



POVS: HCPCS CODES K0800-K0802 AND K0806-K0808

Group 2 POVs (K0806, K0807, K0808) have added capabilities that are not needed for use in the home. Therefore, if a Group 2 POV is provided it will be denied as not reasonable and necessary.

REQUIRED DOCUMENTATION

Standard Written Order (SWO):

NOTE: Power Mobility Devices (PMDs) require a standard written order prior to delivery (WOPD) for the base item. The WOPD for the base item may only be written after the completion of the face-to-face encounter requirements. The treating practitioner who completes the face-to-face requirements must be the same practitioner who writes the order/prescription for the PMD (base item).

Beneficiary's name or Medicare Beneficiary Identifier (MBI)

Order Date

General description of the item

The description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number

For equipment - In addition to the description of the base item, the SWO may include all concurrently ordered options, accessories or additional features that are separately billed or require an upgraded code (List each separately).

Quantity to be dispensed, if applicable

Treating Practitioner Name or NPI

Treating Practitioner's signature

Practitioner's signature meets **CMS Signature Requirements** (<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf>) for a legible identifier

The SWO for the power mobility device was written by the treating practitioner who conducted the face-to-face encounter

The SWO for the power mobility device was written after the completion of the face-to-face encounter requirements

The SWO for the power mobility device was received prior to delivery

The SWO for all options, accessories, and/or supplies that are separately billed in addition to the base was received prior to claim submission

The treating practitioner who reviews and signs the SWO for separately billable options, accessories, and/or supplies does not need to be the same treating practitioner who completed the WOPD for the PMD base and conducted the face-to-face encounter. In this situation, the treating practitioner who orders the options, accessories, and/or supplies must:

Verify that a qualifying face-to-face encounter occurred within 6-months prior to the date of the WOPD for the base item; and,

Have documentation of the qualifying face-to-face encounter that was conducted for the base item;

Review and sign their order.

Delivery Documentation

Beneficiary's name

Delivery Address

Quantity delivered



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A description of the item(s) being delivered. The description can be either a narrative description (e.g., lightweight wheelchair base), a HCPCS code, the long description of a HCPCS code, or a brand name/model number.

Signature of person accepting delivery

Relationship to beneficiary

Delivery date

On-site Home Assessment

Includes information about the home's physical layout, doorway widths, doorway thresholds, and floor surfaces

Confirms that the beneficiary has adequate access between rooms, maneuvering space and surfaces for the operation of a POV

Verifies that the beneficiary is able to use the POV ordered to assist with MRADLs in the home

If the report notes that the beneficiary cannot access certain rooms necessary to accomplish their MRADLs with the POV, there is an explanation of how that will be mitigated so the beneficiary can complete MRADLs

Date verifies that the home assessment occurred on or before the date the POV was delivered

Signed or initialed by the person completing the assessment

Face-to-Face Encounter

The evaluation occurred BEFORE the treating practitioner completed the SWO

The findings are documented in a detailed narrative note in the format used for other entries

The face-to-face encounter was conducted within six (6) months prior to the order date on the SWO for the PMD (base item)

The face-to-face was completed prior to POV delivery

NOTE: To accommodate the requirements at 42 CFR 410.38, when the treating practitioner sees the beneficiary, regardless of whether a referral to an LCMP is made, that visit date starts the six (6) month timeline for completion of the SWO for the PMD base. If the treating practitioner chooses to refer the beneficiary to an LCMP for a mobility evaluation, the treating practitioner's co-signature, dating and indicating agreement or disagreement with the LCMP evaluation must occur within this six (6) month timeframe. In cases where the LCMP evaluation is being adopted into the practitioner's documentation to substantiate the need for the base item, the SWO may not be written until the LCMP report is signed, dated and agreement/disagreement indicated.

