DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official CMS Information for Medicare Fee-For-Service Providers

FACT SHEET

Power Mobility Devices (PMDs):

Complying with Documentation & Coverage Requirements

This fact sheet provides education on Medicare coverage of Power Mobility Devices (PMDs) and describes common Comprehensive Error Rate Testing (CERT) Program errors related to PMDs. It provides a checklist of the documentation needed to support a claim submitted to Medicare for PMDs.

The Centers for Medicare & Medicaid Services (CMS) developed the CERT Program to produce a national Medicare Fee-For-Service (FFS) error rate, as required by the Improper Payments Information Act. CERT randomly selects a statistically-valid sample of Medicare FFS claims and reviews those claims and related medical records for compliance with Medicare coverage, payment, coding, and billing rules.

In order to accurately measure the performance of the Medicare claims processing contractors and to gain insight into the causes of errors, CMS calculates both a national Medicare FFS paid claims error rate and a provider compliance error rate and publishes the results of these reviews annually.

CMS strives to eliminate improper payments in the Medicare Program to maintain the Medicare Trust Fund and protect patients from medically unnecessary services or supplies.

Overview

Power wheelchairs and Power Operated Vehicles (POVs) – also known as scooters – are collectively classified as PMDs and are covered under the Medicare Part B benefit. CMS defines a PMD as a covered Durable Medical Equipment (DME) item, which includes a power wheelchair or a POV that a patient uses in the home. Effective May 5, 2005, CMS revised national coverage policy to create a new class of DME identified as Mobility Assistive Equipment (MAE), which includes a continuum of technology from canes to power wheelchairs.

ICN 905063 September 2011

Basic Coverage Criteria for All PMDs

For Medicare to cover a PMD, **all** of the following three basic coverage criteria must be met:

1. The patient has a mobility limitation that significantly impairs his or her ability to participate in one or more Mobility-Related Activities of Daily Living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:
   - Prevents the patient from accomplishing an MRADL entirely or within a reasonable time frame, or
   - Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL.
2. The patient's mobility limitation cannot be resolved sufficiently and safely by the use of an appropriately fitted cane or walker.
3. 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, or coordination; presence of pain; or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
   - An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories.

Additional Coverage Criteria Based on the Specific Type of PMD Provided

In addition to the basic coverage criteria described above, depending on the type of PMD provided, the following criteria must be met for Medicare to cover the PMD:

POVs

- The patient is able to:
  - Safely transfer to and from a POV,
  - Safely operate the tiller steering system, and
  - Maintain postural stability and position while operating the POV in the home.
- The patient's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home.
- The patient's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided.
- The patient's weight is less than or equal to the weight capacity of the POV that is provided.
- The patient's use of a POV will significantly improve his or her ability to participate in MRADLs. The patient will use the POV in the home.
- The patient has not expressed an unwillingness to use a POV in the home.

Power Wheelchairs

- The patient does **not** meet the additional coverage criteria for a POV.
- The patient has the mental and physical capabilities to safely operate the power

wheelchair that is provided (if the patient is unable to safely operate the power wheelchair, the patient has a caregiver who is available, willing, and able to safely operate the power wheelchair that is provided but is unable to adequately propel an optimally-configured manual wheelchair).

- The patient's weight is less than or equal to the weight capacity of the power wheelchair that is provided.
- The patient's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is provided.
- Use of a power wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use the power wheelchair 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.
- Any coverage criteria pertaining to the specific wheelchair type are met. **For more information, refer to the applicable Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Local Coverage Determination (LCD).**

Power Wheelchairs Group 2 Single Power Option and Above

In addition to the specific wheelchair base coverage criteria listed in the LCD, the following two requirements must be met:

1. The patient must have a specialty evaluation performed by a Licensed/Certified Medical Professional (LCMP) (e.g., Physical Therapist [PT], Occupational Therapist [OT], or a physician with specific training and experience in rehabilitation wheelchair evaluations). The evaluation documents the medical necessity for the wheelchair and its special features. The PT, OT, or physician may not have any financial relationship with the supplier.
2. A supplier that employs a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified Assistive Technology Professional (ATP) must provide the wheelchair. The supplier must specialize in wheelchairs and have a direct, in-person relationship with the patient in selecting his or her wheelchair.

