Power Wheelchairs: What the Physician Must Do to Ensure Medicare Coverage

CMS Finds High Incidence of Improper Payments for Power Wheelchair Claims

Based on the findings of the Comprehensive Error Rate Testing (CERT) program reviews of power wheelchair claims, the Centers for Medicare & Medicaid Services (CMS) conducted a special study of power wheelchair claims.

The power wheelchair categories studied include:

- Group 1: Standard, portable, sling/solid seat/back, capacity up to 300 lbs. (K0813)
- Group 2: Standard, portable, captain’s chair, capacity up to 300 lbs. (K0821)
- Group 2: Standard, sling/solid seat/back, capacity up to 300 lbs. (K0822)
- Group 2: Standard, captain’s chair, capacity up to 300 lbs. (K0823)
- Group 2: Heavy duty, sling/solid seat/back, capacity 301 to 450 lbs. (K0824)
- Group 2: Heavy duty, captain’s chair, capacity 301 to 450 lbs. (K0825)
- Group 3: Heavy duty, sling/solid seat back, capacity 301 to 450 lbs. (K0850)
- Group 3: Very heavy duty, single power option, sling/solid seat/ back, capacity 301 to 450 lbs. (K0861)

What Power Wheelchair Claim Problems Were Found in the Study?

Insufficient Documentation

The majority of power wheelchair errors were due to insufficient documentation errors. Insufficient documentation errors occur when the medical documentation submitted is inadequate to support payment for the services billed. In other words, the medical reviewers could not conclude that some of the allowed services were actually provided, were provided at the level billed, and/or were medically necessary. Claims are also placed into this category when a specific documentation element that is required as a condition of payment is missing. This may include a physician signature on an order, or a form that is required to be completed in its entirety. ***EXAMPLE:*** *Mrs. Smith's medical record showed that she had a physical condition that led to leg weakness and falls at home. However, the face-to-face examination did not address why her mobility limitations could not be sufficiently and safely resolved by the use of an appropriately fitted cane or walker. This claim was scored as an improper payment due to an insufficient documentation error.*

Medical Necessity

A small proportion of claims in this special study were categorized as medical necessity errors. Medical necessity errors occur when the medical reviewers receive adequate documentation from the medical records submitted to make an informed decision that the services billed were not medically necessary based upon Medicare coverage policies. A common reason for medical necessity errors was that the face-to-face examination did not support that the beneficiary's condition required the use of a power wheelchair, such as when they were able to safely ambulate with the use of a walker. ***EXAMPLE:*** *Mr. Jones' medical record showed that he had a physical condition*

that led to leg weakness and falls at home. However, the face-to-face examination mentioned that she was safely ambulating around the house with the use of an appropriately fitted walker, but that she wanted the power wheelchair so that she could travel around the neighborhood. This claim was scored as a medical necessity error.

There is currently a prior authorization pilot underway in seven states where CMS will review the patient's medical record before a device is shipped to ensure they need a wheelchair. The pilot, which started September 1, 2012, is ongoing in California, Illinois, Michigan, New York, North Carolina, Florida, and Texas.

Federal health officials noted that nearly 80 percent of the power wheelchair claims submitted to Medicare don't meet program requirements. Note that this may mean that the protocol was not followed, as opposed to the patient not being eligible based on medical necessity. That error rate represents more than $492 million in improper payments annually. The cost for the devices ranges from $1,500 for scooters to $3,600 for more complex power wheelchairs over the course of the rental period. Medicare payment can only be made on a rental basis for standard power wheelchairs furnished on or after January 1, 2011.

What are the Requirements for Medicare Coverage for Power Wheelchairs?

Medicare provides coverage for wheelchairs and scooters under its Part B Durable Medical Equipment (DME) benefit. Here are the requirements for Medicare payment:

- The physician or treating practitioner must conduct a face-to face history and physical examination (the in-person visit and mobility evaluation together are often referred to as the "face-to-face examination") of the beneficiary and write a prescription for the item. The

prescription must include the following seven items:

1. Beneficiary's name
2. Description of the item that is ordered. This may be general – e.g., "power operated vehicle", "power wheelchair", or "power mobility device" – or may be more specific.
3. Date of completion of the face-to-face examination
4. Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
5. Length of need
6. Physician's signature
7. Date of physician signature

- The beneficiary must show the provider why they cannot use a cane, walker or manually operated wheelchair to effectively perform Mobility-Related Activities of Daily Living (MRADLs) in the home. MRADLs include feeding, dressing, grooming, bathing, and toileting.
- The beneficiary must be able to safely and effectively use the power wheelchair in the home.
- The prescription and medical records documenting the in-person visit and evaluation must be sent to the equipment supplier within 45 days after the completion of the evaluation.
- After the supplier receives the provider's order and the face-to-face information, they will prepare a detailed product description that describes the item(s) being provided including all options and accessories. The provider should review it and, if in agreement with what is being provided, sign, date and return it to the supplier. If not in agreement, the provider should contact the supplier to clarify what you want the beneficiary to receive.

Suppliers must meet all documentation requirements included in the power wheelchair Local Coverage Determinations (LCD) issued by the DME Medicare Administrative Contractors (MACs) in order to receive Medicare payment for a power wheelchair.

The LCD requires that suppliers maintain a variety of documents that support the beneficiary's need for, and the appropriateness of, the provided power wheelchair.

Documentation of the Visit for Your Medical Record (Paper or Electronic) for PWCs

The face-to-face examination must be relevant to the patient's mobility needs and include the following elements:

- 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
- Description of home setting and ability to perform MRADLs in the home.
- Physical examination relevant to mobility needs, including height and weight,
- Trunk stability (sitting/standing),
- Cardiopulmonary examination,
- Arm and leg strength and range of motion; and
- Neurological examination, including gait, balance and coordination.

Examples of vague or subjective

descriptions of the patient’s mobility limitations include:

- upper extremity weakness” “poor endurance”
- “gait instability”
- “weakness”
- “abnormality of gait”
- “difficulty walking”
- “SOB on exertion”
- “pain”
- “fatigue”
- “deconditioned”

Acronyms for power wheelchairs:

PWC – power wheelchairs

POV – power-operated vehicle (scooter)

PMD – power mobility device (includes PWCs and POVs)

MAE – mobility assistive equipment (includes the continuum of technology from canes to power wheelchairs)

How to Bill for Examination & Mobility Evaluation for a Power Wheelchair

- In the outpatient setting, bill the appropriate level of service from the codes 99201 – 99205 for new patients and from the codes 99211 – 99215 for established patients.
- Bill the G0327 for service required to establish and document the need for a power mobility device (the national payment amount for this code is $9.81)
- The diagnosis for the E/M code and the G0327 should be what condition creates medical necessity for the power wheelchair.