BEHIND THE EIGHT BALL

TOP EIGHT REASONS EQUIPMENT MAY BE DENIED

Written by: **KAY ELLEN KOCH,** OTR/L, ATP, RESNA FELLOW & FRIEND OF NRRTS

The client assessment performed by the therapist is a key component in getting equipment justified and provided. As an integral member of the team, the therapist's assessment provides the medical necessity and portrait of the client to a funding source's reviewer who may not even have a medical background, 'know' the client, or be familiar with the technology being requested. The documentation provided from the supplier is equally important to ensure the client gets what is medically needed and the supplier gets paid for what is being provided. Good documentation and justification is essential but so is understanding the coverage criteria, what the funding source considers 'medically necessary' and what documentation is required. Our goal should be to have the equipment being requested be approved and provided with the first submission. Here are eight reasons the goal may not be achieved.

#1- LACK OF KNOWLEDGE OF THE COVERAGE CRITERIA

Have knowledge of what's covered and the funding source's definition of "medically necessary." Most funding sources follow Medicare's guidelines. Medicare covers equipment, such as seating for positioning and pressure redistribution, using the patient's diagnosis as part of the coverage criteria. Some equipment, like bath benches are considered 'hygienic' and not medically necessary.

#2- JUSTIFICATION DOES NOT IDENTIFY THE MEDICAL NECESSITY

"Medical Necessity" as defined by Centers for Medicare and Medicaid Services (CMS) states:

- That the service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition, or disability.
- That the service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition or disability.
- That the service or benefit will assist the individual to achieve or maintain maximum functional capacity in performing daily activities (Mobility Related Activities of Daily Living or MRADLs) in the home.

CMS usually has a trickledown effect to state Medicaid systems and most third-party insurance coverage.

#3- INCOMPLETE OBJECTIVE ASSESSMENT PERTAINING TO THE EQUIPMENT BEING REQUESTED

Complete clinical presentation and level of function of client including educational, social/emotional development, cognitive skills, ambulation, activities of daily living, mobility, joint range of motion, muscle strength, endurance, muscle tone, reflexes, school/home/work requirements, transportation and peer interactions. Describe your client's seating, positioning, mobility and medical needs. Describe any additional information that is relevant to the request.

#4- DESCRIPTION OF SEPARATELY BILLED COMPONENTS NOT PROVIDED

On a manual wheelchair, for example, Medicare considers an armrest standard and bundled into the allowance for the base of the wheelchair. If a removable height adjustable armrest (E0973) is requested, justification for this component is required. This can be to assist with positioning the upper extremities and to assist with transfers, but needs to be supported as described above in #3 with objective information. If the objective assessment (Licensed Certified Medical Professional or LCMP) documents the client is dependent for transfers or has upper extremity strength documented as 1/5, this component may be denied. If the objective assessment (LCMP) documents the client has upper extremity strength of 4/5 and transfers to the commode, the justification can be supported for the removable height adjustable armrest.

#5- JUSTIFICATION AND GETTING TO THE "WHY" – THE SPECIALTY EXAM

The specialty evaluation is a written report providing a detailed explanation of why a particular wheelchair base and each specific option or accessory is needed to address the client's mobility limitation. The assessment should include lower cost or lower technology options and why they cannot be utilized.

