




What's New in Medicare Policy for Seating and Wheeled Mobility?
 ISS 2015
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Acknowledgements

- Clinician Task Force 
- NCART 
 - Cara Bachenheimer
 - Rita Hostak
 - Don Clayback
- Steering Committee CRT SBC 

Outline

1. Reclassification of DME items
2. Expansion of Prior Authorization
3. Final Rule ESRD Prospective Payment System, Quality Incentive Program, and DMEPOS
4. Medicare Wheelchair Repairs
5. Legislation
6. Advocacy

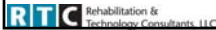
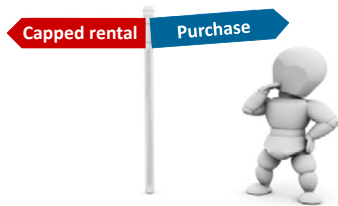
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Acronyms

- CMS Centers for Medicare and Medicaid Services
- NCB National Competitive Bidding
- SPA Single Payment Amount
- RSPA Regional Single Payment Amount
- CBA Competitive Bid Area
- MSA Metropolitan Statistical Area
- PC Product Category
- DME MAC DME Medicare Administrative Contractor
- CBIC Competitive Bidding Implementation Contractor
- Note: "Rural" vs. "Non-bid area"



Reclassification of DME



DME Payment Categories

- Payment categories determine how a supplier is paid for a DME item
- Routinely purchased
 - Supplier is paid in one lump sum
 - Beneficiary assumes ownership immediately
- Capped rental
 - Supplier is paid with 13 monthly payments
 - Supplier retains ownership/responsibility during this time
 - Beneficiary owns at end of the 13 months



Reclassification of DME

- CMS reclassified certain DME items from routinely purchased to capped rental
 - These items “did not comply” with original definition of routinely purchased
- Items that were affected include:
 - Adult manual tilts, all pediatric MWCs
 - Power assist
 - Power seating and PERLs
 - Specialty controls for PWCs
 - Replacement joystick, actuator, motor, gearbox
 - Vent trays
 - Some walkers and Group 1 support surfaces



Reclassification of DME

- Exceptions – some WC accessories when provided with CRT PWC (K0835 – K0864)
 - Power seating, PERLs and electronic connections
 - Gimbaled vent tray
 - Specialty controls
 - Expandable controllers, actuator
- Supplier must give beneficiary option to purchase or rent at time item is furnished.
 - If beneficiary chooses rental, supplier gets paid on monthly basis for 13 months



Items Needed During SNF Stay

- Beneficiary goes into SNF for Part A stay
 - Beneficiary has medical necessity for DME
 - If beneficiary owns the DME, no problem
 - If DME is in middle of capped rental period, SNF is obligated to furnish it under Part A
 - Supplier cannot bill for it during this time
- How does this work for parts, specialty controls, highly individually-configured tilt...



How Was This Determined?

- Definition of routinely purchased from 1987
 - “Equipment that was purchased at least 75% of the time from **July 1986 - June 1987**”
 - Initially established to avoid paying full price for short-term use equipment
- CMS examined how certain **current** items had been paid **during 1986/1987 period**.

Anything that had not been purchased at least 75% of the time in 1986/87 was reclassified



How Did CMS Explain This ?

- Q:** Why use data from 1986/1987 to classify technology not even in existence back then?
- A:** CMS was “following their interpretation of the definition in SSA” (that has never been revised)
- Items must be classified according to the rules
- Therefore.....**
- Because adult tilts did not yet exist, there is no data to support routine purchase $\geq 75\%$ of time
 - 1986/1987 claims data showed that “youth WCs” of that time were purchased only 25% of the time



Implementation

Start Date	Items Affected
Apr 1, 2014	HCPCS codes not included in any CB Program
Jul 1, 2016	HCPCS codes included in a CB Program other than the Round 1 Recompete Program or included in the Round 1 Recompete Program but provided in an area other than a Round 1 Recompete CBA
Jan 1, 2017	HCPCS codes included in the Round 1 Recompete CBAs

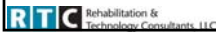
What Are the Issues?

- Many of these items are not used short term
 - CMS is incurring cost of processing 13 monthly claims
- Change in what suppliers are providing
 - Some no longer providing adult tilts
 - Some providing cheaper models and fewer choices
 - Harder to get custom seating
 - Decreases in amount and timeliness of service
- Little change with large rehabs and experienced therapists, but what's happening elsewhere???
- Things that don't affect therapist/consumer.....**YET**
 - Lay-offs, salary cuts, change in business model

This is not sustainable!!



