MAC will also review the beneficiary’s claims history for similar or duplicate claims.\textsuperscript{114} “Only upon submission of a complete claim, can the DME MAC make a full and complete determination.”\textsuperscript{115}

\textsuperscript{108} For example, for Region B, if the ADMC is for a power wheelchair replacement, and it is made within five years of one billed with the same HCPCS code that was previously covered by Medicare, a face-to-face examination is not required. NAT’L GOV’T SERVS., JURISDICTION B DME MAC SUPPLIER MANUAL ch. 9, at 4 (2010), available at http://www.ngs medicare.com/pdf/132_0610_JBSM_CompleteManual.pdf. In Region C, there is no such written exception available in the Region C supplier manual. DME MAC JURISDICTION C SUPPLIER MANUAL, supra note 106.

\textsuperscript{109} CMS has compiled a contact list of all the current DME MACs and their respective websites. On each website, the DME MAC has made its Supplier Manual available online. For each region’s website for information on each region’s respective policies, see CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., DMERC AND DME MAC CONTACTS (2008), available at http://www.cms.gov/DMEPOSFeeSched/Downloads/DMERC_and_DME_MAC_Contacts.pdf.

\textsuperscript{110} Medicare Program Integrity Manual, supra note 4, § 5.16.3.

\textsuperscript{111} Id.

\textsuperscript{112} Id. § 5.16.2. Each DME MAC must publish the mailing address to which these requests should be sent. Id.

\textsuperscript{113} Id. § 5.16.5.

\textsuperscript{114} Id.

\textsuperscript{115} Id. § 5.16.4.
V. AFFIRMATIVE ADMC DETERMINATION

An affirmative ADMC decision assures the supplier and the beneficiary that the request will likely meet Medicare’s medical necessity requirements. An affirmative ADMC decision, however, does not take into consideration whether the beneficiary meets Medicare eligibility requirements, or whether other Medicare requirements have been met. All of the above conditions must be met for a beneficiary to have her power wheelchair covered by Medicare.

When there is an affirmative decision, the decision is valid for six months from the date the affirmative decision was determined. This limit takes the beneficiary’s medical condition into account—rapid improvement or deterioration can obviate the need for a particular item of DME. It is important to anticipate the fact that the DME MAC may revisit a claim to review it before or after payment, and deny or modify an affirmative decision if the decision relied upon incorrect information.

VI. NEGATIVE ADMC DETERMINATION

A negative ADMC decision notifies the supplier and the beneficiary that she does not meet the medical necessity requirements Medicare has established for the item. A negative ADMC decision letter must include the reason for denial. The beneficiary or supplier can resubmit the request with additional medical documentation. However, resubmissions may only be sent once during a six-month period following a negative determination.

116. Id.
117. Id.
118. See Advanced Determination of Medical Coverage (ADMC), CIGNA GOV’T SERVS., http://www.cignagovernmentservices.com/jc/coverage/mr/ADMC.html (last visited Nov. 3, 2010) (explaining that even with an affirmative ADMC, claims can be denied based on other Medicare eligibility issues).
119. MEDICARE PROGRAM INTEGRITY MANUAL, supra note 4, § 5.16.4.
120. Id.
121. Id.
122. Id. § 5.16.5.
123. Id.
124. Id.
125. Id.
VII. DME MAC TRACKING OF ADMC REQUESTS

The DME MACs are required to develop a system to track ADMC requests in order to assure that decisions are "rendered in a timely and appropriate fashion."126 DME MACs shall design a review system to ensure that:

1) items for which an affirmative ADMC decision was made are not denied as not meeting the medical necessary requirements of the policy, and 2) claims for item that received a negative ADMC decision are denied as not covered, unless additional medical documentation submitted with the claims supports coverage.127

VIII. MRS. CARRIE AND REGION C ADMC

Mrs. Carrie is an eligible Medicare beneficiary. Six years ago, her wheelchair was covered by Medicare Part B, and her condition has deteriorated enough to make a power operated wheelchair medically necessary.

