Hello and welcome to another edition of Medicare Minute. I’m Dr. Robert Hoover, medical director at CGS Administrators, the Jurisdiction C DME MAC. This is another video in our series covering the highlights of the DME MAC policies, officially called local coverage determinations or LCDs and related policy articles.

This is a special joint presentation of the DME MAC contractors.

These video segments on the coverage of durable medical equipment, prosthetics, orthotics, and supplies or DMEPOS are designed to give the viewer an overview of the rules and regulations governing these items. It is not intended to replace the policies and guidelines contained in the local coverage determinations or Policy Articles.

Today’s topic is power mobility devices documentation but I’m going to address my comments to the treating physician who is prescribing power mobility devices. So first, let’s go over some of the basic Medicare rules.

On your screen now you’ll see the basic requirements for power mobility devices or PMDs. The term PMDs encompasses both power wheelchairs and power operated vehicles, more commonly called scooters.

In order for Medicare to provide reimbursement to your medical equipment supplier for a power wheelchair, there are several statutory requirements that must be met. An in-person visit, an H & P that documents their mobility limitations and a prescription with 7 specific elements. Once the exam and prescription are completed, the supplier must receive a copy of these documents within 45 days.

Why is this examination so important? Because Medicare takes an algorithmic approach to mobility assistive equipment. In other words, Medicare wants healthcare providers to think in a logical progression of mobility aids that might address a patient’s mobility needs.

Will a cane resolve their mobility deficit?  
How about a walker?  
What about an optimally configured manual wheelchair?

These are all questions to ask before moving on to a power mobility device, whether it be a scooter or a power wheelchair.

So now let’s move on to documentation – every physician’s favorite topic.

I often get questions from doctors and physician extenders along the lines of “What am I supposed to
document so that my patient can get a wheelchair?” My response is often “What you learned in your physical diagnosis class in medical school.”

What I mean by that statement is that there are no complicated tests you need to do or “magic words” that you need to say in your documentation. What our reviewers look for is a history and physical examination tailored to the patient’s specific situation.

In the next couple of slides on your screen, you’ll see some of the things that you should consider documenting as part of your mobility examination.

Again, not everything in these lists need to be covered. For example, if your patient is currently using a mobility aid like a cane or walker, it will be important to document what has changed in their condition such that those devices are no longer sufficient and they now need a PMD. Obviously, if the patient doesn’t currently use a mobility aid, that type of question wouldn’t apply.

Most of these things are pretty obvious, as I said, think back to medical school and that physical diagnosis class.

Do they have co-morbidities that limit ambulation?
Do they have frequent falls and if so, under what circumstances? Were they related to orthostatic changes, medications, throw rugs?

These are some of the things to think about in the history.

Similarly, the physical exam is a targeted physical exam. The slide on your screen has some of the commonly seen elements in a mobility physical exam.

So you see some of the common elements. Height and weight, for example, are important to help determine what type of chair the supplier can dispense because coverage of some types of chairs are based on patient weight.

As you see, most of these things are pretty straight-forward. The history and physical should use as much objective information and descriptions as possible. Quantify things in your exam – “Walked 15 yards and then stopped 5 minutes due to shortness of breath.”

Here are some examples of vague descriptions that should be avoided in documenting a mobility exam.

Upper extremity weakness – Instead, grade the muscle strength or use comparative strength statements like “Has difficulty lifting a gallon of milk.” Similarly, “Fatigues easily” is hard to quantify but a statement like “Has to rest or take a nap after vacuuming 3 rooms in the house” or “Has to rest after doing even small amounts of grocery shopping” is more descriptive.

Again, the history should paint a picture of your patient’s functional abilities and limitations on a typical day. 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. Both should contain as much objective data as possible.
So what if you’re still uncomfortable doing this kind of exam? You may elect to refer the patient to another medical professional, such as a physical therapist as long as that individual has no financial relationship with the wheelchair supplier. However, and this is important, you do have to personally see the patient before or after the PT/OT evaluation. You must review the report, indicate your agreement in writing on the report, and sign and date the report. If you do not see the patient after the PT/OT evaluation, the date that you sign the report is considered to be the date of completion of the face-to-face examination.

So what about providing all of this information in a form, such as those developed by the Texas or Florida Academy of Family Physicians? Personally, I discourage the use of a form though CMS doesn’t prohibit their use. I dislike forms because most are designed to gather selected bits of information and are almost always insufficient.

As you can see from what I described in the history and physical information just covered, what is required by Medicare is a thorough, FOCUSED narrative description of your patient’s current condition, past history, and pertinent physical examination. It should clearly describe their mobility needs in the home and why a cane, walker, or optimally configured manual wheelchair is not sufficient to meet those needs. Most forms don’t meet this standard for documentation.

Finally, let’s talk about the prescription that you’ll need to write. As I mentioned before, it has 7 required elements.

The 7 required elements are shown on your screen now and you, not the DME supplier, must complete this order. In other words, the supplier cannot fill in the 7 elements and send it to you for your signature. Congress was very specific about this when they charged CMS with developing new rules for power mobility equipment back in 2006.

You must forward a copy of the face-to-face evaluation and your seven-element prescription to the medical equipment supplier within 45 days from the completion of the face-to-face mobility examination. You should also include copies of previous notes, consultations with other physicians, and reports of pertinent laboratory, x-ray, or other diagnostic tests if they will help document the severity of your patient’s ambulatory problems.

After the supplier receives your order and the face-to-face information, they will prepare a detailed product description that describes the items being provided including all options and accessories. You should review it and, if you agree with what is being provided, sign, date and return it to the supplier. If you do not agree with any part of the detailed product description, you should contact the supplier to clarify what you want the beneficiary to receive.

That does it for this edition of Medicare Minute. As with all of CGS’ educational offerings, this is only a summary of certain policy requirements. I encourage you to read the applicable LCD and related Policy Article for a complete description of the coverage, coding and documentation requirements.

Thank you for watching and have a nice day.