Expansion of Prior Authorization Demo Project for Power Wheelchairs



Medicare Claims Processing

- Historically no prior approval system
 - Supplier orders and delivers equipment, then submits claim for payment
 - Claims go through electronic approval process
 - Supplier risks denial
- Corroborating documentation is not reviewed unless claim is audited
 - "Pay and chase" system
 - Risk of fraud and abuse
 - Risk of recoupment of money just due to a simple clerical error





PA Demonstration Project


- 3 year project began Sept 1, 2012
- Certain PWC claims must go through prior approval before delivery
 - Group 1 POVs (K0800 - K0802; K0812)
 - All Group 1 and Group 2 PWC (K0813 - K0829, K0835-K0843)
 - Group 3 PWC with NPO (K0848 - K0855)
 - Group 5 PWC (K0890 - K0891)
 - Miscellaneous power wheelchairs (K0898)



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How Has it Rolled Out?

- Began September 1, 2012
 - NY, NC, TX, CA, MI, FL, IL
 - States with 47% of PWC claims
 - 3 year program ends August 31, 2015
- Expanded October 1, 2014
 - Added 12 more states
 - MD, NJ, PA, IN, KY, OH, GA, TN, LA, MO, WA, AZ
 - Ends August 31, 2015



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How Does It Work?

- Supplier submits all documentation to DME MAC for review prior to delivery
- Documentation requirements are still the same
 - F2F examination report
 - 7-element order, detailed product description
 - All relevant and necessary clinical documentation
 - ATP contact note
 - Attestation statement(s)
 - Any other required documents
- Supplier, patient and physician receive notice of approval or denial
 - Postmarked within 10 business days of submission

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How Does It Work?

- If PA is approved:
 - 14-digit unique tracking number – UTN
 - Supplier orders and delivers PWC
 - Claim is submitted and should be paid
- If PA is denied:
 - Letter states specific reason for denial
- Can resubmit with additional or amended documentation
 - Notification of approval/denial postmarked within 20 business days from request
 - No limit on number of resubmissions



How Does It Work?

- If claim is submitted with a negative PA
 - It will deny
- If claim is submitted without any PA
 - Will be pulled for pre-pay review
 - Will be subject to a 25% reduction in reimbursement if approved
- Exceptions
 - Claims from contract supplier in CBA
 - Claims submitted with GA, GY or EY modifiers (not medically necessary or non-covered)



Why is This a Good Thing?

- Informs suppliers if Medicare coverage criteria are met before delivery
 - Increased assurance of payment
 - Less chance of “eating” the cost after audit
- Physicians are informed *by the DME MAC* when documentation is insufficient
- Eliminates current “pay and chase” system
 - Reduces improper payments to unscrupulous and/or poorly informed suppliers
 - Sustainability of Medicare Trust Funds

Should have no negative affects for those who are already “doing it right”



Stats From Sept 2012 – June 2014

- Decrease in monthly \$\$\$\$ for PWCs involved:
 - 12M to 3M in demo states; 20M to 9M in non-demo
 - CMS attributes this to:
 - Suppliers adjusting billing practices nationwide
 - Suppliers complying with policy based on PA experience
 - Education by DME MACs and CMS to prevent fraud
- Decrease in # of beneficiaries receiving a PMD
 - 69% in demo states; 65% in non-demo states
 - CMS attributes this to:
 - PA ensures that only qualifying beneficiaries receive a PMD
- 48,194 PA requests submitted
 - ~ 47% non-affirmed
 - Documentation did not support that beneficiary met criteria



Resources


<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/PADemo.html>



Final Rule ESRD Prospective Payment System, Quality Incentive Program, and DMEPOS





And the Survey Says...



1. How many have heard of this Final Rule?
 - Yes
 - No


2. The Final Rule expands CB fee schedule nationwide including rural areas beginning January 1, 2016.
 - True
 - False



3. The Final Rule includes a provision for bundled payments for DME?
 - Yes
 - No


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What Does The Final Rule Do?



