TWO VANTAGE WAY | NASHVILLE, TN 37228-1504 | CGSMEDICARE.COM

CGS
A CELERIAN GROUP COMPANY

DOCUMENTATION REQUIREMENTS FOR POWER WHEELCHAIRS AND POWER OPERATED VEHICLES
Revised March 2020

We IMPACT lives.

Dear Physician,

For Medicare to provide reimbursement for a power wheelchair (PWC) or power operated vehicle (POV) (scooter), there are several requirements that must be met:

1. There must be an in-person visit with a clinician specifically addressing the patient's mobility needs.
2. There must be a history and physical examination by the clinician 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 standard written order (SWO) must be written AFTER the in-person visit has occurred and the medical evaluation is completed.
4. The SWO for the power mobility base device must be completed within 6 months of the face-to-face encounter and provided to the supplier prior to delivery of the power mobility device.

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

The complete history and physical examination must include a history of your patient's medical condition(s) and past medical history that are relevant to their mobility; and a physical examination that is relevant to their limitations in accomplishing mobility-related activities of daily living (MRADLs).

The history should paint a picture of your patient's functional abilities and limitations in their home 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. Vague terms such as "difficulty walking" or "upper extremity weakness" are insufficient, since they do not objectively address the mobility limitation or provide a clear picture of the patient's mobility deficits in participating in MRADLs.

A power mobility device is covered by Medicare only if the beneficiary has a mobility limitation that significantly impairs their ability to perform their MRADLs **within the home**. Thus, 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 their report, indicate your agreement in writing on the report, and sign and date the report. This must be done within the 6-month timeframe described above. The date you first see the patient is considered to be the date of the face-to-face encounter.

You should record the visit and mobility evaluation in your usual medical record-keeping format. Many suppliers may 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.

You must forward a copy of your SWO to the supplier. The supplier is unable to deliver the power mobility device prior to receiving your SWO. It is also helpful to the supplier if you include your face-to-face encounter and copies of previous notes, consultations with other clinicians, 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/prescription, they may also prepare a second SWO that describes additional options and accessories to be added to the power mobility base device. You must review it and, if you agree with what is being provided, sign and return it to the supplier. If you do not agree with any part of the SWO, you should contact the supplier to clarify what you want the beneficiary to receive.

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 E&M visit code.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Insurance Guidelines for Power Mobility Devices

<u>**SAVE TIME**</u> and avoid future requests for missing information by addressing ALL elements below in an objective, detailed manner within the official exam notes (not a separate letter).

FACE TO FACE EVALUATION: official exam notes must

<u>**specifically address ALL of the following, even details that seem obvious:**</u>

- ❏ **Under Chief Complaint or Reason for visit, list "Face to Face Mobility Evaluation.**
- ❏ Describe all medical conditions and symptoms relating to ambulatory difficulties and any declining health issues, to paint a picture of their limitations and daily difficulties in the home.
- ❏ Include patient's current measured weight and height.
- ❏ Describe what device (cane, walker, manual or power chair, etc) is currently being used at home.
- ❏ **Why** is the current device no longer adequate in the home (Record specific medical reasons or why current PMD requires replacement).
- ❏ Must describe at least 2-3 specific activities of daily living they have difficulty completing (i.e. getting to the bathroom for toileting, meal preparation/getting to meals, dressing, grooming, ect.).
- ❏ Objectively explain why a **cane cannot resolve** their condition inside the home.
- ❏ Objectively explain why a **walker cannot resolve** their condition inside the home.
- ❏ What are the specific medical reasons the **patient cannot self-propel a <u>manual</u> wheelchair in the home**? (i.e."...due to R.A. in hands, pain from rotator cuff tear, no use of right side from stroke").
- ❏ **Note why a scooter with steering tiller cannot be safely used in the home** (i.e. lack of postural stability or upper extremity strength, lack of space in home, need for joystick controller vs. a steering tiller for less upper body exertion, need for elevating leg rests, etc.).
- ❏ Explain how a power chair will improve the patient's ability to perform the activities listed above.
- ❏ Must give objective, numeric rating for Upper AND Lower extremity strength (example ___/5).
- ❏ As applicable to the patient, include objective numeric data regarding pain levels, extremity range of motion, and/or endurance limitations. Need at least 2.
- ❏ Note if patient is oriented and able to safely use a power wheelchair at home.
- ❏ Whether the patient's condition will improve over time.
- ❏ Progress notes must be electronically or hand-signed, with date.
- ❏ **Please be specific when writing if a "motorized wheelchair" OR "mobility scooter" is to be dispensed.**

Please feel free to contact Mobility & More with any questions or concerns.

