COMPLEX REHAB TECHNOLOGY

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PROVIDER RECOMMENDATIONS FOR FY 2024 BUDGET
MEDICAL CARE ADVISORY COMMITTEE MEETING JUNE 2022

NCART
National Coalition For Assistive & Rehab Technology

Complex Rehab Technology Definition

The Products

Complex Rehab Technology (CRT) products include medically necessary, individually configured devices that require evaluation, configuration, fitting, adjustment or programming. These products and services are designed to meet the specific and unique medical, physical, and functional needs of an individual with a primary diagnosis resulting from a congenital disorder, progressive or degenerative neuromuscular disease, or from certain types of injury or trauma. For this document, CRT refers to individually configured manual wheelchair systems, power wheelchair systems, seating and positioning systems, and other adaptive equipment such as bathing devices, standing devices, and gait trainers.

The Person

These products and supporting services are designed to meet the specific and unique medical and functional needs of an individual with a primary diagnosis resulting from a congenital disorder, progressive or degenerative neuromuscular disease, or from certain types of injury or trauma. The primary diagnoses that can require CRT include:

- Spinal Cord Injury; or
- Traumatic Brain Injury; or
- Cerebral Palsy; or
- Muscular Dystrophy; or
- Spina Bifida; or
- Osteogenesis Imperfecta; or
- Arthrogryposis; or
- Amyotrophic Lateral Sclerosis; or
- Multiple Sclerosis; or
- Demyelinating diseases; or
- Myelopathy; or
- Myopathy; or
- Progressive Muscular Atrophy; or
- Anterior horn cell diseases; or
- Post-Polio Syndrome; or
- Cerebellar degeneration; or
- Dystonia; or
- Huntington's disease; or
- Spinocerebellar disease; or
- Certain types of amputation; or
- Paralysis or paresis; or
- Other disability or disease that is determined through individual consideration to require the use of such individually configured products and services

The Process

In establishing a person's need for CRT products and services, consideration is always given to the individual's immediate and anticipated medical and functional needs. These needs include, but are not limited to, activities of daily living (ADLs), instrumental activities of daily living (IADLs), functional mobility, positioning, pressure redistribution, and communication. CRT is used to address these needs and enable the individual to accomplish these tasks safely, timely, and as independently as possible in all environments the individual is expected to encounter. CRT is designed to address people's medical needs and maximize their function and independence. To accomplish this, the proper provision process consists of two interrelated components:

- The **clinical component of providing CRT** includes the physical and functional evaluation, treatment plan, goal setting, preliminary device feature determination, trials/simulations, fittings, function-related training, determination of outcomes and related follow-up. The clinical team is responsible for the prescription and supporting medical necessity documentation.
- The **technology-related component of providing CRT** includes, as appropriate: evaluation of the home environment; transportation assessment; technology assessment; equipment demonstration/trial/simulation; product feature matching to identified medical, physical, and functional needs; system assembly and configuration; fitting; adjustments; programming; and product-related training and follow-up. Ongoing service and repair must also be considered.

The Professionals

The provision of CRT is done through an interdisciplinary team consisting of, at a minimum, a Physician, a Physical Therapist or Occupational Therapist, and a Rehab Technology Professional (referred to as the CRT Team). The team collectively provides clinical services and technology-related services. An individual's medical and functional needs are identified by the clinical team in conjunction with the individual. These needs are then matched to products and configured into custom designed systems by the credentialed Rehab Technology Professional (RTP) with input from the individual and clinical team.

- The clinical CRT services are provided by a licensed/certified Physical Therapist or Occupational Therapist.
- The technology-related CRT services are provided by a certified, registered or otherwise credentialed Rehab Technology Professional.

The Credentials

CRT products must be provided by individuals who are certified, registered or otherwise credentialed by recognized organizations in the field of CRT and who are employed by a business specifically accredited by a CMS deemed accreditation organization to provide CRT.