- Rule establishes methodology CMS will use to **reduce payment amounts for items included in CBP in non-bid areas.**
 1. Adjustments for items included in more than 10 CBAs
 2. Adjustments for lower volume or other items included in 10 or less CBAs
 3. Adjustments for items where the only available SPA is from a CBP no longer in effect
 4. Adjustments for accessories used with different types of base equipment




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What Does This Mean To You?



1. Items included in more than 10 CBAs: **PWC batteries, Group 2 PWCs, standard PWC accessories (casters/forks)**
2. Lower volume or other items included in 10 or less CBAs: **pediatric transport chair**
3. Items where the only available SPA is from a CBP no longer in effect: **CRT accessories, adjustable skin protection cushions**
4. Accessories used with different types of base equipment: **seating components (e.g. headrests, lateral pelvic supports, trays)**


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Non-Bid Areas – January 1, 2016



1	New England	CT, ME, MA, NH, RI, VT	7 *
2	Mideast	DE, DC, MD, NJ, NY, PA	17
3	Great Lakes	IL, IN, MI, OH, WI	19
4	Plains	IO, KS, MN, MO, NE, ND, SD	5
5	Southeast	AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV	34
6	Southwest	AZ, NM, OK, TX	11
7	Rocky Mtn	CO, ID, MT, UT, WY	4
8	Far West	CA, NV, OR, WA	16

* number of bid areas in that region upon which the regional SPAs will be based

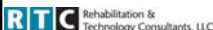

Methodology

- To reduce rates in non-bid areas for items included in > 10 CBAs (#1)
- CMS will use
 - Adjusted payments = RSPA based on 8 regions
 - Calculated using unweighted average of SPAs from CBAs within a region
 - Limited by a national ceiling (110%) and floor (90%) of national average RSPA
 - If any RSPA falls below national floor, payment will be floor amount



Phase-In to Non-Bid Areas January 1, 2016

- January 1, 2016 - rates will be blend of 50% of “old” rate and 50% new RSPA
- July 1, 2016 – rates will be 100% RSPAs
- “Rural” areas will be paid at 110% of national average RSPA
- CMS to announce new RSPA rates prior to implementation

Phase-In to Non-Bid Areas January 1, 2016

- “Rural” = a geographic area represented by a zip code if at least 50% of the total geographic area included in the zip code is estimated to be outside any MSA.
 - Also includes a geographic area represented by a zip code that is a low population density area excluded from a CBA.
 - Includes Alaska, Guam, Hawaii.
- CMS has not yet identified these areas by zip code, but expect very few






RSPAs January 1, 2016 & July 1, 2016

*1. Examples of RSPAs for items included in > 10 CBAs

Code	Current	Ceiling	R1 NE	R2 ME	R3 GL	R4 PL	R5 SE	R6 SW	R7 RM	R8 FW
E0260 1-1-16	132.39	105.36	104.02	100.58	100.83	103.04	101.60	100.92	101.30	101.48
7-1-16 SE Bed		78.33	75.64	68.77	69.27	73.68	70.81	69.44	70.20	70.57
K0001 1-1-16	58.25	43.73	42.53	41.57	41.81	42.27	43.01	42.36	42.53	42.47
7-1-16 MWC		29.20	26.80	24.88	25.37	26.28	27.76	26.46	26.80	26.68
K0823 1-1-16	568.89	442.01	424.22	422.78	424.81	425.63	434.27	424.94	428.91	428.92
7-1-16 Group 2 PWC		315.13	279.55	276.66	280.73	282.36	299.65	280.98	288.92	288.94

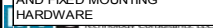

R1= New England, R2= Mideast, R3= Great Lakes, R4= Plains,
R5= Southeast, R6= Southwest, R7= Rocky Mtn, R8= Far West

Example Fee Schedule Adjustments

* 3. Items in <10 CBAs & CBP no longer in effect


DESCRIPTION	Adjusted Fee	Current Fee	\$ Change	% Change
WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, RECLINE ONLY, WITH MECHANICAL SHEAR REDUCTION	\$4,150.26	\$5,404.40	\$1,254.14	23%
SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	\$292.99	\$370.93	\$77.94	21%
POWER WHEELCHAIR ACCESSORY, HEAD CONTROL OR EXTREMITY CONTROL INTERFACE, ELECTRONIC, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE	\$4,278.94	\$5,500.10	\$1,221.16	22%





