CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid (ODM)

Regulation/Package Title: DMEPOS: Wheelchairs

Rule Number(s):

SUBJECT TO BUSINESS IMPACT ANALYSIS:

To Be Rescinded: 5160-10-16

New: 5160-10-16

NOT SUBJECT TO BUSINESS IMPACT ANALYSIS, INCLUDED FOR INFORMATION ONLY:

To Be Rescinded: 5160-10-16.1

Date: September 23, 2015

Rule Type:

- ☑ New
- ☐ Amended
- ☑ 5-Year Review
- ☑ Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

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Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   Existing rule 5160-10-16, "Wheelchairs," sets forth coverage and payment policies for wheelchairs, related accessories, and seating options. This rule is being proposed for rescission. Coverage and payment policies for wheelchairs and related items are incorporated into new rule 5160-10-16.

   Existing rule 5160-10-16.1, "Wheelchair rentals," sets forth coverage and payment policies for the rental of wheelchairs. This rule is being proposed for rescission. Coverage and payment policies for wheelchair rental are incorporated into new rule 5160-10-16.

   New rule 5160-10-16, "DMEPOS: wheelchairs," sets forth coverage and payment policies for wheelchairs, related accessories, seating options, and wheelchair rental. This rule replaces rescinded rules 5160-10-16 and 5160-10-16.1.

   The new rule comprises many substantive changes:

   - The Medicare wheelchair groupings for power mobility devices are adopted. As a result, the current handful of procedure codes in the claim-payment system that represent power wheelchairs are replaced by dozens of additional, item-specific codes, each with its own maximum payment amount (which is often less than the amount currently paid).
   - The concept of a basic equipment package is adopted. When a wheelchair is purchased, no separate payment is made for items in the basic equipment package.
   - Definitions are clarified or created for key terms: basic equipment package, complex rehabilitation technology (CRT), custom wheelchair, customized seating system, individualized seating system, and need verification.
   - Payment is allowed for a manual wheelchair in addition to a power mobility device if having that backup wheelchair significantly improves an individual's mobility and is cost-effective.
   - Payment is allowed for the professional evaluation of an individual's needs for a wheelchair.
   - A replacement schedule for equipment, parts, and accessories is established. The distinction between major and minor repairs is eliminated. Need verification rather than prior authorization is applied to most repair requests and to replacement requests that do not exceed the established frequency guidelines. Replacement requests for wear items (e.g., caster bearings, tires, arm pads) are exempted from need verification.

- Maximum payment amounts for equipment, parts, and accessories are specified by formula (a percentage of Medicare fee-for-service allowed amounts).
- A maximum payment amount for labor is established and specified by formula (based in part on a U.S. Bureau of Labor Statistics hourly wage for medical equipment repair technicians and on certain mileage assumptions).
- Three existing wheelchair-related certificates of medical necessity (CMNs) are merged into a single new form.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   The Ohio Department of Medicaid (ODM) is promulgating these rules under section 5164.02 of the Ohio Revised Code.

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   Provisions in 42 C.F.R. Part 447 Subpart B require each state Medicaid program to maintain documentation of the amounts it pays for supplies and services and to provide public notice of any significant proposed change in its methods and standards for establishing payment amounts. Changes involving the addition, revision, or discontinuation of Healthcare Common Procedure Coding System (HCPCS) codes are required to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA).

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   These rules do not exceed federal requirements.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   Medicaid rules perform several core business functions: They establish and update coverage and payment policies for medical goods and services. They set limits on the types of entities that can receive Medicaid payment for these goods and services. They publish payment formulas or fee schedules for the use of providers and the general public.

ODM has four aims in proposing these changes to the wheelchair rules:

- To increase or enhance access to wheelchair-related services for Medicaid recipients
- To reduce the administrative burden on suppliers of wheelchairs and related equipment
- To increase administrative efficiency within ODM
- To strengthen program integrity

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   The success of these rules will be measured by the extent to which suppliers report the newly adopted procedure codes on the claims they submit and by the extent to which operational updates to the Medicaid Information Technology System (MITS) result in the correct payment of claims.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

   01/21/2014: On-site educational visit with Ohio Association of Medical Equipment Services (OAMES) suppliers

   02/14/2014: On-site educational visit with Sonshine Medical representatives (Canton)

   02/20/2014: On-site educational visit with ABC Pediatric Therapy representatives (Cincinnati)

   03/20/2014: On-site educational visit with OSU Seating Clinic representatives

   03/21/2014: In-person meeting with OAMES representatives

   03/26/2014 – 04/30/2014: Conference phone calls with Georgia, Michigan, and Washington Medicaid staff members

   04/07/2014 – 04/22/2014: In-person meetings and conference phone calls with representatives of the Medicaid managed care plans

   04/17/2014: In-person meeting with Ohio Department of Developmental Disabilities representatives

   04/23/2014: In-person meeting with Ohio Department of Education representatives

04/29/2014: In-person meeting with an Ohio Respiratory Care Board representative

05/01/2014: In-person meeting with ARC of Ohio representatives

05/01/2014: In-person meeting with internal MyCare Ohio staff members

05/04/2014: In-person meeting with Dr. Rosalind Batley, clinical pediatrics specialist at Nationwide Children's Hospital

05/07/2014: In-person meeting with Ohio Department of Aging representatives

05/19/2014: In-person meeting with Ohio Developmental Disabilities Council representatives

06/24/2014: In-person meeting with representatives of BCMH (a program in the Ohio Department of Health)

07/15/2014: In-person meeting with CSIO representatives

01/28/2015 – 02/25/2015: Review of the draft rule by the Health Care Fraud Section of the Office of the Ohio Attorney General

02/03/2015 – 04/27/2015: Review of the draft rule by OAMES

8. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

01/21/2014, OAMES
Input: Information about the wheelchair process, especially the seating and fitting evaluation
Effect: Expansion of the focus of the rule, discussions, and inclusion of stakeholders

02/14/2014, Sonshine Medical
Input: Discussion about how current wheelchair policy affects suppliers of wheelchairs to nursing facility (NF) residents
Effect: Additional information

02/20/2014, ABC Pediatric Therapy
Input: Discussion of the supplier's therapy and wheelchair fitting services and the impact of wheelchair policy changes on its business; comment that the supplier is not currently paid for wheelchair fittings
Effect: Provision in the revised rule allowing payment for an assessment/evaluation

03/20/2014, OSU Seating Clinic
Input: Demonstration of operations
Effect: Use of the OSU Seating Clinic as a reference model; expansion of the focus of the rule, discussions, and inclusion of stakeholders

03/21/2014, OAMES
Input: Discussion of concerns with current wheelchair policy
Effect: Clarification of wording in the revised rule

03/26/2014 – 04/30/2014, Washington, Georgia, and Michigan Medicaid
Input: Policy discussion
Effect: Development of the new payment methodology and the provision allowing payment for backup equipment

04/07/2014 – 04/22/2014, Medicaid managed care plans (MCPs)
Input: Information about MCP policies and procedures, in particular how each plan performs prior authorization review for wheelchairs, accessories, related equipment, and repairs
Effect: Clarification of wording in the revised rule

04/17/2014, Ohio Department of Developmental Disabilities
Input: Discussion of problems encountered in getting access to wheelchair evaluations
Effect: Further development of the provision allowing payment for an assessment/evaluation