In Region C, Mrs. Carrie’s request for a new power-chair base is eligible for ADMC review.128 Her leg-lift, however, is not listed.129 In Region C, the leg-lift itself is not eligible for ADMC review. However, if the wheelchair base is eligible, then all the options and accessories ordered by Mrs. Carrie’s physician will be eligible for ADMC review.130 Mrs. Carrie’s leg-lift is eligible for ADMC because it is ordered as an accessory to her chair. However, Mrs. Carrie should be aware that in the event the wheelchair receives an affirmative ADMC, and the accessories do not, she will not be able to resubmit an ADMC for the accessories.131 If new information is discovered about the leg-lift, an additional claim for ADMC may be submitted and considered.132

To begin the ADMC process, Mrs. Carrie and her physician should work together to prepare the orders for the leg-lift and the power-chair base. Mrs. Carrie’s physician may either mail or fax the ADMC to CIGNA.133 Electronic submissions are not accepted in

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126. Id. § 5.17.
127. Id.
128. See DME MAC JURISDICTION C SUPPLIER MANUAL, supra note 106
129. Id.
130. Id.
131. Id. at 12.
132. Id.
133. Id. at 8.
The CIGNA Request Form for ADMC has several components. The physician or beneficiary must submit medical documentation, which includes a handwritten or electronically generated order with the patient's name, description of the equipment, date of exam, diagnosis, and reasonable assessment of length of need for the equipment. The medical documentation must also be dated and signed by the doctor. Other components are: a "Detailed Product Description," a face-to-face evaluation, a licensed/certified medical professional/specialty evaluation, a home assessment, and an assistive technology professional (ATP) evaluation.

Since Mrs. Carrie already has a power-chair, her ADMC request must indicate why she and her physician want the chair replaced.

It is important to have a good reason for additional equipment such as a leg-lift. Mrs. Carrie has a good reason for her request—her current wheelchair has malfunctioned after its reasonable use lifetime of five years, and a new chair with a leg-lift is medically necessary to provide mobility in spite of her deteriorating condition and edema.

According to the protocol manual for Region C, CIGNA has thirty days from the receipt of Mrs. Carrie's request to issue its determination. Both the supplier and the beneficiary will receive the determination in writing. If CIGNA gives a negative determination for the power-chair base, all accessories will

134. Id.
136. DME MAC JURISDICTION C SUPPLIER MANUAL, supra note 106, at 9, 10.
137. Id. at 10.
138. Id. at 10, 11. Regarding the information for the Detailed Product Description, "it must list the specific wheelchair base and all options and accessories that will be separately billed. For each item, you must enter all of the following: HCPCS code[,] [n]arrative description of the HCPCS item[,] . . . [s]upplier’s charge[,] Medicare fee schedule allowance. . . . The physician must sign and date [the detailed product description] (hand written or electronic only—stamped signature and dates are not acceptable).” Id.
139. Id. at 11.
140. Id. at 12.
141. See CMS, INTEGRITY MANUAL, supra note 93, at § 5.9.2 (noting that the records sent by the physician must give good reason for needing the POV).
142. DME MAC JURISDICTION C SUPPLIER MANUAL, supra note 106, at 12.
143. Id. (noting that, if the determination is negative, the writing must specify why the request was denied).
automatically get a negative determination as well. If, however, the determination for the base is affirmative, the accessories will each receive an individual affirmative or negative determination.

The likelihood of a favorable ADMC determination lies with whether she and her physician complete all inquiries on the CIGNA Request Form and forward all the requested documentation to support the medical necessity of the items ordered. On the CIGNA Request Form, there is an area to include the supplier’s information. When the supplier is enrolled in the Medicare Supplier program, the supplier should have a National Supplier Clearinghouse (NSC) number. NSC states on its website that a supplier may still bill Medicare and choose not to be enrolled in the Medicare Supplier program. However, as discussed in the following section, some suppliers are required to enroll in the Medicare Supplier program in order to receive Medicare payments.

IX. DURABLE MEDICAL EQUIPMENT PROSTHETICS, ORTHOTICS AND SUPPLIES (DMEPOS) SUPPLIER

Mrs. Carrie resides in Fort Lauderdale, Florida, which is one of the Competitive Bidding Areas (CBAs) where beneficiaries will have to use a Medicare Contract Supplier, also known as a certified Durable Medical Equipment Prosthetics, Orthotics and Supplies

144. Id.
145. Id.
146. See id. at 8–11.
147. ADMC REQUEST FORM, supra note 135.
149. See CMS Announces Efforts to Streamline and Improve the Medicare Enrollment Process, Nat’l Supplier Clearinghouse (Apr. 25, 2006), http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers-National%20Supplier%20Clearinghouse-Articles-General-7GMSPN6458/open&navmenu=%7C%7C (“While one of the primary requirements of this rule is that all providers and suppliers (both new and those already in the program) complete the CMS-855 Medicare enrollment application, existing providers and suppliers are not required to take any action at this time.”).
Since Mrs. Carrie would like Medicare to cover her PMD, she must choose a DMEPOS supplier for her area, or else she risks paying in full if she selects a nonparticipating supplier.

