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Power Wheelchairs and Power Operated Vehicles – Documentation Requirements

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 visit with a physician specifically addressing the patient's mobility needs.
2. There must be a history and physical examination by the physician or other medical professional (see below) focusing on an assessment of the patient's mobility limitation and needs. The results of this evaluation must be recorded in the patient's medical record.
3. A prescription must be written AFTER the in-person visit has occurred and the medical evaluation is completed. This prescription has seven required elements (see below).
4. The prescription and medical records documenting the in-person visit and evaluation must be sent to the equipment supplier within 45 days after the completion of the evaluation.

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

The complete history and physical examination typically includes:

- History of the present condition(s) and past medical history that are relevant to the patient's mobility needs in the home:
 - Symptoms that limit ambulation
 - Diagnoses that are responsible for these symptoms
 - Medications or other treatment for these symptoms
 - Progression of ambulation difficulty over time
 - Other diagnoses that may relate to ambulatory problems
 - How far the patient can walk without stopping and with what assistive device, such as a cane or walker
 - Pace of ambulation
 - History of falls, including frequency, circumstances leading to falls, and why a walker isn't sufficient
 - What ambulatory assistance (cane, walker, wheelchair) is currently used and why it isn't sufficient
 - What has changed to now require use of a power mobility device
 - Ability to use a manual wheelchair
 - Reasons why a power operated vehicle (scooter) would not be sufficient for this patient's needs in the home
 - Description of the home setting and the ability to perform activities of daily living in the home
 - Physical examination that is relevant to the patient's mobility needs
 - Weight and height
 - Cardiopulmonary examination
 - Musculoskeletal examination

- Arm and leg strength and range of motion
- Neurological examination
 - Gait
 - Balance and coordination
 - **If the patient is capable of walking, the report should include documented observation of ambulation (with use of a cane or walker, if appropriate)**

Examples of vague or subjective descriptions of the patient’s mobility limitations include:

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| • “upper extremity weakness” • “poor endurance” | • “difficulty walking” |
| • “gait instability” | • “SOB on exertion” |
| • “weakness” | • “pain” |
| • “abnormality of gait” | • “fatigue” |
| | • “deconditioned” |

These types of statements are insufficient and do not objectively address the mobility limitation or provide a clear picture of the patient’s mobility deficits. Objective measurements should be provided.

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 should record the visit and mobility evaluation 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.** That is because they typically contain check-off boxes or space for only brief answers and thus do not provide enough detailed information about the patient’s ambulatory abilities and limitations to allow the Medicare contractor to determine if coverage criteria have been met. Forms such as those developed by the Texas or Florida Academy of Family Physicians are designed to gather selected bits of information and are almost always insufficient. What is required is a thorough narrative description of your patient’s current condition, past history, and pertinent physical examination that **clearly describes their mobility needs in the home** and why a cane, walker, or optimally configured manual wheelchair is not sufficient to meet those needs.

You may write a prescription for a power mobility device 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

You must forward a copy of the face-to-face evaluation and your seven-element prescription to the supplier within 45 days from the completion of the face-to-face mobility exam. 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 <http://www.cms.gov/mcd/overview.asp?from2=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 evaluation and management (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,

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