# FACT SHEET

## Medicare Coverage of Power Mobility Devices (PMDs):

## Power Wheelchairs and Power Operated Vehicles (POVs)

***Power Mobility Devices:*** *PMDs are defined as covered items of Durable Medical Equipment (DME) that are in a class of wheelchairs that includes power wheelchairs (four-wheeled motorized vehicles whose steering is operated by an electronic device or joystick to control direction and turning) or POVs (three- or four-wheeled motorized scooters that are operated by a tiller) that a beneficiary uses in the home.*

***Power (Motorized) Wheelchairs:*** *Most beneficiaries who require power wheelchairs are nonambulatory and have severe weakness of the upper extremities due to a neurologic or muscular condition. Under the new MAE national coverage policy, power wheelchairs may be medically necessary for beneficiaries who cannot effectively perform Mobility-Related Activities of Daily Living (MRADLs) in the home using a cane, walker, manually operated wheelchair, or a POV/scooter. In addition, the beneficiary must demonstrate the ability to safely and effectively operate the power wheelchair in the home environment.*

***Power Operated Vehicles (POVs or scooters):*** *These vehicles have been appropriately used in the home environment to improve the ability of chronically disabled persons to cope with normal domestic, vocational, and social activities. Under the new MAE national coverage policy, POVs may be medically necessary for beneficiaries who cannot effectively perform MRADLs in the home using a cane, walker, or manually operated wheelchair. In addition, the beneficiary must demonstrate sufficient strength and postural stability to safely and effectively operate the POV in the home environment.*

## Recent Changes in Medicare Coverage of PMDs

Wheelchairs (both manual and power), scooters, canes, and walkers are all examples of Mobility Assistive Equipment (MAE). In recent years, considerable public interest had focused on the provision of wheelchairs under the Medicare benefit. In particular, attention had focused on Medicare coverage decisions regarding beneficiary access to and the appropriate prescription of power wheelchairs and Power Operated Vehicles (POVs or scooters). These devices are collectively referred to as Power Mobility Devices (PMDs). In response to this increased interest, the Centers for Medicare & Medicaid Services (CMS) implemented a multi-faceted plan to ensure the appropriate prescription of wheelchairs to beneficiaries who need them.

In 2005, through the National Coverage Determination (NCD) process, CMS issued new function-based criteria for MAE, an algorithmic process called the Clinical Criteria for MAE Coverage. This process replaced the previously used "bed- or chair-confined" standard, which had restricted access to needed equipment for some beneficiaries. CMS believes the revised criteria helps physicians and treating practitioners, as well as suppliers, to better meet beneficiary needs.

Provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) also expanded the types of health professionals who may order certain types of PMDs and required a face-to-face examination of the beneficiary by the prescribing physician or treating practitioner. In addition, codes have been developed for PMDs that allow CMS to tailor payment rates for PMDs to the particular features of the specific equipment supplied.

This Fact Sheet outlines Medicare policy regarding PMDs that physicians, treating practitioners, and suppliers should be aware of to successfully obtain the appropriate covered mobility equipment for beneficiaries.

## Determining Beneficiary Eligibility for MAE Coverage

MAE is considered reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their performance of Mobility-Related Activities of Daily Living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary areas in the home. To determine the appropriate MAE to correct the mobility deficit, physicians and treating practitioners follow the Clinical Criteria for MAE Coverage. Physicians and treating practitioners should be familiar with these clinical coverage criteria to ensure that the appropriate device is prescribed and that there is adequate documentation to support medical necessity.

## Clinical Criteria for MAE Coverage

The beneficiary, the beneficiary's family or caregiver, or a clinician will usually initiate the discussion and consideration of MAE use. Sequential consideration of the following questions provides clinical guidance to the prescribing physician or treating practitioner for the coverage of appropriate, medically necessary equipment to restore the beneficiary's ability to participate in MRADLs.

In individual cases where the beneficiary's condition clearly precludes the reasonable use of a device, it is not necessary to undertake a trial of that device for that beneficiary.

