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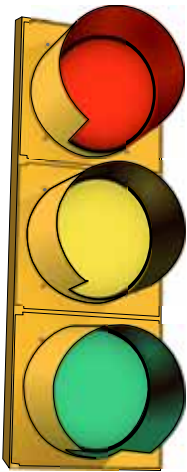
Medlearn Matters Number: MM3791

An Algorithmic Approach to Determine if Mobility Assistive Equipment Is Reasonable and Necessary for Medicare Beneficiaries with a Personal Mobility Deficit (CR 3791 - Mobility Assistive Equipment (MAE))

Provider Types Affected

Providers billing Medicare Durable Medical Equipment Regional Carriers (DMERCs) and/or Fiscal Intermediaries (FIs) for MAE

Provider Action Needed



STOP – Impact to You

This article includes information from Change Request (CR) 3791, in which the Centers for Medicare and Medicaid Services (CMS) addresses numerous items that it has termed Mobility Assistive Equipment (MAE).

CAUTION – What You Need to Know

MAE includes (but is not limited to) canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters. CMS determines that 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 such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. Determination of the presence of a mobility deficit will be made by an algorithmic process (as outlined in the Clinical Criteria for MAE Coverage included in this article) to provide the appropriate MAE to correct the mobility deficit.

GO – What You Need to Do

You should sequentially consider specific questions in CR 3791 that provide clinical guidance for the coverage of equipment (of appropriate type and complexity) to restore the beneficiary's ability to participate in Mobility-Related Activities of Daily Living (MRADLs) (toileting, feeding, dressing, grooming, bathing, etc.) in customary locations in the home. These questions correspond to the numbered decision points on the Clinical Criteria for MAE Coverage flow chart in CR3791. That chart is also included in this article.

Background

Recently, considerable public interest has been focused on the provision of wheelchairs under the Medicare benefit. The agency has responded with a multi-faceted plan to ensure the appropriate

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prescription of wheelchairs to beneficiaries who need them. One facet of this plan is the delineation of suggested clinical conditions of wheelchair coverage. The Centers for Medicare & Medicaid Services (CMS) solicited public comment through a number of open door forums and other methods. Many advocacy groups suggested that the agency adopt a function-based interpretation of its historical “bed or chair confined” criterion for wheelchair coverage.

CMS believes that an algorithmic process that sequentially considers the appropriate “Mobility Assistive Equipment” (MAE) that corrects the mobility deficit is the appropriate process to follow in covering MAEs. CMS believes that the Clinical Criteria for MAE Coverage, in Section 280.3, Chapter 1, of Medicare Publication 100-03 (Medicare National Coverage Determinations), sufficiently describes this process. Utilizing such a process will ensure that the beneficiary (or caregiver) is able to maintain as much independence as physically and mentally possible, thereby ensuring the beneficiary’s Mobility-Related Activities of Daily Living (MRADLs) are maintained.

CMS is extending national coverage regarding MAE for beneficiaries who have a personal mobility deficit sufficient to impair their participation in MRADLs such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. Determination of the presence of a mobility deficit will be made by an algorithmic process, as outlined in the Clinical Criteria for MAE Coverage, to provide the appropriate MAE to correct the mobility deficit. MAE includes, but is not limited to, canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters.

CR 3791 instructs Medicare carriers, DMERCs, and RHHIs to:

- Disregard the “bed- or chair- confined” criterion which has been historically used to determine if a wheelchair is reasonable and necessary as defined by the Social Security Act (Section 1862(A)(1)(a)).
- Use the algorithmic approach as outlined in the Medicare National Coverage Determinations Manual (Pub. 100-03, Section 280.3), Clinical Criteria for MAE Coverage (and included below) to determine coverage eligibility of MAE. MAE includes, but is not limited to, canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters.

As in other cases, if data analysis indicates potentially aberrant billing, Medicare DMERCs and FIs will use these standards when performing medical review of claims.

Medicare beneficiaries may require mobility assistance for a variety of reasons and for varying durations because the etiology of the disability may be due to a congenital cause, injury, or disease. Thus, some beneficiaries experiencing temporary disability may need mobility assistance on a short-term basis, while in contrast, those living with chronic conditions or enduring disabilities will require mobility assistance on a permanent basis.

In addition, Medicare beneficiaries who depend upon mobility assistance are found in varied living situations. Some may live alone and independently while others may live with a caregiver or in a care facility. The beneficiary’s environment is relevant to the determination of the appropriate form of mobility assistance that should be employed.

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For many patients, a device of some sort is compensation for the mobility deficit. However, some beneficiaries experience co-morbid conditions that can impact their ability to safely utilize MAE independently or to successfully regain independent function even with mobility assistance.

