

ORDER REQUIREMENTS

All Power Mobility Devices require a written order **prior to delivery**. The equipment supplier is required by Medicare to have the **written prescription, plus proof you have considered all applicable coverage criteria**, prior to delivering the Power Mobility Device. The **written order** must contain the following:

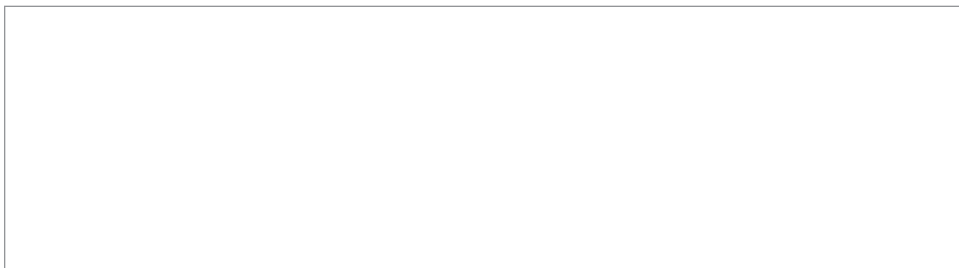
1. Beneficiary's name
2. Description of item that is ordered. This may be general – e.g. “power wheelchair”- or may be more specific.
3. Date of the face-to-face examination
4. Pertinent diagnosis/conditions that relate to the need for the PMD
5. Length of need
6. Physician's signature
7. Date of physician's signature

Please forward the written order, along with supporting documentation, 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 order and supporting documentation for the Power Mobility Device within 45 days from the date of the face-to-face examination. (Note: If the physician saw the patient to begin the examination before referring the patient to an LCMP, then if the physician sees the patient again in person after receiving the report of the LCMP 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 LCMP 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 note from his/her initial visit to evaluate the patient plus the annotated, signed, and dated copy of the LCMP examination to the supplier. The 45-day period begins when the physician signs and dates the LCMP examination.)

The equipment supplier is required to prepare a written document, called a “Detailed Product Description,” that lists the specific base (HCPCS code and manufacturer name/model) and all the options and accessories that will be separately billed. The supplier must list his/her charge and the Medicare fee schedule allowance for each separately billed item. The physician must sign and date the detailed product description and the supplier must receive it prior to delivery of the PMD. The supplier must deliver the product within 120 days from the date of the face-to-face examination.

This information is only intended to be a general summary of the PMD coverage requirements and is not coverage or reimbursement advice. It is your sole responsibility to determine and document medical necessity, to apply Medicare's coverage criteria for MAEs (including PMDs), and to submit the appropriate physician order for specific items and services. Pride Products cannot guarantee coverage or reimbursement based on the information in this Guide. In all cases, you will need to follow local payer policies and all Medicare statutes and regulations for billing and reimbursement and should verify coverage policies prior to submitting any claims.

For more information on Medicare's Clinical Criteria for MAE Coverage, in general, or PMD Coverage Criteria in particular, please refer to the Medicare's Mobility Assistive Equipment Web Page at www.cms.hhs.gov/CoverageGenInfo/06_wheelchair.asp.



This brochure was updated on 7/24/07. Please visit the above web site for more information.

Physician Resource Guide



Jazzy® Select™



Go-Go Elite Traveller® Plus

Medicare's Coverage Criteria and Documentation Requirements for Power Mobility Devices (PMDs)



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Overview of Coverage Criteria and Documentation Requirements for Power Mobility Devices (Power Wheelchairs and Scooters)

National Coverage Determination (NCD) for Power Mobility Devices (PMDs)

Medicare has changed the coverage criteria and documentation requirements for Power Mobility Devices (PMDs) for dates of service on or after May 5, 2005. Power Mobility Devices include power wheelchairs and power operated vehicles (POVs or scooters).

