BRODA®

DURABLE MEDICAL EQUIPMENT
MOBILITY ASSISTIVE EQUIPMENT

FUNDING RESOURCE GUIDE

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WHERE TO START

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If you are considering making a request for DME such as a wheelchair, your first step is to have a Face-to-Face Evaluation completed by your primary care physician. The Affordable Care Act (ACA) has set forth requirements for the completion of the FFE and they can be found in section 6407 of the ACA and are referenced on page 2 of our Funding Guide.

2 Prescription for DME/MAE

The next step is to obtain from the prescriber a detailed written order/ prescription for the requested MAE. The detailed written order/prescription must be in the supplier's possession BEFORE the item is delivered. The date of the written order must be on or before the date of delivery. The detailed written order/ prescription must contain the 7 elements listed on page 3 of our Funding Guide.

3 Clinical Record Documentation

The contents of the Clinical Record is reviewed during the funding process. It is vitally important that your documentation clearly explains the need for the requested equipment. Further details regarding Clinical Documentation can be found on page 4/5 of our Funding Guide.

4 Supporting Documents

The contents of the Supporting Documents will be reviewed during the funding process. The contents of your Supporting Documents should aid in proving medical necessity/need for the requested equipment. It is vitally important that your Supporting Documents clearly identify and support the explanation of need that is detailed in the clinical record. Further details regarding Supporting Documents can be found on page 5 of our Funding Guide.

5 Submit Claim

The process for submitting your claim can vary by care provider as well as insurance provider. It is important to contact the care provider and/ or insurance provider prior to submitting your claim to ensure the required process is followed and delay in processing time is avoided. Page 6 of our Funding Guide provides details to aid you in submitting your claim.

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STEP 1 FACE-TO-FACE EVALUATION

INTRO

When completing the process of requesting reimbursement and/or funding of any kind through an insurance provider, it is important to remember that all reimbursement/funding of any kind is provided on a case by case basis and is dependent upon proof of medical necessity and supporting documentation. The guidelines and regulations regarding coverage for items such as DME/MAE are updated often. It is important that you validate all information you are provided each time you begin to process a claim for coverage. Validating the information with the insurance provider can save you valuable time during the claim process.

The information provided in this reference guide will focus on the process/requirements for submitting a claim when seeking reimbursement/ coverage for a wheelchair. Wheelchairs are considered Durable Medical Equipment (DME)/ Mobility Assistive Equipment (MAE) and will be referenced as such throughout this guide.

Where to start: Step 1: Face-to-Face Evaluation (FFE)

If you are considering/requesting DME such as a wheelchair, your first step is to have a Face-to-Face Evaluation completed by your primary care physician. The Affordable Care Act (ACA) has set forth requirements for the completion of the FFE and they can be found in section 6407 of the ACA and they are as follows:

Face-to-Face Visit Requirements:

As a condition for payment, Section 6407 of the Affordable Care Act (ACA) requires that a physician (MD, DO or DPM), physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS) has had a face-to-face examination with a beneficiary that meets all of the following requirements:

- The treating physician must have an in-person examination with the beneficiary within the six (6) months prior to the date of the written order prior to delivery (WOPD).
- This examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.

A new face-to-face examination is required each time a new prescription for one of the specified items is ordered. A new prescription is required by Medicare:

- For all claims for purchases or initial rentals.
- When there is a change in the prescription for the accessory, supply, drug, etc.
- If a local coverage determination (LCD) requires periodic prescription renewal (i.e., policy requires a new prescription on a scheduled or periodic basis)
- When an item is replaced
- When there is a change in the supplier

BRODA Tip To Remember:

It is recommended that specifics such as dates of treatment(s), name of condition(s) and result of treatment relative to the need for the DME/MAE be included in the FFE documentation.

The FFE must be completed on or before the date of the written order/prescription and may be no older than 6 months prior to the prescription date.

STEP 2 PRESCRIPTION FOR DME/MAE

Step 2: Prescription for DME/MAE

The next step is to obtain from the prescriber a detailed written order/prescription for the requested MAE. The detailed written order/prescription must be in the supplier's possession BEFORE the item is delivered. The date of the written order must be on or before the date of delivery.