Provider-employed Assistive Technology Professionals (ATP) must undergo the required training and testing to earn their credentialed status. This credential is required by CMS for involvement in the supplying of CRT and the requirements of that credential are established by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). RESNA-certified ATPs are

required to uphold established standards of practice as well as earn continuing education credits to maintain their certification.

CRT Provider Request to Maintain/Enhance Access

1. Providers Should be Reimbursed for Labor Associated with Authorized Service and Repairs to Medically Necessary CRT Items

Providing needed service or repair to CRT items is a labor-intensive process that incurs operating expenses well above the cost of equipment alone. Medicare and many other payers, including most Medicaid programs across the country, do not limit which patient-owned CRT items are eligible for billing the K0739 as they recognize that the knowledge of a skilled technician, assessment, and testing are all required to ensure that this unique equipment is diagnosed and serviced appropriately. Currently, the Utah Medicaid program does not reimburse providers for the labor involved in repairing or replacing wheelchair tires, wheels, casters, and batteries.

It is a well-established payer policy that all repair or service to CRT items must include payment for the labor involved. For example, Noridian, the CMS-contracted DME Administrative Contractor for Jurisdiction D in which Utah is located, allows the following units of K0739 for manual and power wheelchairs (information from https://med.noridianmedicare.com/web/jddme/topics/repairs/repairs):

Type of Equipment	Part Being Replaced/Repaired	Allowed Units of Service
Power Wheelchair	Batteries (includes cleaning and testing)	2
Power or Manual Wheelchair	Wheel/Tire (all types, per wheel)	1

We request that UDOH review its current policy and update its coverage of labor for CRT items to align with Medicare policy and the policy of the majority of Medicaid programs and other payers across the country.

2. Payment Amounts for Miscellaneous HCPCS Code K0108 Should be a Discount Off MSRP

Items with definitions that do not have an existing HCPCS code (Healthcare Common Procedure Code System) are billed using miscellaneous code K0108. Currently, UDOH reimburses these items at provider acquisition cost plus 20%. This is not sustainable for Medicaid suppliers in the state and these items should be reimbursed at a reasonable rate agreed upon between CRT providers and UDOH. In discussions between providers and UDOH, providers have recommended utilizing a percentage of MSRP as a more suitable policy. More information related to this recommendation has been attached as a separate document with this presentation.

Utah providers have been accepting current reimbursement in good faith, knowing that a vulnerable population of beneficiaries requires this specialty equipment for their health, safety, and independence. However, providers have also consistently communicated to UDOH that this could not continue indefinitely. The Public Health Emergency has caused unavoidable delays in discussions as well as

presenting CRT providers with additional and significant financial challenges, making the need to find a solution even more urgent.

NCART and its members are committed to maintaining the highest standards of practice. It is our request that Medicaid fee-for-service reimbursement for K0108 be reconsidered and the policy updated to pay these items at a percentage off of MSRP as they were in the past. Without an update to this policy, CRT providers will be forced to determine which services they can and cannot continue to provide to UDOH beneficiaries.

3. Utilization of Medicare Rates Should Include the 'KU' Modifier

UDOH has chosen to adopt the use of the Medicare Competitive Bidding Program (CBP) non-rural rates as a basis for its own DMEPOS reimbursement. However, due to the unique nature and increased cost of providing it, CRT wheelchair bases and their accessories (a.k.a. components) are legislatively excluded from the CBP and should not be reimbursed at those rates. To address this matter, Medicare has established the KU billing modifier to reimburse them appropriately and to safeguard access. Impacted HCPCS codes have been provided with this handout.

Given the federal precedent and the need for appropriate reimbursement, providers respectfully request that UDOH implement the use of the KU modifier and its associated rates to ensure proper payments and protect beneficiary access.

