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**THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PHYSICIAN/SUPPLIER STAFF. BULLETINS ARE AVAILABLE AT NO COST FROM OUR WEB SITE AT WWW.TRICENTURION.COM**  
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### **Power Mobility Devices – Documentation Requirements**

The Final Rule relating to documentation for power wheelchairs and power operated vehicles was published in the Federal Register on April 5, 2006 and became effective for claims with dates of service on or after June 5, 2006. The Final Rule is similar to the Interim Final Rule which became effective for claims with dates of services on or after October 25, 2005 – with one significant change. The Final Rule states that the physician’s order for a power mobility device and a copy of the report of the face-to-face evaluation of a patient’s mobility needs must be received by the supplier within 45 days following the completion of the face-to-face evaluation. The previous requirement was that these documents be received by the supplier within 30 days following the face-to-face examination.

This article incorporates the new time frame into instructions previously published in the Power Wheelchair Bases and Power Operated Vehicles Local Coverage Determinations (LCDs) and Policy Articles. It adds some new documentation requirements. It also provides additional guidance based on claim review experience by the DME PSCs.

Note: The DME PSCs have released revisions of the Power Wheelchairs and Power Operated Vehicles policies as part of the June Supplier Manual update. Those revisions incorporate the new 45 day time frame. However, they do not include the new documentation requirements included in this article. The information in this article supercedes the policies. This information will be included in a future revision of the medical policies.

#### **Orders:**

For a power wheelchair (PWC) or power operated vehicle (POV) to be covered, the supplier must receive from the treating physician a written order containing all of the following elements:

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

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## 7) Date of physician signature

This order must be received by the supplier within 45 days after completion of the physician's face-to-face examination and prior to delivery of the device. (Exception: If the examination is performed during a hospital or nursing home stay, the supplier must receive the order within 45 days after discharge.) If these requirements are not met, the claim will be denied as noncovered.

In order to document that the order was received by the supplier within 45 days after the date of the face-to-face examination, the supplier must use a date stamp or equivalent on the order when it is received.

Once the supplier has finalized the specific power mobility device that will be provided to the beneficiary, the supplier must prepare a written document (termed a detailed product description) that lists the specific base (HCPCS code and manufacturer name/model) and all options and accessories that will be separately billed. For claims with dates of service on or after 8/24/2006, the supplier must list their charge and the Medicare fee schedule allowance for each separately billed item. If there is no fee schedule allowance, the supplier shall enter "not applicable". The physician must sign and date this detailed product description and the supplier must receive it prior to delivery of the PWC or POV. A date stamp shall be used to document receipt date. For claims with dates of service on or after 8/24/2006, the delivery must be within 120 days following the face-to-face examination. (Exception: For PWCs that go through the ADMC process and receive an affirmative determination, the delivery must be within 6 months following the determination.) The signature on the detailed product description is to ensure that the practitioner is well informed about the equipment provided to the patient and has the information necessary to provide feedback to the supplier as necessary about any safety or functional concerns.

If the written order containing all the required elements specified above is not received by the supplier within 45 days after the face-to-face examination or if the PWC or POV is dispensed before the supplier receives the signed detailed product description, an EY modifier must be added to the HCPCS codes for the PWC and all accessories or for the POV. The order and detailed product description must be available to the DME contractor on request.

### Face-to-face examination:

For a PWC or POV to be covered, the treating physician must conduct a face-to-face examination of the patient before writing the order and the supplier must receive a written report of this examination within 45 days after completion of the face-to-face examination and prior to delivery of the device. If this requirement is not met, the claim will be denied as noncovered. (Exceptions: If this examination is performed during a hospital or nursing home stay, the supplier must receive the report of the examination within 45 days after discharge. If the PWC or POV is a replacement, during the item's useful lifetime, of an item billed with the same HCPCS code that was previously covered by Medicare, a face-to-face examination is not required.) The written report(s) of this evaluation must be available to the DME contractor on request.

In order to document that the report of the face-to-face examination was received by the supplier within 45 days after the date of exam, the supplier must use a date stamp or equivalent on the report when it is received.

