Recorded Webinar: Manual Wheelchairs

Contract	DME MAC Jurisdictions B & C
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Good morning, everyone. My name is Sarah Barbian. I'm with the Provider Outreach and Education Department here at CGS and welcome to our webinar for manual wheelchairs.

This is our disclaimer slide; it's in all of our presentation, so you may be familiar with it if you've attended any of other webinars. Medicare changes frequently and this slide is just a reminder that the information presented today was current and accurate at the time it was created. However, it's ultimately your responsibility to say up to date on Medicare rules and regulations, like going after our website on a regular basis. Also, make sure you sign up for our email list to keep informed of any news and updates. And just as a reminder, recording of any portion of this presentation or CGS educational events is not allowed. However, CGS may record webinars for future education purposes.

This is our agenda for today. We'll talk about basic coverage criteria for all manual wheelchairs and then we have additional coverage criteria related to specific manual wheelchair codes. We'll talk about documentation requirements, billing and coding, the Advanced Determination of Medicare Coverage, ADMC, voluntary program. We'll talk about the Comprehensive Error Rate Testing, CERT program. And then we have some helpful resources for you, and we'll have time for a question-and-answer period.

So, starting with the basic coverage criteria. All manual wheelchairs must meet this basic coverage criteria and this information is straight out of the Local Coverage Determination. For a manual wheelchair to be covered by Medicare, it must be primarily used for inside the home and must meet criterion A, B, C, D, and E and either F or G. Additional criteria applies to the HCPCS codes that you see on the slide and HCPCS, if you're not aware, that stands for Healthcare Common Procedure Coding System codes, HCPCS codes.

So that's look at the criteria the beneficiary must meet. Let's start with A. The beneficiary has a mobility limitation that significantly impairs his or her ability to participate in one or more mobility related activities of daily living. We call that MRADLs, since that is a mouthful, in the home. Some examples of those MRADLs are toileting, feeding, dressing, grooming, and bathing in those customary locations in the home.

Then we have B, the beneficiary's mobility limitation cannot sufficiently be resolved by use of an appropriately fitted cane or walker. Can a cane or walker resolve that beneficiary's mobility limitation? Maybe the beneficiary doesn't have the strength to stand that long. Medical records must show that limitation, that the ability to perform those MRADs can't be accomplished with a cane or walker; those must be ruled out.

And we have C, the beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of that manual wheelchair that is provided. The beneficiary must

be able to use their wheelchair throughout the home, basically through those home doorways, over that carpet or wood floor, whatever that surface may be. And this is accomplished, C is accomplished, through the home assessment and we'll discuss that under the documentation.

Then we have D, use of that manual wheelchair significantly improves the beneficiary's ability to participate in those MRADLs. And the beneficiary will use that wheelchair on a regular basis home. So basically, without that wheelchair, the beneficiary cannot perform those MRADLs at all or in a timely manner inside that home. Documentation should show this.

Then we have E, the beneficiary has not expressed an unwillingness to use the manual wheelchair that's provided in the home. If medical records say the beneficiary doesn't want to use the manual wheelchair, then obviously Medicare won't cover it.

As we reviewed previously, A, B, C, D, and E must be met. In addition, either F or G must be met.

So first we have F. The beneficiary has upper strength to maneuver the wheelchair and they are cognitive; they understand what is going on. They can self-propel the manual wheelchair within the home to perform those daily living tasks. If beneficiary can't self-propel themselves, they don't meet F, then they would have to meet G. If the beneficiary can't propel that wheelchair in their home, maybe they don't have the upper strength, then they have a caregiver who's available, willing, and able to provide assistance with that wheelchair.

Here's some examples listed on this slide, what we are looking for in medical records. For example, maybe the beneficiary doesn't again have that upper extremity strength, or they're missing the upper limb and cannot propel that wheelchair on their own. F for G should be documented.

If the beneficiary needs criteria G, you want to have information regarding that caregiver and their availability in medical records. We recommend obtaining your documentation upfront. Medicare doesn't require you to obtain medical records up front, just the order. But you have to have those medical records provided in an audit request. One of the top errors that we see in medical review is that the medical records are actually missing information to meet criteria F or G. So, when you're reviewing records, make sure criteria F or G are met.