04/23/2014, Ohio Department of Education
Input: Statements that there are many different points of entry for wheelchair-referral and that a prescribing physician, although necessary, is not always the starting point when an individual begins the process of obtaining a wheelchair
Effect: Expansion of the focus of the rule, discussions, and inclusion of stakeholders

04/29/2014, Ohio Respiratory Care Board
Input: Board requirements for wheelchair providers
Effect: A better understanding of how to describe rendering and billing providers

05/01/2014, The ARC of Ohio
Input: Discussion of bottlenecks in the current overall wheelchair delivery system
Effect: Other policy discussions and meetings with additional stakeholders

05/01/2014, MyCare staff
Informational meeting about upcoming wheelchair policy changes and discussion of potential impact on MyCare providers and recipients

05/04/2014, Dr. Rosalind Batley, Nationwide Children's Hospital
Input: Discussion of how the wheelchair-fitting process is conducted at Nationwide Children's Hospital
Effect: Further development of the provision allowing payment for backup equipment

05/07/2014, Ohio Department of Aging
Input: Information about how the waiver process works for wheelchairs, what types of wheelchair requests the waiver unit is receiving, and how the waiver unit approves those requests
Effect: Further development of the provision allowing payment for backup equipment

05/13/2014, Ohio Physical Therapy Association
Input: Statement that Ohio Medicaid recipients have to wait months for wheelchair evaluations/assessments because there are not enough physical therapists to perform them
Effect: Further development of the provision allowing payment for an assessment/evaluation.

05/19/2014, Ohio Developmental Disabilities Council
Input: Concerns about current prior authorizations and about obtaining backup wheelchairs (two topics that happen to be addressed in the proposed policy changes)
Effect: Further development of the provision allowing payment for backup equipment

06/24/2014, BCMH (a program in the Ohio Department of Health)
Input: Concerns about backup wheelchairs and the possibility of conducting a reevaluation for a new wheelchair before five years have passed
Effect: Further development of the provision allowing payment for backup equipment and removal of language implying a five-year waiting period for a new wheelchair

07/15/2014, CSIO
Informal presentation of the revised wheelchair rule and the results of the many months of meeting with external stakeholders, planning with internal stakeholders, and discussion with ODM managers

02/25/2015, Health Care Fraud Section of the Office of the Ohio Attorney General
Input: Suggestion that the word *evidence* be added to the requirements for post-delivery record-keeping
Effect: Addition of the word *evidence* within a sentence structure somewhat different from the example offered

04/27/2015, OAMES
Input: Five suggestions for correction, removal, or clarification of wording; one suggestion for a modification to policy involving prior authorization of payment; and two objections to establishing Medicaid payment as a percentage of the corresponding Medicare allowed amount
Effect: Incorporation, with some modification, of the wording changes; rejection of the suggested change in payment policy (on the ground that authorization based on a determination of medical necessity does not in and of itself guarantee that payment will be made); and reaffirmation of the payment structure under development

9. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

Utilization and expenditure data drawn from ODM's Quality Decision Support System were used in projecting the fiscal impact of the proposed changes.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    ODM developed this rule in collaboration with numerous stakeholders. The policy goals of improving access, reducing administrative burden on providers, and increasing efficiencies have been well received by all stakeholders.

11. **Did the Agency specifically consider a performance-based regulation? Please explain. Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.**

    The concept of performance-based rule-making does not apply to these items and services.

12. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    Rules involving Medicaid providers are housed exclusively within agency 5160 of the Ohio Administrative Code. Within this division, rules are generally separated out by topic. It is clear which rules apply to which type of provider and item or service; in this instance, there was no duplication.

13. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

    The policies set forth in the new rule will be incorporated into the Medicaid Information Technology System (MITS) as of the effective date of the rule. They will therefore be automatically and consistently applied by ODM's electronic claim-payment system whenever an appropriate provider submits a claim for an applicable service.

Adverse Impact to Business

14. **Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:**

    a. **Identify the scope of the impacted business community;**

       Changes to policies, payment formulas, or payment amounts affect suppliers of durable medical equipment (DME).

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

The reporting requirements laid out in these rules involve the documentation of medical necessity, which helps to substantiate the appropriateness of the equipment dispensed to Medicaid-eligible individuals.

c. **Quantify the expected adverse impact from the regulation.**
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

The adverse impact lies in the time needed by a supplier to fill out paperwork (or the electronic equivalent). Completing a prior authorization request, which must be accompanied by a completed certificate of medical necessity and involves the entry of certain information (e.g., customer identification, HCPCS codes, part numbers, descriptions of repairs), takes between five and thirty minutes of supplier staff time. This estimate is based on the professional experience of ODM staff members and on figures reported by Medicaid providers. The wage cost depends on who performs the task. The median statewide hourly wage for a billing clerk, according to Labor Market Information (LMI) data published by the Ohio Department of Job and Family Services, is $16.10; for a medical equipment repairer, it is $24.23; for a higher-level manager, it is $36.32. With an additional 30% for fringe benefits, submitting a prior authorization request costs between $1.75 (five minutes at $20.93 per hour) and $23.61 (thirty minutes at $47.22 per hour).

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The paperwork requirements spelled out in these rules for testing, measurement, and documentation are consistent with requirements in the commercial health insurance industry and the federal Medicare program. They are effective tools for preventing fraud, waste, and abuse and for promoting quality and cost-effectiveness; they help to ensure that the Ohio Medicaid program pays for medical equipment that is most appropriate to the needs of the person who will use it.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

These rules outline actions all providers must take in order to receive Medicaid payment. They do not set forth requirements for engaging in business, and no exception is made on the basis of an entity's size.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

These rules impose no sanctions on providers.

18. What resources are available to assist small businesses with compliance of the regulation?

Providers that submit claims through an electronic clearinghouse (a "trading partner") can generally rely on the clearinghouse to know current Medicaid claim-submission procedures.

Information sheets and instruction manuals on various claim-related topics are readily available on the Medicaid website.

The Bureau of Provider Services renders technical assistance to providers through its hotline, (800) 686-1516.

Policy questions may be directed via e-mail to the Non-Institutional Benefit Management section of ODM's policy bureau, at *noninstitutional_policy@medicaid.ohio.gov*.

For questions about program coverage of and limitations on DME, ODM maintains the DME Question Line and Voice Mailbox, (614) 466-1503.

TO BE RESCINDED

5160-10-16 **Wheelchairs.**

(A) Definitions.

(1) "Standard wheelchair" is a wheelchair, including a hemi (low-seat) wheelchair, that would generally satisfy the needs of a child or adult; is constructed to withstand normal daily use; has the dimensions specified in paragraph (A)(6) of this rule; and is equipped with standard seat and back, with wheel locks, with fixed, swingaway or detachable armrests, and with fixed, swingaway or detachable footrests.

(a) "Standard manual wheelchair" is a wheelchair that meets the specifications in paragraph (A)(1) and paragraph (A)(3) of this rule.

(b) "Standard power wheelchair" is a wheelchair that meets the specifications in paragraph (A)(1) and paragraph (A)(4) of this rule.