The detailed written order/prescription must contain the following 7 elements:

- Beneficiary's name
- Physician's name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s)
- The prescribing practitioner's National Provider Identifier (NPI)
- The signature of the ordering practitioner
- Signature date

BRODA Tip To Remember:

The detailed written order/prescription cannot be written prior to FFE being completed. Doing so may result in the claim being denied as statutorily non-covered-failed to meet statutory requirements.

Step 3: Documentation (Clinical Record)

It is vitally important that the content of the clinical record clearly answers/addresses the questions below as they are used during the claims/review process. Per Medicare guidelines, coverage for MAE will be considered if the equipment is reasonable and necessary for beneficiaries who have personal mobility deficit sufficient to impair their performance of mobility-related activities of daily living (MRADLs), such as toileting, feeding, dressing, grooming and bathing in customary locations within the home. The following questions are from Medicare's National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE) 280.3 policy.

NCD Questions:

1) Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs in the home? A mobility limitation is one that:
   a) Prevents the beneficiary from accomplishing the MRADLs entirely, or,
   b) Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to participate in MRADLs, or,
   c) Prevents the beneficiary from completing the MRADLs within a reasonable time frame.

2) Are there other conditions that limit the beneficiary's ability to participate in MRADLs at home?
   a) Some examples are significant impairment of cognition or judgment and/or vision.
   b) For these beneficiaries, the provision of MAE might not enable them to participate in MRADLs if the comorbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with MAE.

3) If these other limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of MAE will be reasonably expected to significantly improve the beneficiary's ability to perform or obtain assistance to participate in MRADLs in the home?
   a) A caregiver, for example a family member, may be compensatory, if consistently available in the beneficiary's home and willing and able to safely operate and transfer the beneficiary to and from the wheelchair and to transport the beneficiary using the wheelchair. The caregiver's need to use a wheelchair to assist the beneficiary in the MRADLs is to be considered in this determination.
   b) If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of MAE coverage if it results in the beneficiary continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of MAE.

4) Does the beneficiary or caregiver demonstrate the capability and the willingness to consistently operate the MAE safely?
   a) Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.
   b) A history of unsafe behavior in other venues may be considered.

5) Can the functional mobility deficit be sufficiently resolved by the prescription of a cane or walker?
   a) The cane or walker should be appropriately fitted to the beneficiary for this evaluation.
   b) Assess the beneficiary's ability to safely use a cane or walker.

6) Does the beneficiary's typical environment support the use of wheelchairs including scooters/power-operated vehicles (POVs)?
   a) Determine whether the beneficiary's environment will support the use of these types of MAE.
   b) Keep in mind such factors as physical layout, surfaces, and obstacles, which may render MAE unusable in the beneficiary's home.

7) Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair in the home to participate in MRADLs during a typical day? The manual wheelchair should be optimally configured (seating options, wheelbase, device weight, and other appropriate accessories) for this determination.
   a) Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.
   b) A beneficiary with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, i.e. light weight, etc., should be determined based on the beneficiary's physical characteristics and anticipated intensity of use.
   c) The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.
   d) Assess the beneficiary's ability to safely use a manual wheelchair.

NOTE: If the beneficiary is unable to self-propel a manual wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair may be appropriate.

CLINICAL RECORD DOCUMENTATION CONTINUED:

8) Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?
   a) A POV is a 3- or 4-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation.
   b) The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a POV.
   c) Assess the beneficiary's ability to safely use a POV/scooter.

9) Are the additional features provided by a power wheelchair needed to allow the beneficiary to participate in one or more MRADLs?
   a) The pertinent features of a power wheelchair compared to a POV are typically control by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.
   b) The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.
   c) The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a power wheelchair.
   d) Assess the beneficiary's ability to safely use a power wheelchair.

NOTE: If the beneficiary is unable to use a power wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair is appropriate. A caregivers inability to operate a manual wheelchair can be considered in covering a power wheelchair so that the caregiver can assist the beneficiary.

BRODA Tip To Remember:

The list of questions provided is not exhaustive as other criteria maybe required and additional clinical documentation may be needed to prove medical necessity. During the review process the following information will need to be present and clearly identifiable in the clinical record.

