

QUALIFYING FOR REIMBURSEMENT FROM MEDICARE

Conditions for Coverage and Payment of Power Mobility Devices
(Power Wheelchairs and Power-Operated Vehicles)

Information for Patients & Physicians

In order to qualify, a beneficiary must have a mobility limitation preventing one or more mobility-related activities of daily living within the home -- dressing, grooming, toileting, bathing, eating -- and provide documentation that other modalities, such as a cane, walker, or manual wheelchair, have been tried and ruled out. Medicare will not consider payment unless a physician or treating practitioner (physician assistant, nurse practitioner, or clinical nurse specialist) has conducted a face-to-face examination of the beneficiary and then provided the beneficiary with a written prescription. The prescription must be written by the physician or treating practitioner conducting the exam. Medicare also requires that the physician document the evaluation from the face-to-face exam in a detailed narrative chart note. The chart notes from the exam must support the need for the requested equipment and must clearly indicate that the major reason for the exam was a mobility evaluation.

The prescription must include the following seven items:

- Beneficiary name and date the prescription is written
- Date of the face-to-face examination
- The diagnosis and conditions that the equipment is expected to modify
- A description of the equipment and the length of need
- The physician or treating practitioner signature

Medical equipment providers may not dispense powered mobility equipment until the prescription and supporting documentation has been received from the physician or treating practitioner who performed the face-to-face exam. This documentation must be received within 45 days after the exam. Once the medical equipment provider has the prescription, the provider will request supporting documentation from the physician, including pertinent parts of the medical record that clearly support the beneficiary's need for the equipment within the home.

Pertinent parts from the documentation evaluation may include the history, physical examination, diagnostic tests, summary of findings, diagnosis and treatment plans. The physician will be required to provide only those parts of the medical record that clearly demonstrate the medical necessity for the powered equipment. The parts of the medical record sufficient to delineate the history of events leading to the request for powered mobility should include:

- The mobility deficits that will be corrected by the powered Mobility Masters
- Other treatments that do not eliminate the need for the powered equipment.
- That the beneficiary lives in an environment that will support the need for the equipment
- That the beneficiary or caregiver is capable of operating the powered equipment

Note: On November 15, 2006, Medicare put in place very specific guidelines on which power equipment can be dispensed to beneficiaries. Choice is limited and specifically determined by the beneficiary's diagnosis(es).