(2) "Specially constructed (SC) wheelchair/specially sized (SS) wheelchair" is a wheelchair that does not meet the dimensions of the standard wheelchair as described in paragraph (A)(6) of this rule; is equipped, at a minimum, with standard seat and back, with wheel locks, and with fixed, swingaway or detachable armrests, and with fixed, swingaway or detachable footrests; and is constructed to generally satisfy the needs of populations which require special features (e.g., extra-wide, amputee, reclining, lightweight, high strength lightweight, ultra-lightweight, heavy-duty, and extra heavy-duty wheelchairs).

(a) "Specially constructed wheelchair/specially sized manual wheelchair (SCM/SSM-wheelchair)" is a wheelchair that meets the specifications in paragraph (A)(2) and paragraph (A)(3) of this rule.

(b) "Specially constructed wheelchair/specially sized power wheelchair (SCP/SSP-wheelchair)" is a wheelchair that meets the specifications in paragraphs (A)(2) and (A)(4) of this rule.

(3) "Manual wheelchair" is a wheelchair that is designed and constructed to be manually operated and meets the requirements of either paragraph (A)(1) or (A)(2) of this rule. The term manual wheelchair includes:

(a) Any manual wheelchair that has been (or has been requested to be) converted to a motorized wheelchair with the addition of a power add-on accessory; and

(b) Any manual wheelchair that has been (or has been requested to be) revised with a push-rim activated power assist device.

(4) "Power wheelchair" is a wheelchair that:

(a) Has been originally designed and constructed to be powered by batteries in order to meet the needs of persons physically unable to operate a manual wheelchair;

(b) Meets the requirement of either paragraph (A)(1) or paragraph (A)(2) of this rule; and

(c) Is not a manual wheelchair that has been converted to a motorized wheelchair with the addition of a power add-on accessory or has been converted to a push-rim wheelchair with the addition of a push-rim activated power assist device.

(5) "Push-rim wheelchair" or a "push-rim activated power assisted wheelchair (PAPAW)" is a wheelchair that has a push-rim activated power assist device added to it.

(6) The dimensions for a standard wheelchair are as follows:

(a) The weight is greater than thirty-six pounds;

(b) The seat height is nineteen inches or greater;

(c) The weight capacity is two hundred and fifty pounds or less;

(d) For adult wheelchairs,

(i) The seat width is fifteen inches to nineteen inches; and

(ii) The seat depth is fifteen inches to nineteen inches;

(e) For pediatric wheelchairs, the seat width or depth must be fourteen inches or less.

(7) "Consumer" is a medicaid-eligible individual.

(8) "Custom seating system" is a wheelchair seating system that is individually constructed from a plaster model, a computer generated model (e.g., CAD-CAM technology), or the detailed measurements of an individual to create either:

(a) A molded, contoured, or carved (foam or other suitable material) seating system that is incorporated into the wheelchair base; or

(b) A seating system made from multiple pre-fabricated components or a combination of custom fabricated materials and pre-fabricated components that have been configured and attached to the wheelchair base or incorporated into a wheelchair seat or back in such a manner that the wheelchair could not be easily re-adapted for use by another individual.

(9) "Adaptive positioning devices" are components that are attached to a wheelchair to facilitate medically necessary, individual-specific posture control, and functioning and are listed as "adaptive positioning devices" under "Wheelchair Part I or Part II" in the appendix to rule 5160-10-03 of the Administrative Code.

(10) "Personal residence" means the consumer's place of residence, if such residence is not a hospital or long-term care facility.

(11) "Long-term care facility (LTCF)" means a nursing facility (NF), which is defined in section 5165.01 of the Revised Code, or an intermediate care facility for individuals with intellectual disabilities (ICF/IID), which is defined in section 5124.01 of the Revised Code.

(12) "Moderate impairment" means an impairment of strength and tone that render a person unable to maintain functional or symmetrical postures; flexible scoliosis; flexible kyphosis; dislocated hip with a leg length discrepancy of less than two inches; or fixed contractures of the hips/knees that cannot be accommodated by standard components (e.g., footrests, legrests).

(13) "Severe impairment" means a severely abnormal (hyper or hypo) tone that

prevents a person from obtaining or maintaining symmetrical postures, or abnormally fixed curvature of the spine.

(14) "Custom wheelchair" is any wheelchair with a custom seating system as defined in paragraph (A)(8) of this rule.

(B) Prior authorization.

(1) Except as set forth in paragraph (C) of this rule, prior authorization pursuant to rule 5160-10-06 of the Administrative Code is required for the wheelchair to be covered and reimbursed under medicaid. All requests for authorization for the purchase of a wheelchair must indicate the length of the warranty period and what is covered under the warranty.

(2) Wheelchairs will not be authorized for individuals under the age of one year. Only those wheelchairs that are designed to expand to accommodate the growth of an individual will be considered for authorization for growing children who do not fit into an adult sized wheelchair, unless there is a more cost effective, medically necessary alternative appropriate to meet the individual's need. Additional parts required to grow a wheelchair, that are not included with the purchase of the wheelchair, are eligible for reimbursement by the department, if the cost of the additional parts is less than the cost of a new wheelchair.

(3) Wheelchairs, wheelchair parts and accessories, and wheelchair modifications that are beneficial primarily in allowing the consumer to perform leisure or recreational activities are not considered medically necessary and will not be authorized.

(4) Prior authorization of wheelchairs (inclusive of all parts, options, or accessories) shall be limited to the wheelchair which has been determined by the department to provide mobility to an individual who is either non-ambulatory or who can ambulate for only a brief period of time, and any self-ambulation or assisted ambulation takes considerable physical effort or causes considerable physical pain; and who, without the specifically approved wheelchair, would be confined to a sedentary state (i.e., lying or sitting, bed-confined or chair-confined). Any bed-confined or chair-confined individual would be considered confined to a sedentary state.

(5) Certain wheelchair parts, accessories, or modifications that are distinctly and separately requested from the original wheelchair request require prior authorization. Refer to rule 5160-10-03 of the Administrative Code to determine which codes require prior authorization.

(6) The department may deny prior authorization requests when the required forms have not been fully completed or the required form does not provide sufficient information to establish medical necessity or to determine that the criteria for coverage has been met.

(C) The department will cover the rental of standard manual, hemi manual and lightweight manual (adult or pediatric) wheelchairs for a period of time not to exceed a maximum of three months without prior authorization. The wheelchair bases eligible for rental are denoted by a double asterisk (**) in the appendix to rule 5160-10-03 of the Administrative Code. For the wheelchair rental to be covered:

(1) The wheelchair must be prescribed by a physician; and

(2) The "Letter of Medical Necessity for Manual Wheelchairs without a Custom Seating System" form (JFS 03414, revised 10/2004) must:

(a) Be completed with sufficient information to support that the wheelchair is medically necessary to provide mobility to an individual who, without the specific wheelchair, would be confined to a sedentary state (e.g., lying or sitting, bed-confined or chair confined) for all but very brief periods of ambulation and to confirm that any self-ambulation or assisted ambulation takes considerable physical effort or causes considerable physical pain;

(b) Be signed by the prescribing physician; and

(c) Be maintained on file by the wheelchair provider.

(D) LTCFs: wheelchair coverage and limitations.