This information is from the LCD and Policy Article. If the manual wheelchair will be used inside the home and coverage criteria is not met, that wheelchair will be denied as not reasonable and necessary. Reasonable and necessary denials hold the supplier financially responsible unless you obtain a valid Advanced Beneficiary Notice of Noncoverage.

If the manual wheelchair will only be used outside the home, that will deny as non-covered, no benefit, and non-covered automatically provides a patient responsibility denial. That doesn't mean the beneficiary may not take the wheelchair outside the home; maybe they're taking it to go to a doctor's appointment, for example, transporting that in their vehicle, that's still acceptable. We, Medicare, just won't pay if the manual chair is only for use outside the home. If the manual wheelchair base is not covered, related accessories will deny is not reasonable and necessary. Basically, Medicare won't pay for accessories for a wheelchair if they don't pay for the base itself.

The wheelchair base, your K0001, is your standard wheelchair. However, there are other wheelchairs that have additional criteria. All the wheelchairs in the section must meet that basic criterion we just discussed in addition to this other criterion.

A transport chair will be covered as an alternative to the standard manual wheelchair if that general coverage criteria are met, A through E and G are meant. The transport chairs are designed for a caregiver to actually transport the beneficiary. And this is why criteria G must be met.

The beneficiary must have a caregiver who can provide assistance with that wheelchair because again, that beneficiary can't self-propel that wheelchair on their own. If this happens to be the case, the medical record should specify that the beneficiary has a caregiver who is able to provide assistance and willing to transport with that transport chair. The medical records should also indicate why that beneficiary cannot use a manual wheelchair, basic K1 through K5 on their own.

A standard hemi wheelchair, that's your K0002, it's covered when the beneficiary requires a lower seat height than 17 to 18 inches because of short stature or to enable the beneficiary to place his or her feet on the ground to propel. They'll be using their feet, not their hands to propel that wheelchair, so that's where the K0002 comes into place. This is why it's a bit lower. It's still satisfies that criteria F, the beneficiary can still self-propel the wheelchair by themselves, they don't require a caregiver; they're using their feet instead.

Next, we have the lightweight wheelchair, the K0003. It's wider than the other two wheelchairs. And for the K3 to be covered, the beneficiary cannot self-propel in the standard wheelchair in the home. Perhaps a standard wheelchair is too heavy for the beneficiary to self-propel, perhaps the beneficiary does not have enough upper strength to provide that standard wheelchair, but they can self-propel that lightweight wheelchair. This is actually another top error we consistently see in medical records over the different quarters and years. Records do not show the beneficiary meets that additional criterion for the K3.

So, when you're reviewing medical records, make sure you do pay attention to that, to see if the beneficial actually qualifies or not and then you can consider getting an ABN and that's why we do emphasize getting your documentation upfront rather than waiting until you receive an audit. We also have a "Dear Physician" letter for all these manual wheelchairs we're talking about. And you can provide that to practitioners, to make sure they're aware of Medicare coverage criteria before seeing that beneficiary.

We're going to look at a couple of examples now for the K3 to give you a better idea. We actually received these records we are going to review, but of course all private, protected health information was removed. And just keep your mind this is not the entire record; this is just examples of the record.

And this example, medical records mentioned the patient requires a lightweight manual wheelchair to complete those daily activities. Transferring to and from the bed, as you can see, toileting, meal prep. It explains the beneficiary cannot self-propel the standard wheelchair, which is one of the requirements for K3, and the reason why they can't is significant debility and weakness of their upper extremities.

And then it goes on to say they can self-propel the ordered lightweight wheelchair. The medical records also ruled out a walker. And explained why a walker cannot be used to all their mobility issues in a timely manner. They are only able to ambulate 10 feet before needing to rest with that walker due to fatigue and weakness. Also, just to note, 10 feet is objective information. You want to make sure there is some sort of objective information that's specific to the patient and not a cut and paste basically from the LCD.