Starting January 1, 2011, CMS will initiate a new competitive bidding program for suppliers of certain items of DMEPOS in selected geographic areas across the country, including Fort Lauderdale, Florida. Under this program, the Secretary has established a supplier certification and bidding methodology, identified certain items of DME that are subject to the program, and identified the geographic CBAs in which the program is being applied on a phased-in basis. A major element of the current controversy is whether the program will decrease beneficiary access to suppliers. At this point, our anecdotal experience is that suppliers are applying for certification and complying with other DMEPOS requirements that are described below. Nonetheless, provider associations and beneficiary advocates remain watchful as


154. Id. §§ 414.402, .408.

155. Id. § 414.410. CBAs are occurring in the nine largest Metropolitan Statistical Areas: Cincinnati-Middletown (OH, KY, and IN); Cleveland-Elyria-Mentor (OH); Charlotte-Gastonia-Concord (NC and SC); Dallas-Fort Worth-Arlington (TX); Kansas City (MO and KS); Miami-Fort Lauderdale-Miami Beach (FL); Orlando (FL); Pittsburgh (PA); and Riverside-San Bernardino-Ontario (CA). METRO STATISTICAL AREAS, supra note 151.
the program unfolds. In June 2010, CMS announced that if you live in (or get the items while visiting) one of these areas that use equipment or supplies included in the program, you will have to use Medicare Contract Suppliers (suppliers who participate in the competitive bidding program because they have met Medicare quality and financial standards and they have successful bids) if you want Medicare to help pay for the item. In general, if a non-contract supplier in a CBA furnishes a competitively bid item to any Medicare beneficiary, Medicare will not make a payment unless there is an applicable exception, regardless of whether the beneficiary maintains a permanent residence in the CBA or in a different area. In these circumstances, the beneficiary is not liable for payment unless the non-contract supplier in a CBA obtains an Advance Beneficiary Notice of Noncoverage (ABN) signed by the beneficiary. A signed ABN indicates that the beneficiary was informed in writing—prior to receiving the item—that there would be no Medicare coverage due to the supplier’s contract status, and that


158. WHAT YOU SHOULD KNOW, supra note 157, at 1 (“If you . . . don’t use a Medicare contract or a grandfathered supplier, Medicare won’t pay for the item and you will likely pay full price.”); see also CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., GENERAL OVERVIEW OF THE FINAL RULE FOR COMPETITIVE ACQUISITION FOR CERTAIN DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES 4–6 (Apr. 10, 2007), https://www.cms.gov/DMEPOSCompetitiveBid/Downloads/DMEPOSRegSumm.pdf (summarizing the program’s grandfathering provisions, special rules, and small supplier considerations).

159. WHAT YOU SHOULD KNOW, supra note 157, at 7.

160. Id. (”[An ABN] says Medicare probably won’t pay for the item or service. The supplier will probably require you to pay for the full cost of the item.”).
the beneficiary understands that he or she will be liable for all costs that the non-contract supplier may charge for the item.\textsuperscript{161}

The new program is designed primarily to reduce waste and fraud.\textsuperscript{162} The objective is to have Medicare pay “lower, more accurate prices” because suppliers would have to “submit bids for certain medical equipment and supplies that must be lower than what Medicare now pays for these items.”\textsuperscript{163} The goals of the program are to (1) help Medicare and the beneficiary save money; (2) ensure that the beneficiary has access to certain quality medical equipment, supplies and other services; and (3) “[h]elp limit fraud and abuse in the Medicare Program.”\textsuperscript{164} CMS clearly lists “Standard Power Wheelchairs, Scooters and Related Accessories” and “Complex Rehabilitative Power Wheelchairs and Related Accessories (Group 2)” as part of the competitive bidding program.\textsuperscript{165}