(1) Except as provided for under paragraph (D) (2) of this rule, all standard and specially constructed or specially sized manual wheelchairs without custom seating systems and all standard and specially constructed or specially sized power wheelchairs without custom seating systems, which are necessary for the appropriate care of the residents of a LTCF are the responsibility of the facility. Reimbursement of any wheelchairs described in this paragraph is made by the department to the LTCF through the cost-report mechanism. Except as provided for under paragraph (D) (2) of this rule, eligible providers of DME services may not bill or be reimbursed by the medicaid program for wheelchairs dispensed to residents of the LTCF.

(2) Only custom wheelchairs as defined in paragraph (A)(14) of this rule (i.e., those wheelchairs with a custom seating system as defined in paragraph (A)(8) of this rule) and determined by the department to be medically necessary for the resident, in accordance with paragraph (F) of this rule, are eligible for direct payment to the provider. Wheelchairs and wheelchair parts and accessories, prescribed for LTCF residents who do not meet all of the medical necessity criteria listed in paragraph (F) of this rule, are the responsibility of the facility and are reimbursed through the per diem rate calculated under Chapter 5124. or 5165. of the Revised Code.

(a) A standard or specially constructed or specially sized manual wheelchair may be authorized for direct reimbursement to an eligible DME provider for a resident of a LTCF only if the resident meets the coverage requirements for a custom seating system in accordance with paragraphs (D) (2) and (F) of this rule.

(b) A standard or specially constructed or specially sized power wheelchair may be authorized for direct reimbursement to an eligible DME provider for a resident of a LTCF only if the resident meets the coverage requirements for a custom seating system in accordance with paragraphs (D) (2) and (F) of this rule, and also meets the requirements for power wheelchairs in accordance with paragraph (G) of this rule.

(3) Reimbursement of any parts, options and accessories for wheelchairs described in paragraph (D) (1) of this rule is made by the department to the LTCF through the cost-reported mechanism.

(4) Parts, options and accessories for the wheelchairs described in paragraph (D) (2) of this rule and meeting the criteria for coverage as set forth in paragraph (D)(2)(a) or (D)(2)(b) are eligible for direct reimbursement to the DME provider.

(E) Personal residences: Wheelchair coverage and limitations.

For a consumer who resides in a personal residence, the following criteria must be met for the authorization of a wheelchair:

(1) For a standard manual or specially constructed/specially sized manual wheelchair without a custom seating system to be covered:

(a) The consumer must be evaluated by a physician, licensed physical therapist or licensed occupational therapist who is fiscally,

administratively and contractually independent from the DME provider and receives no form of compensation (monetary or otherwise) from the billing DME provider.

(i) The evaluation must be performed not earlier than ninety days prior to the submission of the prior authorization request;

(ii) The results of the evaluation must support the information submitted on the required form JFS 03414,; and

(iii) A copy of the dated and signed written evaluation must be maintained by the billing provider. The results of the evaluation must be written, signed and dated by the individual who evaluated the consumer as required in paragraph (E)(1)(a) of this rule. If the evaluator personally reported the results of the evaluation on the required form JFS 03414 and signed and dated the form, a copy of the form will be considered the written evaluation.

(b) The wheelchair must be prescribed by a physician who personally performed the evaluation or who has reviewed and agreed with the results of the evaluation of the qualifying physician, physical therapist or occupational therapist, in accordance with paragraph (E)(1)(a) of this rule.

(c) Form JFS 03414 must:

(i) Be completed and submitted, based on the results of the evaluation required in paragraph (E)(1)(a) of this rule, and with sufficient information to support that the specific wheelchair is medically necessary to provide mobility to an individual who, without the specifically prescribed wheelchair, would be confined to a sedentary state (e.g., lying or sitting, bed-confined or chair-confined) for all but very brief periods of ambulation and to confirm that any self-ambulation or assisted ambulation takes considerable physical effort or causes considerable physical pain; and

(ii) Be signed by the prescribing physician.

(2) For standard power wheelchairs and specially constructed/sized power wheelchairs without a custom seating system to be covered for consumers who reside in (or who will be residing in) a personal residence:

(a) The consumer must meet all the requirements set forth in paragraph (G) of this rule; and

(b) A visit must be performed in the home (i.e., personal residence) and documented in a written report by a person qualified to determine that the consumer or the consumer's caregiver(s) has(have) the ability to properly maintain the power wheelchair; there is electricity available and easily accessible to maintain power to the batteries; transportation of this wheelchair is available, as necessary; the consumer's home (place of residence) is accessible by the power wheelchair; and there is sufficient space and storage area for the wheelchair or power operated vehicle (POV) to assure that it is protected from the elements. The written report may be completed in part E of the "Letter of Medical Necessity for Power Wheelchairs and/or Custom Wheelchairs (i.e., with a Custom Seating System)" form (JFS 03411, revised 10/2004). The home will be considered accessible only if the consumer can enter and leave the home by power wheelchair or POV; and, within the home the consumer can enter and leave without assistance the living room, kitchen/dining area, the consumer's bedroom (or the room with the consumer's bed), and a bathroom.

(i) Except as provided for in paragraph (E)(2)(b)(iii) of this rule, a power wheelchair or POV will not be authorized if all of the conditions set forth in paragraph (E)(2)(b) of this rule are not met.

(ii) A power operated vehicle will not be authorized if the POV is needed only for outside the home or if, because of its size or other features, the vehicle is intended primarily for outside use.

(iii) A power wheelchair or power operated vehicle may still be authorized as long as the written report supports that access to some of the rooms listed in paragraph (E)(2)(b) of this rule are not necessary because special accommodations have been made to meet the consumer's activities of daily living.

(3) For any manual wheelchair with a custom seating system to be covered, the criteria set forth in paragraph (F) of this rule must be met.

(4) For any power wheelchair with a custom seating system to be covered, the criteria set forth in paragraphs (F) and (G) of this rule must be met.

(F) Custom wheelchairs (i.e., wheelchairs with custom seating systems): coverage and

limitations.

The following criteria and documentation requirements must be met for authorization of a wheelchair with a custom seating system:

(1) The consumer must be evaluated by a physician who is licensed and board certified as a physiatrist, an orthopedic surgeon, or a neurologist; or by a licensed physical therapist or a licensed occupational therapist. In a LTCF, the evaluator also must be fiscally, administratively and contractually independent from the DME provider, and must not receive any form of compensation (monetary or otherwise) from the billing DME provider.

(a) The evaluation must be performed not earlier than ninety days prior to the submission of the prior authorization request;

(b) The results of the evaluation must support the information submitted on form JFS 03411; and

(c) A copy of the dated and signed written evaluation must be maintained by the billing provider. The evaluation must be written, signed and dated by the individual who evaluated the consumer as required in paragraph (F)(1) of this rule. If the evaluator personally reported the results of the evaluation on the required form JFS 03411 and signed and dated the form, a copy of the form would be considered the written evaluation.

(2) The wheelchair must be prescribed by a physician who personally performed the evaluation or who has reviewed and agreed with the results of the evaluation of the qualifying physician, physical therapist or occupational therapist in accordance with paragraph (F)(1) of this rule; and

(3) Form JFS 03411 must:

(a) Be completed and submitted based on the results of the evaluation required in paragraph (F)(1) of this rule and with sufficient information to support that the wheelchair is medically necessary to provide mobility to an individual who is either non-ambulatory, or who can ambulate for only very brief periods of ambulation, and any self-ambulation or assisted ambulation takes considerable physical effort or causes considerable physical pain, and who, without the specifically prescribed wheelchair, would be confined to a sedentary state (e.g., lying or sitting, bed-confined or chair-confined); and with sufficient information to support that the consumer meets the criteria set forth in paragraph (F)(4) of this rule; including information that is

consistent with the consumer's reported diagnosis (or diagnoses), medical history, medical records; and current plan of care; and

(b) Be signed by the prescribing physician.