Your documentation should clearly,
- Provide the history of events that have taken place leading to the request of the MAE
- Identify the mobility deficit to be corrected by the MAE
- Identify all treatments provided that did not successfully eliminate the need for MAE
- Identify all other MAE (walker, cane, crutch) used and clearly explain specifically why they did not meet the patients' needs
- Identify that the beneficiary lives in an environment that allows for safe adequate use of the MAE
- Identify that the beneficiary or caregiver is capable of safely using/operating the requested MAE

To review the National Coverage Determination for Mobility Assistive Equipment policy in its entirety. Please visit https://goo.gl/hCEJXq

Step 4: Required Supporting Documents

ALL requests for coverage/funding of DME/MAE (wheelchair) requires clinical documentation that outlines/substantiates patient need and proves medical necessity.

Noridian Health Care Solutions, a Medicare contracted Health Care Administrator has compiled a documentation checklists for Manual Wheelchairs (MWC). The checklist can be found by following the link: https://goo.gl/2Azwew

When utilizing the documentation checklist provided by Noridian Health Care Solutions, you can utilize the "hover function" with your cursor, provided on the items shaded in blue. Doing so will allow you to view additional notes explaining the required/needed item(s).

Please note that it is important to know which (if any) HCPCS code is assigned to the type of wheelchair being requested. For example, HCPCS code E1161 is assigned to all Adult Tilt in Space Wheelchairs. Being aware of and understanding the HCPCS code will allow you to better navigate the checklist and ensure you obtain the appropriate documents. For questions regarding the assigned HCPCS codes please contact the Manufacturer/ Provider of the equipment being requested.

During the funding process, you may be asked for additional supporting documents. Additional supporting documents can aid in proving medical necessity for the requested equipment. You may be asked to provide a copy of a completed Anatomical Assessment or to have a Trial completed for the requested equipment. For your reference, we have included our Clinical Resource Section where you will find Anatomical Assessment forms (standard and bariatric) as well as a Case Evaluation Form that can be used to document the trial of the requested equipment.

BRODA Tip To Remember:

It is important to make copies of all required documents requested during this process. Maintaining copies of the requested/required documents can save you valuable time if documents are requested a second time.

STEP 5 SUBMIT CLAIM

Step 5: Submit Claim

Once you have completed the above requirements and are ready to submit your claim, it is recommended that you do the following;

1) Make copies of ALL the documents you will be submitting and maintain them for your records
2) Write a simple cover letter that explains the reason for your submission, including your contact information
3) Contact the provider or insurance company that you will be submitting your claim to
4) Verify that you have all the required documents (obtain a copy of a check list if available)
5) Verify mailing address and best/preferred method of delivery
6) Mail ALL original signatures/documents to the provider/insurance company
7) Obtain tracking number for your package to ensure appropriate delivery
8) Follow up with provider/insurance company to ensure they received your submission and obtain a file number if one is available

BRODA Tip To Remember:

If a PO BOX is given as the delivery address, remember that FEDEX/UPS does not deliver to PO BOXES. If you intend to send your package via FEDEX/UPS ask for a physical address that can be used for delivery of a FEDEX/UPS package. Mail ALL original documents/signatures to the provider/insurance company. If you send copies, it may delay the processing of your claim.

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CLINICAL RESOURCE TOOLS

Regardless of age, patients seated for extended periods deserve to be comfortable. Comfort reduces stress, improves recovery, wellbeing, and is therefore… absolutely essential to one's quality of life. Comfort is the key, and when it comes to providing comfort, there is no substitute for a ***BRODA.***

ANATOMICAL ASSESSMENT

Contact Name: _____ *Phone:* _____ *Date:* _____

Patient Name: _____ *Height:* _____ *Weight:* _____

Please measure the patient at their widest points while sitting in an upright position and add 1"- 2" inches to obtain proper seat width. Please use a soft flexible measuring tape to avoid injuries such as skin tears. This sheet is used for patients weighing up to 350lbs. For patients weighing more than 350lbs, please use our Bariatric Anatomical Assessment.