4. Conclusion

NCART and the CRT providers joining in these requests wish to convey our sincere thanks for the Department's willingness to work through issues in order to best serve UT Medicaid beneficiaries with complex medical needs. We appreciate the Department's mission to ensure appropriate access to care while balancing the need for cost-effective programs and services. We share that goal and look forward to continued discussions to ensure timely access and the best outcomes for beneficiaries with significant disabilities who require CRT products and supporting services.

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National Coalition For Assistive & Rehab Technology

Complex Rehab Technology: Importance of Manufacturer Suggested Retail Price (MSRP)

Manufacturer Suggested Retail Price (MSRP) provides important information regarding the development of payment rates for items that do not have associated fee schedule amounts. This is particularly true for Complex Rehab Technology (CRT) products, due to their specialized and highly individualized nature and the varied configurations needed to meet the complex needs of a person with a disability. Over the years, MSRP amounts for CRT have been highly stable with minimal annual increases.

In the marketplace, the purpose of the MSRP is to standardize selling prices among authorized suppliers. CRT manufacturers establish and publish MSRP schedules and related order forms on their company websites to allow consumers, prescribers, payers, and other parties to have access to this information. These documents provide a universally acceptable and efficient source to independently verify amounts being billed and helpful data to identify product options best suited for each CRT client.

Manufacturers develop MSRP to provide a consistent reference point to establish a level of payment that allows appropriate access to their products. The MSRP is developed to encompass all the costs from both the manufacturer and the supplier and allow a reasonable profit margin for the businesses. The factors that are considered in developing an MSRP for an item include:

- Manufacturer Costs- Cost of parts and components; manufacturing labor; engineering and product management; building and production equipment; regulatory (FDA, quality assurance, and other regulatory compliance costs); customer service (order intake, order entry, communication with suppliers and consumers); technical support; marketing support; field support; and warranty management and expense.
- Supplier Costs- Acquisition cost of the product; order entry and product receiving; customer service- intake, customer interface; Assistive Technology Professional (ATP) interface- technology assessment, product research, equipment trials; delivery of equipment- fitting, education, training; ongoing adjustments, repair, and maintenance; documentation, billing, collection; vehicles and transportation; building, infrastructure, systems; and quality assurance and compliance.

The use of MSRP for establishing appropriate payment rates ensures that the parties involved in a transaction (manufacturer and supplier) obtain adequate reimbursement to cover their costs and earn an acceptable profit to support the ongoing stability of the respective companies.

Cost analyses completed in the CRT market demonstrate that the “product acquisition cost” is less than half of the total costs associated with the delivery of products and related services. On average, the breakdown of total costs/expenses for the CRT supplier is forty-nine (49) percent for “product acquisition cost” and forty-six (46) percent for “operating expenses” which includes the staffing, systems, and infrastructure needed to provide and support the CRT items. These percentages do not include interest and income tax expenses that can also be incurred.

As described above, Manufacturer Suggested Retail Price recognizes the full spectrum of product and operating costs. It can be used as a consistent, efficient, and reliable reference in establishing payment rates for Complex Rehab Technology to ensure people with disabilities have adequate access to the specialized equipment and supporting services they require.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: MM9642 **Related Change Request (CR) #: CR 9642**

Related CR Release Date: June 23, 2016 **Effective Date: July 1, 2016**

Related CR Transmittal #: R3551CP **Implementation July 5, 2016**

July Quarterly Update for 2016 Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

Provider Action Needed

Change Request (CR) 9642 advises providers of fee schedule amounts for codes in effect on January 1, 2016, and July 1, 2016, for all other changes. The instructions include information on the data files, update factors and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

Background

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedules on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the "Medicare Claims Processing Manual," Chapter 23, Section 60 (**https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf**).

Payment on a fee schedule basis is required by the Social Security Act (the Act) for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR

Section 414.102, for Parenteral and Enteral Nutrition (PEN), splints, casts and Intraocular Lenses (IOLs) inserted in a physician's office. The Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas for the items, based on information from Competitive Bidding Programs (CBPs) for DME. The CBP product categories, HCPCS codes and Single Payment Amounts (SPAs) included in each Round of the CBP are available on the Competitive Bidding Implementation Contractor (CBIC) website (**http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home**). The changes for the Calendar Year (CY) 2016 are detailed in **MM9431**.