Example Fee Schedule Adjustments

* 3. Items in <10 CBAs & CBP no longer in effect




HCPCS	DESCRIPTION	ADJUSTED FEE	CURRENT FEE	\$\$ CHANGE	% CHANGE
E1004	Wheelchair accessory, power seating system, recline only, mechanical shear reduction	\$4150.26	\$5,404.40	\$1,254.14	23%
E2624	Skin protection and positioning wheelchair cushion, adjustable	\$292.99	\$370.93	\$77.94	21%
E2338	Power wheelchair accessory, head or extremity control interface, proportional	\$4,278.94	\$5,500.10	\$1,221.16	22%


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Bundling

- Phase-in of new bundling payment method
- In place of current capped rental and purchase payment rules
- Payment will be on continuous rental basis
 - No ownership transfer to beneficiary
- SPA will be for monthly payment
- Suppliers must bid on payment for:
 - Base equipment and all accessories provided
 - Maintenance and servicing,
 - Replacement of supplies and accessories

Bundling Phase-In

- First phase: up to 12 new bid areas
 - 80 possible MSAs, population of at least 250,000
 - **Next phase: via rulemaking!**
- Starting with power wheelchairs and CPAP
- Later phases could include manual WCs, beds, oxygen, enteral, respiratory assist devices

Bundling – Many Questions????

▪ **When?**

- In conjunction with Round 2 Recompete?
- In 2017?



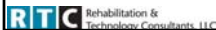
▪ **How many items will be bundled together?**

- Could be one bundled code for all standard base power chairs, accessories, batteries, etc.
- Could keep base codes separate, and bundle in for each base everything else

▪ CMS will provide “advance notice” of details



Medicare Wheelchair Repairs



Repair Policy Update



- CMS announced policy on August 26, 2014, rescinded and updated October 17, 2014, effective November 4, 2014
- If Medicare paid for base equipment initially, then medical necessity for the base equipment has been established
- Contractors are to only review the necessity of the repair and make a payment determination
- The necessity of the repair must be addressed in either the physician's or supplier's records



Repair Policy Update



- The contractor shall ensure that the supplier's documentation records include the nature of the repair and the work performed to restore the equipment to functionality to meet the beneficiary's medical need.
- Supplier must have info in records documenting
 - Item being repaired
 - Why equipment needs to be repaired
 - Why replacement part is needed to repair equipment
 - Any other info specified by DME MAC
 - Sufficient detail to justify the units of labor charged to K0739

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Repair Policy Update



- Medicare contractors shall not require a face-to-face examination for repair of items already covered and paid for by Medicare.
- Documentation from the physician or treating practitioner that indicates that the DMEPOS item being repaired continues to be medically necessary is required.
- Documentation is considered timely when it is on record in the preceding 12 months, unless otherwise specified in relevant Medicare policy.

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Repair Policy Update





- Medicare contractors shall:
 - Only apply this guidance when reviewing claims for repairs of beneficiary owned equipment if it was covered and paid for by Medicare.
 - Continue to adhere to the coverage and payment policies and procedures.
 - Only assess the necessity of the repair and whether the equipment was fixed
- Medical records are not required to address the medical necessity of the equipment as when it was originally ordered

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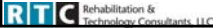

Replacement of CB Items

- Any Medicare-enrolled supplier can **repair** and replace parts of bene-owned equipment if repair is:
 - Necessary to make equipment serviceable
 - Non-routine maintenance performed by authorized techs
 - Labor to repair equipment is payable at fee schedule
- Only a contract supplier can **replace** a CB item if it is not part of a repair and is provided to a bene in a CBA
- Medicare pays SPA for replacement part if it is a CB item in the CBA and is used to repair base equipment that is also a CB item in the CBA.
 - Otherwise payment for part is based on lower of actual charge or fee schedule amount for replacement part.