1. Shoulder Width — Measure the patient at the widest point of the shoulders.

2. Seat Width – While sitting on a firm surface, measure the width of the hips/thighs at the widest point.
** The seat width of a BRODA chair is determined by measuring from the inside of the left armrest to the inside of the right armrest.*

3. Width at knee - Measure across the widest point of the knees.

4. Back Height – Measure from the seating surface to the top of the head.

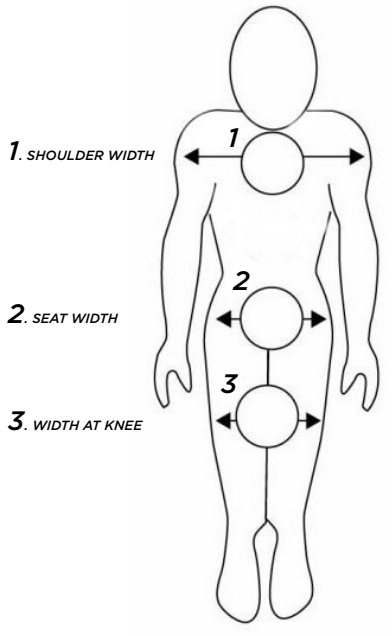
5. Back Length – Measure from the seating surface to the base of the neck.

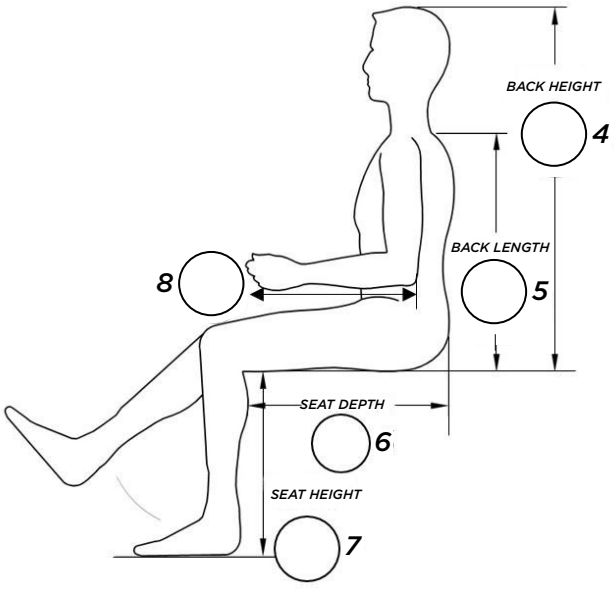
6. Seat Depth – Is measured from the posterior (back) of the buttocks to the popliteal (underside of the knee).

7. Seat Height – If the patient utilizes a cushion when in the chair, complete measurements with the cushion in the chair to obtain proper measurements. With feet flat on the floor & knees bent at 90°, measure from the floor to the underside of the knee and add 1"- 2" inches to allow for clearance of the footrest.

8. Armrest Length- With the shoulder in a neutral position measure from the 90-degree angle at the elbow to the finger tips.

CLIENT MEASUREMENTS:
(Write Measurements inside of circles)





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ANATOMICAL ASSESSMENT

Patient Name: _____ *Height:* _____ *Weight:* _____

To assist in determining the appropriate BRODA chair for your patient, please complete the questions below and provide any additional information you feel can aid us in selecting the appropriate chair.

Location:

Please provide width of doorway in inches: _____

Types of surfaces: ***Carpet*** *Y or N* ***Tile*** *Y or N* ***Transition Strips*** *Y or N*

Posture/Function:

Does the patient have decreased head and/or trunk control? Y or N

Does the patient require a full range of positioning (vertical to flat?) Y or N

Skin Integrity:

Does the patient have decreased skin integrity? Y or N

Does the patient have a history of pressure ulcers? Y or N

Does the patient present with boney prominences? Y or N

Does the patient have incontinence issues? Y or N

Strength/Coordination/Motor Function:

Is the patient caregiver dependent for ambulation needs? Y or N

Does the patient complete a stand pivot transfer to the chair? Y or N

Does the patient transfer with the use of a lift? Y or N

Can the patient propel themselves with use of their legs in seated position? Y or N

Can the patient propel themselves with use of their arms? Y or N

Please provide an explanation below for all questions answered with Yes, and any conditions that may require special accommodations.

_____

_____

_____

_____

Assessment Completed by: _____ *Phone:* _____ *Date:* _____

BARIATRIC ANATOMICAL ASSESSMENT

Contact Name: _____ *Phone:* _____ *Date:* _____

Patient Name: _____ *Height:* _____ *Weight:* _____

Please measure the patient at their widest points while sitting in an upright position and add 1"- 2" inches to obtain proper seat width. Please use a soft flexible measuring tape to avoid injuries such as skin tears. This sheet is used for the assessment of bariatric patients weighing 350lbs or more. For non-bariatric patients please use our standard Anatomical Assessment.