(4) To establish the medical necessity of a custom wheelchair (i.e., a wheelchair with a custom seating system), the following criteria must also be met and documented:

(a) The consumer must have a moderate impairment as defined in paragraph (A)(12) of this rule or a severe impairment as defined in paragraph (A)(13) of this rule;

(b) The consumer must have:

(i) Moderately to severely abnormal tone that prevents him or her from obtaining or maintaining symmetrical postures, or fixed curvature of the spine, for which a custom seating system is necessary; or

(ii) Skeletal or physical deformities or abnormalities that require a custom seating system;

(c) The addition of a custom seating system to the wheelchair must create a wheelchair that is made to fit the consumer's body or positioning needs so specifically that the wheelchair can only be used by the individual for whom it was designed; and

(d) The consumer's need for prolonged sitting tolerance, postural support to permit functional activities, or pressure reduction cannot be met adequately by a planar type seat, a lap tray, or a spinal orthotic. To meet this condition, the documentation must explain why a specialized seat, a lap tray, or a spinal orthotic is not adequate for the consumer, and include a statement of the number of hours per day that the patient is expected to be in the wheelchair. If a custom seating system is being prescribed for a consumer who also requires a spinal orthotic, document why both the seating system and the orthotic are medically necessary for the consumer.

(5) Equipment prescription.

An equipment prescription (see part C of JFS form 03411) specifying that the wheelchair and a custom seating system that is medically necessary must be

completed. The equipment prescription must be prepared by the same professional that performs the assessment, in conjunction with the prescribing physician, and must be signed by all team members involved in the wheelchair prescription process and by the equipment supplier.

(G) Power wheelchairs and power operated vehicles (POVs): coverage and limitations.

For a power wheelchair or a power operated vehicle to be covered, all the requirements specified in this paragraph must be met:

(1) The consumer must be evaluated by a physician, licensed physical therapist or licensed occupational therapist who is fiscally, administratively or contractually independent from the DME provider and receives no form of compensation (monetary or otherwise) from the DME provider billing for the wheelchair.

(a) The evaluation must be performed not earlier than ninety days prior to the submission of the prior authorization request;

(b) The results of the evaluation must support the information submitted on form JFS 03411; and

(c) A copy of the dated and signed written evaluation must be maintained by the billing provider. The results of the evaluation must be written, signed and dated by the individual who evaluated the consumer as required in paragraph (G)(1) of this rule. If the evaluator personally reported the results of the evaluation on the required form JFS 03411 and signed and dated the form, a copy of the form will be considered the written evaluation.

(2) The wheelchair must be prescribed by a physician who personally performed the evaluation or who has reviewed and agreed with the results of the evaluation performed by the qualifying physician, the physical therapist or occupational therapist in accordance with paragraph (G)(1) of this rule.

(3) Form JFS 03411 must:

(a) Be completed and submitted based on the results of the evaluation required in paragraph (G)(1) of this rule, with sufficient information to support that the wheelchair is medically necessary to provide mobility to an individual who, without the specifically prescribed wheelchair, would be bed-confined or chair-confined; with sufficient information to

support that the consumer meets the criteria set forth in paragraph (G)(4) of this rule; and with information that is consistent with the consumer's reported diagnosis (or diagnoses), medical history, medical records, or current plan of care;

(b) Include the consumer's diagnosis (or diagnoses) and the estimate of expected hours of use per day; and

(c) Be signed by the prescribing physician.

(4) Except as provided for in paragraph (G)(6) of this rule, the following criteria must be met and documented to establish medical necessity:

(a) The consumer is totally non-ambulatory and has severe weakness of the upper and lower extremities due to an orthopedic, neurological, or muscular condition;

(b) The consumer has no physical ability to operate a manual wheelchair;

(c) The consumer has both the physical and mental ability to safely operate a power wheelchair. Provide documentation addressing head control, upper extremity functioning, joy stick control steering, directionality-steering skill, visual/spatial perception, safety, mobility skills in power wheelchair operation;

(d) The consumer is dependent upon a power wheelchair for functional activities, or there is a significant delay in the acquisition of independence in functional activities that can be positively impacted by a power wheelchair. Document functional status describing how the power wheelchair will allow the consumer to be independent in mobility and allow substantial improvement in achieving independence in one or more of the following functional activities (include a description of how a power wheelchair will increase the consumer's ability to perform these functional activities):

(i) Bathing;

(ii) Grooming;

(iii) Toileting/toilet hygiene;

(iv) Meal preparation;

(v) Housekeeping;

(vi) Laundry;

(vii) Telephone use;

(viii) Medication management;

(ix) Finance management;

(x) Transfers;

(xi) Use and care of equipment; or

(xii) Activities for which the power wheelchair facilitates independent functioning while in school or work.

(5) When applicable, the following additional criteria must also be met:

(a) For consumers residing in a personal residence, a power wheelchair will be covered only if the criteria set forth in paragraphs (E)(2)(b) to (E)(2)(b)(iii) of this rule are met;

(b) For consumers residing in a LTCF, the power wheelchair will be covered only if the criteria set forth in paragraph (F) of this rule are met; and,

(c) Power operated vehicles will be covered only for consumers residing in a personal residence and only if the criteria set forth in paragraphs (E)(2)(b)(i) to (E)(2)(b)(iii) of this rule are met.

(6) The department may determine that coverage of a power wheelchair is necessary under the following circumstances:

(a) The consumer has severe weakness of the upper and lower extremities due to an orthopedic, neurological, or muscular condition but is not totally non-ambulatory; and meets the criteria set forth in paragraphs (G)(4)(b) to (G)(4)(d) of this rule; and meets the criteria set forth in paragraph

(G)(5) of this rule, as applicable; and meets the criteria for limited ambulation as set forth in paragraph (B)(4) of this rule; or

(b) The consumer does not meet the criteria set forth in paragraph (G)(4)(b) of this rule, but has limited ability to operate a manual wheelchair; and the consumer meets the criteria set forth in paragraphs (G)(4)(a), (G)(4)(c), and (G)(4)(d) of this rule; and, as applicable, the consumer meets the criteria set forth in paragraph (G)(5) of this rule.

(H) Duplicate equipment.

Medicaid reimbursement is not available for the purchase of more than one wheelchair for current use by a consumer; see paragraph (G) of rule 5160-10-05 of the Administrative Code. A wheelchair will not be authorized if the consumer is in possession of a wheelchair or any other equipment, regardless of payer source, which serves the same or similar purpose.

(I) Provider responsibility.

(1) The cost of any changes or modifications of a specially constructed/specially sized wheelchair, a custom seating system, or adaptive positioning devices purchased by the department, which are found to be necessary within the first ninety days following dispensing, must be borne in full by the provider.

