

## Medicare Policies for Mobility Assistive Equipment

### Overview

Wheelchairs (both manual and power), scooters, canes, and walkers are referred to as “Mobility Assistive Equipment (MAE)” and are covered by Medicare under the Durable Medical Equipment benefit (DME) if certain criteria are met. For Medicare to cover mobility assistive equipment, the patient must meet coverage criteria that indicate he/she has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (e.g. toileting, feeding, dressing, grooming, bathing, etc.). Through the National Coverage Determination (NCD) process, CMS has established an algorithmic process for determining whether Medicare will cover MAE. There are also additional requirements that apply to Power Mobility Devices (PMDs). In addition to the National Coverage Determination, DME Medicare Administrative Contractors (MACs) have Local Coverage Determinations that describe criteria for coverage of mobility assistive equipment. Physical therapists should be familiar with these clinical criteria to ensure that the appropriate device is selected and that there is sufficient documentation to support medical necessity.

While safety and quality of care is of the utmost importance when working with patients and clients, documentation throughout the episode of care is a professional responsibility, a legal requirement, and the most important factor to successful payment of a claim. The patient’s medical records are expected to reflect the need for the care you provide and equipment you recommend. If you provide the correct documentation, and it follows the policies of the local coverage determinations (LCDs) and Centers for Medicare and Medicaid Services (CMS) Manual guidelines and APTA Documentation guidelines as outlined in the [General Mobility Device Clinical Documentation Guide\(.pdf\)](#), the claim is likely to be allowed.

### Key Medicare Requirements to Support the Need for Power Mobility Devices

Medically necessary manual wheelchairs, power mobility devices (power operated vehicles (scooters) and power wheelchairs), and related wheelchair seating and wheelchair options/accessories for Medicare beneficiaries must be prescribed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist.

To support the need for a power mobility device, Medicare requires the following requirements be met and documented:

- 1) A face-to-face examination consisting of a medical evaluation performed by the ordering physician;
- 2) A written prescription of the PMD created after the face-to-face examination that includes seven required elements; and
- 3) Receipt of the records of the face-to-face examination and the 7-element written order by the power mobility supplier within 45 days of completion of the face-to face examination. The 7-elements of the written order are listed below:
  - i. Beneficiary’s name;
  - ii. Description of item that is ordered. This description may be general (for example, “power operated vehicle,” “power wheelchair,” or “power mobility device”) or more specific;
  - iii. Date of completion of the face-to-face examination;
  - iv. Pertinent diagnoses/conditions that relate to the need for a PMD;
  - v. Length of need;
  - vi. Physician’s signature; and
  - vii. Date of physician’s signature.
- 4) The physician may refer the patient to a qualified licensed certified medical professional (LCMP) such as a physical therapist who has experience and training in mobility evaluations, to perform part of the evaluation. The physical therapist must have no financial relationship with the wheelchair supplier.

The physician must personally see the patient before or after the PT evaluation. The physician reviews the PT report, indicates agreement in writing on the report, and signs and dates the report.

The date that the physician signs the LCMP report is considered the date of completion of the face-to-face examination. If the physician does not see the patient after the PT/OT evaluation, the date that the physician signs the report is considered the date of completion of the face to face examination as required on the written 7-element order. For Medicare claims, the date of the face-to-face examination starts the 45-day clock for submitting documentation, delivering equipment, and submitting certain claims. See the LCD for your jurisdiction and details.

## Medicare Policy Resources

Below are links to Medicare resources regarding coverage and documentation requirements for Mobility Assistive Equipment.

[National Coverage Determination \(NCD\) for Mobility Assistive Equipment](#) This is a policy created by CMS that outlines national coverage criteria for mobility assistive equipment under Medicare.

**Local Coverage Determinations (LCDs):** For Medicare, remember that there are two applicable coverage policies: one LCD for the therapy services that you provide and a different LCD for the Durable Medical Equipment (DME) that is requested.

To find your local outpatient physical therapy, home health, and/or DME policies, use the search function in the [CMS Medicare Coverage Database](#). Select your Geographic Area/Region, then use the search suggestions below:

- [LCD for Therapy Services](#): Use keyword search “*physical therapy*” OR “*physical medicine AND rehabilitation*” OR “*occupational therapy*” OR CPT/HCPCS code “97001” or “97003”.
- [LCD for DME and related articles](#): Use keyword search: “*manual wheelchair bases*” OR “*power mobility devices*” OR “*wheelchair options/accessories*” OR “*wheelchair seating*”.

### **DME Medicare Administrative Contractor (MAC) websites**

Each DME MAC website posts useful tools, Documentation Checklists, “Dear Physician” letters, Denial Help Aids, FAQs, etc. Utilize these resources to assist you in your documentation, when educating physicians and colleagues and to assist in your understanding of these complex policies. All 4 contractors release identical policies. The **Power Mobility Resource Center** of DME MAC Jurisdiction C, CGS Administrators, LLC, is a rich easily navigated resource. [http://www.cgsmedicare.com/jc/coverage/mr/power\\_mobility\\_resources.html](http://www.cgsmedicare.com/jc/coverage/mr/power_mobility_resources.html)

[CMS Algorithm for MAE Coverage](#) This algorithm walks through the clinical criteria for MAE coverage.

[Medicare Program Integrity Manual \(Chapter 5, section 5.9.2\)](#) This manual, created and updated by CMS, provides guidance regarding the regulatory requirements for DME.

### **Power Mobility Devices**

See CMS’s MLN Matters: “[Complying with Documentation & Coverage Requirements](#)”

### **Face to Face Encounter Requirements for certain DME items**

Effective July 1, 2013, the Affordable Care Act (section 6407) established a face-to-face encounter requirement for certain other items of DME, including manual wheelchairs and accessories, and other items.(MLN Matters Number: MM8304). See CMS’s MLN Matters: “[Detailed Written Orders and Face-to-Face Encounters](#)”