The following questions correspond to the numbered decision points on the accompanying flow chart:

The beneficiary, the beneficiary's family or caregiver, or a clinician will usually initiate the discussion and consideration of MAE use. Sequential consideration of the following questions provides clinical guidance to the prescribing physician or treating practitioner for the coverage of appropriate, medically necessary equipment to restore the beneficiary's ability to participate in MRADLs.

In individual cases where the beneficiary's condition clearly precludes the reasonable use of a device, it is not necessary to undertake a trial of that device for that beneficiary.

# Power Wheelchair Coverage Overview

The following questions correspond to the numbered decision points on the accompanying flow chart:

1. **Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs in the home? A mobility limitation is one that:**
   a. Prevents the beneficiary from accomplishing the MRADLs entirely, or,
   b. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to participate in MRADLs, or,
   c. Prevents the beneficiary from completing the MRADLs within a reasonable time frame.
2. **Are there other conditions that limit the beneficiary's ability to participate in MRADLs at home?**
   a. Some examples are significant impairment of cognition or judgment and/or vision.
   b. For these beneficiaries, the provision of MAE might not enable them to participate in MRADLs if the comorbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with MAE.
3. **If these other limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of MAE will be reasonably expected to significantly improve the beneficiary's ability to perform or obtain assistance to participate in MRADLs in the home?**
   a. A caregiver, for example a family member, may be compensatory, if consistently available in the beneficiary's home and willing and able to safely operate and transfer the beneficiary to and from the wheelchair and to transport the beneficiary using the wheelchair. The caregiver's need to use a wheelchair to assist the beneficiary in the MRADLs is to be considered in this determination.
   b. If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of MAE coverage if it results in the beneficiary continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of MAE.
4. **Does the beneficiary or caregiver demonstrate the capability and the willingness to consistently operate the MAE safely?**
   a. Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.
   b. A history of unsafe behavior in other venues may be considered.
5. **Can the functional mobility deficit be sufficiently resolved by the prescription of a cane or walker?**
   a. The cane or walker should be appropriately fitted to the beneficiary for this evaluation.
   b. Assess the beneficiary's ability to safely use a cane or walker.

**6. Does the beneficiary's typical environment support the use of wheelchairs including scooters/power-operated vehicles (POVs)?**

a. Determine whether the beneficiary's environment will support the use of these types of MAE.

b. Keep in mind such factors as physical layout, surfaces, and obstacles, which may render MAE unusable in the beneficiary's home.

**7. Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair in the home to participate in MRADLs during a typical day? The manual wheelchair should be optimally configured (seating options, wheelbase, device weight, and other appropriate accessories) for this determination.**

a. Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.

b. A beneficiary with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, i.e. light weight, etc., should be determined based on the beneficiary's physical characteristics and anticipated intensity of use.

c. The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.

d. Assess the beneficiary's ability to safely use a manual wheelchair.

NOTE: If the beneficiary is unable to self-propel a manual wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair may be appropriate.

**8. Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?**

a. A POV is a 3- or 4-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation.

b. The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a POV.

c. Assess the beneficiary's ability to safely use a POV/scooter.

**9. Are the additional features provided by a power wheelchair needed to allow the beneficiary to participate in one or more MRADLs?**

a. The pertinent features of a power wheelchair compared to a POV are typically control by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.

b. The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.

