# California Makes Substantive and Positive Changes in Policy Impacting CRT

On Monday, July 16th the California Department of Health Care Services (DHCS) posted updates to three important policies that strengthen the CRT message, protect access to medically necessary complex rehab technologies for Medi-Cal beneficiaries with disabilities and complex medical conditions.

NCART would like to thank our dedicated members in California and DHCS for the collaboration that resulted in these changes.

## Durable Medical Equipment (DME): Bill for DME (dura)

**"By Report" Codes**

In compliance with W&I Code, Section 141105.48, claims billed for wheelchairs, wheelchair accessories and/or replacement parts for member-owned equipment using codes with no specific maximum allowable rate ("By Report") are reimbursed the least of:

- Amount billed pursuant to CCR, Title 22, Section 51008.1, or
- Manufacturer's purchase invoice (cost) amount, plus a 67 percent markup, or
- The percentage of the Manufacturer's Suggested Retail Price (MSRP), as follows:
  - ‹‹85 percent of the MSRP for unlisted wheelchairs, wheelchair accessories and/or replacement parts is allowed if the provider documents on the claim that (s)he has on staff at least one Qualified Rehabilitation Technology Professional (QRTP) as a W-2 employee for each location, and that QRTP was directly involved in determining the specific wheelchair equipment needs of the member and is directly involved with or closely supervises the final fitting and delivery of the wheelchair:
    - ❖ Assistive Technology Professional (ATP) or Seating and Mobility Specialist (SMS) credentialed by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)
    - ❖ Certified Complex Rehabilitation Technology Supplier (CRTS®) credentialed by the International Registry of Rehabilitation Technology Suppliers
    - ❖ Licensed California physical therapist (PT) who is a Qualified Health Care Professional (QHCP)
    - ❖ Licensed California occupational therapist (OT) who is a QHCP

**Note**: The name and title of the W-2 employed QRTP must be entered in the Additional Claim Information field (Box 19).››

**Repair and/or Maintenance – Documentation**

Claims for labor for member-owned equipment require the following documentation:

- ‹‹A statement that the labor is performed on "Medi-Cal member-owned equipment" in the Additional Claim Information field (Box 19) or on an attachment.››

**Medicare/Medi-Cal Crossovers – Reimbursement**

Providers of DME items may bill Medi-Cal for reimbursement of the difference between Medicare's rate and Medi-Cal's rate for items provided to Medicare/Medi-Cal dually entitled members. ‹‹This method of reimbursement is the result of a permanent injunction in the case of Charpentier v. Belshe (also referred to as Charpentier) in which the court has mandated that for Medicare Part B items and services (excluding physician services), DHCS may not limit reimbursement to 20 percent of Medicare's "reasonable charge" limit.››

**Medicare/Medi-Cal Crossovers – Authorization**

‹‹Providers are encouraged but not required to obtain a TAR from DHCS for DME items for dually eligible members before providing the item and billing Medicare. DHCS will process an authorization request for a dually eligible member in the same manner as a Medi-Cal-only member, regardless of whether Medicare (or any Other Health Coverage [OHC]) has authorized the DME or been billed.

Under Charpentier requirements, DHCS must process TARs for dually eligible Medi-Cal members in the same manner as Medi-Cal-only members. See the Durable Medical Equipment (DME): An Overview section of this manual. Providers may check with DHCS if they have not received a response to a TAR within 14 business days of the request or within 72 hours for an expedited request.

**Note**: For Medi-Cal managed care members who receive DME, including CRT manual and power wheelchairs, through their assigned Medi-Cal Managed Care Plan (MCP), TARs are not submitted to DHCS. Instead, providers must adhere to each individual Medi-Cal MCP's utilization management control policies, which may include prior authorization and can vary depending on the Medi-Cal MCP. However, like DHCS, Medi-Cal MCPs are required to process prior authorizations for dually eligible members in the same manner as a Medi-Cal-only member pursuant to Charpentier requirements. Additionally, providers must ensure they are following individual Medi-Cal MCP OHC policies to ensure timely and accurate reimbursement. Providers may check with the member's MCP if they have not received a response to their request for prior approval within 14 business days of the request or within 72 hours for an expedited request.››

