

# *“Partners In Care”*

## *Healthcare Professionals & Care Medical Equipment*



## *Understanding The New Medicare Coverage Criteria & Documentation Requirements for Power Mobility Devices*

### *Care Medical & Rehabilitation Equipment*

Established in 1970, Care Medical & Rehabilitation Equipment is a family-owned and operated business that has served the home medical equipment, rehabilitation equipment and respiratory needs of the Northwest for over 35 years. Care Medical is committed to providing our customers and referral sources with the latest industry updates and changes on documentation and prescription requirements for home medical equipment. The following information is designed to assist you in understanding how changes in coverage criteria and documentation requirements for Power Mobility Devices have affected the prescription and funding process with Medicare.

### *Medicare’s National Coverage Determination For Power Mobility Devices*

Medicare has changed the coverage criteria and documentation requirements for power mobility devices (PMD). Power Mobility Devices include power wheelchairs and scooters/power operated vehicles (POV). Medicare has replaced the “Bed or Chair Confined” requirement with consideration now given to the beneficiary’s ability to **safely** and in a **reasonable time frame** participate in one or more **Mobility Related Activities of Daily Living (MRADLs)**. MRADLs include dressing, grooming, toileting, bathing and eating (including Assisted Living Facilities) in customary locations within the home.

**For a Power Mobility Device to be covered, the treating physician must conduct a face-to-face examination of the patient to determine and document the medical necessity for the item.** Coverage criteria for power mobility devices are found in the National Coverage Documentation (NCD) for Mobility Assistive Equipment (NCD Manual Section 280.3). (See [www.cms.hhs.gov/coverage/wheelchairs.asp](http://www.cms.hhs.gov/coverage/wheelchairs.asp) to view the NCD and the regulation.) The examination must include pertinent elements of the patient’s history, physical examination, and functional assessment describing the patient’s mobility limitation and his/her physical and mental ability to operate a PMD. **The treating physician must complete this evaluation before writing an order for the PMD.** A copy of the examination report must be received by the supplier within 45 days after the examination is complete. (Exception: If this examination is performed during a hospital or nursing home stay, the supplier must receive the report within 45 days after discharge.)

## The Face-To-Face Examination

The face-to-face examination does not necessarily have to occur at a single visit and is not always performed by a single individual. For example, the physician may refer the patient to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), to perform part of this face-to-face examination. (This person may not be an employee of the supplier or have a financial relationship with the supplier. Exception: If the supplier is owned by a hospital, a PT/OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination.) In these situations, the documentation requirements and the start of the “45-day window” for getting documentation to the supplier depend on whether the physician saw the patient in person to begin the examination prior to the referral.

If the patient was referred to the PT/OT before being seen by the physician, then once the physician has received and reviewed the written report of this examination, the physician must see the patient and perform any additional examination that is needed. The report of the physician’s visit should state concurrence or any disagreement with the PT/OT examination. In this situation, the physician must provide the supplier with a copy of both examinations within 45 days after the face-to-face examination with the physician.

If the physician saw the patient to begin the examination before referring the patient to a PT/OT, then if the physician sees the patient again in person after receiving the report of the PT/OT examination, the 45-day period begins on the date of that second physician visit. However, it is also acceptable for the physician to review the written report of the PT/OT examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the physician must send a copy of the notes from his/her initial visit to evaluate the patient plus annotated, signed, and dated copy of the PT/OT examination to the supplier. The 45-day window begins when the physician signs and dates the PT/OT examination.

Finally, there may be cases in which the physician has treated a patient for an extended period of time and the information recorded at the face-to-face examination refers to previous notes in the medical record. In that case, copies of those previous notes should be forwarded to the supplier.

***NOTE:** If only wheelchair accessories or repairs are being ordered, a face-to-face examination is not required. Standard documentation requirements would apply. If the POV or power wheelchair is a replacement of a similar item that was previously covered by Medicare, a face-to-face examination is not required.*

## Clinical Algorithm For Prescribing Mobility Assistive Equipment

**A face-to-face examination of your patient is required prior to prescribing mobility assistive equipment.** The evaluation of a patient with mobility deficits is a complex process. Often other modalities of treatment may ameliorate the need for Mobility Assistive Equipment (cane, walker, manual wheelchair, POV/scooter, and power wheelchair). The following nine questions are the method for examination and should be used to determine the appropriate Mobility Assistive Equipment (MAE) for your patient.