Patient Costs for PMDs

Power Wheelchairs

Patients who qualify for coverage of a power wheelchair furnished prior to January 1, 2011, may purchase the power wheelchair when it is initially furnished. Based on recent changes in Medicare rules, the lump sum purchase option is no longer available for standard power wheelchairs furnished on or after January 1, 2011. These changes do not apply to standard power wheelchairs furnished to patients in Competitive Bidding Areas (CBAs) of the Round 1 Rebid of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) competitive bidding program. The purchase option remains in effect for complex, rehabilitative power wheelchairs (e.g., power wheelchairs with power seating systems and/or special controls needed by the patient) furnished on or after January 1, 2011.

Medicare payment can only be made on a rental basis for standard power wheelchairs furnished on or after January 1, 2011. If the patient declines the purchase

option, or in the case of all standard power wheelchairs furnished on or after January 1, 2011, Medicare will pay for the power wheelchair on a rental basis for up to 13 months. On the first day after the 13th rental month, the supplier is required to transfer the title to the equipment to the patient. The patient may elect to obtain a replacement power wheelchair, if medically necessary, when the power wheelchair has been in use on a continuous basis for five years. Under a special rule established for certain patient-owned equipment, such as a power wheelchair for which the title has been transferred to the patient after 13 continuous months of rental, the supplier must replace the equipment free of charge if it does not last the full 5-year period (i.e., is no longer serviceable or needs substantial repairs). This replacement equipment does not need to be "new." For more information, refer to 42 Code of Federal Regulations (CFR) Section 414.210(e)(4).

POVs

Patients may choose to rent or purchase a POV. If the rental option is selected, the supplier retains ownership of the POV, and Medicare limits its total rental payments to the purchase price. Therefore, if the patient needs the POV for an extended period, purchase is a preferable option. The patient may elect to obtain a replacement POV, if medically necessary, when the POV has been in use on a continuous basis for five years. Table 1, below, summarizes the patient costs for purchasing or renting a power wheelchair or POV.

Table 1. Summary of Patient Costs

If the patient...	Then Medicare Part B will pay...	And the patient will pay...*
Chooses to purchase the power wheelchair, if applicable, or POV...	80% of the allowed purchase price in one lump sum payment…	20% of the allowed purchase price.
Chooses to rent the power wheelchair...	80% of the allowed rental price for months 1 through 13…	20% of the allowed rental charge.
Chooses to rent the POV...	80% of the allowed rental price. Total Medicare payments cannot exceed 80% of the allowed purchase price…	20% of the allowed rental charge.

*** Patient payment responsibility is based upon receiving equipment from a provider that accepts assignment. Patient costs are higher when obtaining wheelchairs from suppliers that do not accept assignment. If the patient is enrolled in a Medicare Managed Care Plan, the patient will need to contact the plan to determine his or her costs. In addition, the managed care plan may require preauthorization and have a limited number of participating DME suppliers.**

NOTE: If the power wheelchair or POV is purchased, Medicare will pay 80 percent of the allowable service and maintenance charge each time the equipment is actually serviced.

Common PMD Errors

1. No documentation of a physician face-to-face visit.
2. No physician documentation of the patient's mobility limitations within the home setting to support medical need for the equipment.

3. No physician documentation justifying the need for a power option over the need for a manual wheelchair.
4. Patient is ambulatory and does not qualify for a wheelchair/PMD.

Why Were These Errors Identified?

1. Medicare requires a thorough face-to-face visit with the treating physician prior to dispensing any power mobility equipment. The face-to-face visit must be completed before the written order (consisting of seven elements) is received.
2. Medicare requires documentation of the mobility limitations that cause the patient's inability to complete Activities of Daily Living (ADLs) within the home.
3. Medicare requires documentation of the reasons why a cane, walker, or manual wheelchair cannot be used to complete the patient's ADLs.
4. Medicare does not cover PMDs for patients who are able to complete their ADLs by ambulating within the home in a reasonable time frame. PMDs used only outside the home do not meet the definition of the DME benefit category and are denied as noncovered. Therefore, when a PMD is only prescribed for use outside the home, the -KX modifier, indicating coverage criteria are met, should **not** be used.

Required PMD Documentation

In addition to prescribing the PMD, the physician or treating practitioner must provide the supplier with supporting documentation. This documentation should include portions of the medical record that support medical necessity for the PMD in the patient's home. The medical record must contain sufficient information to show that the coverage criteria for a PMD are met. This information must directly relate to the patient's use of a PMD.