Adjusted Fee Schedule Amounts

The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjusted fee schedule amounts as well as codes that are not subject to the fee schedule CBP adjustments. The adjustments to the fee schedule amounts have been phased in for claims with dates of service January 1, 2016, through June 30, 2016, so that each fee schedule amount is based on a blend of 50 percent of the fee schedule amount that would have gone into effect on January 1, 2016, if not adjusted based on information from the CBP, and 50 percent of the adjusted fee schedule amount. As part of this update, for claims with dates of service on or after July 1, 2016, the July quarterly update files include the fee schedule amounts based on 100 percent of the adjusted fee schedule amounts. Information from CBPs that take effect on July 1, 2016 is factored into the adjusted fee schedule amounts effective on July 1, 2016, in accordance with the regulations at 42 CFR 414.210(g)(8).

Fee schedule amounts that are adjusted using information from CBPs will not be subject to the annual DMEPOS covered item update, but will be updated in accordance with 42 CFR 414.210(g)(8) when information from the CBPs is updated. Pursuant to 42 CFR §414.210(g)(4), for items where the Single Payment Amounts (SPAs) from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment would go into effect (for example, 2016 for this update) and for each subsequent year such as 2017, and 2018.

There are three general methodologies used in adjusting the fee schedule amounts:

1. Adjusted Fee Schedule Amounts for Areas Within the Contiguous United States

The average of SPAs from CBPs located in eight different regions of the contiguous United States are used to adjust the fee schedule amounts for the states located in each of the eight regions. These regional SPAs (RSPAs) are also subject to a national ceiling (110% of the average of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90% of the average of the RSPAs for all contiguous states plus the District of Columbia). The methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (those included in more than 10 Competitive Bidding Areas (CBAs)).

Also, the fee schedule amounts for areas within the contiguous United States that are designated as rural areas are adjusted to equal the national ceiling amounts described above. Regulations at 42 CFR 414.202 define a rural area to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any Metropolitan Statistical Area (MSA). A rural area also includes any ZIP Code within an MSA that is excluded from a CBA established for that MSA.

2. Adjusted Fee Schedule Amounts for Areas Outside the Contiguous United States

Areas outside the contiguous United States (areas such as Alaska, Guam, Hawaii) receive adjusted fee schedule amounts so that they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States.

3. Adjusted Fee Schedule Amounts for Items Included in 10 or Fewer CBAs

DME items included in 10 or fewer CBAs receive adjusted fee schedule amounts so that they are equal to 110 percent of the average of the SPAs for the 10 or fewer CBAs. This methodology applies to all areas, non-contiguous and contiguous.

In order to apply the rural payment rule for areas within the contiguous United States, the DMEPOS fee schedule file is updated to include rural payment amounts for certain HCPCS codes where the adjustment methodology is based on average regional SPAs. Also, on the PEN file, the national fee schedule amounts for enteral nutrition transitions to statewide fee schedule amounts. For parenteral nutrition, the national fee schedule amount methodology remains unchanged.

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts based on information from the CBPs. ZIP codes for non-contiguous areas are not included in the DMEPOS Rural ZIP code file. The DMEPOS Rural ZIP code file is updated on a quarterly basis as necessary.