## Durable Medical Equipment (DME): Bill for Wheelchairs and Wheelchair Accessories (dura bil wheel)

**TAR and Documentation Requirements for Repair, Maintenance or Replacement Parts**

For any DME within the wheelchair group (including CRT manual and power wheelchairs), TAR requirements for repair, maintenance or replacement parts are as follows:

- TARs (either retroactive or prior authorization) are **not** required when the cumulative cost is less than or equal to $2,500 within a calendar month. This includes all billable HCPCS codes listed in this section.
- TARs (either retroactive or prior authorization) are required when the cumulative cost is greater than $2,500 within a calendar month. This includes all billable HCPCS codes listed in this section.

**Note**: For Medi-Cal managed care members who receive DME through their assigned Medi Cal MCP, including CRT manual and power wheelchairs, TARs are not submitted to DHCS. Instead, providers must adhere to each individual Medi-Cal MCP's utilization management control policies, which may include prior authorization, and can vary depending on the Medi-Cal MCP.

Additionally, for CRT power wheelchairs, providers are required to maintain documentation that the repair company being utilized by the provider to repair the CRT power wheelchair and/or any component part(s) have appropriately trained staff to complete the repair. Providers must maintain appropriate supporting documentation in the member's file and make it available to DHCS upon request or in the event of a state or federal audit.

**Seat Risers (Electric and Hydraulic)**

HCPCS codes K0830 (power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds) and K0831 (power wheelchair, group 2 standard, seat elevator, captain's chair, patient weight capacity up to and including 300 pounds) for power wheelchairs must be billed with modifiers NU, RR or NURB/RBNU. Documentation of the member-owned equipment these accessories are applied to must be included in the Additional Claim Information field (Box 19) of the claim. When providing a heavy duty or very heavy-duty power wheelchair (HCPCS codes K0824 thru K0829), if it includes a seat elevation system, it can be billed separately by providers using HCPCS code K0108.

**Temporary Replacement and Backup Wheelchairs – Temporary Wheelchairs**

Since the provision of a temporary wheelchair is considered to be part of all providers' overarching service obligations, providers may bill using HCPCS code K0462 (temporary replacement for patient-owned equipment being repaired, any type) for separate reimbursement of a one-month rental while a member-owned wheelchair is being repaired and the repair is expected to take more than one day.

HCPCS code K0462 has a frequency limitation and may be billed two times per year without a TAR. A TAR will be required to exceed this frequency limitation. When billing HCPCS code K0462, providers must include the following information on the claim and, when applicable, also with the TAR submission:

- The unique HCPCS code(s) or manufacturer and brand name/number of the member-owned wheelchair being repaired and original date of purchase; and

- A narrative description, manufacturer and brand name/number of the replacement equipment;
- A description of what was repaired or replaced on the member-owned wheelchair; and
- An explanation as to why the repair took more than one day to complete.

**Temporary Replacement and Backup Wheelchairs – Backup Wheelchairs**
Medi-Cal may cover repairs and/or replacement parts for a member-owned backup wheelchair on a case-by-case basis if medically necessary due to the non-functionality of the member's primary wheelchair (for example, the primary wheelchair is also in need of repairs/replacements and is therefore temporarily unusable).

A TAR would only be required for repairs and/or replacement parts for a member-owned backup wheelchair when the cumulative cost exceeds $2,500 in a calendar month, consistent with the "TAR and Documentation Requirements for Repair, Maintenance or Replacement Parts" policy in this manual section. In these circumstances, providers should note the following:

- Repairs and/or replacement parts for a member-owned backup wheelchair would be covered instead of providing a temporary replacement wheelchair as described in this section.
  - This may be preferable to the member, as the member-owned backup wheelchair would be more closely tailored to their needs if it was formerly a primary wheelchair.
  - Since repairs and/or replacement parts are being performed on a member-owned backup wheelchair, providers may not bill HCPCS code K0462 in the same month.
- Providers seeking to make repairs and/or order replacement parts for a backup wheelchair for a member must submit documentation of medical necessity.