This is another record that we received. The beneficiary was ordered that K3, that lightweight wheelchair. Although it states the beneficiary has ability to self-propel a lightweight wheelchair, it doesn't say a beneficiary cannot propel the standard wheelchair. Looking at this, you can also see the documentation does not mention at all about the use of a cane or walker. It doesn't mention that there are limitations, that it cannot be resolved by use of that cane or walker. So, these are things just so watch out for when you're reviewing medical records.

Moving on to the K4, that's a high strength lightweight wheelchair. It's again even lighter than the K3. Again, it must meet that general coverage criteria. Medical records should show the beneficiary self-propels that K4 wheelchair while engaging in frequent activities in the home that can't be performed in one of those other wheelchairs we just discussed, the standard or lightweight. Also, it requires the beneficiary needs a seat, width, depth, or height, that cannot be accommodated by the K1, K2, or K3. And they have to spend at least two hours per day in that wheelchair and that should be notated in medical records as well. Which is why it's really important to use these "Dear Physician" letters, make sure the practitioners are educated about what they're ordering for their patients. A high-strength lightweight wheelchair is rarely reasonable and necessary if the expected duration of need is less than three months, for example post-operative recovery.

I'm going to move on to the K5 wheelchair, that's the ultra-lightweight wheelchair. As you can see, we're going for all the lightweight wheelchairs, and this is even lighter than the other ones we discussed.

The K5 is more customizable for each beneficiary. And to qualify, of course, that general criteria must be met. Also, criteria 1 or 2 and 3 must be met. So, either 1; the beneficiary must be at full time wheelchair user or 2; the beneficiary requires individual fitting and adjustments for one or more features that can't be accommodated by the K1 through K4 minimal wheelchair base.

For example, the axel plate on that K5 can be adjusted; it's very customizable to change the center of gravity to increase stability for the beneficiary or maybe accommodate the weight of the beneficiary or decrease upper extremity pain.

Those are just a few examples for you. So, either 1 or 2 must be met. And then the beneficiary must meet 3 and 4.

Criteria 3 is the beneficiary must have a specialty evaluation performed by a License Certified Medical Professional or LCMP. And that could be a physical therapist or occupational therapist or a physician who has specific training and experience in rehab wheelchair evaluations. And they document the medical need for the wheelchair and special features. The LCMP also may not have any financial relationship with the supplier. And in an audit, we would need an attestation that the LCMP had no financial relationship with the supplier.

Lastly, for that wheelchair, it's provided by a Rehabilitative Technology Supplier, RTS, that employs a RESNA-certified Assisted Technology Professional, ATP, lots of acronyms, that specializes in wheelchairs and who has direct in-person involvement in selecting that wheelchair for that patient.

Little bit more about the K5: the medical record should specify the medical necessity for the K5 and its special features. That includes the description of that beneficiary's routine activities that they frequently do, maybe going to the bathroom, preparing food, whatever it may be. Their degree of independence if they're using that K5 wheelchair. And you also need to have a medical record with the description of features of K5 which are needed compared to the K4 wheelchair. Why the K4 wheelchair won't work, but the K5 wheelchair will.

Next, we have the manual wheelchair with a tilt in space, your E1161. This can tilt the frame of a wheelchair greater than or equal to at least 20 degrees horizontal while maintaining the same back to seat angle. In addition to the general coverage criteria for this wheelchair, beneficiaries also must have an LCMP specialty evaluation. Again, that can be physical therapist, occupational therapist, or a physician that has a specific training. And they document the medical need for the wheelchair and the special features. Again, that LCMP cannot have any financial relationship with the supplier. And that wheelchair also must be provided by an RTS supplier that employees a RESNA Certified ATP that specializes in wheelchairs and has direct in person involvement in selecting that wheelchair for the patients.

This reviews a lot of what we just talked about for the K5 and E1161. These are the only two manual wheelchairs that require an ATP and LCMP. So first for these two wheelchairs, the beneficiary must have especially evaluation performed by the LCMP. Again, that can be a physical therapist, occupational therapist, or a practitioner with that specific training. That LCMP documents the need for the beneficiary's wheelchair. Again, it's important to note that LCMP cannot have financial relationship with the supplier. This must be noted in the documentation that there's no financial relationship with the supplier. We often see claims deny for missing this information so make sure you do have that.

