



Power Mobility Devices (PMDs)

● ● ● Complying with Documentation & Coverage Requirements

This fact sheet describes common Comprehensive Error Rate Testing (CERT) Program errors related to power mobility devices (PMDs) and provides a checklist of the documentation needed to support a claim submitted to Medicare for PMDs.

The Centers for Medicare & Medicaid Services (CMS) developed the CERT Program to produce a national Medicare Fee-For-Service (FFS) error rate, as required by the Improper Payments Information Act. CERT randomly selects a small sample of Medicare FFS claims and reviews those claims and medical records from providers/suppliers who submitted them for compliance with Medicare coverage, coding, and billing rules.


In order to accurately measure the performance of the Medicare claims processing contractors and to gain insight into the causes of errors, CMS calculates both a national Medicare FFS paid claims error rate and a provider compliance error rate. The results of these reviews are published in an annual report and semi-annual updates.

CMS strives to eliminate improper payments in the Medicare Program to maintain the Medicare trust funds and protect patients.

Common PMD Errors

1. No documentation of a physician face-to-face visit.
2. No physician documentation of mobility limitations to support medical need for the equipment.



- 
3. No physician documentation justifying the need for a power option over the need for a manual wheelchair.
 4. Patient is ambulatory and does not qualify for a wheelchair/PMD.

Why Were These Errors Identified?

1. Medicare requires a thorough face-to-face visit with the treating physician prior to dispensing any power mobility equipment. The face-to-face visit must be completed before the written order (consisting of seven elements) is received.
2. Medicare requires documentation of the mobility limitations that cause the patient's inability to complete activities of daily living (ADLs).
3. Medicare requires documentation of the reasons why a cane, walker, or manual wheelchair cannot be used to complete the patient's ADLs.
4. Medicare does not cover PMDs for patients who are able to complete their ADLs by ambulating within the home in a reasonable time frame. PMDs used only outside the home do not meet the definition of the DME benefit category and are denied as noncovered. The KX modifier, indicating coverage criteria are met, should not be used.

PMD Documentation Checklist

In order for Medicare to cover a PMD, the supplier **must** obtain the written order within 45 days of a face-to-face examination by the treating physician, or discharge from a hospital or nursing home, **and** before the PMD is delivered. A PMD **cannot** be delivered based on a verbal order. If the supplier delivers the item prior to receipt of a written order, the PMD will be denied as noncovered. If the written order is not obtained prior to delivery, payment will not be made even if a written order is subsequently obtained. The following documentation is required for PMDs:



□ Face-to-Face Examination

The face-to-face examination must be relevant to mobility needs and include*:

- History of present condition and relevant past medical history, including:
 - Symptoms that limit ambulation,
 - Diagnoses that are responsible for symptoms,
 - Medications or other treatment for symptoms,
 - Progression of ambulation difficulty over time,
 - Other diagnoses that may relate to ambulatory problems,
 - Distance patient can walk without stopping,
 - Pace of ambulation,
 - Ambulatory assistance currently used,
 - Change in condition that now requires a PMD, and
 - Description of home setting and ability to perform ADLs in the home;
- Physical examination relevant to mobility needs, including:
 - Height and weight,
 - Cardiopulmonary examination, and
 - Arm and leg strength and range of motion; and
- Neurological examination, including:
 - Gait, and
 - Balance and coordination.

The physician may refer the patient to a licensed/certified medical professional (LCMP), such as a physical therapist (PT) or occupational therapist (OT), who has experience and training in mobility evaluations to perform part of the face-to-face examination. All LCMP information should be clearly documented and included as part of the complete medical record to sufficiently demonstrate medical need.

*While it is important to fully evaluate the patient during the face-to-face examination, it is important to note that all elements listed may not apply to every patient. Professional discretion is necessary to determine if these items are required as part of the face-to-face examination.



Valid Written Order

The valid written order must be completed by the treating physician and contain the following seven elements:

1. Patient's name;
2. Description of item ordered (description may be general [e.g., "power operated vehicle", "power wheelchair", or "power mobility device"] or more specific);
3. Date of face-to-face examination;
4. Pertinent diagnoses/conditions that relate to the need for a PMD;
5. Length of need;
6. Physician's signature; and
7. Date of physician signature.

Detailed Product Description

The detailed product description must be completed by the supplier, and reviewed and signed by the treating physician. It must contain:

- Specific Healthcare Common Procedure Coding System (HCPCS) code for base and all options and accessories that will be separately billed;
- Narrative description of the items;
- Manufacturer name and model name/number;
- Supplier's charge for each item;
- Medicare's fee schedule allowance for each item (if no allowance, list "not applicable");
- Physician signature and date signed; and
- Date stamp to document receipt date.

Home Assessment

The home assessment must be completed at or prior to delivery. It must:

- Verify that the patient can adequately maneuver the device, considering:
 - o Physical layout,
 - o Doorway width,
 - o Doorway thresholds, and
 - o Surface; and
 - Be documented in a written report.
-

Patient Authorization

The patient's signature, authorizing submission of a Medicare claim, must be on file.