In order to document the need for a PMD, there are a few specific statutory requirements that must be met **before** the prescription is written:

1. A face-to-face examination (described in detail below in the "PMD Documentation Checklist" section) consisting of:
   - An in-person visit between the ordering physician and the patient. This visit must document the decision to prescribe a PMD.
   - A medical evaluation performed by the ordering physician. The evaluation must clearly document the patient's functional status with attention to conditions affecting the patient's mobility and his or her ability to perform ADLs within the home. This may be done all or in part by the ordering physician. If all or some of the medical examination is completed by another medical professional, the ordering physician must sign off on the report and incorporate it into his or her records.
2. A written prescription for a PMD created only after the face-to-face examination that includes the seven required elements as listed below in the "PMD Documentation Checklist" section.
3. **Receipt** of the records of the face-to-face examination and the seven-element written prescription by the PMD supplier within 45 days of the completion of the face-to-face examination.

4. Consideration as to what other items of MAE (e.g., canes, walkers, manual wheelchair, etc.) might be used to resolve the patient's mobility deficits (as required by the CMS National Coverage Determination [NCD]). Information addressing MAE alternatives must be included in the face-to-face medical evaluation.

As noted above, in order for Medicare to cover a PMD, the supplier **must receive** the written prescription within 45 days of a face-to-face examination by the treating physician, or discharge from a hospital or nursing home, **and** before the PMD is delivered. The date of service on the claim must be the date the PMD device is furnished to the patient. A PMD **cannot** be delivered based on a verbal order. If the supplier delivers the item prior to receipt of a written prescription, the PMD will be denied as noncovered. If the written prescription is not obtained prior to delivery, payment will not be made even if a written prescription is subsequently obtained. Upon request, suppliers must submit to CMS or its agents the PMD prescription and supporting documentation received from the physician or treating practitioner.

If requested, suppliers must also submit additional documentation to support medical necessity, which may include physician office records, hospital records, nursing home records, home health agency records, records from other health professionals, and test reports.

NOTE: Physicians, treating practitioners, and suppliers should contact the DME MAC for coverage instructions related to specific items.

PMD Documentation Checklist

The following documentation is required for PMDs:

□ Face-to-Face Examination

The face-to-face examination must be relevant to the patient's mobility needs and include the following elements*:

- History of present condition and relevant past medical history, including:
  - Symptoms that limit ambulation,
  - Diagnoses that are responsible for symptoms,
  - Medications or other treatment for symptoms,
  - Progression of ambulation difficulty over time,
  - Other diagnoses that may relate to ambulatory problems,
  - Distance patient can walk without stopping,
  - Pace of ambulation,
  - Ambulatory assistance currently used,
  - Change in condition that now requires a PMD, and
  - Description of home setting and ability to perform ADLs in the home;
- Physical examination relevant to mobility needs, including:
  - Height and weight,
  - Trunk stability (sitting/standing),

- Cardiopulmonary examination, and
- Arm and leg strength and range of motion; and

- Neurological examination, including:
  - Gait, and
  - Balance and coordination.

NOTE: The face-to-face examination is not required when only accessories for PMDs are being ordered.

*** While you should fully evaluate the patient during the face-to-face examination, note that all elements listed may not apply to every patient. Professional discretion is necessary to determine if these items are required as part of the face-to-face examination.**

The face-to-face examination should be tailored to the individual patient's conditions. **The medical history should contain a well-documented description 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.

The information from the physical examination must not be recorded in vague and subjective terms (e.g., weak, breathless, tired, etc.), but instead must provide quantifiable, objective measures or tests of the abnormal characteristic (e.g., range of motion, manual muscle test scores, heart rate/respiratory rate/pulse oximetry). Each medical record is expected to be individualized to the unique characteristics of the patient. Included in **all** physical examinations must be a detailed description of the patient's **observed** ability or inability to transfer and/or walk.

The physician may refer the patient to an LCMP, such as a PT or OT, who has experience and training in mobility evaluations to perform part of the face-to-face examination. All LCMP information should be clearly documented and included as part of the complete medical record to sufficiently demonstrate medical need.

For more information on the face-to-face examination, a sample checklist for the face-to-face examination, and examples of insufficient and sufficient documentation, refer to the Medicare Learning Network® (MLN) Matters® Special Edition Article SE1112, "Power Mobility Device Face-to-Face Examination Checklist" at http://www.cms.gov/MLNMattersArticles/Downloads/SE1112.pdf on the CMS website.