The note clearly indicates that a major reason for the visit was a mobility examination

Author's signature meets CMS signature requirements for a legible identifier

The assessment includes information about the following (not all-inclusive, the exam should be tailored to the individual beneficiary):

History of the present condition(s) and past medical history that is relevant to mobility needs

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 beneficiary can walk without stopping

Pace of ambulation

What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used

What has changed to now requires use of a power mobility device

Ability to stand up from a seated position without assistance

Description of the home setting and the ability to perform activities of daily living in the home



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Physical examination that is relevant to mobility needs

Weight and height

Cardiopulmonary examination

Musculoskeletal examination including arm and leg strength and range of motion

Neurological examination including gait and balance and coordination

The face-to-face encounter supports that the beneficiary's condition meets all LCD coverage criteria:

The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) in the home

Use of a POV will significantly improve the beneficiary's ability to participate in MRADLs in the home

The mobility deficit cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker

The beneficiary 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

The beneficiary is able to safely transfer to and from a POV, operate the tiller steering system and maintain postural stability and position while operating the POV in the home

The beneficiary'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 beneficiary's weight is less than or equal to the weight capacity of the POV that is provided

The beneficiary has not expressed an unwillingness to use a POV in the home

Treating practitioner co-signed and dated any portion of the exam that was completed by an LCMP and stated concurrence or any disagreement with that examination

Supplier Attestation Statement

File includes a signed statement from the supplier (or the LCMP) stating that there is no financial relationship between the LCMP(s) completing portions of the face-to-face examination and the supplier

ATTENTION!

Many suppliers have created forms which have not been approved by CMS which they send to practitioners and ask them to complete. Even if the practitioners completes this type of form and puts it in their chart, this supplier-generated form is not a substitute for the comprehensive medical record. Suppliers are encouraged to help educate practitioners on the type of information that is needed to document a beneficiary's mobility needs.

The information that the supplier must obtain before submitting a claim to the DME contractor is described in detail in the Power Mobility LCD and Policy Article. However, if the DME MAC or other Medicare Contractor asks for documentation on individual claims, additional documents (e.g., notes from prior visits, test reports, etc.) shall also be obtained from the treating practitioners to provide a historical perspective that reflects the beneficiary's condition in the continuum of care, corroborating the information in the face-to-face examination, painting a picture of the beneficiary's condition and progression of disease over time.

GROUP 2 POVs (K0806 – K0808)

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REMINDERS

- All new rental series claims for HCPCS Codes K0800, K0801, K0802, K0806, K0807, and K0808, with a date of delivery on or after April 13, 2022 must be associated with a prior authorization request as a condition of payment.
- If the POV that is provided is only needed for mobility outside the home, the GY modifier **must** be added to the codes for the item and all accessories.
- A KX modifier may be added to the code for a POV and all accessories only if all of the coverage criteria have been met for the product that is provided.
- If the requirements for use of the KX modifier or GY modifier are not met, the GA or GZ modifier **must** be added to the code. When there is an expectation of a medical necessity denial, suppliers **must** enter GA on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or GZ if they have not obtained a valid ABN.
- Claim lines billed without a KX, GA, GY, or GZ modifier will be **rejected** as missing information.
- Items with no physician or other licensed health care provider order must be submitted with an “EY” modifier added to each affected HCPCS code.

ONLINE RESOURCES

- **Power Mobility Resources**
 - **JB:** https://www.cgsmedicare.com/jb/mr/power_mobility_resources.html
 - **JC:** https://www.cgsmedicare.com/jc/mr/power_mobility_resources.html
- **Power Mobility Devices LCD and Policy Article**
 - **JB:** <https://www.cgsmedicare.com/jb/coverage/lcdinfo.html>
 - **JC:** <https://www.cgsmedicare.com/jc/coverage/lcdinfo.html>
- **Required Prior Authorization Program**
 - **JB:** https://www.cgsmedicare.com/jb/mr/pmd_prior_auth.html
 - **JC:** https://www.cgsmedicare.com/jc/mr/pmd_prior_auth.html

DISCLAIMER

This document was prepared as an educational tool and is not intended to grant rights or impose obligations. This checklist may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either written law or regulations. Suppliers are encouraged to consult the *DME MAC Supplier Manual* and the Local Coverage Determination/Policy Article for full and accurate details concerning policies and regulations.