

JANUARY 1, 2008 DME UPDATE

Please note the following changes relating to HCPCS coding, Wheeled Mobility and Labor fees and a new process for some commonly requested miscellaneous equipment.

1. HCPCS changes:

Effective for **order dates** on and after January 1, 2008, the following code has been **discontinued**:

E2618 #Wheelchair accessory, solid seat support base (replaces sling seat), for use with manual wheelchair or lightweight power wheelchair, includes any type mounting hardware

Cross-reference:

- **For a manual wheelchair:**
 - If a new **folding wheelchair** is being delivered use code E0992.
 - If a replacement is needed, use E0992.
 - A solid seat support base is included with the payment for a rigid manual wheelchair; no additional payment will be made.
- **For pediatric seating:**
 - A solid seat support base is included with the payment for planar and contoured pediatric seating codes E2292 and E2294: no additional payment will be made.
 - If a replacement solid seat support base is needed, use the wheelchair code with the RP modifier.
- **For a power wheelchair:**
 - A solid seat support base is included with the payment for a new wheelchair: no additional payment will be made.
 - If a replacement solid seat support base is needed, use wheelchair code with the -RP modifier.

2. Fee schedule updates:

- Effective for **dates of service** on and after January 1, 2008 the fee for E1161 #Manual adult size wheelchair, includes tilt in space is **\$2287.24**. **The fee includes any transport option.**
- Effective for **dates of service** on and after January 1, 2008 the fee for E0992 #Manual wheelchair accessory, solid seat insert will be **\$112.28**. **The code describes a solid seat support base and the fee includes any type mounting hardware.**

JANUARY 1, 2008 DME UPDATE

3. New process for commonly requested miscellaneous items:

Effective for **order dates** on and after January 1, 2008, a new process is established for commonly requested items categorized as E1399 Durable Medical Equipment, miscellaneous. An **upper extremity support system (UESS)** and **rolling recline shower commode chair** will not be subject to medical review and will have maximum reimbursable amounts (MRA) assigned to them.

- A **UESS** is covered when the medical need for positioning in a wheelchair cannot be met with less costly alternatives such as any combination of a safety belt, pelvic strap, harness, prompts, armrest modifications, recline, tilt in space or other existing or potential seating or wheelchair features. Documentation should also include the patient's ability to effect knowing and purposeful position changes using the UESS. UESS dimensions should not exceed the positioning length of the forearms (e.g., 12-15"). A UESS featuring enhancements (i.e. rims, lips, padding) or dimensions greater than medically needed for upper extremity support alone will not be approved. A wheelchair tray is not considered a seating tray and will not be approved for completion of activities of daily living. **The MRA for a UESS, any type, includes all modifications, padding and mounting hardware is \$199.88.**
- A **rolling recline shower commode chair** is covered when recline is necessary to complete hygiene needs **and** the patient **either** has positioning needs that cannot be met by upright and fixed angle chair **or** the patient's postural control requires recline feature. **The MRA for a rolling recline shower commode chair, any size, including safety belt and padded headrest with any type armrest is \$390.45.** A medically justified foot rest may be billed separately using code E0175 *#Foot rest, for use with commode chair, each (one or two piece)*.

E1399 will be used for the UESS and rolling recline shower commode chair to obtain a prior approval number without submission of medical documentation using the following procedure:

- a) DME provider obtains valid order and medical documentation (to maintain in their records for audit purposes) from the ordering practitioner;
- b) DME provider submits a prior approval request containing a copy of valid order and **either** a manufacturer's price quote **or** the item's make and model;
- c) These items must be submitted singularly on a separate prior approval from all other prior approval items;

JANUARY 1, 2008 DME UPDATE

- d) The DME provider will be issued a prior approval priced up to the established MRA and may bill Medicaid upon dispensing.

Reviewers will contact a requesting DME provider and ordering practitioner for clarification if same or similar items have recently been provided and/or currently being requested by another provider.

4. Effective for **dates of service** on and after January 1, 2008, the fee for E1340 *#Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes (more than 2 hours requires prior approval)* will be **\$10.00**.

Billing instructions for labor and repairs:

- E1340 is reported when:
 - a) No specific code exists to describe the item in need of service, **and**
 - b) The charge for replacement parts and related labor exceeds the fee for A9900.
- The –RP (*Repair and replacement*) modifier should be reported when a specific code and fee is listed in the DME Provider Manual for the item requiring service.
- E1340 must not be billed in conjunction with the specific code plus –RP for repair and replacement of the same item. For listed codes, the labor component of repair and replacement is included in the payment resulting from use of the specific listed code with the –RP.
- Labor is included in the payment for new equipment and components. E1340 and –RP must not be billed in conjunction with new equipment or components, with the following exception:
 - When over two hours of labor is required for a skilled technician to perform complex disassembly and assembly to add a new component to existing equipment dispensed previously.
- Repairs and replacement covered under the manufacturer's warranty are not to be billed.
- When repair and replacement is performed by a manufacturer, Medicaid pays the Medicaid provider the line item labor cost on the manufacturer's invoice and the applicable Medicaid fee on the parts. If labor and parts charges are not separately itemized on the invoice as required by 18NYCRR 505.5, the Medicaid provider is not entitled to a markup on the cost of parts and will only be paid the manufacturer invoice cost of parts and labor.
- See Rule 12 in the DME Provider Manual, Procedure Codes Section, for further information on repair and labor.

Questions? Call the Pre-Payment Review Group at 1-800-342-3005