Then have the ATP. They must physically see and interact with that beneficiary and document that. The role of that ATP is to ensure the equipment selected is appropriate to address the beneficiary's medical needs that are identified during the practitioner encounter and the LCMPs, specialty evaluation. Basically, beneficiary has the face-to-face or visit with a practitioner, then the LCMP specialty evaluation. And from that information, the ATP selects that wheelchair that best helps that beneficiary. And the record should show how the ATP was involved. This is documenting the special features such as body measurements for proper fit of the wheelchair, trials of the wheelchair, and so on.

Next, we have our heavy duty, the K6, and extra heavy-duty wheelchair the K7. Of course, they need to meet that general coverage criteria. For the K6, the beneficiary must have severe spasticity, or they weigh over 250 pounds. And for the K7 wheelchair, the beneficiary must weigh more than 300 pounds. To justify a heavy duty or extra heavy-duty manual wheelchair, the supplier cannot document the beneficiary's weight as far as an audit goes. The beneficiary's weight must be included in the physician or practitioner's medical documentation; it's important to remember that.

Now we have the K8 wheelchair. This is a custom wheelchair base. These are considered for coverage in addition to the general coverage criteria we just talked about. There must be a need for the K8 that cannot be provided by any of those lower wheelchairs we just covered. The beneficiary's needs cannot be accommodated by any other existing manual wheelchairs and accessories, including customized seating arrangements.

So, it's very unique. It's uniquely constructed or modified for a specific beneficiary according to the treating practitioner's description and orders. And it's so different from any other item used for the same purpose that the two cannot be put together for pricing purposes. Since it's a custom manual wheelchair, a lot of work goes into the custom manual wheelchair, it's going to be typically more expensive. It's not reasonable and necessary if the expected duration of the need is less than three months. If the K8 is used to describe a prefabricated manual wheelchair, even one that has then modified, the claim will be denied for incorrect coding. It's a customized wheelchair, customized to that beneficiary.

Here's a little bit more information regarding the K8, the customized manual wheelchair base. Payment for the K8 will be on a lump sum payment based on individual consideration. Documentation must include, again, a description of the beneficiary's unique physical and functional characteristics that require a customized manual wheelchair base. If documentation is requested, auditors must be able to determine that wheelchair delivered is a customized item, it's a one-of-a-kind item, fabricated to meet the beneficiary's unique physical and functional needs and those needs cannot be met using another manual wheelchair base; that does need to be ruled out in medical records.

Your responsibility here for the K8 as a supplier is that you must provide information as of why the item is customized. This would include written documentation of the item's costs, design, fabrication, assembly, cost. And labor costs; time it took to make that wheelchair customized. What types of materials were used in fabricating and constructing that custom item? The MAC may require a step-by-step description of the construction process and labor skills needed to make this customized.

Last but not least, before we go into documentation requirements, is a K9; that is another manual wheelchair base. The K9 must have a written coding verification review made by PDAC contractor and listed on the product classification list. The link to their website is listed on the slide and then is under resources as well. If you bill a K9 but that product is not on the PDAC's product classification list, that claim will deny for incorrect coding. When billing the E13, excuse me, when billing the K0009, make sure you check that item at PDAC. And if anyone during the question-and-answer session has questions about PDAC website.

Next, we're going to look at documentation requirements. This information is in the Standard Documentation Requirements for All Claims Submitted to the DME MAC. If you've never seen this article, make sure you go out and look at it or if you just need a refresher. It has a lot of valuable information that applies. You can locate it via the link on the slide or you can go out to our website under LCDs.

First, documentation should include information regarding the medical necessity of the item as well as the beneficiary's diagnosis that contributes to the need for that manual wheelchair. This is their diagnosis of their mobility limitation. Maybe they have ALS, whatever that may be. Medical records should also include the beneficiary's abilities and limitations. How long their condition has existed?

Expected prognosis. And past experiences using similar equipment and, that's only if applicable.