Key Points of CR9642

Public Use Files (PUFs)

In October 2015, CMS posted sample 2016 DMEPOS and PEN Medicare payment PUFs that were modified to accommodate the adjusted fee schedule amounts effective January 1, 2016. At that time, CMS communicated that different PUF file formats would be used for the January 2016 Excel file update as opposed to the July 2016 update and all subsequent fee schedule updates. CMS has recently determined that it is necessary to retain separate rural fee fields for each state and not transition, beginning July 1, 2016, to one field titled "Contiguous United States Rural Fee" as previously communicated. Therefore, beginning with the July 2016 update, the July DMEPOS and PEN Excel PUF record layouts will retain

the separate rural fees for each state as implemented January 1, 2016. As discussed above, the phase in of adjusted fees are based on 100 percent of the adjusted fee schedule amounts effective July 1, 2016. The rural fee for the contiguous United States, which is equal to the national ceiling amount, applies to all rural areas within the contiguous United States. However, in any case where the application of the adjusted fee methodology results in an increase in the fee schedule amount that would otherwise apply, the rural adjustment for an area/state is not made. Non-contiguous areas are not subject to rural fees under the CY 2016 DMEPOS fee schedule methodology.

The CY 2016 DMEPOS and PEN fee schedules and the July 2016 DMEPOS Rural ZIP code file PUFs will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the data files at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched**.

KU Modifier for Complex Rehabilitative Power Wheelchair Accessories & Seat and Back Cushions

Section 2 of the Patient Access and Medicare Protection Act (PAMPA) mandates that the adjustments to the CY 2016 fee schedule amounts for certain DME based on information from CBPs not be applied to wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs prior to January 1, 2017. Group 3 complex rehabilitative power wheelchair bases are currently described by codes K0848 through K0864 of the HCPCS.

As a result, the fees for wheelchair accessories and seat and back cushions denoted with the HCPCS modifier 'KU' are included in the July 2016 DMEPOS fee schedule file and are effective for dates of service January 1, 2016, through December 31, 2016. The fee schedule amounts associated with the KU modifier represent the unadjusted fee schedule amounts (the CY 2015 fee schedule amount updated by the 2016 DMEPOS covered item update factor of -0.4 percent) for these wheelchair accessory codes.

The codes for wheelchair accessories and seat and back cushions affected by this change along with claims processing instructions are available in CR9520 at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3535CP.pdf**. In accordance with that article, if brought to their attention, MACs may adjust claims for the Group 3 complex rehabilitative power wheelchair accessories referenced in Attachment A of related CR9520 for dates of service January 1, 2016, through June 30, 2016.

Discontinuation of KE Modifier for Items in Initial Round 1 CBP

As part of this update, the fees for certain items included in Round 1 CBP, denoted with the HCPCS pricing modifier 'KE', are deleted from the DMEPOS fee schedule file. Program instructions on the implementation of these fees and the list of applicable HCPCS codes were issued via CR6720, dated November 7, 2008 (see related article **MM6720**).

The KE fees were retained on the fee schedule file for dates of service January 1, 2016, through June 30, 2016, because of the phase-in of the adjusted fee schedule amounts, but are no longer needed.

Reclassification of Certain DME Included in CBPs

As part of this update, capped rental fees are established for payment of the following 14 HCPCS codes: E0197, E0140, E0149, E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070, and E0955.

For dates of service on or after July 1, 2016, these HCPCS codes are reclassified from the payment category for inexpensive and routinely purchased DME to payment on a capped rental basis in all areas except the 9 Round 1 Re-compete (Round 1 2014) CBAs. These changes are made to align the payment with the regulatory definition of routinely purchased equipment. Articles **MM8822** and **MM8566** discuss these program instructions.

When submitting claims, suppliers in areas outside of Round 1 Re-compete CBAs that furnish these 14 HCPCS codes on a capped rental basis use the capped rental modifiers KH, KI, and KJ as appropriate. Beginning January 1, 2017, payment for these codes in all geographic areas will be made on a capped rental basis.

Also, certain HCPCS codes for wheelchair options/accessories (E1020, E1028, E2368, E2369, E2370, E2375, K0015, and E0955) that are furnished to be used as part of a complex rehabilitative power wheelchair (wheelchair base codes K0835 – K0864) can be paid under the associated lump sum purchase option set forth in article **MM8566**.