Before the supplier may submit a bid to be awarded a contract under the Competitive Bidding Program, the supplier must meet quality and financial standards.\textsuperscript{166} All DMEPOS suppliers must enroll or participate in the Medicare Program in order to be eligible to receive Medicare payment for covered services.\textsuperscript{167} To
“participate” in the Medicare Program means that the supplier will always have to accept assignment of claims for all services and products furnished to Medicare beneficiaries, and the supplier will always accept Medicare allowed amounts as payment in full.168

X. PMDS MUST BE USED PRIMARILY IN THE HOME

Beneficiaries seeking Medicare coverage for a PMD must have either a permanent or temporary disability that impairs mobility.169 Medicare Part B will cover the rental or cost of purchasing a PMD as long as the equipment is used primarily in the home, or a facility that is used like a home.170 The term “home” encompasses the traditional family residence and all other facilities that do not qualify as hospitals or skilled nursing facilities (SNFs) under the Social Security Act, such as Assisted Living Facilities, or nursing facilities in which care does not rise to the level of a SNF.171 Beneficiaries should keep in mind that Medicare does not consider a skilled nursing facility or a hospital a home, and thus a beneficiary who is in such a facility would not be eligible for a PMD or other Durable Medical Equipment (DME).172

In addition, the beneficiary must have a condition that qualifies an item of DME as medically necessary for the treatment of the patient’s illness or injury, or for the improvement of a malformed body member, as prescribed or ordered by the patient’s 

168. \textit{Id.} at 2.
169. \textit{Decision Memo for Mobility Assistive Equipment, supra} note 52.
171. Only facilities that provide enough skilled care or rehabilitative services to fall under the definitions of “hospital” and “skilled nursing facility” in the Social Security Act do not constitute “homes” for the purpose of DME coverage. For the definition of DME, see Social Security Act, 42 U.S.C. § 1395x(n) (2006); for the definition of a hospital, see \textit{id.} § 1395x(c); and, for the definition of a skilled nursing facility, see \textit{id.} § 1395l–5(a). Nursing homes that are “dually-certified” under Medicare and Medicaid primarily provide skilled care or rehabilitative services, and do not qualify as DME “homes.” \textit{CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., PUB. 100-20 ONE-TIME NOTIFICATION, TRANSMITTAL 637 CHANGE REQUEST 6695} (2010), http://www.cms.gov/transmittals/downloads/R637OTN.pdf.
physician. The patient may also obtain a Certificate of Medical Necessity personally signed and dated by the patient’s treating physician or other licensed healthcare provider.\(^\text{175}\) Documentation of medical necessity should include: the beneficiary’s name and full address; the physician’s signature; the date the physician signed the prescription or order; a description of the items of DME needed; the start date of the order; and the patient’s medical diagnosis, along with a “realistic estimate of the total length of time the equipment will be needed (in months or years).”\(^\text{174}\)

Many beneficiaries have been confused by the use of the term “in the home,” believing it means that their scooter or wheelchair should not be used outside of the home.\(^\text{175}\) The term, however, relates to whether the need for the PMD is based primarily on improving mobility for activities that take place in the home.\(^\text{176}\) Additionally, the fact that a beneficiary lives alone, with family, or in a facility that is not a SNF, does not impact eligibility.\(^\text{177}\) The beneficiary need only show capacity and willingness to use the PMD in a safe manner in the home, and that the PMD will improve mobility, and therefore health.

XI. CO-PAYMENT RESPONSIBILITY

In Fort Lauderdale, Florida, Medicare will only reimburse suppliers that are participating in the DMEPOS program. Mrs. Carrie should inquire whether her supplier of choice is a DMEPOS supplier. Generally, all beneficiaries are responsible for a twenty percent co-payment of the amount authorized by Medicare,

\(^{173}\) See DME MAC A SUPPLIER MANUAL, supra note 3.


\(^{175}\) See DECISION MEMO FOR MOBILITY ASSISTIVE EQUIPMENT, supra note 51 (describing “quite a few” comments on proposed regulation as revealing confusion over whether Medicare-covered wheelchairs could be used outside of the home).

\(^{176}\) Id.; see supra note 80 and the accompanying text for the questions related to a beneficiary’s ability to perform tasks in the home.