Many rental items require documentation of continued use and need. For wheelchairs, continued use and need can only be met through medical records. Medical records should show the beneficiary's need and use of the wheelchair in the last preceding 12 months of the date service in question. For example, if you're billing for a capped rental item for 13 rental months, you have that initial need documentation that typically lasts for those 12 months. But if that 13th month is audited, auditors will be looking for medical records in the last 12 months from that 13th month.

You also have to have a standard written order for all claims submitted to Medicare for payment consideration. Let's look at what the standard written order entails.

It must contain the beneficiary's name or their Medicare Beneficiary Identifier, MBI. And the order date. And the order date is typically when the order is first communicated to the supplier. It also requires a general description of the item. For example, it could be the HCPCS code, HCPCS code narrative, or brand name or model number. We see sometimes manual wheelchair or maybe the K0001. It also needs quantity to be dispensed, if applicable. Medicare assumes you are only providing one wheelchair so quantity would not be required for a single manual wheelchair.

The standard written order must have the treating practitioner's name or their National Provider Identifier, NPI. And then the treating practitioner must sign the Standard Written Order. We do sometimes see errors in the Standard Written Order so when you do receive a standard order, make sure that you evaluate it, that it has everything necessary. A supplier actually can create a standard written order and send it to the practitioner to sign. Of course, a supplier cannot sign the practitioner's signature; that must be the treating practitioner themselves. Before submitting a claim to Medicare, you must have a standard written order on file.

You also must have proof of delivery to show the beneficiary received the item you're billing Medicare for. Medicare wants to know that the beneficiary received whatever they're paying for.

For manual wheelchairs, proof of delivery is Method 1; that's direct delivery. And direct delivery to the beneficiary is when the supplier delivers a wheelchair to the beneficiary via a company vehicle or a personal vehicle. Or the beneficiary comes and picks it up at your store front. Regardless,

the proof of delivery should include what you see here: beneficiary's name, and the delivery address, the date the manual wheelchair was delivered to the beneficiary, the quantity delivered, a description of the item being delivered. And again, there's variance here; narrative description, you know, wheelchair, brand name, model number, HCPCS code K0003, for example. Or a long HCPCS code description.

And then it does require the beneficiary, or it could be their designee, to sign that proof of delivery. You notice the beneficiary does not need to date the proof of delivery; they just need to sign it. And the date of service, when you bill a claim, is the date that the beneficiary received that wheelchair, that you delivered it to that beneficiary. So, if you deliver that wheelchair today, on September 6th, that would be your date of service.

The home assessment is required. The beneficiary must be able to use the wheelchair in their home to perform those daily living activities and documentation must show that. And there's adequate access between rooms, maneuvering space, and surfaces for use of the chair that's provided.

The home assessment should address things like physical layout of the home, measurements of door frames. It should include surfaces to be traversed, such as wood floor, carpet; make sure they can use that wheelchair over that carpet and so on. And if there's any obstacles to maneuvering within the home.

For example, if the beneficiary can't fit the wheelchair through any of the doorways, that's a big issue because the beneficiary must be able to use a wheelchair in the home to perform daily activities.

But when it comes to the home assessment, that can be documented itself in the medical record or elsewhere by the supplier. If a home assessment is completed indirectly, such as you have a conversation with the beneficiary, they give you the measurements of the doorframes, then the supplier must verify the item meets requirements when they actually deliver that wheelchair.

This is a great example of a home assessment. Suppliers do have various templates for a home assessment. Or whoever is doing that home assessment. Medicare does not have a template for a home assessment. This just gives you a great idea of what Medicare is looking for.

And as you can see in this example, it shows that the beneficiary can navigate through the home. Let's pause a minute to let you look at that.

Now let's talk about billing and coding in relation to manual wheelchairs. A complete manual wheelchair includes all the items listed here. It's important to note that these items that are listed here are not separately payable at the time of the initial issue of the wheelchair.

For example, Medicare won't pay for brakes when you provide that manual wheelchair, it already includes those brakes. However, they are separately billable, some wheelchair accessories, at the time of issue of the wheelchair. And that information can be found in the wheelchair accessories, LCD, and Policy Article. So, there may be some other accessories that wheelchair uses needs beyond what's included in the manual wheelchair base.