(2) Wheelchair authorizations are specific as to manufacturer/make and model, parts, accessories, adaptive positioning devices, modular components, and custom-molded seating. Providers may only bill the department for the specific wheelchair and manufacturer/make and model, parts, accessories, adaptive positioning devices and custom-molded seating that are authorized and subsequently dispensed to the consumer.

(J) Repair and replacement.

(1) Medicaid reimbursement for repairs is limited to one wheelchair per consumer. Payment for loaner wheelchairs, in addition to reimbursement for repairs, is not covered. Repairs for multiple wheelchairs will not be authorized, regardless of the payer source of the wheelchairs. To be eligible for coverage for repairs, the wheelchair must have been determined by the department to be medically necessary, except as provided for in paragraph (J)(7) of this rule. (See rule 5160-10-08 of the Administrative Code regarding reimbursement for repairs.)

(2) For residents of LTCFs the cost of wheelchair maintenance and minor repairs is

reimbursed through the per diem rate calculated under Chapter 5124. or 5165. of the Revised Code and as specified in rules 5160-3-19 and 5123:2-7-11 of the Administrative Code.

(3) For residents of LTCFs direct medicaid reimbursement for repairs is limited to the following "major repairs" as defined in rule 5160-10-08 of the Administrative Code.

(a) Major repair of a wheelchair which would be eligible for direct purchase (i.e., only major repairs for custom wheelchairs) in accordance with this rule and is owned by an eligible consumer; and

(b) Major repairs/replacement of custom seating systems purchased by the department.

(4) Direct reimbursement is limited to a maximum of one wheelchair in five years per consumer. However, if the consumer's condition changes and warrants new or different equipment within the five-year period, the department may authorize new or replacement equipment. Appropriate medical necessity documentation must be submitted when prior authorization is requested for new or different equipment within the five-year period. (See paragraph (B)(2) of this rule regarding growing wheelchairs.)

(5) The replacement of any type of wheelchair, replacement of any custom seating system, or the replacement of adaptive positioning devices will only be prior authorized when medically necessary, regardless of the age of the current equipment, and only when modification or repair of the current equipment is judged by the department not to be cost-effective. A request for authorization for replacement of a consumer-owned wheelchair must meet all the requirements of this rule for the type of chair being requested.

(6) A description, model number, manufacturer serial number, date of purchase, and the condition of a consumer's current equipment must be specified on a request for authorization of additional or replacement equipment. (See paragraph (G) of rule 5160-10-05 of the Administrative Code regarding duplicate and conflicting equipment.)

(7) A current prescription must be submitted with a request for authorization of a repair when the department did not authorize the purchase of the wheelchair. In this case, a current prescription and documentation of medical necessity must be submitted with the initial request for repair. If the wheelchair is determined to be medically necessary and the repair is authorized, subsequent repairs may be authorized without the submission of a current prescription

and documentation of medical necessity.

(8) For a consumer who resides in a personal residence, reimbursement may be authorized for the repair of a consumer-owned wheelchair that is not eligible for purchase in accordance with this rule, if it is determined that the wheelchair meets the seating/wheeled mobility needs of the consumer and it would be more cost effective for the department to authorize the repair rather than the replacement of the wheelchair. Authorization for the repair of a wheelchair does not necessarily indicate that the wheelchair would be authorized for purchase. Replacement of any consumer-owned wheelchair will be authorized in accordance with this rule.

(9) When requesting prior authorization (PA) for a major wheelchair repair service requiring the replacement/repair of wheelchair parts or accessories on or after the effective date of this rule, the process set forth in this paragraph will apply.

(a) Providers must itemize in the request for PA all the parts/accessories in need of repair or replacement using the procedure codes listed in part I or part II of the "Wheelchair" section of the appendix to rule 5160-10-03 of the Administrative Code with the modifier RB. If the part does not have a specific procedure code listed, use K0108 modified by the modifier RB and provide a description of the part(s). The RB modifier attached to a wheelchair procedure code indicates that the item described by the code is to be repaired or replaced as part of the major wheelchair repair service.

(b) Providers must itemize in the request for PA the labor services associated with the major wheelchair repair services using the labor code K0739. The PA request should state the estimated labor time.

(c) Under the prior authorization process, the department will continue to issue the repair and labor codes for wheelchair repair services as listed in the appendix to rule 5160-10-03 of the Administrative Code. Both the repair/replacement part(s) component and the labor component of any major wheelchair repair will be bundled into the all-inclusive major wheelchair repair codes. When deemed appropriate, the department may separately authorize any of the codes listed in "Wheelchairs: Part I" of the appendix to rule 5160-10-03 of the Administrative Code, if no additional labor, parts, or accessories are being requested.

(10) Providers must continue to submit claims, and be paid, for both the repair/replacement part(s) and the labor components as an all-inclusive major

or minor wheelchair repair service using the wheelchair repair and labor codes specified in the appendix to rule 5160-10-03 of the Administrative Code. The procedure codes/modifiers for claims submitted for major repair services must match the codes issued in the prior authorization approval issued by the department.

(K) Valid wheelchair modifiers.

(1) The following modifiers are valid for wheelchair services:

(a) RR - short term rental; or

(b) RB - major repair or replacement of part(s).

(2) The appropriate modifier, as listed in paragraph (K)(1) of this rule, must be added to the procedure when requesting authorization for payment for wheelchair rentals or major repair services.

(3) Codes and modifiers submitted on the claim must match the codes and modifiers issued in the prior authorization approval letter.

Effective:

Five Year Review (FYR) Dates:

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Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02, 5165.01, 5165.47
Prior Effective Dates:	04/07/1977, 12/21/1977, 12/30/1977, 01/01/1980, 03/01/1984, 05/01/1990, 12/30/1991, 07/01/1994, 08/01/1995, 08/01/1997, 04/01/1998, 10/01/2004, 04/01/2006, 07/31/2009 (Emer), 10/29/2009, 12/31/2013

TO BE RESCINDED

5160-10-16.1 **Wheelchair rentals.**

(A) Definition

A "Rental Wheelchair" is defined in accordance with paragraph (C) of rule 5101:3-10-16 of the Administrative Code.

(B) Billing

The procedure necessary for billing the Ohio medicaid program for a wheelchair rental is defined in appendix A to rule 5101:3-10-03 of the Administrative Code.

(C) Reimbursement

(1) The reimbursement rate for wheelchair base codes utilizing the following "Healthcare Common Procedure Coding System" (HCPCS) codes in conjunction with the "RR" modifier are as follows:

(a) E1235 reimburses at sixty-five dollars per month.

(b) E1236 reimburses at sixty-five dollars per month.

(c) E1237 reimburses at sixty-five dollars per month.

(d) E1238 reimburses at sixty-five dollars per month.

(e) K0001 reimburses at forty-five dollars per month.

(f) K0002 reimburses at fifty-five dollars per month.

(g) K0003 reimburses at sixty-dollars per month.

(2) The department will reimburse submitted claims at the provider's usual and customary charge or at the maximums listed in this paragraph, whichever is less.

(3) The department will authorize only one rental wheelchair per consumer per

month.

(4) Wheelchair rental codes are not to be used for temporary replacement equipment due to repair of consumer's primary transportation equipment.

(5) Wheelchair rental codes are not to be billed in conjunction with any other wheelchair codes referenced in appendix A to rule 5101:3-10-03 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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Rule Amplifies:	5162.03, 5164.02, 5164.70
Prior Effective Dates:	10/27/2005, 04/25/2011

5160-10-16 **DMEPOS: Wheelchairs.**

(A) Definitions and explanations.