POWER MOBILITY DOCUMENTATION REQUIREMENTS

REFERENCE CHART: PMD/ MWC **EVALUATION / ASSESSMENT REQUIREMENTS**

PMD/MWC Group	HCPCS Code Range	Face-to-Face Exam	Specialty Exam	Home Evaluation**	ATP In-person Appraisal
Ultra Lightweight / Manual Tilt in Space	K0005/ E1161	Yes	Yes	Yes	Yes
Group 1 POV	K0800-K0802	Yes	No	Yes	No
Group 2 POV	K0806-K0808	Yes	No	Yes	No
Group 1 PWC	K0813-K0816	Yes	No	Yes	No
Group 2 PWC – NPO	K0820-K0829	Yes	No	Yes	No
Group 2 PWC – SPO	K0835-K0840	Yes	Yes	Yes	Yes
Group 2 PWC – MPO	K0841-K0843	Yes	Yes	Yes	Yes
Group 3 PWC – NPO	K0848-K0855	Yes	Yes	Yes	Yes
Group 3 PWC – SPO	K0856-K0860	Yes	Yes	Yes	Yes
Group 3 PWC – MPO	K0861-K0864	Yes	Yes	Yes	Yes
Group 5 PWC	K0890-K0891	Yes	Yes	Yes	Yes

Abbreviation Key

PMD = Power Mobility Device
POV = Power Operated Vehicle
PWC = Power Wheelchair

K0005= Ultra Light-weight Manual Wheelchair
E1161 = Manual Tilt in Space Wheelchair

MPO = Multiple Power Options
NPO = No Power Options
SPO = Single Power Option

**A Home Assessment for the manual wheelchair and all levels of powered mobility, is required before or at delivery, according to Medicare policy. The person conducting this assessment should verify and document, in a written report, that the patient's typical environment supports the use of the mobility device. The home assessment can be performed by the supplier (or supplier's employee) or a practitioner (physician, physician's employee or LCMP, etc.). The policy does not specify a particular format or form to use.

The home assessment for a manual wheelchair may be done directly by visiting the beneficiary's home or indirectly based upon information provided by the beneficiary or their designee. When the home assessment is based upon indirectly obtained information, the supplier must, at the time of delivery of the manual wheelchair, verify that the item delivered meets the requirements specified by the funding policy. This would include that the home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided. Home assessment addresses issues such as the physical layout of the home, surfaces to be traversed, and obstacles to maneuvering within the home. Home assessment is fully documented in the medical record or elsewhere by the supplier.

For powered mobility, the policy does state that the assessments and measurements should include physical layout of the home, doorway width, doorway thresholds, and surfaces the device will have to move over. Additionally, if the home assessment should indicate that if the patient is unable to access one or more rooms, e.g. the bathroom, while in the wheelchair, an explanation as to how this issue will be mitigated to allow the patient to complete his/her MRADLs must be provided.

ADAPTED FROM:
Power Mobility Documentation Requirements | https://www.cgsmedicare.com/jc/pubs/news/2008/0708/cope7962.html
Manual Mobility Information added by Kay Koch, OTR/L, ATP, RESNA Fellow

The specialty exam must be performed by a licensed/certified medical professional, such as a physical or occupational therapist, or physician who has specific training and experience in rehabilitation wheelchair evaluations. The clinical person performing this exam may, but is not required to be, a RESNA-certified Assistive Technology Professional (ATP). REMINDER: The physical or occupational therapist, or physician performing the specialty exam may not have a financial relationship with the supplier. The supplier may create a document that states this or it can be documented as part of your exam.

Medicare policy does not prescribe a specific format for reporting the specialty exam findings. However, the report should be in the facility's usual medical record form; it should not be on a supplier-generated form. If "check box" style documentation is

CONTINUED ON PAGE 46

BEHIND THE 8 BALL ...
(CONTINUED FROM PAGE 45)

used to identify or list issues pertaining to the MRADL and mobility limitations, an objective, written narrative that matches the issues needs to support what is checked. For example, if the "box" is checked that identifies "weak upper extremities" objective assessments like a manual muscle test should also be included in documentation to justify why a wheelchair base and the accessories are being recommended for that specific client.

#6- ILLEGIBLE DOCUMENTATION

If the funding source cannot read the documentation due to illegible hand writing, faded documentation from multiple faxing or a fax that is unclear due to the way it was transmitted to the reviewer, it may be denied. If the identity of the person who created or wrote the documentation cannot be ascertained, a denial may also occur. This could include illegible signatures or illegible signature dates. Medicare will accept a printed name under the signature to identify the author of the documentation. Medicare requires that services provided or ordered be authenticated by the author. The method used can be a handwritten or electronic signature. If the signature is illegible or missing from the medical documentation (other than an order), the review contractor may request a signature log or attestation statement to determine the identity of the author of a medical record entry.