\(^{177}\) See Social Security Act § 1861(n), 42 U.S.C § 1395x(n) (2006) (including institutions in the definition of “home” as long as they do not fall under definition of “hospital” in §1861(e) of the Act or “skilled nursing facility” in §1819(a) of the Act); see also DECISION MEMO FOR MOBILITY ASSISTIVE EQUIPMENT, supra note 51 (describing algorithmic process as individualized and meant to encompass differing circumstances of beneficiaries).
whether the beneficiary lives in a DMEPOS competitive bidding zone or not. When a supplier is enrolled in Medicare assignment, the supplier is “agreeing to accept Medicare’s reasonable charge calculation as payment in full with the beneficiary paying only the twenty percent co-payment.” “Dual-eligibles,” who are eligible for both Medicare and Medicaid coverage of DME, should make sure that the state is contributing its share of the cost of the wheelchair, following the state’s Medicaid Plan.

If the supplier is not participating in the Medicare program, Mrs. Carrie may also be charged the difference between Medicare’s reasonable charge calculation and the provider’s price for the PMD. Mrs. Carrie is advised to work with a participating supplier enrolled in the Medicare assignment program in order to keep her out-of-pocket costs down. Medicare.gov lists participating suppliers; Mrs. Carrie can enter her zip code, 33355, and the site will generate the list of eighteen DMEPOS suppliers within a ten mile radius.

XII. RENT VERSUS PURCHASE OPTION

The beneficiary may choose to purchase or rent their PMD. Either way, Medicare coverage will not exceed eighty percent of

181. Id.
182. Id.
the allowed purchase price. \(^{185}\) The decision to purchase or rent may depend on how long the beneficiary will need the PMD. \(^{186}\) This decision can only be made when the beneficiary first gets the PMD, \(^{187}\) or after ten continuous months of renting. \(^{188}\)

If the beneficiary decides to purchase after the ten month period, the eighty-percent-twenty-percent payment split between Medicare and the beneficiary continues for three months. \(^{189}\) In total, Medicare will pay for a total of thirteen months, including maintenance. \(^{190}\) After month thirteen, the title to the chair is transferred to the beneficiary. \(^{191}\) If after the initial ten month rental, the beneficiary decides to continue renting, Medicare will pay five more months of rental payments. \(^{192}\) After the fifteenth month, title to the chair goes to the supplier. \(^{193}\) Payment may also be made for repairs, maintenance, and delivery, as well as for expendable and non-reusable items that are essential to effective use of the equipment. \(^{194}\) However, routine periodic servicing such as testing, cleaning, regulating, and checking the equipment is not covered. \(^{195}\)

When making the decision to rent or purchase, beneficiaries should be aware that those who purchase are responsible for twenty percent of the service charges each time the equipment is serviced, and, for unassigned claims, for the balance of the supplier’s charge above the Medicare payment rate. \(^{196}\) In the instant case, Mrs. Carrie

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185. See Power Wheelchairs in the Medicare Program, supra note 90, at 6.
187. Id. § 30.5.5.
188. Id. § 30.5.2.
189. Id. § 30.5.3.1.
190. Id.
192. Medicare Claims Processing Manual, supra note 186, at § 30.5.3.1.
193. Id.
194. Id. § 10.2; see also Social Security Act § 1834(a)(7)(A)(iv), 42 U.S.C. § 1395m(a)(7)(A)(iv) (2006) (providing that “maintenance and servicing payments shall, if the Secretary determines such payments are reasonable and necessary, be made”).
196. Id. § 30.5.3.1. Note, however, that if a supplier participates in the Medicare assignment program, he or she agrees to accept Medicare’s payment amount, leaving the beneficiary responsible for the twenty percent co-payment
should proceed with the purchase option, since she has used her previous chair for six years continuously. Her age and deteriorating condition strongly support a decision to purchase the wheelchair.

XIII. THE RIGHT TO APPEAL A MEDICARE DENIAL OF A DME

An ADMC is not an initial determination subject to appeal because there is no accompanying request for payment. Mrs. Carrie should keep in mind that, in the event she receives a favorable ADMC, she can still be denied Medicare coverage for reasons not relating to medical necessity of the item. The rules applicable to the Medicare A/B appeals process apply. A review of the Medicare appeals process is helpful. An appeal for denial amount. See also Social Security Act § 1848(g), 42 U.S.C. § 1395W-4(g) (2006) (providing for limitations on beneficiary liability for physicians' services).

