**11000 Nursing Facility Services**

Revision 20-1; Effective March 16, 2020

**11100 CPWC Benefit for NF Residents Enrolled in STAR+PLUS or a Medicare-Medicaid Plan**

Revision 20-1; Effective March 16, 2020

Custom power wheelchairs (CPWCs) are a benefit for STAR+PLUS/Medicare-Medicaid Plan (MMP) members residing in a Medicaid enrolled nursing facility (NF) when the CPWC is medically necessary and prior authorized by the Texas Health and Human Services Commission (HHSC) or its designee. CPWC is a Medicaid benefit for Medicaid-only NF residents, as well as NF residents who are dually eligible for Medicare and Medicaid.

**Eligibility Requirements**

The managed care organization (MCO) must ensure the following criteria are met to establish eligibility for the CPWC benefit for NF residents. The MCO must ensure the resident:

* is eligible for and receiving Medicaid services, including dual-eligible NF residents, in a licensed and certified NF that has a Medicaid contract with HHSC;
* is age 21 or older;
* has a signed statement or written order from an attending physician certifying the CPWC is medically necessary;
* has a signed and dated physical or occupational therapy evaluation to address functional mobility and a safety assessment that includes an evaluation of the resident’s ability to safely operate the chair; and
* has a seating assessment completed and signed by a licensed occupational or physical therapist and a Qualified Rehabilitation Professional (QRP) documenting that the client is able to safely operate a power wheelchair and all of its medically necessary components and equipment.
	+ Trials must be conducted in a power wheelchair to demonstrate the ability to independently navigate the typical obstacles found in the environment and functionally operate the powerized accessories in a safe manner.
	+ The QRP must be employed by, or contracted with, the durable medical equipment (DME) provider. The QRP is not required to be contracted directly with the MCO but must be enrolled in Texas Medicaid as a performing provider under a DME provider group.
	+ The QRP must be present during the seating assessment, fitting, training and delivery of the CPWC.

The evaluation must show the resident is:

* unable to consistently ambulate independently more than 10 feet;
* unable to operate a manual wheelchair or independently operate other ambulation devices;
* without cognitive impairment that would impact the ability to manipulate controls or meet other safety concerns for the resident or others;
* unable to be positioned in a standard power wheelchair;
* has a mobility status that would be compromised without the requested CPWC; and
* a reasonable expectation that the resident will benefit from the use of this chair for a minimum period from six months to five years.

**Required Elements of a CPWC**

A CPWC is defined as a professionally manufactured wheeled mobility system that consists of a power base and customized seating system and provides motorized wheeled mobility and body support specifically for individuals with impaired mobility.

The power mobility base may include programmable electronics and may utilize alternate input devices.

The wheelchair must be medically necessary, adapted and fabricated to meet the

individualized needs of the resident, and intended for the exclusive and ongoing use of

the resident.

For safety, all chairs must include a stop switch for use by the client sitting in the chair.

Components of the customized seating system must be in part, or entirely usable, only

by the resident for whom the power wheelchair is adapted and fabricated. This means

at least one of the components of the seating system may be usable only by that

resident.

* In order to be considered customized, the seat must be specifically measured to fit the resident’s needs.
* Customized seating may include a customized seat cushion and/or back cushion or a molded seat. The resident should have a documented condition that requires custom seating that includes, but is not limited to, one or more of the following:
* poor trunk control;
* contractures of elbows and/or shoulders;
* muscle spasticity;
* tone imbalance through shoulders and/or back;
* kyphosis, lordosis or other skeletal deformity; or
* lack of flexibility in pelvis or spine.
* Molded seat-billable labor to create may not exceed 15 hours.
* Tilt in space capabilities. The resident should have a condition that meets medical necessity for a tilt in space feature, including, but not limited to, one or more of the following:
* documented weak upper extremity strength or a condition that leads to weakened upper extremities;
* severe spasticity;
* hemodynamic problems;
* quadriplegia;
* excess extensor tone;
* the need to rest in a recumbent position two or more times per day when the resident cannot transfer between the bed and the wheelchair without assistance; and/or
* be at risk for skin breakdown because of an inability to reposition in the chair to relieve pressure areas.



For a combination power tilt and recline seating system (reclining capabilities), the resident should demonstrate the need to rest in a recumbent position two or more times per day when the resident cannot transfer between the bed and the wheelchair without assistance and/or be at risk for skin breakdown because of an inability to reposition in the chair to relieve pressure areas.

* Power Elevating Leg Lifts. A power elevation feature involves a dedicated motor and related electronics with or without variable speed programmability, which allows the leg rest to be raised and lowered independently of the recline and/or tilt of the seating system. It includes a switch control which may or may not be integrated with the power tilt and/or recline control(s).
* The resident should meet the criteria for reclining capabilities.
* The resident should have documented limitations with upper extremity functioning that would limit their ability to use manual elevating leg rests.
* The resident should have a condition with one of the following:
* A musculoskeletal condition such as flexion contractures of the knees or the placement of a brace that prevents 90-degree flexion.
* Significant edema of the lower extremities that requires leg elevation.
* Hypotensive episodes that require frequent positioning changes.
* Required need to maintain anatomically correct positioning and reduction of exposure to skin shear.
* Power Seat Elevation System. A power seat elevation system is used to raise and lower the client in their seated position without changing the seat angles to provide varying amounts of added vertical access when the resident does not have the ability to stand or pivot transfer without assistance. It may address one or more of the following:
* Facilitate independent transfers, uphill transfers and transfers across unequal seat heights to and from the wheelchair; and
* Augment the client’s reach in cases of limited reach and range of motion in the shoulder, arm and/or hand.