A signature log identifies the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. In order to be considered valid for Medicare medical review purposes, the log must be a part of the client's medical record.

An attestation statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information to be considered valid for Medicare medical review purposes

Should a provider choose to submit an attestation statement, the following statement can be used:

"I, _____[print full name of the physician/practitioner]___, hereby attest that the medical record entry for _____[date of service]___ accurately reflects signatures/notations that I made in my capacity as _____[insert provider credentials, e.g., M.D.]___ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

#7- INCORRECT 'CORRECTIONS'

Medicare has policy on what they consider valid corrections to the medical document. Clearly indicate the date and author of any amendments, corrections or addenda. Clearly identify all original content and do not delete or use white out. Any correction made should have a single line through what is being corrected and the initials or signature of the person making the corrections as well as the date the correction was made.

#8- SUPPLIER WRITTEN JUSTIFICATION AND THE ATP REQUIREMENT

The supplier ATP evaluation is required by Medicare for certain Group 2 and Group 3 power wheelchairs, ultra lightweight manual wheelchairs and manual tilt in space wheelchairs. Please see the reference chart attached. The intent of this evaluation is to show how the ATP supplier was involved in the direct assessment. This assessment can include measurements of the client and or include a description of the equipment that was provided for a trial, for example.

The documentation must be complete and detailed enough so a third party would be able to understand the nature of the ATP involvement and to show that the Medicare requirements identified in the policy for this documentation was met. Just "signing off" on a form completed by another individual would not adequately document direct, in-person involvement. Also, merely signing a statement such as, "I am a RESNA-certified professional specializing in wheelchairs and had direct, in-person involvement in the wheelchair selection for this client" does not sufficiently verify that this policy requirement was met. Finally, a home assessment completed by a supplier-employed ATP would not meet the ATP requirement unless the documentation showed how the ATP applied the assessments and measurements to the wheelchair selection process.

The therapist is responsible for writing the medical necessity for the mobility base and accessories requested. The supplier can write which accessories will be needed to have the equipment function to meet the medical needs identified in the mat assessment or technology evaluation, but the supplier cannot write the justification for the accessories and then have the therapist agree and sign the document. This will be considered invalid.

The requirement for the supplier to employ an ATP and for this person to have direct, in-person involvement in the wheelchair selection process is not waived if the specialty exam is performed by a clinical ATP. The person performing the specialty exam cannot work for the supplier and the person involved in the ATP in-person appraisal must have a financial relationship with the supplier. Therefore, one individual cannot meet both requirements.

Getting the documentation requirements correct, accurate and in line with the Medicare or funding source requirements will result, in theory, in fewer denials and faster delivery to your beneficiaries. If the team – therapists, supplier and physician – understand what is required, addendums and corrections can be minimized as well. Isn't that something we all should strive for?

HELPFUL LINKS AND RESOURCES:

https://www.cgsmedicare.com/
https://med.noridianmedicare.com/
https://www.cms.gov/medicare/medicare-contracting/contractorlearningresources/downloads/ja6698.pdf

---

CONTACT THE AUTHOR
Kay may be reached at
KKOTRCHOA@YAHOO.COM

Kay Ellen Koch, OTR/L, ATP, has more than 36 years seating and wheeled mobility experience. She is a graduate of the Occupational Therapy program at the Ohio State University in Columbus, Ohio. She has been an Assistive Technology Professional (ATP) since 1996. Her focus has been on pediatric seating positioning, wheeled mobility, assistive technology solutions and accreditation. Koch has spent her years as an occupational therapist in various roles, from clinician to manufacturer's representative. She has presented at various national and international conferences and webinars.