197. If Mrs. Carrie had been renting from a non-contract supplier in the Fort Lauderdale, Florida, area and had wished to continue renting the device from that particular supplier, then that item may have been covered if she rented from a grandfathered supplier. A grandfathered supplier is a non-contract supplier that elects to continue to furnish the rented DME to a current Medicare beneficiary who is already renting the item prior to the beginning of the competitive bidding program, which will be January 1, 2011. See Guide to Answer Consumer Questions, supra note 162, at 6, 7.


of coverage can move through up to five levels of appellate review. The first level of appeal is a Request for Redetermination to the DME MAC. If there is a negative redetermination, then the process moves to the second level, a Reconsideration Request reviewed by a Qualified Independent Contractor (QIC). There is one DME QIC, RiverTrust Solutions, Inc., that reviews all reconsideration requests throughout the nation. The third level of appeal is an Administrative Law Judge (ALJ). The fourth is the Medicare Appeals Council, and the fifth is review by the Federal District Court and subsequent federal courts.

When considering an appeal, beneficiaries should start by reviewing their Medicare Summary Notice (MSN). The MSN will indicate whether, and to what extent, the DME MAC has covered an item, service, or procedure, and the amount of payment, including explanatory notes about denials of coverage or reductions in the amount paid. This information will be helpful in formulating the appeal strategy. In addition, a printable Medicare inquiry/Request for Reconsideration form can be obtained from the DME MAC’s website.

In many cases, a successful Request for Reconsideration is accompanied by additional medical documentation, such as a strong physician’s statement, corrected DME coding, and clarifying responses to specific DME MAC information requests. It is also important to review Medicare’s National Coverage Decisions Manual to ascertain additional coverage policy guidance.

/AdvocatesAlliance/IssueBriefs/10_02.08.AppealsCharts.pdf (all giving a general overview of the Medicare appeals process).

202. Id.
203. Id.
205. OVERVIEW ORIGINAL MEDICARE (FEE-FOR-SERVICE) APPEALS, supra note 201.
206. Id.
207. Ctrs. for Medicare & Medicaid Servs., U.S. Dep’t of Health & Human Servs, Fact Sheet, Original Medicare (Fee-For-Service) Appeals Data 1 (2008), http://www.cms.gov/OrgMedFFSAppeals/Downloads/Factsheet2008.pdf. On assigned claims, the MSN is mailed on a ninety-day cycle; for non-assigned claims, they are mailed to beneficiaries as they are processed.
XIV. CONCLUSION

Finding the appropriate PMD can mean a great improvement to the quality of life for a beneficiary. Knowledge of the Medicare coverage rules is essential to help individuals obtain the necessary equipment. Beneficiaries like Mrs. Carrie, who want Medicare coverage for a PMD, are more likely to be successful if they know the required procedures to secure Medicare coverage of a certain PMD. Moreover, beneficiaries should be aware of the optional procedures and the appeals process in order to exhaust all methods of obtaining Medicare coverage for the PMD.

A successful determination requires that a beneficiary (1) provide support that she has mobility limitations that impair her ability to engage in Mobility Related Activities of Daily Living (MRADLs), (2) show that her use of the PMD will improve her ability to do MRADLs, and (3) show that the PMD can be used safely within her home. Although the primary purpose of the PMD is improvement in the beneficiary’s ability to perform MRADLs in the home, it can be used outside the home as well.

In the instant case, Mrs. Carrie must select a DMEPOS supplier because she resides in a CBA or risk losing Medicare coverage for the equipment entirely. She should be aware that DMEPOS suppliers must accept Medicare payments in full and satisfy other requirements in order to receive any Medicare reimbursement. Beneficiaries should make sure that their practitioner provides the Medicare supplier with all supporting documentation, including the prescription for the PMD, within forty-five days of the face-to-face consultation.

Even though it is completely voluntary, beneficiaries and physicians are strongly encouraged to complete a request for an ADMC review by their DME MAC. In some instances, the ADMC will simply assure beneficiaries like Mrs. Carrie of the likelihood of coverage. In others, the ADMC will warn beneficiaries of the need to compile more medical records to show that the equipment is medically necessary.