**Stair-Climbing Wheelchair Systems**
Medi-Cal covers stair-climbing wheelchair systems for eligible members, subject to an approved TAR and consistent with federal Food and Drug Administration (FDA)-approved indications, which may have age and other limitations (for example, some systems may only be FDA-approved for members under age 21). Providers are responsible for validating the most current FDA-approved indications. Providers must include documentation of member evaluation and applicable training on the safe and effective use of the system along with the TAR.

Please refer to the policy for the appropriate HCPCS codes.

**Wheelchair Transportation Securement System**
A wheelchair transportation securement system refers to all components and accessories mounted on a wheelchair (for example, securement-point brackets) needed to secure the wheelchair into or on a vehicle while it is being transported. Providers must bill this using HCPCS code E1022 (wheelchair transportation securement system, any type includes all components and accessories).

A wheelchair transit securement system refers to all components and accessories mounted on a wheelchair (for example, wheelchair-anchored pelvic/lap belt) needed to secure the member into a wheelchair during transit. Providers must bill this using HCPCS code E1023 (wheelchair transit securement system, includes all components and accessories).

HCPCS code E1023 must be billed with modifiers NU, RR or RB. Documentation of the member requiring a wheelchair and wheelchair accessories must be included in the Additional Claim Information field (Box 19) of the claim.

**OHC Coverage/Payer of Last Resort**

State and federal statutes provide for Medi-Cal to be the payer of last resort. Generally, providers must bill a member's OHC coverage (for example, Medicare or commercial insurance) before billing Medi-Cal when OHC coverage is known to exist. When other entitlements are discovered after billing Medi-Cal, providers are prohibited from billing the third party because Medi-Cal reimbursement (regardless of the percent of billed amount) constitutes reimbursement in full. For more information on OHC and related policy, refer to the following sections in the provider manual:

- Other Health Coverage (OHC) in the appropriate Part 1 manual
- Other Health Coverage (OHC) Guidelines for Billing in this manual
- Provider Regulations in the appropriate Part 1 manual
- Provider Guidelines in the appropriate Part 1 manual

Providers are encouraged but not required to obtain a TAR from DHCS for DME items for dually eligible members before providing the item and billing Medicare. DHCS will process an authorization request for a dually eligible member in the same manner as a Medi-Cal-only member, regardless of whether Medicare (or any OHC) has authorized the DME or been billed. Under Charpentier requirements, DHCS must process TARs for dually eligible members in the same manner as Medi-Cal-only members. See the Durable Medical Equipment (DME): Bill for DME and Durable Medical Equipment (DME): An Overview sections in this manual. Providers may check with DHCS if they have not received a response to a TAR within 14 business days of the request, or within 72 hours for an expedited request.

**Note**: For Medi-Cal managed care members who receive DME, including CRT manual and power wheelchairs, through their assigned Medi-Cal MCP, TARs are not submitted to DHCS. Instead, providers must adhere to each individual Medi-Cal MCP's utilization management control policies, which may include prior authorization and can vary depending on the Medi-Cal MCP. However, like DHCS, Medi-Cal MCPs are required to process prior authorizations for dually eligible members in the same manner as a Medi-Cal-only member pursuant to Charpentier requirements. Additionally, providers must ensure they are following individual Medi-Cal MCP OHC policies to ensure timely and accurate reimbursement. Providers may check with the member's MCP if they have not received a response to their request for prior approval within 14 business days of the request, or within 72 hours for an expedited request.

**Billing for Dually Eligible Medi-Cal Members**

When billing for dually eligible members, providers must adhere to the following requirements:

- The TAR/SAR must include a complete medical justification and documentation that would normally accompany a Medi-Cal-only TAR and include one of the following notes in the "Medical Justification" section:
  - Medi/Medi: Charpentier/Rates
  - Medi/Medi: Charpentier/Benefits Limitation, or
  - Medi/Medi: Charpentier/Both Rates and Benefit Limitation
- The provider must bill Medicare or OHC, consistent with Medi-Cal's OHC policy, as noted in this section.
- The provider then bills Medi-Cal with documented proof of costs that Medicare or OHC does not cover, up to the maximum Medi-Cal allowable amount, consistent with Medi-Cal's OHC policy, as noted in this section.

## Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines (dura wheel guide)

**General Clinical Guidelines for Wheelchairs, Seating and Positioning Components – Wheelchairs are Not Covered When:**

‹‹Not prescribed by a licensed practitioner, or, in the case of a Complex Rehabilitation Technology (CRT) wheelchair, a Qualified Health Care Professional (QHCP) and a Qualified Rehabilitation Technology Professional (QRTP) and provided by an accredited CRT supplier.››

**Wheelchair Medical Necessity Criteria – Coverage Criteria**

The coverage criteria for Medi-Cal reimbursement of a wheelchair is based on a stepwise progression of medical necessity listed in the clinical guidelines in Section I above and the specific criteria in Section II. ‹‹In order for these criteria to be met, the member must have an evaluation that was performed by a QHCP such as a physical therapist (PT), occupational therapist (OT) or other practitioner who has specific training and/or experience in wheelchair evaluation. The QHCP must document, to the extent required by the coverage criteria for the specific wheelchair, how the member's medical condition supports Medi-Cal reimbursement.››

‹‹Maintaining documentation of least costly alternatives reviewed and attempted is the responsibility of the QHCP.››

**The following criteria applies to ultra-lightweight manual wheelchairs; manual tilt-in-space wheelchairs; pediatric wheelchairs; power assist devices and power mobility devices.**

‹‹The member has had a specialty evaluation that was performed by a QHCP, such as a PT or OT, or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and that documents the need for the device in the member's home or nursing facility.›› The PT, OT or practitioner must have no conflict of interest or financial relationship with the supplier. ‹‹The records from suppliers/vendors or healthcare professionals (PT, OT or

practitioner) that do not have specific training and experience in rehabilitation wheelchair evaluations, or with a financial relationship or conflict of interest in the claim or outcome are not considered sufficient by themselves for determining that an item is medically reasonable and medically necessary, and

The wheelchair is provided by an accredited CRT supplier that employs a W-2 QRTP who specializes in wheelchairs and has direct, in-person involvement in the wheelchair selection for the member.››

**Definitions**

**‹‹Complex Rehabilitation Technology (CRT)**

CRT – DME, whether modified or customized, that is individually configured for members to meet their specific and unique medical, physical and functional needs and capacities for ADLs and IADLs, as medically necessary. CRT is used to increase, maintain or improve functional capabilities with respect to mobility and reduce anatomical degradation and complications of members with disabilities. CRT may only be provided by an accredited CRT supplier.

**CRT Supplier**

CRT Supplier – accredited as a DME CRT supplier that specializes in the evaluation, configuration, fitting, adjustment, modification and/or programming of complex rehab technology to meet the specific and unique medical, physical and functional needs of members with disabilities and complex medical conditions.››

**Licensed Practitioner**

Licensed Practitioners – clinical professionals furnishing medical care, or any other type of remedial care recognized under State law within their scope of practice as defined by State Law.

**Note**: ‹‹A QHCP must be a licensed practitioner, but not all licensed practitioners have the specialized knowledge, skills and training of a QHCP that are required for the provision of complex rehab technology.››

**‹‹Power Assist Device (PAD)**

‹‹PAD – an option that temporarily transforms a manual wheelchair to a powered mobility device when the PAD is attached, activated or engaged, but allows the wheelchair to operate manually when the device is detached, deactivated or disengaged.›› Batteries are included.

**‹‹Qualified Health Care Professional (QHCP)**

QHCP – a licensed/certified medical professional, such as a PT, OT or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and member's seating and positioning needs. The QHCP may have no financial relationship with the CRT supplier, QRTP, manufacturer of the recommended CRT product(s) or third-party payor.

**Qualified Rehabilitation Technology Professional (QRTP)**

QRTP – a professional with competence in analyzing the needs of members with disabilities, who has direct, in-person involvement in the selection of appropriate assistive technology for the member's needs and is directly involved with or closely supervises the final fitting and delivery of the wheelchair. The QRTP must be a W-2 employee of an accredited CRT supplier; hold the credential of Assistive Technology Professional (ATP) or Seating and Mobility Specialist (SMS) from RESNA; and/or hold the credential of CRT Supplier from the International Registry of Rehabilitation Technology Suppliers.››