The supplier must give the beneficiary the option of purchasing these accessories at the time they are furnished for initial or replacement. If the beneficiary declines the purchase option, the supplier must furnish the items on a capped rental basis and payment shall be made on a monthly rental basis in accordance with the capped rental payment rules.

Diabetic Testing Supplies (DTS)

The fee schedule amounts for non-mail order DTS without KL modifier for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4258 are not updated by the covered item update. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they were equal to the SPAs for mail order DTS established in implementing the national mail-order CBP under Section 1847 of the Act. The non-mail order payment amounts on the fee schedule file are updated each time the single payment amounts are updated. As part of the this update, the non-mail order payment amounts on the fee schedule file for the above codes will be updated, effective July 1, 2016, using the SPAs established under the National Mail-Order Re-compete CBP.

As part of this update, the DTS mail order (with KL modifier) fee schedules for all states and territories are removed from the DMEPOS fee schedule file. The SPAs calculated under the National Mail-Order CBPs replace the mail order fee schedule amounts for diabetic

testing supply codes listed above. The SPAs are available at **http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home**.

The Northern Mariana Islands are not considered an area eligible for inclusion under a national mail order competitive bidding program. However, in accordance with Section 42 Code of Federal Regulations (CFR) 414.210(g) (7), the fee schedule amounts for mail order DTS furnished in the Northern Mariana Islands are adjusted to equal 100 percent of the SPAs established under the national mail-order competitive bidding program (79 FR 66232).

Because the Northern Mariana Islands adjustment is subject to the 6-month transition phase-in period, the adjusted Northern Mariana Island DTS mail order fees, which were based on 50 percent of the un-adjusted mail order fee schedule amounts and 50 percent of the adjusted mail order SPAs, were provided on the DMEPOS fee schedule file in the Hawaii column of the 8 mail-order (KL) DTS codes listed above for dates of service January 1, 2016, through June 30, 2016.

Beginning July 1, 2016, the fully adjusted mail order fees (the SPAs) will apply for mail order DTS furnished in the Northern Mariana Islands. As part of this update, the Northern Mariana Island DTS transition mail-order payment amounts will no longer appear in the Hawaii column of the fee schedule file and the DTS mail order (KL) fee schedules for all states and territories are removed from the DMEPOS fee schedule file as of July 1, 2016.

Specific Coding and Pricing Issues

As part of this update, fees are established for HCPCS codes A6450 and A6451 which were added to the HCPCS file in CY 2004. Claims for codes A6450 and A6451 with dates of service on or after January 1, 2016, that have already been processed may be adjusted to reflect the newly established fees if brought to your MAC's attention.

Additional Information

The official instruction, CR9642 issued to your MAC regarding this change is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3551CP.pdf** on the CMS website.

42 CFR 414.202 is available at **https://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol3/CFR-2011-title42-vol3-sec414-202**.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

HCPCS Codes with Medicare KU Modifier Payment Amounts

#	HCPCS	HCPCS Code Description
1	E0705	Transfer device
2	E0950	Tray
3	E0951	Loop heel
4	E0952	Toe loop/holder, each
5	E0953	W/c lateral thigh/knee support
6	E0955	Foot box, any type, each foot
7	E0954	Cushioned headrest
8	E0956	W/c lateral trunk/hip suppor
9	E0957	W/c medial thigh support
10	E0958	Whlchr att- conv 1 arm drive
11	E0959	Amputee adapter
12	E0960	W/c shoulder harness/straps
13	E0961	Wheelchair brake extension
14	E0966	Wheelchair head rest extensi
15	E0967	Man wc rim/projection rep ea
16	E0971	Wheelchair anti-tipping devi
17	E0973	W/ch access det adj armrest
18	E0974	W/ch access anti-rollback
19	E0978	W/c acc,saf belt pelv strap
20	E0981	Seat upholstery, replacement
21	E0982	Back upholstery, replacement
22	E0985	W/c seat lift mechanism
23	E0990	Wheelchair elevating leg res
24	E0992	Wheelchair solid seat insert
25	E0995	Wc calf rest, pad replacemnt
26	E1002	Pwr seat tilt
27	E1003	Pwr seat recline
28	E1004	Pwr seat recline mech
29	E1005	Pwr seat recline pwr
30	E1006	Pwr seat combo w/o shear
31	E1007	Pwr seat combo w/shear
32	E1008	Pwr seat combo pwr shear
33	E1010	Add pwr leg elevation
34	E1012	Ctr mount pwr elev leg rest
35	E1015	Shock absorber for man w/c
36	E1016	Shock absorber for power w/c
37	E1020	Residual limb support system
38	E1225	Manual semi-reclining back
39	E1226	Manual fully reclining back
40	E1028	W/c manual swingaway
41	E1029	W/c vent tray fixed
42	E1030	W/c vent tray gimbaled
43	E2201	Man w/ch acc seat w>=20"<24"
44	E2202	Seat width 24-27 in

