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Power Wheelchairs and Power Operated Vehicles – Documentation Requirements

October 2008

Dear Physician,

In order for Medicare to provide reimbursement for a power wheelchair (PWC) or power operated vehicle (POV) (scooter), there are several statutory requirements that must be met:

1. There must be an in-person physician-patient encounter.
2. The physician must perform a medical examination for the specific purpose of assessing the beneficiary's mobility limitation and needs. The results of this exam must be recorded in the patient's medical record.
3. The prescription must only be written AFTER the in-person visit has occurred and the medical evaluation is completed. This prescription has seven required elements.
4. The prescription and medical records documenting the in-person visit and examination report must be sent to the equipment supplier with in 45 days of the completion of the examination.

The in-person visit and medical examination together are often referred to as the "face-to-face" exam.

You should record the visit and examination in your usual medical record-keeping format. Many suppliers provide forms for you to complete. Suppliers often try to create the impression that these documents are a sufficient record of the in-person visit and medical evaluation. Based upon our auditing experience, most of them are not. This is usually because these documents do not record a complete medical examination and thus do not provide enough detailed information to adequately describe the medical necessity for the power mobility device in the patient's home.

There are numerous sources that have developed forms. Many are home-grown by the individual supplier, some have been created by equipment manufacturers or other industry sources, and some have even been developed by medical groups, e.g., the Texas Academy of Family Physicians and Florida Academy of Family Physicians.

While there is no specific prohibition against the use of a form to facilitate record-keeping, any instrument you choose must be a complete and comprehensive record of your in-person visit and the examination that was performed. Documents such as the Texas or Florida Academy of Family Physicians forms that are designed to simply gather selected bits of information to be used for reimbursement purposes are insufficient to meet the statutory requirements. Even if you complete this type of form and include it in the patient's chart, it does not provide sufficient documentation of a comprehensive assessment of a patient's mobility needs.

You should perform a complete examination and document the results of the face-to-face examination in the same format that you use for other entries in your patient records. This assessment typically includes:

- History of the present condition(s) and past medical history that is relevant to mobility needs
    - Symptoms that limit ambulation
    - Diagnoses that are responsible for these symptoms
    - Medications or other treatment for these symptoms

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- Progression of ambulation difficulty over time
- Other diagnoses that may relate to ambulatory problems
- How far the patient can walk without stopping
- Pace of ambulation
- What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used
- What has changed to now require use of a power mobility device
- Ability to stand up from a seated position without assistance
- Description of the home setting and the ability to perform activities of daily living in the home

- Physical examination that is relevant to mobility needs
  - Weight and height
  - Cardiopulmonary examination
  - Musculoskeletal examination
    - Arm and leg strength and range of motion
  - Neurological examination
    - Gait
    - Balance and coordination

The evaluation should be tailored to the individual patient's conditions. The history should paint a picture of your patient's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the patient's ambulatory difficulty or impact on the patient's ambulatory ability.

It is important to keep in mind that because of the way that the Social Security Act defines durable medical equipment, a power mobility device is covered by Medicare only if the beneficiary has a mobility limitation that significantly impairs his/her ability to perform activities of daily living **within the home**. If the wheelchair/POV is needed in the home, the beneficiary may also use it outside the home. However, in your evaluation you must clearly distinguish your patient's mobility needs within the home from their needs outside the home.

You may elect to refer the patient to another medical professional, such as a physical therapist or occupational therapist, to perform part of the evaluation – as long as that individual has no financial relationship with the wheelchair supplier. However, you do have to personally see the patient before or after the PT/OT evaluation. You must review the report, indicate your agreement in writing on the report, and sign and date the report. If you do not see the patient after the PT/OT evaluation, the date that you sign the report is considered to be the date of completion of the face-to-face examination.

You may write the prescription for these items ONLY after the visit and examination are complete. This prescription must contain the following seven elements:

1) Beneficiary's name
2) Description of the item that is ordered. This may be general – e.g., "power operated vehicle", "power wheelchair", or "power mobility device"– or may be more specific.
3) Date of completion of the face-to-face examination
4) Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
5) Length of need
6) Physician's signature
7) Date of physician signature

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You must forward a copy of the face-to-face record and your seven-element prescription to the supplier within 45 days from the completion of the face-to-face. You should also include copies of previous notes, consultations with other physicians, and reports of pertinent laboratory, x-ray, or other diagnostic tests if they will help to document the severity of your patient's ambulatory problems.

After the supplier receives your order and the face-to-face information, they will prepare a detailed product description that describes the item(s) being provided including all options and accessories. You should review it and, if you agree with what is being provided, sign, date and return it to the supplier. If you do not agree with any part of the detailed product description, you should contact the supplier to clarify what you want the beneficiary to receive.

This information is not intended to serve as a substitute for the complete DME MAC local coverage determination on Power Mobility Devices. It is only a synopsis detailing the highlights of documentation. Refer to the complete LCD and Policy Article on the CMS Web site at www.cms.hhs.gov/mcd/overview.asp for additional information.

Medicare does provide you additional reimbursement (HCPCS code G0372) to recognize the additional time and effort that are required to provide this documentation to the supplier. This code is payable in addition to the reimbursement for your E&M visit code.

Your participation in this process and cooperation with the supplier will allow your patient to receive the most appropriate type of mobility equipment. We appreciate all your efforts in providing quality services to your Medicare patients.

Sincerely,

Adrian M. Oleck, M.D.
Medical Director, DME MAC, Jurisdiction B

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