1. Shoulder Width - Measure the patient at the widest point of the upper arms/shoulders.

2. Torso Width – With the patient sitting in an upright position, measure across from lateral elbow to lateral elbow. This measurement will help ensure the proper width for the chair is obtained.

3. Seat Width – While sitting on a firm surface, measure the hips/thighs at the widest point.
** The seat width of a BRODA chair is determined by measuring from the inside of the left armrest to the inside of the right armrest.*

4. Calf Width - Measure across the widest point from the knee/calf.

5. Back Height – Measure from the seating surface to the top of the head.

6. Back Length – Measure from the seating surface to the base of the neck.

7. Gluteal Shelf – Is measured from the patients back when seated upright to the extension of the gluteus.

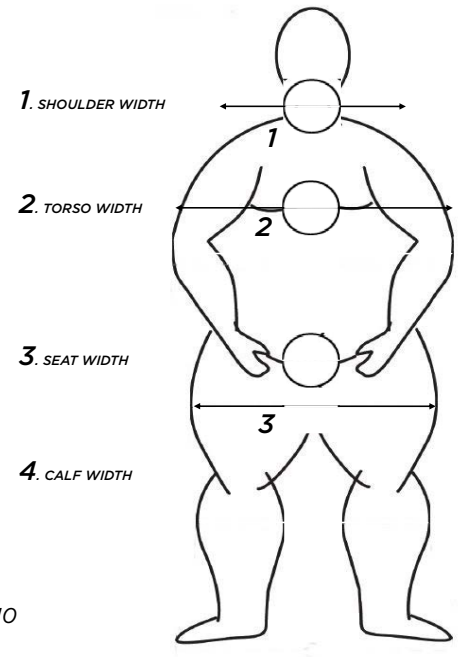
8. Armrest Height – With the patient seated, place the shoulder in a neutral position and arm parallel to the floor, measure from the seating surface to the forearm.

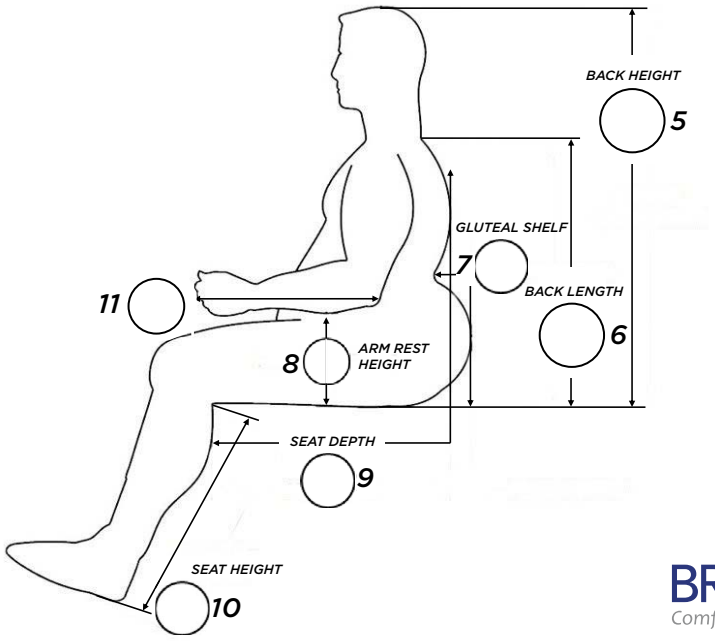
9. Seat Depth – Is measured from the posterior (back) of the buttocks to the popliteal (underside of the knee.)

10. Seat Height – If the patient utilizes a cushion when in the chair, complete measurements with the cushion in the chair to obtain proper measurements. Measure from the base of the heel to the most prominent portion of the posterior (back of) thigh and add 1"- 2" inches to allow for clearance of the footrest.

11. Armrest Length - With the shoulder in a neutral position measure from the 90-degree angle (bend) at the elbow to the finger tips.