HCPCS Codes with Medicare KU Modifier Payment Amounts

#	HCPCS	HCPCS Code Description
45	E2203	Frame depth less than 22 in
46	E2204	Frame depth 22 to 25 in
47	E2205	Manual wc accessory, handrim
48	E2206	Man wc whl lock comp repl ea
49	E2207	Crutch and cane holder
50	E2208	Cylinder tank carrier
51	E2209	Arm trough each
52	E2210	Wheelchair bearings
53	E2211	Pneumatic propulsion tire
54	E2212	Pneumatic prop tire tube
55	E2213	Pneumatic prop tire insert
56	E2214	Pneumatic caster tire each
57	E2215	Pneumatic caster tire tube
58	E2216	Foam filled propulsion tire
59	E2217	Foam filled caster tire each
60	E2218	Foam propulsion tire each
61	E2219	Foam caster tire any size ea
62	E2220	Solid propuls tire, repl, ea
63	E2221	Solid caster tire repl, each
64	E2222	Solid caster integ whl, repl
65	E2224	Propulsion whl excl tire rep
66	E2225	Caster wheel excludes tire
67	E2226	Caster fork replacement only
68	E2228	Mwc acc, wheelchair brake
69	E2310	Electro connect btw control
70	E2311	Electro connect btw 2 sys
71	E2231	Solid seat support base
72	E2321	Hand interface joystick
73	E2322	Mult mech switches
74	E2323	Special joystick handle
75	E2324	Chin cup interface
76	E2325	Sip and puff interface
77	E2326	Breath tube kit
78	E2327	Head control interface mech
79	E2328	Head/extremity control inter
80	E2329	Head control nonproportional
81	E2330	Head control proximity switc
82	E2351	Electronic sgd interface
83	E2359	Gr34 sealed leadacid battery
84	E2360	22nf nonsealed leadacid
85	E2361	22nf sealed leadacid battery
86	E2362	Gr24 nonsealed leadacid
87	E2363	Gr24 sealed leadacid battery
88	E2364	U1nonsealed leadacid battery