With this change, Medicare has modernized the policy and replaced the “bed- or chair-confined” standard 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) such as toileting, feeding, dressing, grooming, and bathing in customary location in the home. In addition, Medicare has created sequential “Clinical Criteria for Mobility Assistive Equipment (MAE) Coverage,” which must be followed by the physician or treating practitioner to determine which MAE (from canes to scooters) is appropriate to meet the beneficiary’s MRADL needs. (For more information on the Clinical Criteria for MAEs, please refer to the Medicare’s Mobility Assistive Equipment Web Page at www.cms.hhs.gov/CoverageGenInfo/06_wheelchair.asp)

If you are considering prescribing a **Power Mobility Device**, the following information may assist you in understanding how these changes have affected the PMD ordering and funding process for Medicare patients.

The physician or treating practitioner must:

- Conduct a face-to-face examination of the patient prior to prescribing a PMD.
- Write an order for the PMD within 45 days after the examination.
- Furnish pertinent medical information to the supplier to support medical necessity.

As a prescribing physician or treating practitioner of a PMD you are entitled to a new add-on payment for conducting the face-to-face examination and for preparing and sending the required documentation to the PMD equipment supplier. The new add-on HCPCS code is G0372 and 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).

OVERVIEW OF COVERAGE CRITERIA

In general, the following basic coverage criteria must be met for a PMD to be covered (additional coverage criteria for specific devices may apply):

- The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) in the home. A mobility limitation is one that prevents them from accomplishing their MRADLs entirely or within a reasonable time frame or places them at reasonable determined heightened risk of morbidity or mortality secondary to the attempts to participate in MRADLs.
- The patient’s mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.
- The patient does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day. Limitations of strength, endurance, range of motion, coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

In order for a POV/Scooter to be covered, additional coverage criteria, including the following, must be met in addition to the basic criteria listed above.

- The patient is able to safely transfer to and from a POV/Scooter, operate the tiller steering system, and maintain postural stability and position while operating the POV/Scooter in the home.
- The patient’s mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient to safely operate a POV/scooter in the home.
- The patient’s home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV/scooter.
- The patient’s weight is less than or equal to the weight capacity of the POV/scooter.
- Use of a POV/scooter will significantly improve the patient’s ability to participate in MRADLs and the patient will use it in the home.
- The patient has not expressed an unwillingness to use a POV in the home.

A power wheelchair is covered if all basic coverage criteria are met and the patient does not meet the criteria for a POV/Scooter. The following criteria must also be met in order for a power wheelchair to be covered.

- The patient has the mental and physical capabilities to safely operate the power wheelchair or, if the patient is unable to safely operate the power wheelchair, the patient must have a caregiver who is unable to adequately propel a manual wheelchair, but is available, willing, and able to safely operate the power wheelchair.
- The patient’s weight is less than or equal to the weight capacity of the power wheelchair.
- The patient’s home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair.
- Use of a power wheelchair will significantly improve the patient’s ability to participate in MRADLs and the patient will use it in the home. For patients with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver.
- The patient has not expressed an unwillingness to use a power wheelchair in the home.

You may refer the patient to a licensed/certified medical professional (LCMP) who has the experience and training in mobility evaluations to perform part of the face-to-face examination. This individual may have no financial relationship with the supplier. (Exception: If the supplier is owned by a hospital, an LCMP working in an inpatient or outpatient hospital setting may perform part of the face-to-face examination.)

DOCUMENTATION REQUIREMENTS

The patient’s medical record must support the need for the PMD that is ordered. The medical record includes such items as your progress notes, chart notes, hospital records, home health records and any records from other health care professionals and test reports. Once you complete the face-to-face examination with your patient and have determined that a PMD is reasonable and necessary you may write an order for a PMD.

IMPORTANT: Physicians must document the evaluation from the face-to-face examination in a detailed narrative note in their charts in the format that they use for other entries. The note must clearly indicate the major reason for the visit was a mobility evaluation.

Many suppliers have created forms which they send to physicians asking them to complete. Even if this form is completed and placed in your chart, Medicare will not accept this form as a substitute for the comprehensive medical records as indicated above.