NCB New Rules- Round 2 Recompete

- Phase in of New Repair Rule
 - In up to 12 CBAs (in Round 2 rebid?)
 - Under current rental rules, bidders will factor into their bids the costs of:
 - Repair and maintenance after ownership transfer,
 - Until medical need ends, or
 - 5 years, or
 - Beneficiary moves outside CBA
 - Limited to items you originally furnished
 - Not responsible for repairing items someone else provided
 - Doesn't address most of the problem


Other Legislation





CRT Legislation

- Ensuring Access to Quality Complex Rehabilitation Technology Act
 - Separate category for CRT in DMEPOS Benefit
 - Differentiate CRT from standard DME
- For an informative update please attend:
 - IC11: Complex Rehab Technology Update
 - Presented by Don Clayback
 - 2:30 - 3:45 in Room _____







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Sign up for Updates on CRT Issues






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Competitive Bidding

- Medicare DMEPOS Competitive Bidding Improvement Act (H.R. 284 and S. 148)
 - Last year's HR 4920 and S. 2975
 - Rep Tiberi (R-OH) and Rep Larson (D-CT); Sen Portman (R-OH) and Sen Cardin (D-MD)
- Requires a bid bond in order to submit a bid
 - CMS collects on bond if bidding provider declines a contract that is offered
 - Prevent "gaming" and speculative bidding
- CMS must verify bidder's compliance with state licensure laws before accepting bid
 - Elevates the current CMS licensure requirement to a statutory requirement



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Competitive Bidding



- Market Pricing Program (MPP)
 - Originally H.R. 1717
 - Created by auction experts
 - Will be monitored by qualified experts
 - Requires bid deposit and binding bids
 - Payment amount would be the clearing price bid
 - Non-local bidders can't overwhelm local bidders
 - Ensures transparency through financial standards, capacity allocation, bidding rules, winning awards and performance accountability
 - Allows any supplier to provide items in 8 of 10 categories



Audits

- Huge backlog reported last year by Office of Medicare Hearings and Appeals
 - ~ 900,000 claims awaiting review at ALJ level
 - ALJs receiving ~ 14,000 claims per week
- With no additional appeals and the goal of 1000 appeals / year this would require:
 - 12.5 years with current # of ALJ teams
 - 1 year with 828 ALJ teams
- Many of these claims should be addressed at a lower level of appeals!



AIR Act

- Audit Improvement and Reform Act 2014
 - H.R. 5083 introduced by Rep Ellmers (R-NC) and Barrow (D-GA)
 - Will be reintroduced in 2015
 - Designed to increase transparency, education and outreach and reward low error rates
 - Will apply to all MACs, RACs and other contractors performing audits on DMEPOS providers
 - DME focused!
- www.FixMedicareAudits.org
 - Copy of legislation, issue brief and how to support it



Air Act Provisions

- Reviewers allowed to use clinical inference
- Reporting of error rates on audited claims after adjustment for those overturned on appeal
- All suppliers are audited at least once every 2 years and those with low error rates are excused from some or all audits during that 2 year period
- Suppliers with error rates < 15% are subject to only one claim audit for that year
- Look-back periods limited to 3 yrs (MACs, RACs)
- Transparency and reporting by contractors
- Education and outreach program to help providers understand regulations and how to document



Advocacy

- People For Quality Care (PFQC)
- www.peopleforqualitycare.org
- <http://www.peopleforqualitycare.org/uploads/articles/428ae3a0d81423d8423169a46877de98.pdf>
- <http://www.peopleforqualitycare.org/uploads/articles/d5827a56fb6f4eca101334b5a72e90f5.pdf>



Complaint Hotlines

2,701 Total PFQC Complaints Received

120 Total Complaints Reported by CMS

MEDICARE BENEFICIARY HOTLINE COMPLAINTS by state

PERCENT OF LEGISLATIVE SUPPORT FOR H.R. 1717 by state



Number of Complaints

Percent of Legislative Support for H.R. 1717 by State

How does CMS define and register a "complaint"?

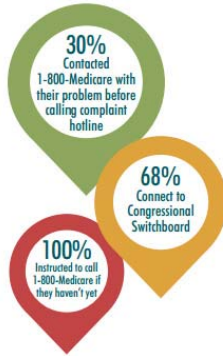


Type of Complaint PFQC Hotline

- Change of provider / was happy with old provider - quality of care was excellent, provider was local / no choice / rights violated / unhappy with policy (872)
- Difficult / unable to receive supplies (687)
- Increased cost to beneficiary (169)
- No provider available for repair (167)
- Difficult to find new provider (161)
- Product choice unavailable (151)
- Slow to receive equipment/supplies (109)
- Poor quality of care (94)
- Distance of provider is too far (88)
- Confusion / poor communication from CMS (82)



Of Those Who Called In.....





Questions???

Thank You for Attending!