The functional limitation (as experienced by a beneficiary) depends on:

- The beneficiary's physical and psychological function,
- The availability of other support, and
- The beneficiary's living environment.

A few examples include muscular spasticity, cognitive deficits, the availability of a caregiver, and the physical layout, surfaces, and obstacles that exist in the beneficiary's living environment.

Nationally Covered Indications

Effective May 5, 2005, CMS finds that the evidence is adequate to determine that MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their performance of Mobility-Related Activities of Daily Living (MRADL) such as toileting, feeding, dressing, grooming, and bathing in customary areas in the home. **Determination of the presence of a mobility deficit will be made by an algorithmic process, Clinical Criteria for MAE Coverage, to provide the appropriate MAE to correct the mobility deficit.**

Clinical Criteria for MAE Coverage

The beneficiary, the beneficiary's family or other caregiver, or a clinician, will usually initiate the discussion and consideration of MAE use. **Sequential consideration of the questions below provides clinical guidance for the coverage of equipment of appropriate type and complexity to restore the beneficiary's ability to participate in MRADLs such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.** These questions correspond to the numbered decision points on the accompanying flow chart.

1. Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs in the home? A mobility limitation is one that:
 - a. Prevents the beneficiary from accomplishing the MRADLs entirely, or,
 - b. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to participate in MRADLs, or,
 - c. Prevents the beneficiary from completing the MRADLs within a reasonable time frame.
2. Are there other conditions that limit the beneficiary's ability to participate in MRADLs at home?
 - a. Some examples are significant impairment of cognition or judgment and/or vision.
 - b. For these beneficiaries, the provision of MAE might not enable them to participate in MRADLs if the comorbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with MAE.

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3. If these other 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?
 - a. A caregiver, for example a family member, may be compensatory, if consistently available in the beneficiary's home and willing and able to safely operate and transfer the beneficiary to and from the wheelchair and to transport the beneficiary using the wheelchair. The caregiver's need to use a wheelchair to assist the beneficiary in the MRADLs is to be considered in this determination.
 - b. If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of wheelchair coverage if it results in the beneficiary continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of MAE.
4. Does the beneficiary or caregiver demonstrate the capability and the willingness to consistently operate the MAE safely?
 - a. Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.
 - b. A history of unsafe behavior in other venues may be considered.
5. Can the functional mobility deficit be sufficiently resolved by the prescription of a cane or walker?
 - a. The cane or walker should be appropriately fitted to the beneficiary for this evaluation.
 - b. Assess the beneficiary's ability to safely use a cane or walker.
6. Does the beneficiary's typical environment support the use of wheelchairs including scooters/power-operated vehicles (POVs)?
 - a. Determine whether the beneficiary's environment will support the use of these types of MAE.
 - b. Keep in mind such factors as physical layout, surfaces, and obstacles, which may render MAE unusable in the beneficiary's home.
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 optimally configured (seating options, wheelbase, device weight, and other appropriate accessories) for this determination.
 - a. Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.
 - b. A beneficiary with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, i.e. light weight, etc., should be determined based on the beneficiary's physical characteristics and anticipated intensity of use.

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- c. The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.
- d. Assess the beneficiary's ability to safely use a manual wheelchair.

(Note: If the beneficiary is unable to self-propel a manual wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair may be appropriate.)

