MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 08-10

Distribution: Medical Suppliers

Issued: March 1, 2008

Subject: Clarification of Medicaid Wheelchair Coverage Policy for Nursing Facility Residents

Effective: Upon Receipt

Programs Affected: Medicaid

This bulletin provides further clarification of Medicaid wheelchair coverage policy for a beneficiary who is a resident in a nursing facility. This additional information will assist providers in preparing and submitting appropriate requests for prior authorization and should expedite the authorization review process.

Most durable medical equipment, including wheelchairs, is considered to be covered as part of the nursing facility's Medicaid per diem payment rate. Wheelchairs must be available in sufficient quantities so that residents who require them may have them assigned for personal use. Also, in accordance with federal and state nursing facility regulations and licensure requirements, nursing care includes the responsibility for patient positioning, skin integrity and care and resident transport within the nursing facility. Wheelchair requests for the primary purpose of meeting resident nursing care needs that are the responsibility of the nursing facility such as positioning and transferring are not covered. Wheelchairs for social or recreational purposes are not covered.

Section 1.8.A (Standard and Custom-Modified Versus Custom-Made Equipment) in the Medical Supplier Chapter of the Medicaid Provider Manual explains that custom made equipment may be covered for nursing facility residents when other available products do not meet the beneficiary's specific medical and/or functional needs. This Section also includes the definition of custom made equipment.

Section 2.47 (Wheelchairs, Pediatric Mobility Items and Seating Systems - Payment Rules for Beneficiaries Residing in a Nursing Facility) further state that custom fabricated Durable Medical Equipment (DME) must offer physical/restorative function to the beneficiary and allow for independence in the nursing facility setting that is not possible with standard DME, i.e. the item will allow the resident to be mobile without the assistance of an aide, nurse or other staff. For power wheelchairs, Section 2.47 explains that the beneficiary must demonstrate the ability to safely control a power wheelchair. This policy reflects the beneficiary's cognitive and physical abilities to safely operate the wheelchair.

Section 1 (Program Overview) states that Medicaid covers the least costly alternative that meets the beneficiary's medical need for medical supplies, durable medical equipment and orthotics/prosthetics.

Tilt-In-Space Modification

Under Section 2.47 - The standards of coverage for wheelchair modifications states that a tilt-in-space power modification for a beneficiary residing in a nursing home may be covered if it will permit movement to a less restrictive setting, i.e. the resident is being discharged to their own home or other assisted living option available in the community.

Clinical Documentation

It is the medical supplier's responsibility to submit the extensive, complete clinical documentation that is necessary to support a request for prior authorization of an exception to the nursing facility coverage policy. This includes documentation related to the application of the nursing care requirements noted above. For nursing facility residents, the most commonly requested documentation is a copy of the current Minimum Data Set (MDS) form and nursing notes for the two months prior to the submission date of the authorization request. These documents provide the most effective and complete clinical documentation for exception requests. A face to face wheelchair evaluation completed by an Occupational Therapist (OT) or Physical Therapist (PT) who is not affiliated in any way with the medical supplier is also required.

An evaluation performed by a Certified Occupational Therapy Assistant (COTA), Physical Therapy Assistant (PTA), or other assistant is not accepted as documentation. An evaluation co-signed by a Michigan registered occupational therapist or a Michigan licensed physical therapist is not accepted as documentation.

Providers may not write any part of the clinical documentation for the request.

Providers are expected to submit complete documentation when the request is initially submitted. This will avoid any unnecessary processing delays due to the need to return the request for additional information. However, if Michigan Department of Community Health (MDCH) staff cannot make a determination of exception based on the documentation submitted, the request may be denied or returned for further information. MDCH may request any clinical documentation necessary to determine that coverage criteria requirements for an exception are met.

Product and Cost Documentation

- Wheelchair exception requests must include appropriate identification of the specific product requested including the brand and model number.
- Exception requests must include the correct and valid Healthcare Common Procedure Coding System (HCPCS) Level II national code for all items. If no HCPCS code exists for an item, the appropriate Not Otherwise Classified (NOC) code may be used.
- If there is no established Medicaid fee screen for the HCPCS code or a NOC code is used, the provider must submit documentation of the acquisition cost via actual invoice. Manufacturer quotes or dealer list prices are not accepted as documentation of cost. If the quote or dealer list is the actual cost, the provider must write on the quote or dealer list, "This amount is the actual acquisition cost", and sign and date the statement.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

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