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DOCUMENTATION REQUIREMENTS FOR POWER WHEELCHAIRS AND POWER OPERATED VEHICLES
Revised March 2020

We IMPACT lives.

Dear Physician,

For Medicare to provide reimbursement for a power wheelchair (PWC) or power operated vehicle (POV) (scooter), there are several requirements that must be met:

1. There must be an in-person visit with a clinician specifically addressing the patient's mobility needs.
2. There must be a history and physical examination by the clinician or other medical professional (see below) focusing on an assessment of the patient's mobility limitation and needs. The results of this evaluation must be recorded in the patient's medical record.
3. A standard written order (SWO) must be written AFTER the in-person visit has occurred and the medical evaluation is completed.
4. The SWO for the power mobility base device must be completed within 6 months of the face-to-face encounter and provided to the supplier prior to delivery of the power mobility device.

The in-person visit and mobility evaluation together are often referred to as the "face-to-face encounter".

The complete history and physical examination must include a history of your patient's medical condition(s) and past medical history that are relevant to their mobility; and a physical examination that is relevant to their limitations in accomplishing mobility-related activities of daily living (MRADLs).

The history should paint a picture of your patient's functional abilities and limitations in their home on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the patient's ambulatory difficulty or impact on the patient's ambulatory ability. Vague terms such as "difficulty walking" or "upper extremity weakness" are insufficient, since they do not objectively address the mobility limitation or provide a clear picture of the patient's mobility deficits in participating in MRADLs.

A power mobility device is covered by Medicare only if the beneficiary has a mobility limitation that significantly impairs their ability to perform their MRADLs **within the home**. Thus, in your evaluation you must clearly distinguish your patient's mobility needs within the home from their needs outside the home.

You may elect to refer the patient to another medical professional, such as a physical therapist or occupational therapist, to perform part of the evaluation – as long as that individual has no financial relationship with the wheelchair supplier. However, you do have to personally see the patient before or after the PT/OT evaluation. You must review their report, indicate your agreement in writing on the report, and sign and date the report. This must be done within the 6-month timeframe described above. The date you first see the patient is considered to be the date of the face-to-face encounter.

You should record the visit and mobility evaluation in your usual medical record-keeping format. Many suppliers may provide forms for you to complete. Suppliers often try to create the impression that these documents are a sufficient record of the in-person visit and medical evaluation. Based upon our auditing experience, most of them are not.

You must forward a copy of your SWO to the supplier. The supplier is unable to deliver the power mobility device prior to receiving your SWO. It is also helpful to the supplier if you include your face-to-face encounter and copies of previous notes, consultations with other clinicians, and reports of pertinent laboratory, x-ray or other diagnostic tests if they will help to document the severity of your patient's ambulatory problems.

After the supplier receives your order/prescription, they may also prepare a second SWO that describes additional options and accessories to be added to the power mobility base device. You must review it and, if you agree with what is being provided, sign and return it to the supplier. If you do not agree with any part of the SWO, you should contact the supplier to clarify what you want the beneficiary to receive.

Medicare does provide you additional reimbursement (HCPCS code G0372) to recognize the additional time and effort that are required to provide this documentation to the supplier. This code is payable in addition to the reimbursement for your E&M visit code.

This information is not intended to serve as a substitute for the complete DME MAC local coverage determination (LCD) on Power Mobility Devices. It is only a synopsis detailing the highlights of required medical documentation. Please refer to the complete LCD and Policy Article on the CMS Web site at https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx for additional information.

Your participation in this process and cooperation with the supplier will allow your patient to receive the most appropriate type of mobility equipment. We appreciate all your efforts in providing quality services to your Medicare patients.

Sincerely,

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DME STANDARD WRITTEN ORDER (SWO)

ORDER DATE:			Name of Practice / Facility:	
			Phone #:	
PATIENT DEMOGRAPHICS				
FIRST NAME:	***LAST NAME:***	M.I.	***PHONE:***	
Street Address:		City:	State:	Zip:
DOB:	Sex: M F	Ht:	Wt:	2nd Contact/Phone:
Primary Insurance: ❑ Medicare ❑ Medicaid ❑ Other			**Secondary Insurance:** ❑ Medicare ❑ Medicaid ❑ Other	
Name:			Name:	
Phone:			Phone:	
MBI/Policy #:			Policy #:	

SUPPORTING ICD-10 CODES

1.	2.	3.	4.

The patient named above is being treated under a comprehensive plan of care. I, the undersigned treating physician certify that the below prescribed is medically necessary for the patient. I believe that the following products are both reasonable and necessary for the overall patient's wellbeing, condition and/or rehabilitation. I certify that the patient's medical records reflect the need for the item ordered and will be sent to the DME provider along with this SWO.

Please list the medical equipment to be provided below:

_____

_____

_____

_____

_____

_____

QUANITY TO BE DISPENSED: _____ *LENGTH OF NEED:* _____

PHYSICIANS NAME:			***NPI #:***
Street Address:	City:	State:	Zip
Contact:	Phone:	Fax:	

PHYSICIANS SIGNATURE: _____ ***DATE:*** _____

FAX this SWO to 704-821-7777 or email to info[redacted]@mobility-more.com