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. If the reason your patient is not safely mobile in his/her home is due to cognitive impairment, document the impairment.
  - b. For these beneficiaries, the provision of MAE might not enable them to participate in MRADLs if the comorbidity prevents the 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 Mobility Assistive Equipment will be reasonably expected to significantly improve the beneficiary’s ability to perform or obtain assistance to participate in MRADLs in the home?***

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- a. A caregiver, for example a family member, may be compensatory, of 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 the 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 resolved with the prescription of a cane or walker? Can your patient safely and within a reasonable time frame use a cane or walker to participate in MRADLs?***
6. ***Does the beneficiary's typical environment support the use of wheelchairs including scooters/power-operated vehicles? The PMD supplier will perform a home assessment to determine that the beneficiary's living environment is suitable for a PMD. A copy of this home assessment will be kept in the PMD supplier patient's file.***
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. Consider the patient's upper extremity function. Does the patient have the strength, range of motion and endurance to safely propel a manual wheelchair all day, every day (and in a reasonable time frame) to participate in MRADLs?***
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 modifications 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. The supplier will determine through a home assessment what is the appropriate PMD (i.e. scooter/POV, power wheelchair) for the patient to use in his/her home.
  - 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. The supplier will determine through a home assessment if the beneficiary's home will provide the access needed for 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 caregiver's inability to operate a manual wheelchair can be considered in covering a power wheelchair so that the caregiver can assist the beneficiary.***

## Documentation Requirements

Medicare requires the information obtained in the face-to-face examination be supported by the patient's medical record. Medicare's expectation is that the medical record reflect that the clinician has addressed the nine questions in the clinical algorithm. The medical record includes your progress notes, chart notes, hospital records, home health records and/or through a physical/occupational wheelchair evaluation. Once you complete the face-to-face examination with your patient and have determined that a mobility assistive device is appropriate you may write a prescription for a power mobility device.

**The patient's medical record must support the prescription for the device ordered.**

**Useful Life of the PMD** - The "useful life" of Durable Medical Equipment (PMDs are in this category) is considered no less than 5 years beginning with the date of delivery. If you prescribe a PMD please consider the patient's usage and his/her prognosis for at least 5 years. Considerations include the patient's condition (foreseen changes in his/her medical condition - i.e., a progressive condition such as MS) and the patient's current weight along with history of weight gain and predicted

## Prescription Requirements

All power mobility devices require a written prescription **prior to delivery**. The equipment supplier is required by Medicare to have the **written prescription, plus proof you have considered the nine questions** on the previous page, in their files prior to delivering the power mobility device.

**The written prescription must contain the following:**

1. Beneficiary's name
2. Description of the item that is ordered. This may be general - e.g. "power wheelchair" - or may be more detailed.
3. Date of the face-to-face examination
4. Pertinent diagnosis/conditions that relate to the need for the power mobility device
5. Length of need
6. Prognosis - Required for DSHS (Washington Medicaid) billing.
7. Physician's signature
8. Date of physician's signature

Send the detailed written prescription, along with supporting documentation of the nine questions, to the equipment supplier as soon as possible to ensure that your patient receives the prescribed equipment in a timely manner. The supplier must receive the written prescription and supporting documentation for the power mobility device within 45 days from the date of the face-to-face examination.

## Obtaining Payment For Prescribing Power Mobility Devices

Physicians may bill Medicare for the face-to-face examination through the appropriate evaluation and management (E&M) code corresponding to the history and physical examination of the patient. In addition, in order to recognize the additional physician work related to the documentation, CMS has established an add-on G code (G0372) that will be paid at a rate equal to the physician fee schedule relative values established for a level 1 office visit for an established patient (CPT Code 99211). Maintaining all documentation in your patient's medical record is critical in the event of an audit by a 3rd party payer such as Medicare.

Use of code G0372 signifies that:

- ◆ All of the information necessary to document that power mobility device prescription is included in the medical record; and,
- ◆ The prescription, along with the supporting documentation, has been received by the power mobility device supplier within 45 days after the face-to-face examination.

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