The report of the face-to-face examination shall provide information relating to the following questions:

- What is this patient's mobility limitation and how does it interfere with the performance of activities of daily living?
- Why can't a cane or walker meet this patient's mobility needs in the home?
- Why can't a manual wheelchair meet this patient's mobility needs in the home?
- If a PWC is provided, why can't a POV (scooter) meet this patient's mobility needs in the home?
- Does this patient have the physical and mental abilities to operate a PWC/POV safely in the home?
- Is the patient willing and motivated to use the PWC or POV ?

The report shall provide pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.

- Symptoms
- Related diagnoses
- History
  - How long the condition has been present
  - Clinical progression
  - Interventions (including medications) that have been tried and the results
  - Past use of walker, manual wheelchair, POV, or power wheelchair and the results
- Physical exam
  - Weight
  - Impairment of strength, range of motion, sensation, or coordination of arms and legs
  - Presence of abnormal tone or deformity of arms, legs, or trunk
  - Neck, trunk, and pelvic posture and flexibility
  - Sitting and standing balance
- Functional assessment – any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person
  - Transferring between a bed, chair, and PMD
  - Walking around their home – to bathroom, kitchen, living room, etc. – provide information on distance the patient is able to walk without stopping, speed, and balance

The elements that are addressed will depend on the diagnoses that are responsible for the mobility deficit. For example, for patients with COPD, heart failure, or arthritis, the major emphasis will be on symptoms and history of the progression of their condition rather than on the physical examination. Functional assessment is important for all patients.

Physicians shall also provide reports of pertinent laboratory tests, x-rays, and/or other diagnostic tests (e.g., pulmonary function tests, cardiac stress test, electromyogram, etc.) performed in the course of management of the patient.

Although patients who qualify for coverage of a power wheelchair may use that device outside the home, because Medicare's coverage of a wheelchair is determined solely by the patient's mobility needs within the home, the examination must clearly distinguish the patient's abilities and needs within the home from any additional needs for use outside the home.

Physicians shall document the evaluation in a detailed narrative note in their charts in the format that they use for other entries. The note must clearly indicate that a major reason for the visit was a mobility evaluation.

Many suppliers have created forms which they send to physicians and ask them to complete. Even if the physician completes the form and puts it in his/her chart, this is not a substitute for the comprehensive medical record as noted above. We encourage suppliers to help educate physicians on the type of information that is needed to document a patient's mobility needs.

The physician may refer the patient to a licensed/certified medical professional (LCMP) who has experience and training in mobility evaluations to perform part of the face-to-face examination. This person may not be an employee of the supplier or have any financial relationship with the supplier. (Exception: If the supplier is owned by a hospital, an LCMP working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination.)

If the report of an LCMP evaluation is to be considered as part of the face-to-face examination, there must be a signed and dated attestation by the supplier that the LCMP has no financial relationship with the supplier. This requirement will be enforced on claims that are received by the DME contractor on or after 8/10/2006. (Note: Evaluations performed by an LCMP who has a financial relationship with the supplier may be submitted to provide additional clinical information, but will not be considered as part of the face-to-face examination by the physician.)

If the patient was referred before being seen by the physician, then once the physician has received and reviewed the written report of this examination, the physician must see the patient and perform any additional examination that is needed. The report of the physician's visit shall state concurrence or any disagreement with the LCMP examination. In this situation, the physician must provide the supplier with a copy of both examinations within 45 days after the face-to-face examination with the physician.

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.

It is important to emphasize that even if an LCMP performs a major part of the mobility evaluation, there still must be a face-to-face examination by the physician.

The information that the supplier must obtain before submitting a claim to the DME contractor is described above. However, if the DME PSC asks for documentation on individual claims, additional documents (e.g., notes from prior visits, test reports, etc.) shall also be obtained from the treating physician to provide a historical perspective that reflects the patient's condition in the continuum of care, corroborating the information in the face-to-face examination, painting a picture of the patient's condition and progression of disease over time.