Proof of Delivery

- The patient must sign a delivery ticket.
 - A copy of the supplier's standards must be provided to the patient for review.
-

Basic Coverage Criteria for All PMDs

For Medicare to cover a PMD, **all** of the following three basic coverage criteria must be met:

- 1.** The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:
 - Prevents the patient from accomplishing an MRADL entirely; or
 - Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
 - Prevents the patient from completing an MRADL within a reasonable time frame.
- 2.** The patient's mobility limitation cannot be resolved sufficiently and safely by the use of an appropriately fitted cane or walker.
- 3.** The patient 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.
 - Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
 - An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.



Additional Coverage Criteria Based on the Specific Type of PMD Provided

In addition to the basic coverage criteria described above, depending on the type of PMD provided, the following criteria must be met for Medicare to cover the PMD:

Power Operated Vehicles (POV)

- The patient is able to:
 - Safely transfer to and from a POV;
 - Safely operate the tiller steering system; and
 - Maintain postural stability and position while operating the POV in the home.
- The patient'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 patient's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided.
- The patient's weight is less than or equal to the weight capacity of the POV that is provided.
- Use of a POV will significantly improve the patient's ability to participate in MRADLs and the patient will use the POV in the home.
- The patient has not expressed an unwillingness to use a POV in the home.

Power Wheelchairs

- The patient does **not** meet the additional coverage criteria for a POV.
- The patient has the mental and physical capabilities to safely operate the power wheelchair that is provided (if the patient is unable to safely operate the power wheelchair, the patient has a caregiver who is available, willing, and able to safely operate the power wheelchair that is provided but is unable to adequately propel an optimally configured manual wheelchair).
- The patient's weight is less than or equal to the weight capacity of the power wheelchair that is provided.
- The patient's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is provided.
- Use of a power wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use the power wheelchair in the home (for patients with severe cognitive and/or physical impairments,



participation in MRADLs may require the assistance of a caregiver).

- The patient has not expressed an unwillingness to use a power wheelchair in the home.
- Any coverage criteria pertaining to the specific wheelchair type are met. For more information, refer to the DME Medicare Administrative Contractor (MAC) Local Coverage Determination (LCD).

Power Wheelchairs Group 2 Single Power Option and Above

In addition to the specific wheelchair base coverage criteria listed in the LCD, the following two requirements must be met:

1. The patient had a specialty evaluation that was performed by an LCMD, such as a PT, OT, or a physician with specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features. The PT, OT, or physician may not have any financial relationship with the supplier.
2. The wheelchair is provided by a supplier that employs a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the selection of the patient's wheelchair.

Learn More

Detailed education is available from the DME MACs serving Jurisdictions A, B, C, and D. Education is provided in a variety of formats including: self-paced online tutorials, podcasts, video education, and webinars. Additionally, each DME MAC jurisdiction staffs a Regional CERT Coordinator who can assist you with various CERT-related questions and/or concerns, such as:

- General CERT information;
- Detailed review results of a CERT claim;
- Explanation of a CERT-related overpayment;
- How to have a CERT overpayment re-reviewed;
- Clarification of the type of documentation CERT is requesting; and
- Why you may still be receiving request letters for medical records when you have already submitted the documentation.

DME MAC jurisdiction website addresses and Regional CERT Coordinator contact information can be found in Table 1.

Table 1. Website Addresses and Regional CERT Coordinators for Each DME MAC

Jurisdiction	Website Address	Regional CERT Coordinator
Jurisdiction A: NHIC, Corp.	http://www.medicarenhic.com/dme/index.shtml	Alina Jimenez 213-593-6020 alina.jimenez@hp.com
Jurisdiction B: National Government Services (NGS)	http://www.ngsmedicare.com	Sharon Gulley 1-800-338-6101 Education@wellpoint.com
Jurisdiction C: CIGNA Government Services (CGS)	http://www.cignagovernmentservices.com/jc/index.html	Brenda Normandia 615-782-4485 Brenda.Normandia2@cigna.com
Jurisdiction D: Noridian Administrative Services, LLC (NAS)	https://www.noridianmedicare.com/dme	Jennifer Huber 701-433-3064 jennifer.huber@noridian.com and Melissa Gordon 701-433-3092 melissa.gordon@noridian.com

For a complete listing of all national educational products related to provider compliance, including CERT, please visit the Medicare Learning Network® (MLN) Products web page at <http://www.cms.gov/MLNProducts> on the CMS website.

This fact sheet was prepared as a service to the public and is not intended to grant rights or impose obligations. This fact sheet 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 the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

The Medicare Learning Network® (MLN), a registered trademark of CMS, is the brand name for official CMS educational products and information for Medicare Fee-For-Service Providers. For additional information, visit the MLN's web page at <http://www.cms.gov/MLNGenInfo> on the CMS website.

October 2010 ICN 905063