When you bill, there are modifiers that you must use related to manual wheelchairs. A lot of you may be familiar with these modifiers, some may not.

First, we have the KX modifier. If the beneficiary meets requirements in a manual wheelchair LCD, you need to append the KX modifier.

If the beneficiary does not qualify for a manual wheelchair LCD, if those requirements have not been met, and you have a valid Advanced Beneficiary Notice of Noncoverage, ABN on file, you use the GA modifier. ABNs are issued to transfer financial liability to the beneficiary when they do not meet that reasonable and necessary coverage criterion in the LCD.

Then we have the GZ. This is similar to the GA because the requirements in the manual wheelchair LCD have not been met. But you have no ABN on file.

Then you have the GY modifier. You use a GY modifier if that manual wheelchair is statutorily excluded. You expect it to deny as non-covered and non-covered language can be found in the Policy Article for manual wheelchairs. And there's an example here. If a wheelchair is only to be used for mobility outside the home, the GY modifier should be appended to the code because per the Policy Article, if a wheelchair is only used outside the home, it will deny as non-covered, no benefit. You should have a standard written order on file. But if for some reason you do not, you cannot obtain a valid standard written order, you would use the EY modifier.

If you bill a claim without a KX, GA, GY, or GZ modifier, that claim will be returned as missing information and it must be resubmitted.

This is a handy chart that can assist you with the appropriate modifiers to use when billing wheelchairs. I won't read this whole chart off to you, but it's there if you need it. You can see the fee schedule category; most are capped rental items except for the K5 and the K8. And then it lists the pricing modifiers. And the rental month modifiers which are only applicable for capped rental items. And then it gives you examples of how those would be billed.

Also, you can always refer to our Advanced Modifier Engine, AME tool, that will show you exactly what modifiers to use based on the HCPCS code and scenario or scenarios that you select. If you're ever confused about the use of modifiers, I highly recommend using AME to verify that you have correct modifiers. Maybe your claim denied for missing a modifier or maybe you just don't know what modifiers to use before submitting the claim, go out to AME. It's going to be very helpful for you.

Let's talk about repairs and replacements. Medicare will only pay for one wheelchair at a time. If you bill a backup chair, that will deny as not reasonable and necessary. In that case you do want to consider obtaining an ABN to hold the beneficiary liable.

If you're repairing a beneficiary-owned wheelchair, Medicare will cover one month rental for a standard wheelchair. If you're billing temporary replacement chair, that should be coded as a K0462. And you'll receive the payment for that standard manual wheelchair while the other wheelchair is being repaired.

But if you are billing that temporary replacement as a K0462 for that one month, it should include everything that you see listed here; HCPCS code of the item you're repairing, for example a K2; it should include the K0002, or it could be the manufacturer name and brand model of equipment being repaired. And you do need the date of purchase, at least the month and year.

You need to include what the replacement equipment is for that month, including the manufacturer and brand name model number, a description of what's being repaired, and a description of why it took more than one day to complete. That's important to know.

Medicare only pays for repairs up to the cost of replacing an item. Replacement of the entire wheelchair due to wear is not covered during the reasonable useful lifetime of equipment, which is 5 years for a new wheelchair. And if you're replacing a specific part of the wheelchair, but not that entire base equipment, this is considered a repair and you can use the RB modifier on the claim. Again, the AME, the Advanced Modifier Engine, will assist you if you happen to be repairing an accessory and using the RB modifier. You can find out more information in our Supplier Manual about repairs and replacements. That's Chapter 5, Section 9.

Now we're going to talk about CERT, Comprehensive Error Rate Testing.

CMS established CERT to measure the error rate for Medicare Fee-for-Service payments. What CERT does is select a random sample of claims for review and asks the supplier for supporting documentation. The error rate measures payments that don't meet Medicare requirements. In this case, CERT is not only auditing suppliers, but they're also auditing CGS to ensure we processed your claim correctly.

