Medicare Learning Network
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CMS
Information for Medicare Fee-For-Service Health Care Professionals

Related Change Request (CR) #: 3952 MLN Matters Number: MM3952
Related CR Release Date: October 28, 2005
Related CR Transmittal #: 128
Effective Date: May 5, 2005
Implementation Date: The implementation date for the Medicare system changes contained in CR3952 is April 3, 2006; otherwise, implementation will occur on October 25, 2005.

# *MMA - Evidence of Medical Necessity: Power Wheelchair and Power Operated Vehicle (POV)/Power Mobility Device (PMD) Claims*

Note: This article was updated on February 12, 2013, to reflect current Web addresses. This article was previously changed on October 24, 2007, to refer to Change Request (CR) 5128, which is a supplement to CR3952. CR5128 contains updated changes based on the final regulation that differ from CR3952. The key points are outlined in MLN Matters article MM5128, which is related to CR5128 and located at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5128.pdf on the CMS website.

## Provider Types Affected

Providers prescribing Power Mobility Devices (PMDs) and suppliers billing Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for PMDs

## Provider Action Needed


STOP – Impact to You

Effective for dates of service on or after May 5, 2005, the procedure for documenting and submitting a claim for a wheelchair or PMD has changed.


CAUTION – What You Need to Know

Make certain to meet criteria regarding who can prescribe PMDs, retain appropriate prescribing documentation, and understand the boundaries for prescribing and billing for PMDs.

## GO – What You Need to Do

Please be aware of the criteria addressed in the related instruction (CR3952) and ensure that billing staffs submit claims accordingly.

## Background

This article includes information from Change Request (CR) 3952 that outlines the changes regarding Medicare adjudication of claims for PMDs as set forth in Section 302 (a) (2) (E) (iv) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Also outlined are criteria determining who can prescribe PMDs and a definition of the devices. The following rules are in place for claims with dates of service on or after May 5, 2005:

### *Rules for Adjudicating Claims for PMDs*

Physicians should be aware of the critical role they play in prescribing power wheelchairs. Specifically, physicians evaluate a patient's medical conditions and need for mobility and, as such, are the primary gatekeepers of the information CMS uses to base decisions for payment.

To this end, physicians should be conscientious when documenting patient encounters and pay particular attention to describing the patient's clinical condition (e.g., medical history, disease progression, changes in health status), as well as their need for mobility, their living situation (e.g., family support and caregivers), and other treatments that have been tried and considered. All of this information is used by our contractors (Medicare's DME MACs) when evaluating a claim for payment.

### *Face-to-Face Examination and Prescription*

A condition for payment for motorized or power wheelchairs is that the PMD must be prescribed by a physician or treating practitioner (a physician assistant, nurse practitioner, or a clinical nurse specialist) who has conducted a face-to-face examination of the beneficiary and has written a prescription for the PMD. The face-to-face examination requirement does not apply when only accessories for PMDs are being ordered.

The written prescription (order) must include the following:

- Beneficiary's name;
- Date of the face-to-face examination;
- Diagnoses and conditions that the PMD is expected to modify;
- Description of the item;
- How long it is needed;
- The physician or treating practitioner's signature; and
- The date the prescription is written.

The written prescription (order) must be:

- In writing;
- Signed and dated by the physician or treating practitioner (a physician assistant, nurse practitioner or clinical nurse specialist) who performed the face-to-face examination; and
- Be received by the supplier within 30 days after the face-to-face examination.

The physician or treating practitioner must submit a written prescription (order) for the PMD to the supplier. This prescription must be received by the supplier within 30 days of the face-to-face evaluation, or, in the case of a recently hospitalized beneficiary, within 30 days after the date of discharge from the hospital.

### *Additional Documentation*

The physician or treating practitioner must also provide the supplier with additional documentation describing how the patient meets the clinical criteria for coverage as described in the National Coverage Determination (NCD), as documented in CR3791. (Instructions for accessing CR3791 are in the *Related Instructions* section of this article.)

The actual documentation needed to describe how the coverage is met varies, but may include the history, physical examination, diagnostic tests, summary of findings, diagnoses, and treatment plans, along with any other information explaining the patient's need for the equipment.

DME suppliers should retain on file the prescription (written order), signed and dated by the treating physician or treating practitioner, along with the supporting documentation that supports the PMD as reasonable and necessary.

### *Other Rules*

- It is no longer necessary to require a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology to provide a written order for Power Operated Vehicles (POVs).
- The use of the Certificates of Medical Necessity (CMNs) for motorized wheelchairs, manual wheelchairs, and POVs will be phased out for claims with Dates of Service (DOS) on or after May 5, 2005.
- Until Medicare systems changes are fully implemented in April 2006, for claims with dates of service on or after May 5, 2005, suppliers must submit a partially completed and unsigned CMN.
- For claims with dates of service before May 5, 2005, claims must be submitted and processed using the appropriate fully completed and signed CMN.

## Implementation

The implementation date for the system changes contained in CR3952 is April 3, 2006; otherwise, implementation will occur on October 25, 2005.

## Related Instructions

MM3791 provides additional information that describes the steps the healthcare provider must take to justify the POV. MM3791 lists the Clinical Criteria for MAE Coverage, along with the MAE Coverage Flow Chart. Go to http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3791.pdf on the CMS website to view that information.

For complete details, please see the official instruction regarding this change. The instruction includes the complete section 280.3; it may be viewed by going to http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R574CP.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R37NCD.pdf on the CMS website.

The file reflecting transmittal number 37 contains the revisions to the Medicare National Coverage Determinations Manual, and the file with transmittal number 574 contains the Medicare claims processing business requirements/instructions.

## Additional Information

For more information regarding wheelchair coverage, visit http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/index.html on the CMS website.

For complete details regarding CR3952, please see the official instruction issued to your DME MAC regarding this change. The instruction may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R128PI.pdf on the CMS website.

If you have any questions, please contact your DME MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.