CLIENT MEASUREMENTS:
(Write Measurements inside of circles)





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BARIATRIC ANATOMICAL ASSESSMENT

Patient Name: _____ *Height:* _____ *Weight:* _____

To assist in determining the appropriate BRODA chair for your patient, please complete the questions below and provide any additional information you feel can aid us in selecting the appropriate chair.

Location:

Please provide width of doorway in inches: _____

Types of surfaces: ***Carpet*** *Y or N* ***Tile*** *Y or N* ***Transition Strips*** *Y or N*

Posture/Function:

Does the patient have decreased head and/or trunk control? Y or N

Does the patient require a full range of positioning (vertical to flat?) Y or N

Skin Integrity:

Does the patient have decreased skin integrity? Y or N

Does the patient have a history of pressure ulcers? Y or N

Does the patient present with boney prominences? Y or N

Does the patient have incontinence issues? Y or N

Strength/Coordination/Motor Function:

Is the patient caregiver dependent for ambulation needs? Y or N

Does the patient complete a stand pivot transfer to the chair? Y or N

Does the patient transfer with the use of a lift? Y or N

Can the patient propel themselves with use of their legs in seated position? Y or N

Can the patient propel themselves with use of their arms? Y or N

Please provide an explanation below for all questions answered with Yes, and any conditions that may require special accommodations.

_____

_____

_____

_____

Assessment Completed by: _____ *Phone:* _____ *Date:* _____

CASE EVALUATION FORM

*Date of Evaluation:*_____ *Primary Diagnosis:*_____

*Patient Name: (optional)*_____ *Age:*_____ *Sex: M/F*

BRODA chair model and accessories used: _____

_____

Residents specific seating conditions and needs: _____

_____

Evaluator: please provide information relative to the evaluation prior to the placement of a BRODA chair

Cognitive: (Interactive with surroundings) (Non-interactive) *Able to make needs known: Y or N*

*Psychotropic medications used? Y or N Name/Dosage:*_____

*Pain medications used? Y or N Name/Dosage:*_____

Functional Abilities, ADL Status in reference to wheelchair use: Prior to the placement of BRODA

ADL	*Independent*	*Independent with Equipment*	*Moderate Assist*	*Dependent*	*Not Assessed*	*Comments*
Self Care						
Ambulation						
Transfers						
Toileting						

Skin integrity issues: Prior to the placement of BRODA

History of Skin Issues: Y or N *At risk from prolonged sitting: Y or N* *Time spent in chair daily:*_____

Risk factors: ☐ *Boney prominences* ☐ *Immobility* ☐ *Impaired nutritional or hydration status*

*Braden Scale score:*_____ *Other:*_____

*Able to perform effective pressure relief: Y or N If yes, method used:*_____

If no, why? _____

List Interventions and Outcomes observed/noted: Prior to the placement of BRODA

Intervention	*Time Frame*	*Outcome*

CASE EVALUATION FORM

Please document your observations and findings during the evaluation. You can continue your documentation on the following page as needed.

Pre BRODA Trial

	Skin Integrity Issues				*Falls History*	
	Location on body	*Severity (stage)*	*size of pressure sore area (Inches)*	*Change in size and/or stage (+/-)*	*Number of falls*	*Frequency of falls (daily, weekly etc)*

During BRODA Trial

Immediate (if applicable)						
Week 1 Date:						
Week 2 Date:						
Week 3 Date:						
Week 4 Date:						

Pre BRODA Trial

	Positioning/Comfort				*Behaviors*			
	Poor	*Average*	*Above average*	*Good*	*Aggressive Unhappy*	*Agitated*	*Neutral*	*Happy*

During BRODA Trial

Immediate (if applicable)								
Week 1 Date:								
Week 2 Date:								
Week 3 Date:								
Week 4 Date:								

*Braden Scale score post trial:*_____

*Change in risk factors following placement of BRODA? Please explain:*_____

_____

*Increase in sitting tolerance/time spent in chair with placement of BRODA? Please explain:*_____

_____

CASE EVALUATION FORM

Post Trial

Functional Abilities:

Were there improvements in the patients ADL status in reference to wheelchair use? Y or N. If Yes, please explain:

_____

_____

_____

Medication Use

Was there a change in the psychotropic medications used during the BRODA trial? Y or N