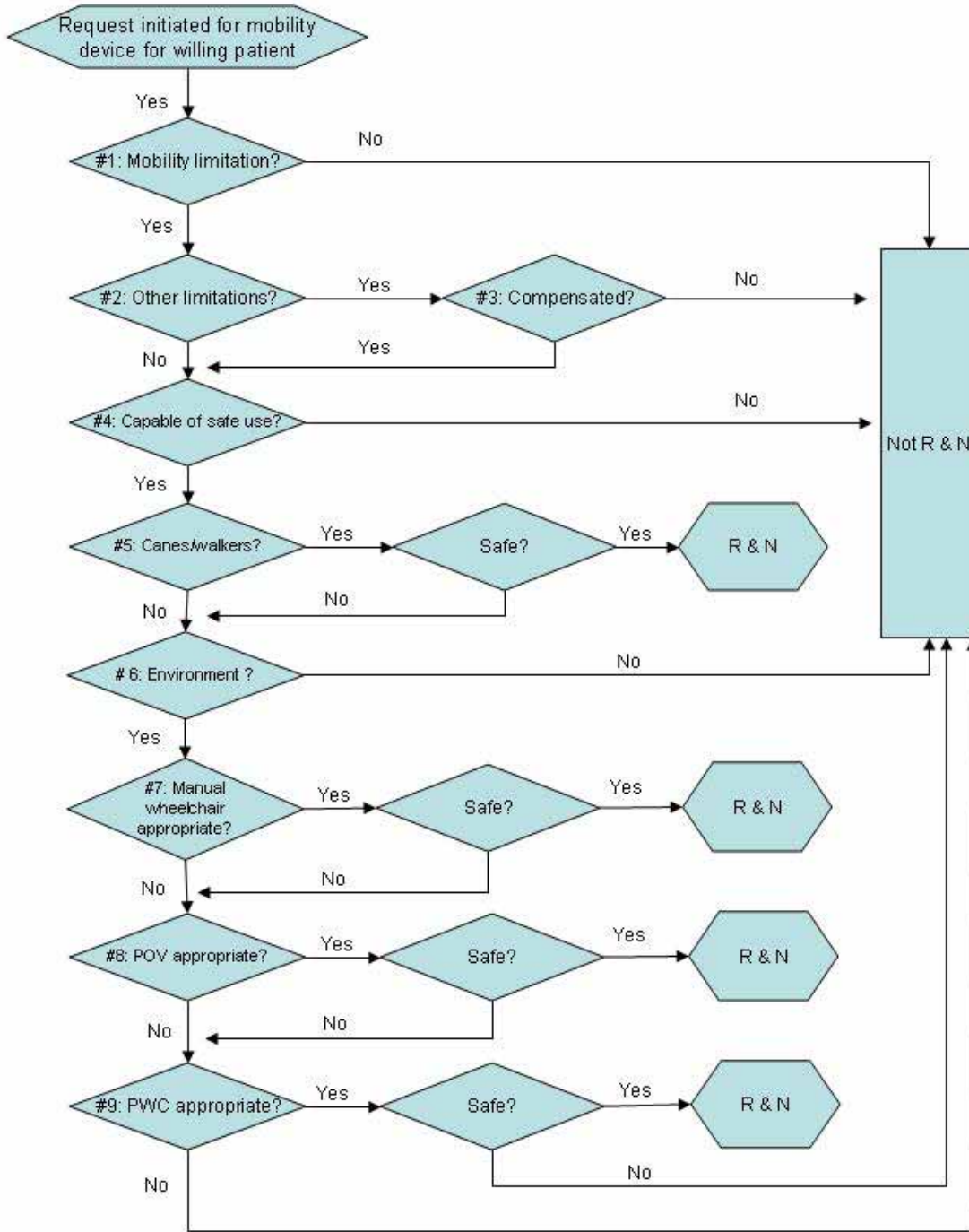
- 8. Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?
 - a. A POV is a 3- or 4-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation.
 - b. The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a POV.
 - c. Assess the beneficiary's ability to safely use a POV/scooter.
- 9. Are the additional features provided by a power wheelchair needed to allow the beneficiary to participate in one or more MRADLs?
 - a. The pertinent features of a power wheelchair compared to a POV are typically control by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.
 - b. The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.
 - c. The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a power wheelchair.
 - d. Assess the beneficiary's ability to safely use a power wheelchair.

Note: If the beneficiary is unable to use a power wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair is appropriate. A caregiver's inability to operate a manual wheelchair can be considered in covering a power wheelchair so that the caregiver can assist the beneficiary.

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Clinical Criteria for MAE Coverage



policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of, or limit the effect of, regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Nationally Non-Covered Indications

Medicare beneficiaries not meeting the clinical criteria for prescribing MAE as outlined above, and as determined by the beneficiary's physician, would not be eligible for Medicare coverage of the MAE.

Note: All other Durable Medical Equipment (DME) not meeting the definition of MAE as described in this instruction will continue to be covered, or noncovered, as is currently described in the NCD Manual at section 280, Medical and Surgical Supplies.

Also note that CR 3791 revises the Medicare National Coverage Determinations Manual (Pub. 100-03, Section 280.3), and this revision is a National Coverage Determination (NCD) made under the Social Security Act (section 1862(a)(1)).

NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (see the Code of Federal Regulations (CRF), Title 42, Sections 405.732, 405.860). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an administrative law judge may not review an NCD. (See the Social Security Act (Section 1869(f)(1)(A)(i).)

Implementation

The implementation date for this instruction is July 5, 2005. Your DMERC or FI will adjust claims affected by this change, but processed before July 5, 2005, if you bring such claims to the attention of the DMERC/FI.

Additional Information

For complete details, please see the official instruction issued to your DMERC or FI regarding this change. That instruction includes the complete section 280.3 and the instruction may be viewed by going to:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3791 in the CR NUM column on the right, and click on the files for that CR. You will note two files for CR 3791. The file reflecting transmittal number 37 contains the revisions to the Medicare National Coverage Determinations Manual and the file with transmittal number 574 contains the Medicare claims processing business requirements/instructions.

If you have any questions, please contact your DMERC/FI at their toll-free number, which may be found at

<http://www.cms.hhs.gov/medlearn/tollnums.asp>

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