ADMINISTRATIVE POLICY STATEMENT
OHIO MYCARE

Policy Name		Policy Number	Date Effective
Custom and Power Wheelchairs		AD-0845	02/01/2021-07/31/2023
Policy Type			
Medical	**ADMINISTRATIVE**	Pharmacy	Reimbursement

Administrative Policy Statements prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

Administrative Policy Statement 1
A. Subject 2
B. Background 2
C. Definitions 3
D. Policy 3
E. Conditions of Coverage 4
F. Related Policies/Rules 4
G. Review/Revision History 4
H. References 5

A. Subject

Custom and Power Wheelchairs

B. Background

A nursing home qualifies as a beneficiary's home only if it does not provide primarily skilled care or rehabilitation. Only a small number of nursing homes that are certified Medicaid-only, called nursing facilities (NF), or distinct parts of nursing homes (hereafter referred to as distinct part nursing homes) may qualify as a beneficiary's home.

Consequently, each nursing home must provide DME as an integral part of its basic daily rate unless it is not providing primarily skilled care or rehabilitation. Yet, very few nursing homes provide care lower than skilled.

In contrast, no SNFs or dually certified nursing homes (those certified for both Medicare and Medicaid) qualify as a beneficiary's home because they provide primarily skilled care or rehabilitation. To identify inappropriate payments for DME, we used resident assessment data from the Centers for Medicare & Medicaid
Services (CMS) to determine all nursing home stays nationwide during 2006. We then analyzed related Medicare claims data for any DME payments during these stays.

If the nursing home provides primarily skilled care or rehabilitation, DME is not covered.

When setting DME payment policy, Congress recognized the responsibility of institutions to meet patients' medical needs, regardless of the primary payer for the stays (i.e., Medicare, Medicaid, or private resources). Consequently, each nursing home must provide DME as an integral part of its basic daily rate unless it is not providing primarily skilled care or rehabilitation. Yet, very few nursing homes provide care lower than skilled. Although payment contractors routinely deny DME payment for claims submitted with a nursing home place of service designation, an incorrect place of service designation (i.e., home) results in inappropriate payment. Past OIG studies have highlighted this issue; however, payment controls are still insufficient to stop inappropriate DME payments.

This non-coverage stems from the legal requirement that DME be used in a beneficiary's home or an institution that can be considered a home. Section 1861(n) of the Act states that any nursing home meeting the basic definition of a SNF in § 1819(a)(1) of the Act may not be considered a patient's home for this purpose. Thus, only when a nursing home provides primarily a nonskilled level of care and few rehabilitation services can it be considered a beneficiary's home and qualify for DME payment.

Suppliers and Place of Service Coding Suppliers must designate the physical location of the beneficiary, called place of service, on submitted claims.

C. Definitions

- **Customized Wheelchair** - the wheelchair shall be treated as a customized item if the wheelchair has been measured, fitted, or adapted in consideration of the patient's body size, disability period of need, or intended use, and has been assembled by a supplier or ordered from a manufacturer who makes available customized features, modification or components for wheelchairs that are intended for an individual patient's use in accordance with instructions from the patient's physician.
- **Durable Medical Equipment (DME)** - is covered under Part B as a medical or other health service of the Social Security Act and is equipment that:
  - Can withstand repeated use;
  - Is primarily and customarily used to serve a medical purpose;
  - Generally is not useful to a person in the absence of an illness or injury; and
  - Is appropriate for use in the home.
- **Long Term Care Facility (LTCF)** - facilities providing a spectrum of medical and non-medical supports and services to frail or older adults unable to reside independently in the community.
- **Place of Service (POS)** – place of service codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided
- **Place of Residence** – non-temporary physical location that member resides as their home.
- **Skilled Nursing Facility (SNF)** – nursing home that provides primarily skilled care or rehabilitation

D. Policy

I. Those members that do not have CareSource as their Medicare Advantage, but do have CareSource for Medicaid, are considered **opt-out members**.
   A. When a request for a Custom or Power Wheelchair is denied by Medicare, All providers for opt out members must submit the Medicare denial along with the request to CareSource for prior authorization.
   B. Once the Medicare denial is received, CareSource will review for medical necessity under Medicaid guidelines as payer of last resort.

II. Those members that have CareSource for both their Medicare Advantage and Medicaid are considered **opt-in members**.
   A. When a request for a Custom or Power Wheelchair is submitted for opt-in members, CareSource can internally take an active part of determining whether the custom or power wheelchair can be covered under the member's Medicare Part B.
   B. If the request is denied under Medicare guidelines, CareSource will review for medical necessity under Medicaid guidelines as payer of last resort.

III. To prevent unnecessary delay in prior authorization requests, CareSource encourages providers to follow the following:

1. If the member is in custodial care, the DME provider should indicate POS 33 (custodial care) on the Medicare claim submission, so the request will not be automatically rejected.
   A. POS 33 indicates that the member is not receiving skilled nursing care and the POS is considered the member place of residence, as defined above.
2. If the member is in a SNF or a nursing facility and receives skilled nursing care, the facility cannot be considered a place of residence for purposes of DME coverage under Part B. POS 31 (SNF) and POS 32 (NF) indicates that the member receives skilled nursing care.
   A. When an inpatient in a hospital or SNF is not entitled to Part A inpatient benefits, payment may not be made under Part B for DME provided in the hospital or SNF because such facilities do not qualify as a patient's home.
   B. DME is covered by Part B only when intended for use in the home, which explicitly does not include a SNF or hospital.

IV. Any DME furnished to inpatients under a Part A covered stay is included in the SNF or hospital PPS rate.

V. DME providers need to check with the facility/member to see if the member is truly in custodial care at the nursing facility, and also not receiving skilled care (at that point in time).
   A. If member is only in custodial care, this would categorize the nursing facility as being the member's home. Providers should submit prior authorization request and claims with POS 33
   B. If the member is receiving ANY skilled services, then the nursing facility is not constitute as the member's home. Providers should submit prior authorization request and claims with POS 31 or POS 32.

VI. Ensuring the appropriate POS is utilized will decrease processing time and ensure proper reimbursement according to the Medicare/Medicaid guidelines.

VII. Providers that do not adhere to the appropriate processing, according to this policy, may be subject to claims auditing and investigation.

E. Conditions of Coverage
F. Related Policies/Rules
G. Review/Revision History

DATES		ACTION
Date Issued	10/14/2020	New policy
Date Revised		
Date Effective	02/01/2021	
Date Archived	07/31/2023	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

N/A

The Administrative Policy Statement detailed above has received due consideration as defined in the Administrative Policy Statement Policy and is approved.