(1) "Basic equipment package" is the following standard set of parts and accessories that come with a wheelchair at the time of purchase:

(a) A sling or solid seat with back, a captain's chair, or a stadium-style seat;

(b) Standard casters or wheels with tires;

(c) Standard armrests;

(d) Standard front rigging (e.g., non-elevating legrests with footrests, a footplate);

(e) Wheel locks or brakes;

(f) With a power mobility device, motors;

(g) With a power mobility device, a non-expandable controller;

(h) With a power mobility device, a battery charger;

(i) With a power wheelchair, a standard proportional joystick; and

(j) With a power-operated vehicle, batteries.

(2) "Complex rehabilitation technology (CRT)" is a categorization of wheelchair equipment items that require individual evaluation, fitting, configuration, adjustment, or programming to meet the specific medical and functional needs of the user, as well as services related to those products. CRT includes, for example, customized seating systems, adaptive positioning devices, and alternative drive systems (directional interfaces other than a standard joystick).

(3) "Custom wheelchair" is a wheelchair that has a customized seating system. A custom wheelchair, therefore, cannot be easily used or adapted for use by another individual.

(4) "Customized seating system" is a wheelchair seat, wheelchair back, or combination of wheelchair seat and back that has been tailored specifically to the particular body shape and positioning needs of an individual user. Customization may be achieved by means of molding, contouring, carving, or other forms of fabrication or by the integration of prefabricated components

into the wheelchair frame. Items such as seat cushions and other removable positioning aids do not by themselves constitute a customized seating system.

(5) "Individualized seating system" is a wheelchair seat, wheelchair back, or combination of wheelchair seat and back that has been tailored to the body shape and positioning needs of an individual user by means of installing and configuring prefabricated cushions or other removable positioning aids.

(6) "Medical necessity" is defined in rule 5160-1-01 of the Administrative Code. Wheelchairs and wheelchair parts and accessories must meet additional criteria in order to be considered medically necessary:

(a) Wheelchairs and wheelchair parts and accessories are generally not necessary nor even useful in the absence of illness, injury, impairment, disability, or other condition that limits ambulation. A wheelchair must therefore provide mobility to an individual for whom ambulation is not possible, takes inordinate physical effort, or causes considerable physical discomfort.

(b) A wheelchair must also be suited to the purposes and daily routines of the individual using it.

(c) A manual wheelchair must provide a level of needed functionality that cannot be achieved with an assistive device such as a cane, a crutch or crutches, or a walker.

(d) A power mobility device (PMD) must provide a level of needed functionality that cannot be achieved with a manual wheelchair.

(e) A PMD must be functional in the environment in which it is used. The individual (or someone assisting the individual) must have the ability to take proper care of the PMD, the individual's place of residence must be accessible and have adequate electrical service, transportation of the PMD must be available as necessary, and there must be sufficient protection for the PMD from the elements. The place of residence is considered to be accessible only if the individual will be able to use the PMD without assistance to enter and leave the residence and to move easily about the main living space (which is used for purposes such as food preparation, eating, sleeping, personal hygiene, and relaxation).

(f) A customized seating system must enable an individual to sit (or recline, as appropriate) for long periods of time, provide postural support to permit functional activities, or reduce pressure on the body to a degree that cannot be achieved with items such as a standard wheelchair seat, an individualized seating system (e.g., a prefabricated seat cushion or other removable positioning aid or combination of positioning aids), or a spinal orthotic device.

(7) "Need verification" is a process, similar to prior authorization, by which the department determines whether to make payment for the repair of a wheelchair part or accessory that exceeds the established frequency guideline. One purpose of need verification is to enable the department to consider whether the purchase of a new piece of equipment might be more cost-effective than continued repair.

(8) "Power mobility device (PMD)" is a collective term for a power wheelchair or a power-operated vehicle (POV, commonly referred to as a "scooter"). Each PMD is classified on the basis of performance into one of eight groups developed under the auspices of the centers for medicare and medicaid services (CMS):

(a) Group one power-operated vehicles;

(b) Group two power-operated vehicles;

(c) Group one power wheelchairs;

(d) Group two power wheelchairs;

(e) Group three power wheelchairs;

(f) Group four power wheelchairs;

(g) Group five power wheelchairs; and

(h) Power mobility devices not otherwise classified.

(9) "Routine maintenance" of a wheelchair is any upkeep that is necessary to maintain optimum functioning of the equipment and that does not require a skilled or trained technician to perform.

(10) "Wheelchair" is a collective term for a manual wheelchair or a power mobility device.

(B) Providers.

(1) Prescribing providers. Eligible medicaid providers of the following types, acting within their scope of practice, may certify the medical necessity of a wheelchair:

(a) A physician;

(b) An advanced practice registered nurse with a relevant specialty (e.g., clinical nurse specialist, nurse practitioner);

(c) A physician assistant; or

(d) A podiatrist.

(2) Evaluators. The following professionals may evaluate an individual's particular needs:

(a) For wheelchairs incorporating CRT, a physiatrist, orthopedic surgeon, neurologist, physical therapist, or occupational therapist; or

(b) For wheelchairs not incorporating CRT, a physician, physical therapist, or occupational therapist.

(3) Rendering providers. The following eligible providers may furnish a wheelchair, part, or accessory or may render a related service:

(a) For manual wheelchairs without CRT, a provider enrolled as a basic durable medical equipment (DME) supplier; or

(b) For PMDs and CRT, a provider enrolled as a DME supplier with appropriate certification or licensure from the Ohio respiratory care board (ORCB) to engage in business involving wheelchairs.

(4) Billing providers. The following eligible providers may receive medicaid payment for submitting a claim for a wheelchair, part, accessory, or related service:

(a) For manual wheelchairs without CRT, a provider enrolled as a basic DME supplier; or

(b) For PMDs and CRT, a provider enrolled as a DME supplier with appropriate certification or licensure from the ORCB to engage in business involving wheelchairs.

(C) Coverage.

(1) Principles.

(a) A wheelchair must be determined to be medically necessary before the department will make payment. For a wheelchair purchased by the department, this necessity is documented on form ODM 03411, "Certificate of Medical Necessity: Wheelchairs" (01/2016). The medical necessity of a wheelchair that has not been purchased by the department is documented either on this certificate of medical necessity (CMN) or on an equivalent form.

(b) If more than one type of wheelchair will meet an individual's needs and satisfy the criteria of medical necessity, then the maximum payment amount is the lowest of the respective costs, regardless of which wheelchair is supplied.

(c) The provision of or payment for the purchase, repair, or rental of a medically necessary non-custom wheelchair for a resident of a long-term care facility (LTCF) is the responsibility of the LTCF. This responsibility holds even if the wheelchair incorporates CRT other than a customized seating system. In turn, the LTCF receives medicaid payment in accordance with Chapter 5160-3 of the Administrative Code. Therefore, claims submitted to the department by wheelchair suppliers for the purchase, repair, or rental of non-custom wheelchairs furnished to LTCF residents will be denied.

(2) Purchase.

(a) Custom wheelchairs for individuals living in a LTCF and wheelchairs for individuals not living in a LTCF. Prior authorization (PA) is required, and a face-to-face evaluation of need must be performed by a prescribing provider not earlier than one hundred eighty days before the submission of the PA request.