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ITEMS RECLASSIFIED TO CAPPED RENTAL

The following items were reclassified to capped rental on April 1, 2014

HCPCS	Description
E0986	Push Activated Power Assist
E1002*	Power Seating, Tilt Only
E1003*	Power Seating, Recline Only, Without Shear Reduction
E1004*	Power Seating, Recline Only, With Mechanical Shear Reduction
E1005*	Power Seating, Recline Only, With Power Shear Reduction
E1006*	Power Seating, Combination Tilt And Recline, Without Shear Reduction
E1007*	Power Seating, Combination Tilt And Recline, With Mechanical Shear Reduction
E1008*	Power Seating, Combination Tilt And Recline, With Power Shear Reduction
E1010*	Power Elevation Legrests
E1014	Reclining Back, Addition To Pediatric Size Wheelchair
E1029	Ventilator Tray, Fixed
E1030*	Ventilator Tray, Gimbaleed
E1161	Manual Adult Size Tilt In Space Wheelchair
E1232	Wheelchair, Pediatric Size, Tilt-In-Space, Folding, Adjustable, With Seating
E1233	Wheelchair, Pediatric Size, Tilt-In-Space, Rigid, Adjustable, Without Seating
E1234	Wheelchair, Pediatric Size, Tilt-In-Space, Folding, Adjustable, Without Seating
E1235	Wheelchair, Pediatric Size, Rigid, Adjustable, With Seating
E1236	Wheelchair, Pediatric Size, Folding, Adjustable, With Seating
E1237	Wheelchair, Pediatric Size, Rigid, Adjustable, Without Seating
E1238	Wheelchair, Pediatric Size, Folding, Adjustable, Without Seating
E2227	Gear Reduction Drive Wheel
E2310*	Electronic Connection Between WC Controller and 1 Power Seating System Motor
E2311*	Electronic Connection Between WC Controller and 2 or More Power Seating System Motors
E2312*	Hand or Chin Control Interface, Mini-Proportional Remote Joystick, Proportional
E2313*	Harness For Upgrade To Expandable Controller
E2321*	Hand Control Interface, Remote Joystick, Nonproportional
E2322*	Hand Control Interface, Multiple Mechanical Switches, Nonproportional
E2325*	Sip And Puff Interface, Nonproportional
E2326*	Breath Tube Kit For Sip And Puff Interface
E2327*	Head Control, Mechanical, Proportional
E2328*	Head Control or Extremity Control, Electronic, Proportional
E2329*	Head Control, Contact Switch Mechanism, Nonproportional
E2330*	Head Control, Proximity Switch Mechanism, Nonproportional
E2351*	Electronic Interface To Operate SGD Using Power Wheelchair Control Interface
E2373*	Hand or Chin Control, Compact Remote Joystick, Proportional
E2374*	Hand or Chin Control, Standard Remote Joystick, Proportional, Replacement Only
E2376*	Expandable Controller, Replacement Only
E2377*	Expandable Controller, Upgrade Provided At Initial Issue
E2378*	Actuator, Replacement Only
E0198	Water Pressure Pad for Mattress
E0144	Walker, Enclosed, 4-Sided Framed, Rigid or Folding, Wheeled with Posterior Seat

* Item is billable as a purchase with CRT PWCs K0835 - K0864

The following items will be reclassified to capped rental as follows:
July 1, 2016 in Round 2 Competitive Bidding Areas
January 1, 2107 in Round 1 Recompete Competitive Bidding Areas

HCPCS	Description
E0955	Headrest, Cushioned, Any Type
E0985	Seat Lift Mechanism
E1020	Residual Limb Support System For Wheelchair
E1028	Manual Swingaway, Retractable or Removable Mounting Hardware For Joystick, Other Control Interface or Positioning Accessory
E2228	Wheelchair Breaking System And Lock, Complete, Each
E2368	Drive Wheel Motor, Replacement Only
E2369	Drive Wheel Gear Box, Replacement Only
E2370	Integrated Drive Wheel Motor And Gear Box Combination, Replacement Only
E2375	Non-Expandable Controller, Replacement Only
K0015	Detachable, Non-Adjustable Height Armrest, Each
K0070	Rear Wheel Assembly, Complete, With Pneumatic Tire, Spokes Or Molded, Each
E0197	Air Pressure Pad for Mattress, Standard
E0140	Walker with Trunk Support (Gait Trainer)
E0149	Walker, Heavy Duty Wheeled, Rigid or Folding (Rollator, Gait Trainer)