Name/Dosage: _____

If Yes, do you believe this change was associated with the use of BRODA? _____

Was there a change in pain medications used during trial? Y or N

Name/Dosage: _____

If Yes, do you believe this change was associated with the use of BRODA? _____

Initial assessment of BRODA chair impact:

_____

_____

_____

Final assessment of BRODA chair impact:

_____

_____

_____

Additional comments/requests:

_____

_____

_____

Have you worked with BRODA prior to this evaluation? Y or N

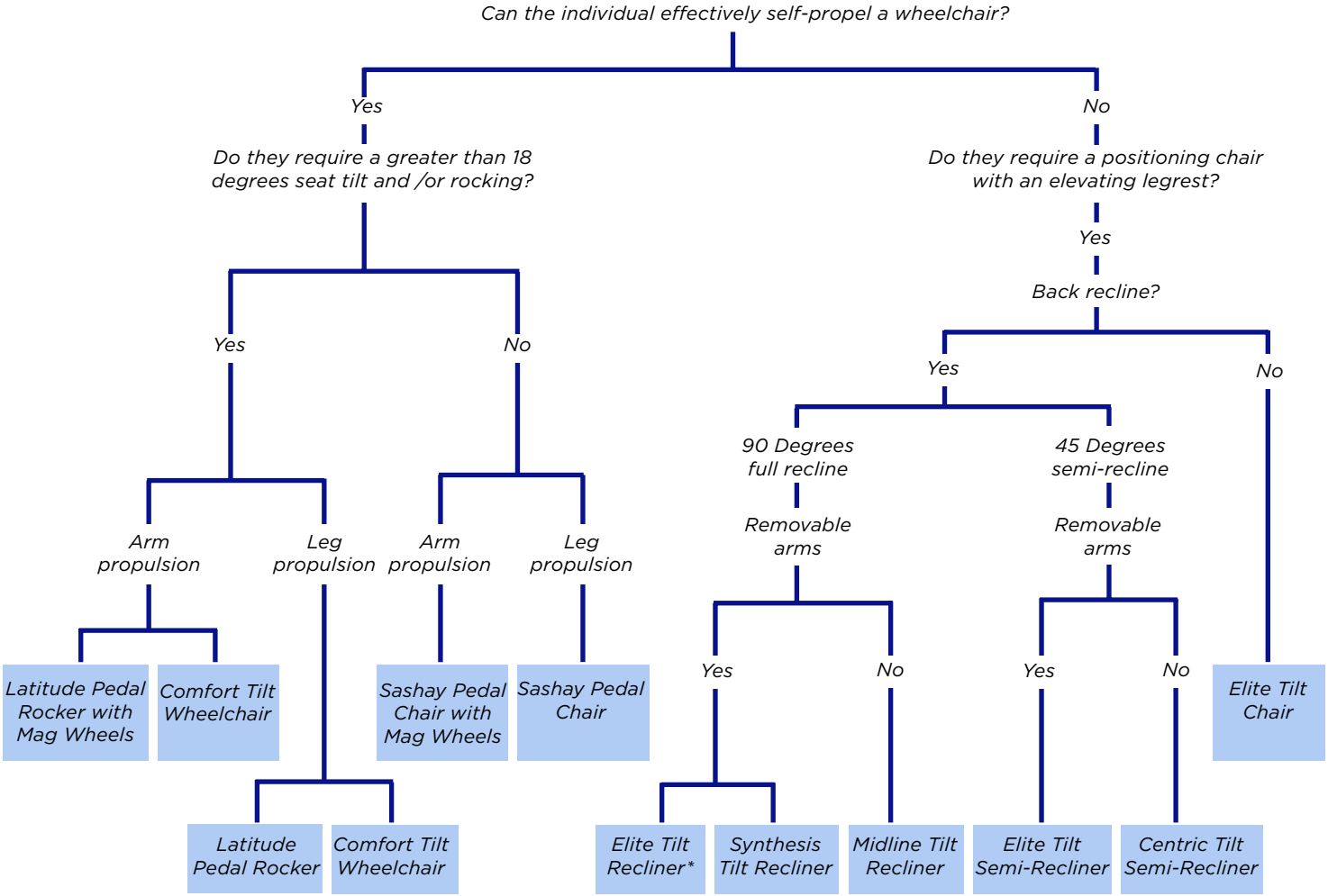
May we use this information on our website and/or our marketing materials? Y or N

Evaluation completed by: _____

Name *Title* *Department*

Evaluators signature: _____ *Date:* _____

DETERMINING THE APPROPRIATE BRODA CHAIR MODEL



** Restrictions apply. Please contact BRODA Customer Service.*

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APPENDIX: FREQUENTLY ASKED QUESTIONS

Who submits the "claim/bill" for the chair?