The CPWC must be:

* designed to assist the resident to be independently mobile in their environment (this includes surfaces inside and outside the facility);
* designed to meet the medical and physical needs of the resident and prevent or minimize any further decline;
* for the exclusive use of the resident for whom it is authorized; and
* the personal property of the resident for whom it is authorized.

It becomes the personal property of the resident’s estate upon death.

**Prior Authorizations and Billing**

The MCO/MMP is responsible for the prior authorization and reimbursement of CPWCs.

When a resident changes MCO/MMP for any reason (i.e., choice, moves out of the service delivery area, etc.), and the prior authorization has already been approved but the chair has not yet been delivered to the NF resident, the MCO issuing the initial authorization is responsible for reimbursement of the CPWC. This is consistent with the Uniform Managed Care Contract, Section 5.06, Span of Coverage.

When the MCO receives a prior authorization request from a contracted DME provider

to construct a CPWC for an NF resident, the MCO is required to respond with a decision of approval, denial or modification within three business days of the receipt of the request.

Medicare does not cover CPWCs for skilled nursing facility (SNF) residents. MCOs must not deny NF CPWC claims or prior authorization requests nor require a Medicare Explanation of Benefit (EOB) for dual-eligible NF residents, in compliance with *Uniform Managed Care Manual* (UMCM) Chapter 2.0, Claims Manual, Section VII, Claims Processing Requirements, F. STAR+PLUS and STAR Kids Services for Dual-Eligibles. STAR+PLUS MCOs and MMPs should ensure staff processing CPWC prior authorization requests and claims are informed of this benefit for dual-eligible NF residents. MCO systems must have the functionality to prevent the request of a Medicare EOB or the denial of a CPWC with a reason related to the resident having Medicare as their primary insurance.

Denial notices should include responses that are specific and individualized, reference criteria outlined in this policy, and outline the process and timelines for filing an appeal to the decision. Refer to UMCM Chapter 3.21.

Upon the MCO’s approval of the prior authorization request, the MCO must instruct the provider to proceed with construction of the chair and request that claims be billed directly through the MCO portal upon delivery of the chair to the NF resident. Specific billing codes should be used to identify the power base type and each accessory or component.

To be eligible for Medicaid reimbursement, the member must be on a Medicaid NF stay at the time of assessment and upon the CPWC delivery.

The MCO/MMP must adjudicate a clean claim within 30 days. MCOs will be required to pay providers interest at an 18 percent annual rate if a claim, or portion of a claim, remains unadjudicated beyond the 30-day claims processing deadline.

The MCO is responsible for chair modifications and adjustments.

The MCO/MMP is responsible for the prior authorization and reimbursement for

Modifications, as described below. CPWC modifications are the replacement of

components due to changes in the resident’s condition.

* All modifications within the first six months after delivery of the chair are considered part of the purchase price.
* Components that no longer function as they were originally designed are not considered modifications.
* Modifications to a CPWC after the first six months following delivery must be sent for a prior authorization request due to a change in the resident’s needs, capabilities, or physical or mental status which was unknown or not anticipated. The MCO will request the following documentation to be used in the prior authorization process:
* all changes in the resident’s mobility needs;
* the original date of delivery;
* the serial number of the current equipment; and
* the cost of requested modification(s).

The MCO/MMP is responsible for prior authorization and reimbursement for CPWC

Adjustments, as described below. Adjustments require labor only and do not include the

addition, modification or replacement of components or supplies needed to complete

the adjustment.

* Adjustments are allowable after the first six months following delivery of the chair. Adjustments prior to the first six months are considered part of the purchase price.
* A maximum of one hour of labor, as needed, may be requested.
* Adjustments do not require the purchase of supplies, as this is not defined as a repair.

The MCO/MMP is responsible for the prior authorization and reimbursement for medically necessary CPWC replacement requests at or after five years of the original date of purchase.

The MCO/MMP is responsible for prior authorization and reimbursement of replacement

chairs prior to five years of the original date of purchase when the CPWC no longer

meets the resident’s needs. Other circumstances that would warrant chair replacement prior to the passage of five years from the purchase date are indicated below:

* Serious damage was incurred through no fault of the resident. If it is determined that the chair was damaged due to abuse by staff of the NF, the NF is responsible for replacing the chair.
* CPWC was stolen and a police report is provided to document the theft.

The following items are not a benefit and cannot be billed additionally:

* Additional accessories, such as tire pumps, color upgrades, gloves, back packs, USB ports and flags. (These items are not considered medically necessary and this list is not all inclusive.)
* Attendant control switch.
* Elevators or platform lifts.

In all other circumstances from those listed above, the NF is responsible for the routine

maintenance and repair, including battery and battery charger replacement of the resident’s CPWC.