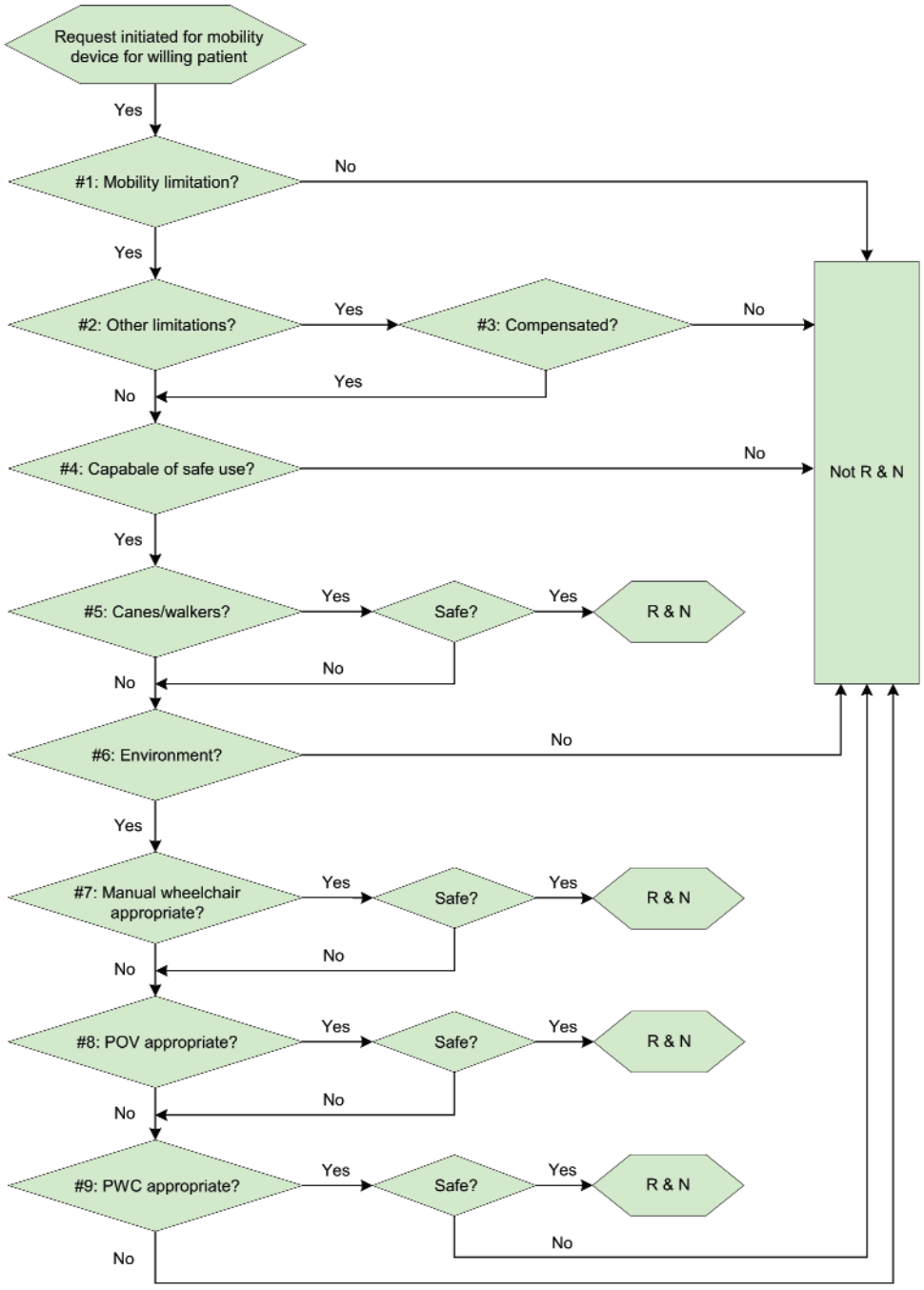
c. The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a power wheelchair.

d. Assess the beneficiary's ability to safely use a power wheelchair.

NOTE: If the beneficiary is unable to use a power wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair is appropriate. A caregiver's inability to operate a manual wheelchair can be considered in covering a power wheelchair so that the caregiver can assist the beneficiary.

The following flow chart illustrates the process of the Clinical Criteria for MAE Coverage. The numbered decision points on the flow chart correspond to the questions listed above.

**Clinical Criteria for MAE Coverage**



## Coverage and Documentation Requirements for PMDs

Medicare beneficiaries not meeting the clinical criteria for prescribing MAE as previously outlined, and as documented by the beneficiary's physician, would not be eligible for Medicare coverage of the MAE. Additionally, Medicare will not cover the costs of a PMD if the use of the PMD primarily benefits the beneficiary in his or her pursuit of leisure or recreational activities.