There is a link on your slide. This link is to this CERT 2022 report if you are interested in reviewing that. We'll just go over a few highlights. The CERT error rate for DMEPOS is still pretty high when compared to all the other improper payment rates. We are at 25.2% compared to the other areas of Medicare. So, we all need to work together to reduce this improper payment rate and protect the Medicare funds.

The CERT report found that manual wheelchairs are in the top 20 highest improper payment services for DEMPOS, that's Durable Medical Equipment, Prosthetics, Orthotics, and Supplies. Out of 245 claims reviewed, there was almost 41% improper payment rate, which is really high. We would like to see it much less. This chart just shows you how manual wheelchairs compare to other top 20 service types. The manual wheelchairs are in that orangish red color. The highest error, as you can see, is insufficient documentation. That could be an error in the standard written order, incomplete proof of delivery, and so on.

These are the top trends we're seeing in CERT. There was inadequate documentation to support coverage criteria was met. There was missing documentation to support those MRADLs cannot sufficiently be resolved by a cane or walker. Make sure the cane or walker is ruled out. There was missing documentation to support the beneficiary can't self-propel the standard wheelchair but can propel that lightweight wheelchair. There was missing home assessments, missing medical

records. And the NPI on the claim wasn't the same as the ordering referring physician. So, when you go bill a claim, make sure you look at the standard written order. And whoever signed that standard written order, their NPI must be on the claim.

There are five ways to respond to a CERT request. You'll receive a letter notifying you that you are requesting to send documentation to CERT. You can respond by fax, mail, esMD, and encrypted CD or encrypted email. So, you really want to make sure you don't miss the deadline. They will contact you not only by letter, but if they don't hear from you in a certain amount of time, they're going to follow up with a phone call, another letter, maybe another phone call. CERT really tries to give you the chance to respond. On the 76th day, which is a lot of time to get your documentation in, but on the 76th day, if they don't receive response, CERT counts that as an error.

This is a copy of the CERT documentation letter request and envelope. Make sure that whoever collects your mail is aware of what this envelope looks like and what that letter looks like so they can get it to the correct area. The letter contains information about what documentation you need to submit, about the deadline, when you need to submit it by, why it was selected. It also will have information about how to respond to CERT.

Empower AI Incorporated is the CERT documentation center. And here I have listed the CERT resources in contact information should you need them. They have a wonderful website. It's very thorough if you would ever want to go out to look at that.

We have a few CERT reminders I'd like to talk about. I know you've heard me say this throughout the webinar today, but make sure you implement a thorough intake procedure, it starts when that beneficiary walks into your door. Try to get all that documentation upfront to ensure the documentation requirements are met.

Make sure you respond to CERT within the requested timeframe. And that is to avoid recruitment of payment. If you don't respond within that timeframe, CERT let the MAC or CGS know, and we will have to recoup your payment.

When responding to CERT, use the barcode cover sheets as a cover letter; that will be in the letter that's sent. If CERT finds errors in your documentation and you disagree with that documentation, make sure you file an appeal with CGS, not CERT, because sometimes people accidentally do that. And that would be the Redetermination request.

We also have a dedicated web page for Jurisdiction B and C and a CERT Claim Identifier tool. CERT doesn't send a notification letter with the findings to suppliers, but you can use our

CID claim tool using that 7-digit CID number. It is listed on the letter.

Now we're going talk about this wonderful program that we offer, Advanced Determination of Medicare Coverage, ADMC, for short. Many suppliers find this program helpful; it's voluntary, it's not mandatory. This will allow suppliers and beneficiaries to request prior approval of eligible items before actually delivering that item to the beneficiary.

You can see the eligible items when it pertains to the wheelchairs listed here. If you do receive approval, that approval only applies to medical necessity of the item. It does not guarantee the claim will be paid. For instance, maybe the ADMC is approved. But when you submit that claim, the claim denies because the beneficiary does not have Medicare on that date service or maybe they're in a skilled nursing facility on that date service. But if you're unsure if documentation meets Medicare requirements, just not quite sure, or maybe you think your documentation does meet Medicare requirements. Either way, you can submit ADMC to be certain. Or maybe the beneficiary or physician wants in writing; if you don't think that documentation meets Medicare coverage guidelines, you can submit an ADMC.