XX**251 N. Trade St. Matthews, NC 28105**XX

(704) 821-7777 EXT 101

2301-A Crownpoint Executive Dr.
Charlotte, NC 28227

DME STANDARD WRITTEN ORDER (SWO)

ORDER DATE:			Name of Practice / Facility:	
			Phone #:	
PATIENT DEMOGRAPHICS				
FIRST NAME:	***LAST NAME:***	M.I.	***PHONE:***	
Street Address:		City:	State:	Zip:
DOB:	Sex: M F	Ht:	Wt:	2nd Contact/Phone:
Primary Insurance: ❑ Medicare ❑ Medicaid ❑ Other			**Secondary Insurance:** ❑ Medicare ❑ Medicaid ❑ Other	
Name:			Name:	
Phone:			Phone:	
MBI/Policy #:			Policy #:	

SUPPORTING ICD-10 CODES

1.	2.	3.	4.

The patient named above is being treated under a comprehensive plan of care. I, the undersigned treating physician certify that the below prescribed is medically necessary for the patient. I believe that the following products are both reasonable and necessary for the overall patient's wellbeing, condition and/or rehabilitation. I certify that the patient's medical records reflect the need for the item ordered and will be sent to the DME provider along with this SWO.

Please list the medical equipment to be provided below:

_____

_____

_____

_____

_____

_____

QUANITY TO BE DISPENSED: _____ *LENGTH OF NEED:* _____

PHYSICIANS NAME:			***NPI #:***
Street Address:	City:	State:	Zip
Contact:	Phone:	Fax:	

PHYSICIANS SIGNATURE: _____ ***DATE:*** _____

FAX this SWO to 704-821-7777 or email to info[redacted]@mobility-more.com

NC DMA Request for Prior Approval CMN/PA

DMA372-131

Recipient Information

1. Recipient Last Name:_____ 2. First Name:_____

3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Diagnosis Information

	Diagnosis (code AND description)	Date of Onset	Primary?
1			
2			

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☒ Health Choice: ☐

Provider Information

7. Requesting Provider #:_____ NPI: ☒ Atypical: ☐ 8. Taxonomy: _____

9. Address: _____ 10. Nine Digit Zip Code: _____

11. Billing Provider # (if different from requesting): 1043725104 NPI: ☒ Atypical: ☐ 12. Taxonomy: 332BX2000X

13. Address: 2301-A Crownpoint Executive Dr. Charlotte, NC 14. Nine Digit Zip Code: 28227

15. Rendering Provider # (if different from billing):_____ NPI: ☐ Atypical: ☐ 16. Taxonomy: _____

17. Address: _____ 18. Nine Digit Zip Code: _____

Requester Contact Information Name:_____ Phone #:_____ Ext:_____

Medical and Functional Status

19. **Condition:** Stable: ☐ Unstable: ☐ Height: _____ Weight: _____

20. **Prognosis:** Terminal: ☐ Poor: ☐ Guarded: ☐ Fair: ☐ Good: ☐ Excellent: ☐

21. **Patient:** Requires positioning not feasible in ordinary bed: ☐ Unattended for long periods of time: ☐ Lives alone: ☐

22. **Equipment:** Necessary to retard deterioration of condition: ☐ Necessary for function: ☐ Specify_____ Length of need: _____

23. **Mental:** Oriented: ☐ Forgetful: ☐ Disoriented: ☐ Agitated: ☐ Comatose: ☐ Depressed:☐ Lethargic: ☐ Infant: ☐ Other: _____

24. **Neurological:** Muscle Tone: Normal: ☐ Increased: ☐ Decreased: ☐ Fluctuating: ☐

Sensation: Normal: ☐ Abnormal: ☐ Specify:_____

25. **Respiratory:** Normal: ☐ SOB on minimal exertion: ☐ Tracheostomy: ☐

O2: ☐ Flow Rate:_____ Frequency: _____ Test Date: _____ Results: _____

26. **Skin:** Normal: ☐ Other: ☐ Specify: _____ Decubiti: ☐ Specify: _____

27. **Ambulatory:** Complete bedrest: ☐ Up as tolerated: ☐

Transfers bed-chair (indep): ☐ Transfers bed-chair (w/assistance): ☐ Confined to wheelchair?☐ Hours per day: _____

Walks unassisted: ☐ Walks with assistive device: ☐ Specify: _____ Max distance walked: _____

28. Can place of residence physically accommodate equipment being requested? ☐ Yes ☐ No

29. Patient's status will be monitored by physician while assistance is provided? ☐ Yes ☐ No

30. Medical Necessity of equipment: _____

_____

_____

Service Information

	From Date	To Date	New/Used/Rental	HCPCS Code	Equipment Description
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Jay Bunicky _____ _____ _____ _____ _____

Requesting Provider's Signature Date Physician, PA, Nurse Practitioner Signature Date