□ Valid Written Prescription

The valid written prescription must be completed only by the **treating physician** and contain the following seven elements:

1. Patient's name,
2. Description of item ordered (description may be general [e.g., "power operated vehicle", "power wheelchair", or "power mobility device"] or more specific),
3. Date of face-to-face examination,
4. Pertinent diagnoses/conditions that relate to the need for a PMD,

5. Length of need,
6. Physician's signature, and
7. Date of physician's signature.

□ Detailed Product Description

The detailed product description must be completed by the **supplier**, and reviewed and signed by the **treating physician**. It must contain:

- Specific Healthcare Common Procedure Coding System (HCPCS) code for base and all options and accessories that will be separately billed,
- Narrative description of the items,
- Manufacturer name and model name/number,
- Supplier's charge for each item,
- Medicare's fee schedule allowance for each item (if no allowance, list "not applicable"),
- Physician signature and date signed, and
- Date stamp to document receipt date.

□ Home Assessment

The home assessment must be completed at or prior to delivery. It must:

- Verify that the patient can adequately maneuver the device, considering:
  - Physical layout,
  - Doorway width,
  - Doorway thresholds, and
  - Surface; and
- Be documented in a written report.

□ Patient Authorization

The patient's signature, authorizing submission of a Medicare claim, must be on file.

□ Proof of Delivery

- The patient must sign a delivery ticket.
- A copy of the supplier's standards must be provided to the patient for review.

Resources

Detailed education is available from the DME MACs serving Jurisdictions A, B, C, and D. Education is provided in a variety of formats including: self-paced online tutorials, podcasts, video education, and webinars. Additionally, each DME MAC jurisdiction staffs a Regional CERT Coordinator who can assist you with various CERT-related questions and/or concerns, such as:

- General CERT information,
- Detailed review results of a CERT claim,
- Explanation of a CERT-related overpayment,

- How to have a CERT overpayment re-reviewed,
- Clarification of the type of documentation CERT is requesting, and
- Why you may still be receiving request letters for medical records when you have already submitted the documentation.

You can find DME MAC jurisdiction website addresses and Regional CERT Coordinator contact information in Table 2 below.

Table 2. Website Addresses and Regional CERT Coordinators for Each DME MAC

Jurisdiction	Website Address	Regional CERT Coordinator
Jurisdiction A: NHIC, Corp.	http://www.medicarenhic.com/dme	Alina Jimenez 323-432-7840 alina.jimenez@hp.com
Jurisdiction B: National Government Services (NGS)	http://www.ngsmedicare.com/wps/portal/ngsmedicare/home	Sharon Gulley 1-800-338-6101 Education@wellpoint.com
Jurisdiction C: CGS	http://www.cgsmedicare.com/jc	Brenda Normandia 615-782-4485 Brenda.Normandia2@cigna.com
Jurisdiction D: Noridian Administrative Services, LLC (NAS)	https://www.noridianmedicare.com/dme	Jennifer Huber 701-433-3064 jennifer.huber@noridian.com and Melissa Gordon 701-433-3092 melissa.gordon@noridian.com

For a complete listing of all national educational products related to provider compliance, including CERT, visit the MLN Products web page at http://www.cms.gov/MLNProducts on the CMS website.

For more information on Medicare PMD coverage, refer to the following resources:

MLN Matters® Special Edition Article SE1112, "Power Mobility Device Face-to-Face Examination Checklist"

http://www.cms.gov/MLNMattersArticles/Downloads/SE1112.pdf

MLN Matters® Article SE1112 is designed to provide education on how to improve compliance with documentation requirements for the face-to-face examination that occurs prior to the physician or treating practitioner ordering a PMD for his or her Medicare patients. It includes a checklist that providers may use for this examination, in addition to some tips to help providers and suppliers avoid denial of their PMD claims.

Medicare Coverage – Mobility Assistive Equipment Web Page

http://www.cms.gov/CoverageGenInfo/06_wheelchair.asp

This web page contains links to numerous policy and Question and Answer (Q&A) documents related to MAE and PMD policy.

Medicare Coverage Database

http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

The Medicare Coverage Database permits searching of NCDs, LCDs, and DME MAC provider education articles regarding coverage policies.

CMS Internet-Only Manual, "Medicare Claims Processing Manual" (Publication 100-04), Chapter 20

http://www.cms.gov/manuals/downloads/clm104c20.pdf

The "Medicare Claims Processing Manual" describes the basic billing requirements. Chapter 20 focuses on DME billing.

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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