This is a list of the ADMC resources. And just to hint, when you're on our website, if you don't know where something is and maybe you don't want to go back to this webinar to find ADMC resources, just type a key word in the search engine on our website and you'll find those resources.

This slide shows various submission methods for ADMCs for both Jurisdiction B and C. You can use the myCGS Web Portal; this is a little image of how that my CGS web portal works. Mail or fax, of course. myCGS Web Portal is going be your fastest method; it is free, but there is a registration process.

If you submit an ADMC, CGS will review your ADMC within 30 calendar days and make that decision. You'll receive a written confirmation. You can also verify that status on the myCGS Web Portal. If you're using the myCGS Web Portal, the ADMC form is already built in.

But if you're using mail or fax, make sure your request specifies ADMC. We have suggested forms that we suggest you use as a cover sheet before all documentation to help your documentation go to the correct area, so our system does recognize that.

Another thing I want to mention is that if you receive an affirmative ADMC, that's only valid for items delivered within 6 months following the date of the determination. If you don't deliver that wheelchair within that timeframe, you can submit a new ADMC request prior to providing the item. Or you don't send a new ADMC request and just file the claim. Keep in mind there are also no appeal rights on ADMC decisions. However, a claim can be appealed after it is processed.

Next, we are going to look at some helpful resources for you. We have Local Coverage Determinations and Policy Articles. I strongly recommend you review those for the manual wheelchair.

We have documentation checklists. There are checklists that we have for manual wheelchairs. Basically, a checklist so you can mark off things to make sure you have everything.

We have "Dear Physician" letters that I mentioned earlier for manual wheelchairs. There are publications which includes our news and our DME Supplier Manual.

We have dedicated web pages for COVID-19 information and that Public Health Emergency has ended as a May 11,2023. And then we have a tool, Specialty Evaluation for Wheelchairs Look-up tool. Basically, you put in a HCPCS code, and it tells you if a specialty evaluation is required or not.

We also have another program. It's a little quicker than ADMC. It's called CGS Connect. It doesn't grant approval like ADMC does. However, the program allows you to submit your documentation to the medical review staff for certain wheelchairs, the K1 through the K4.

If you're hesitant about reviewing documentation, if you're new to documentation, maybe again, the beneficiary doesn't believe you that you say the documentation does not meet requirements, this is a good method to use. You'll receive educational feedback once your documentation is reviewed. It provides you with a higher assurance that your documentation meets Medicare requirements or maybe it doesn't. But it never guarantees payment, and this does not exempt you unfortunately from the audit process.

These are Jurisdiction B resources. We have more listed on our website. But these are the most common resources that we have. It makes a nice reference if you need to refer to that.

Next, we have our Jurisdiction C resources. Just make sure that you contact the correct jurisdiction to prevent any delays because CGS does have two different contracts. And often times, phone numbers, addresses, and fax numbers do differ between those two jurisdictions.

These are some other contractor resources. We mentioned PDAC earlier, Pricing Data Analysis and Coding. But if you need help with PDAC, if you have an item, you're not sure that HCPCS code, you can contact PDAC. Common Electronic Data Interchange or CEDI; they assist with free low-cost software and electronic front end claim rejection reports.

Lastly, we have the National Provider Enrollment, NPE. They are responsible for issuing or revoking Medicare supplier billing privileges for suppliers. If you have questions about enrollment or if you have any changes to your enrollment, contact the NPE. If you're east of the Mississippi River, you would contact Novitas Solutions. If your supplier is located west of the Mississippi River, you would contact Palmetto GBA.

This slide is to stress the importance of signing up for the Jurisdiction B and C electronic mailing list. These are emails. It's the quickest way for us at CGS to communicate updates about the Medicare program to the supplier community. It's a free service where we send emails directly to you, notifying you of any changes, upcoming education, and other such relevant information. I'm signed up for both Jurisdiction B and C. This slide provides details on how to sign up. If you have not already, I highly recommend you do so. It takes no time at all.

This concludes the recording of today's webinar.