(b) Requirements, constraints, and limitations.

(i) The purchase of a wheelchair includes the basic equipment package, delivery, setup, instruction and training in use, and adjustments or minor modifications. No separate payment is made for these items. Payment for other parts or accessories, either parts or accessories that are substituted for individual items in the basic equipment package or parts or accessories outside the basic equipment package that are added after a wheelchair is purchased, requires PA.

(ii) Authorization will not be given for the purchase of more than one wheelchair for concurrent use by an individual. An exception to this restriction may be made if it can be satisfactorily demonstrated that having a second wheelchair (e.g., a manual wheelchair in addition to a PMD) significantly improves an individual's mobility and is cost-effective.

(3) Repair, including replacement of existing parts or accessories.

(a) Custom wheelchairs for individuals living in a LTCF and wheelchairs for individuals not living in a LTCF. The repair of a component such as a frame, seating system, motor, drive system, or battery is subject to need

verification. No verification is required for the repair of a wear item (e.g., caster bearing, tire, arm pad).

(b) Requirements, constraints, and limitations.

(i) For a wheelchair not purchased by the department, submission of documentation of the medical necessity of the wheelchair itself is required for the initial repair but not for subsequent repairs. The determination that a wheelchair not purchased by the department is medically necessary does not indicate that the wheelchair itself would be authorized for purchase.

(ii) Payment is not permitted for temporary replacement equipment provided while an individual's wheelchair is being repaired (e.g., a "loaner wheelchair").

(iii) No payment is made for routine maintenance.

(4) Rental.

(a) Custom manual wheelchairs. PA is required.

(b) Non-custom manual wheelchairs for individuals not living in a LTCF. No PA is required for the first three months. PA is required for rental periods after the first three months.

(c) PMDs. PA is required.

(d) Requirements, constraints, and limitations.

(i) Payment will not be made for the rental of more than one wheelchair per month for an individual.

(ii) Payment for rental is all-inclusive; no separate payment is made for any other wheelchair-related items.

(iii) During a rental period and for ninety days afterward, all rental amounts paid are applied toward purchase. The total of the rental amounts must not exceed the purchase amount.

(5) Evaluation and management.

(a) An evaluator may receive payment for determining an individual's needs for a wheelchair. Not more than one payment will be made per wheelchair per individual.

(b) Payment includes all services rendered by the evaluator, including

evaluation, product selection, confirmation at delivery, and follow-up.

(D) Additional requirements, constraints, and limitations.

(1) After delivery, the supplier must maintain documentary evidence that the following statements are true concerning a wheelchair and any related accessories:

(a) They were delivered to the individual for whom they were prescribed;

(b) They are consistent with the items described in the CMN; and

(c) They correspond exactly to the items listed on the submitted claim.

(2) Claim payments for which there is insufficient documentation are subject to recovery.

(3) A PA request must specify all relevant information (e.g., HCPCS code, manufacturer, model). A PA request for repair must include the serial number of the equipment and a complete itemization of parts and estimated labor needed.

(4) When an authorization specifies a manufacturer, model, part number, or other information identifying a particular item, then a supplier may provide and subsequently submit claims only for the specified item.

(5) Payment will not be authorized for a wheelchair to be used by an individual younger than one year. For a child one year of age or older whose needs are not met by an adult-sized wheelchair, consideration for authorization will be given only to wheelchairs that accommodate growth, unless there is a more appropriate, cost-effective, medically necessary alternative available. Payment may be made for additional parts required to "grow" a wheelchair if the combined cost of the parts and related labor is less than the cost of a new wheelchair.

(6) Payment will not be authorized for wheelchairs, parts, accessories, or modifications whose primary application is leisure or recreational activities.

(7) Payment will not be authorized for a PMD intended exclusively for outdoor use.

(8) A wheelchair purchased by medicaid is the property of the individual for whom it was prescribed.

(E) Claim payment.

(1) As of the effective date of this rule, the payment amount is established as the lesser of the submitted charge or the applicable medicaid maximum from the

following list:

(a) For purchase of a covered new wheelchair, part, or accessory, ninety per cent of the amount allowed under fee-for-service medicare for the jurisdiction that includes Ohio;

(b) For purchase of a covered group four power wheelchair for which there is no medicare allowed amount, one hundred ten per cent of the medicaid maximum payment amount allowed for purchase of the most closely corresponding covered group three power wheelchair;

(c) For purchase of any other covered wheelchair, new part, or new accessory for which there is no medicare allowed amount, payment by report;

(d) For purchase of a covered wheelchair, part, or accessory that has been previously used but remains in good working order, fifty per cent of the medicaid maximum payment amount allowed for purchase of a comparable new wheelchair, part, or accessory;

(e) For monthly rental of a covered wheelchair to which rental applies, ten per cent of the medicaid maximum payment amount allowed for purchase;

(f) For performance of an evaluation and related services, eighty per cent of the amount established by the medicare physician fee schedule; or

(g) For labor provided for a covered repair or covered maintenance, the result L obtained by the formula $L = ([W + B] \times P + M) \times A \times 0.25$.

(i) L is the medicaid maximum payment amount for labor, reported in fifteen-minute units.

(ii) W is the hourly median wage for medical equipment repairers in Ohio reported by the United States bureau of labor statistics (available at http://www.bls.gov/oes/). (The initial wage figure used was from May 2014.)

(iii) B is hourly employee-related expenses such as benefits, calculated as thirty-five per cent of wages.

(iv) P is a productivity adjustment factor, defined as the ratio of the number of total work hours per day (specified as eight) to the number of available productive work hours per day (specified as six and a half).

(v) M is an hourly mileage allowance, defined as the ratio of the daily mileage allowance to the number of available productive work hours per day. The daily mileage allowance is the product of the

average travel speed (specified as thirty-five miles per hour), the average total travel time (specified as one hour and fifteen minutes), and the federal standard mileage rate for business (available at http://www.irs.gov). (The initial standard mileage rate used was for 2015.)

(vi) A is an administrative cost factor, specified as one hundred ten per cent.

(2) After the effective date of this rule, if the medicare amount for an item or service becomes less than the current medicaid maximum payment amount, then the medicaid maximum payment amounts related to that item or service are reestablished on the basis of the new medicare amount.

(3) After the effective date of this rule, if updates to the median hourly wage or the federal standard mileage rate would cause a variance of at least five per cent in the maximum payment amount for labor, then the maximum payment amount is reestablished on the basis of the updated figures.

(4) The payment provisions of this rule supersede entries in appendix DD to rule 5160-1-60 of the Administrative Code that pertain to wheelchairs, parts, accessories, or related services.

Replaces: 5160-10-16, 5160-10-16.1

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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Statutory Authority:	5164.02
Rule Amplifies:	5164.02, 5165.01, 5165.47
Prior Effective Dates:	04/07/1977, 12/21/1977, 12/30/1977, 01/01/1980, 03/01/1984, 05/01/1990, 12/30/1991, 07/01/1994, 08/01/1995, 08/01/1997, 04/01/1998, 10/01/2004, 10/27/2005, 04/01/2006, 07/31/2009 (Emer), 10/29/2009, 04/25/2011, 12/31/2013