Beneficiary Costs for PMDs

Power Wheelchairs

Beneficiaries may elect to purchase a power wheelchair when it is furnished. If the beneficiary declines the purchase option, Medicare will pay on a rental basis for 10 months. After the 10th rental payment, the beneficiary may again elect to purchase the wheelchair. If the beneficiary elects the purchase option, Medicare will make three additional monthly rental payments, and then the beneficiary owns the wheelchair. If the beneficiary declines this purchase option, Medicare will make five additional monthly rental payments, and the supplier, not the beneficiary, owns the wheelchair.

POVs

Beneficiaries 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 beneficiary needs the POV for an extended period, purchase is a preferable option.

For more information about PMDs, DME, or Medicare, please visit one of the following online references:

Medicare Learning Network (MLN)

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at *http://www.cms.hhs.gov/MLNGenInfo* on the CMS website.

Medicare Coverage ~ Mobility Assistive Equipment Web Page

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

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

Medicare Coverage Database

http://www.cms.hhs.gov/mcd/search.asp

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

Medicare Claims Processing Manual

http://www.cms.hhs.gov/Manuals/IOM/list.asp

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

Medicare Learning Network

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DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Centers for Medicare & Medicaid Services

Overview of Medicare Coverage of Power Mobility Devices (PMDs): Power Wheelchairs and Power Operated Vehicles (POVs)

CMS Centers for Medicare & Medicaid Services

Medicare Learning Network

In 2005, the Centers for Medicare & Medicaid Services (CMS) revised the Medicare conditions of coverage for power wheelchairs and Power Operated Vehicles (POVs) to conform to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). In the Medicare Program, power wheelchairs and Power Operated Vehicles (POVs or scooters) are collectively classified as Power Mobility Devices (PMDs). PMDs are covered under the Medicare Part B benefit.

Durable Medical Equipment Medicare Administrative Contractor (DME MACs)[1] process Medicare claims for PMDs furnished by suppliers. To qualify for Medicare reimbursement, the physician or treating practitioner must do the following:

- Conduct a face-to-face examination of the beneficiary.
- Write a prescription for the PMD within 45 days after the examination.[2]
- Furnish pertinent beneficiary medical information to the supplier to support medical necessity.

A completed Certificate of Medical Necessity (CMN) is no longer required for claims with dates of service on or after May 5, 2005 that are received by the DME MAC on or after April 1, 2006.

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. CMS determined that MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair the performance of Mobility-Related Activities of Daily Living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. This Clinical Criteria for MAE Coverage must be used to determine the appropriate MAE for each individual, replacing the previously used "bed- or chair-confined" criterion.

Medicare Coverage Provisions

A PMD is a covered item of DME in a class of wheelchairs that includes a power wheelchair or a POV that a beneficiary uses in the home. Following MAE national coverage policy, PMDs may be medically necessary for beneficiaries who cannot effectively perform MRADLs in the home using a cane, walker, or manually operated wheelchair. The beneficiary must also demonstrate the ability to safely and effectively operate the PMD in the home environment. Although a PMD may be used outside the home, the beneficiary must first demonstrate a medical need to use it inside the home for the PMD to be covered.

Requirements for Physicians and Treating Practitioners

In addition to a physician, a physician assistant, nurse practitioner, or clinical nurse specialist may order a PMD. The physician or treating practitioner must be familiar with the provisions of the MAE National Coverage Determination (NCD) to discuss available options with the beneficiary and to identify the appropriate medically necessary PMD.

The physician or treating practitioner must conduct a face-to-face examination of the beneficiary before writing a PMD prescription. The following exceptions apply:

- A beneficiary discharged from a hospital does not require a separate face-to-face examination if the physician or treating practitioner that performed the face-to-face examination during the hospital stay issues the prescription and supporting documentation to the supplier within 45 days[2] after the date of discharge.
- The face-to-face examination is not required when only accessories for PMDs are being ordered.

In addition to the prescription for the PMD, the physician or treating practitioner must provide the supplier with supporting documentation consisting of pertinent parts of the medical record that clearly support the medical necessity for the PMD in the beneficiary's home. In most cases, the information recorded at the face-to-face examination will be sufficient to support medical necessity; however, prior documentation may be necessary when the information recorded at the face-to-face examination refers to previous notes in the medical record.

Requirements for Suppliers

The supplier must obtain the prescription and supporting documentation prior to dispensing the PMD. 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.

Clinical Criteria for MAE Coverage

The Clinical Criteria for MAE Coverage is a nine-question algorithmic process that replaced the "bed- or chair-confined" criterion historically used to determine if a wheelchair is reasonable and necessary. Before a beneficiary can qualify for a power wheelchair or POV, the Clinical Criteria for MAE Coverage algorithm must be sequentially followed by the physician or treating practitioner to determine which MAE is appropriate to meet the beneficiary's MRADL needs.

The Clinical Criteria for MAE Coverage may be viewed in detail (including a diagram) in Chapter 1, Part 4, Section 280.3 of the Medicare National Coverage Determinations Manual available at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website.

Summary of Beneficiary Costs

If the beneficiary...	Then Medicare Part B will pay...	And the beneficiary will pay...*
Chooses to purchase the power wheelchair 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 - 10.	20% of the allowed rental charge.
Chooses purchase option for the power wheelchair after 10 rental months...	80% of the allowed rental price for months 11 - 13.	20% of the allowed rental charge.
Chooses rental option for the power wheelchair after 10 rental months...	80% of the allowed rental price for months 11 - 15.	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.

* Beneficiary payment responsibility is based upon receiving equipment from a provider that accepts assignment. Beneficiary costs are higher when obtaining wheelchairs from suppliers that do not accept assignment. If the beneficiary is enrolled in a Medicare Managed Care Plan, the beneficiary 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 is rented, Medicare will pay 80% of the allowable service and maintenance charge once every six months, whether or not the equipment is actually serviced, to the extent that the charges are not covered under a supplier or manufacturer warranty. Therefore, the beneficiary must pay 20% of the allowed service charge as his or her co-insurance once every six months.

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

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[1] *Medicare Contracting Reform (MCR) Update - Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. Currently, there are three Durable Medical Equipment (DME) MACs that handle the processing of DME claims and one A/B MAC (Jurisdiction 3) to handle the processing of both Part A and Part B claims for those beneficiaries located within the states included in Jurisdiction 3. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes at www.cms.hhs.gov/MedicareContractingReform/ on the CMS website.*

[2] *Claims for PMD with dates of service prior to June 6, 2006 require that the PMD prescription and supporting documentation are issued 30 days after the face-to-face examination/date of discharge.*