1) Most commonly the provider of the chair would be the one to complete and submit the paperwork. However, it may be the responsibility of the patient and/or the patient's family depending on how the chair is obtained. It is recommended that the individual requesting the chair clarify the billing process prior to obtaining the chair.

2) If the individual needs assistance with completing the required paperwork refer them to the Social Worker's office (if in a facility) or to their Doctors office. You can also refer them to their insurance provider for guidance.

Contacting the Insurance Provider:

When contacting an insurance provider of any type you will need the following information to complete the call:

1) Recipients full name as listed on the insurance card
2) Recipients date of birth (Month/Date/Year)
3) Recipients complete home address
4) Recipients Social Security Number (This is usually requested to ensure they are looking at the appropriate recipient's policy/coverage)
5) Recipients Policy Number, Group ID or Member ID. These descriptors can vary by provider, however are generally found on the front of the card
6) Claims address and contact number generally located on the back of the card
7) If your recipient has both a primary and secondary insurance that you will be utilizing for reimbursement of the equipment, it is important that you mention this on the call as it may change the process for submitting your claim

If you are requesting information regarding coverage for DME/MAE (I.e. Wheelchair) you may also need the following information:

1) Referring physicians name and contact information
2) ICD 9/10 Code(s) associated with the need for the equipment
3) Copy of physicians order maybe requested, however if you do not have it on hand you can simply explain that you are in the beginning stages of completing this process. Doing so should eliminate any further questions regarding the physicians order.

Suggested questions to ask when calling the insurance agency:

1) Can you provide me with a copy of your guidelines for determination of coverage?
2) Is there a check lists for documentation required to process/submit a claim?
3) What is the best number to call if I have any further questions?

Contact information for Insurance Providers:

Medicare Coverage Database for Providers:

https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx
Medicare contact number for Providers: Toll-Free: 877-267-2323

*** Medicare Program Integrity Manual Chapter 5 (This explains Medicare's requirements and provides reference to required forms etc.) This can be found on the Medicare Website.

Medicare contact information for Patient/Family:

When contacting Medicare call: 800-MEDICARE (800-633-4227)
TTY Toll Free: 877-486-2048

Medicaid Contact Information:

To obtain the appropriate state specific contact information for your state please contact your local Department of Health and Human Services, or visit the following website to obtain the contact information by Regional Office location.
https://www.medicaid.gov/about-us/contact-us/index.html

APPENDIX: REFERENCES

National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE) (280.3)
https://goo.gl/83Ywve
[https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=219&ncdver=2&bc=AAAAgAAAAAAAAA%3d%3d&]

Noridian Documentation Check List
https://goo.gl/XYa2yu
[https://med.noridianmedicare.com/documents/2230703/6750839/Documentation+Checklist+-+Manual+Wheelchairs+%28MWC%29]

Affordable Care Act Face to Face requirements
https://goo.gl/K1zgyU
[https://med.noridianmedicare.com/web/jddme/topics/affordable-care-act-face-to-face-and-detailed-written-order/affordable-care-act-6407-face-to-face]

Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services
https://goo.gl/bpP9LE
[https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf]

Medicare Program Integrity Manual Chapter 5 – Items and Services Having Special DME Review Considerations
https://goo.gl/UOL0aP
[https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c05.pdf]

CMS Manual Systems Pub. 100-04 Medicare Claims Processing Transmittal 574
https://goo.gl/PNDJv1
[https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R574CP.pdf]

Please note:

The information provided in this guide is intended to assist healthcare providers by providing an overview of the process for submitting a claim/reimbursement. It is not intended to be used as a substitute for the policies provided by the provider/agencies themselves and should only be used as a quick-reference guide.

You may also contact your local DME provider or Medicare Part B Contractor (MAC) for copies of current policies at:
http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

ADDITIONAL NOTES

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