HCPCS Codes with Medicare KU Modifier Payment Amounts

#	HCPCS	HCPCS Code Description
89	E2365	U1 sealed leadacid battery
90	E2366	Battery charger, single mode
91	E2367	Battery charger, dual mode
92	E2368	Pwr wc drivewheel motor repl
93	E2369	Pwr wc drivewheel gear repl
94	E2370	Pwr wc dr wh motor/gear comb
95	E2371	Gr27 sealed leadacid battery
96	E2373	Hand/chin ctrl spec joystick
97	E2374	Hand/chin ctrl std joystick
98	E2375	Non-expandable controller
99	E2376	Expandable controller, repl
100	E2377	Expandable controller, initl
101	E2378	Pw actuator replacement
102	E2381	Pneum drive wheel tire
103	E2382	Tube, pneum wheel drive tire
104	E2383	Insert, pneum wheel drive
105	E2384	Pneumatic caster tire
106	E2385	Tube, pneumatic caster tire
107	E2386	Foam filled drive wheel tire
108	E2387	Foam filled caster tire
109	E2388	Foam drive wheel tire
110	E2389	Foam caster tire
111	E2390	Solid drive wheel tire
112	E2391	Solid caster tire
113	E2392	Solid caster tire, integrate
114	E2394	Drive wheel excludes tire
115	E2395	Caster wheel excludes tire
116	E2396	Caster fork
117	E2397	Pwc acc, lith-based battery
118	E2601	Gen w/c cushion wdth < 22 in
119	E2602	Gen w/c cushion wdth >=22 in
120	E2603	Skin protect wc cus wd <22in
121	E2604	Skin protect wc cus wd>=22in
122	E2605	Position wc cush wdth <22 in
123	E2606	Position wc cush wdth>=22 in
124	E2607	Skin pro/pos wc cus wd <22in
125	E2608	Skin pro/pos wc cus wd>=22in
126	E2611	Gen use back cush wdth <22in
127	E2612	Gen use back cush wdth>=22in
128	E2613	Position back cush wd <22in
129	E2614	Position back cush wd>=22in
130	E2615	Pos back post/lat wdth <22in
131	E2616	Pos back post/lat wdth>=22in
132	E2619	Replace cover w/c seat cush

HCPCS Codes with Medicare KU Modifier Payment Amounts

#	HCPCS	HCPCS Code Description
133	E2620	Wc planar back cush wd <22in
134	E2621	Wc planar back cush wd>=22in
135	E2622	Adj skin pro w/c cus wd<22in
136	E2623	Adj skin pro wc cus wd>=22in
137	E2624	Adj skin pro/pos cus<22in
138	E2625	Adj skin pro/pos wc cus>=22
139	E2626	Seo mobile arm sup att to wc
140	E2627	Arm supp att to wc rancho ty
141	E2628	Mobile arm supports reclinin
142	E2629	Friction dampening arm supp
143	E2630	Monosuspension arm/hand supp
144	E2631	Elevat proximal arm support
145	E2632	Offset/lat rocker arm w/ela
146	E2633	Mobile arm support supinator
147	K0015	Detach non-adj ht armrst rep
148	K0017	Detach adjust armrest base
149	K0018	Detach adjust armrst upper
150	K0019	Arm pad repl, each
151	K0020	Fixed adjust armrest pair
152	K0037	Hi mount flip-up footrest ea
153	K0038	Leg strap each
154	K0039	Leg strap h style each
155	K0040	Adjustable angle footplate
156	K0041	Large size footplate each
157	K0042	Standard size ftplate rep ea
158	K0043	Ftrst lowr exten tube rep ea
159	K0044	Ftrst upr hanger brac rep ea
160	K0045	Ftrst compl assembly repl ea
161	K0046	Elev lgrst lwr exten repl ea
162	K0047	Elev legrst upr hangr rep ea
163	K0050	Ratchet assembly replacement
164	K0051	Cam rel asm ft/legrst rep ea
165	K0052	Swingaway detach ftrest repl
166	K0053	Elevate footrest articulate
167	K0056	Seat ht <17 or >=21 ltwt wc
168	K0065	Spoke protectors
169	K0069	Rr whl compl sol tire rep ea
170	K0070	Rr whl compl pne tire rep ea
171	K0071	Fr cstr comp pne tire rep ea
172	K0072	Fr cstr semi-pne tire rep ea
173	K0073	Caster pin lock each
174	K0077	Fr cstr asmb sol tire rep ea
175	K0098	Drive belt for pwc, repl
176	K0105	Iv hanger

HCPCS Codes with Medicare KU Modifier Payment Amounts

#	HCPCS	HCPCS Code Description
177	K0195	Elevating whlchair leg rests
178	K0733	12-24hr sealed lead acid