In addition to a physician, a physician assistant, nurse practitioner, or clinical nurse specialist may prescribe a PMD. The physician or treating practitioner must be familiar with the provisions of the MAE NCD (see previous section, Clinical Criteria for MAE Coverage) to inform beneficiaries of available options and to identify the appropriate medically necessary PMD.

### Physician and Treating Practitioner Requirements

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

- The PMD prescription must be in writing and signed and dated by the physician or treating practitioner who performed the face-to-face examination, and must be received by the supplier within 45 days[1] after the face-to-face examination.
- The PMD prescription must include the beneficiary's name, the date of the face-to-face examination, the diagnosis and conditions that the PMD is expected to modify, a description of the item, the length of need, the physician or treating practitioner's signature, and the date the prescription was written.

The following exceptions apply to the face-to-face examination requirement:

- 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 PMD prescription and supporting documentation to the supplier within 45 days[1] 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, which will include relevant parts of the beneficiary's medical record that clearly support the medical necessity for the PMD in the beneficiary's home.

- Relevant information may include the history, physical examination, diagnostic tests, summary of findings, diagnoses, and treatment plans.
- The selected records should be sufficient to:
  - o delineate the history of events that led to the request for the PMD
  - o identify the mobility deficits to be corrected by the PMD
  - o document that other treatments do not obviate the need for the PMD
  - o establish that the beneficiary lives in an environment that supports the use of the PMD

  AND
  - o establish that the beneficiary or caregiver is capable of operating the PMD

[1] *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.*

- 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.

### Supplier Requirements

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/or test reports. Please note that a completed Certificate of Medical Necessity (CMN) will no longer be required for claims received by the DME MAC[2] on or after April 1, 2006 that have dates of service on or after May 5, 2005.

The PMD must meet any safety requirements specified by CMS.

NOTE: Physicians, treating practitioners, and suppliers should contact the Durable Medical Equipment Medicare Administrative Contractor (DME MAC)[2] for coverage instructions related to specific items.

### Privacy Requirements

Any physician, treating practitioner, and supplier that is a Health Insurance Portability and Accountability Act of 1996 (HIPAA)-covered entity should make sure to redact any materials that may be contained in the medical record that are not necessary to support the prescription.

## Beneficiary Costs for Obtaining PMDs

With the MMA requirement that the physician or treating practitioner create a written prescription, and the new regulatory requirements that the physician or treating practitioner prepare relevant parts of the medical record for submission to the supplier, the physician or treating practitioner can bill using the add-on Healthcare Common Procedure Coding System (HCPCS) G code (G0372) for the required face-to-face examination. The relative value for G0372 is equivalent to the existing Evaluation and Management (E&M) code for a level-1 office visit for an established patient [Current Procedural Terminology (CPT®) 99211]. Medicare Part B will pay 80% of the allowed charges from a provider accepting assignment (after any remaining deductible), and the beneficiary will pay 20% (beneficiary costs for providers not accepting assignment are subject to the limiting charge).

[2] *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 http://www.cms.hhs.gov/MedicareContractingReform/ on the CMS website.*

# Power Wheelchair Coverage Overview

Medicare pays for power wheelchairs and POVs differently:

## 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 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.

### Summary of Patient Costs

| If the patient... | Then Medicare Part B will pay... | And the patient 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 their 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 their 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.

NOTE: All other DME not meeting the definition of MAE as described in this Guide will continue to be covered or noncovered as is currently described in the NCD Manual, Section 280, available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website.

## Additional Resources

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 National Coverage Determinations Manual

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

The Medicare National Coverage Determinations Manual provides current coverage guidelines for all DME other than MAE in Section 280.

### Medicare Program Integrity Manual

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

The Medicare Program Integrity Manual includes information regarding medical necessity of PMDs in Chapter 5, Section 5.8.



*This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.*

*This fact sheet was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this fact sheet. This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.*