MEDICARE MODIFIES ITS CONDITIONS FOR OBTAINING POWER WHEELCHAIRS AND OTHER POWER MOBILITY DEVICES

The Centers for Medicare & Medicaid Services (CMS) has issued a final rule, effective June 5, 2006, that defines the term power mobility devices (PMDs) as power wheelchairs and power operated vehicles (POVs or scooters); revises payment rules for PMDs; defines who may prescribe PMDs; and clarifies CMS’s requirement of a face-to-face examination of the beneficiary in advance of obtaining a PMD. 71 Federal Register 17021 (April 5, 2006).

In the new rule, CMS defines a power mobility device to mean a covered item of durable medical equipment that is in a class of wheelchairs that includes a power wheelchair (a four-wheeled motorized vehicle whose steering is operated by an electronic device or a joystick to control direction and turning), or a power operated vehicle (a three or four wheeled motorized scooter that is operated by a tiller) that a beneficiary uses in the home.

The “for use in the home” requirement remains a contentious point for advocates who find it unduly restrictive. To this point of contention, CMS has responded that the use of a PMD outside the home is not prohibited, but that the PMD must be primarily for use in the home in order to obtain Medicare coverage.

A prescription for a PMD means a written order completed by the physician or treating practitioner who performed the face-to-face examination of the patient’s need for the PMD. The prescription must include the beneficiary’s name, the date of the face-to-face examination, the diagnoses and conditions that the PMD is expected to modify, a narrative description of the item, the length of the beneficiary’s need for the item, the physician’s or treating practitioner’s signature, and the date on which the prescription was written.

CMS also clarifies in the new rule that a treating practitioner, for purposes of writing the prescription for PMD, can be a physician assistant, a nurse practitioner, or a clinical nurse specialist, recognized under the laws of the state in which the treating practitioner practices, who conducted the required face-to-face examination of the beneficiary.

The new rule represents a liberalization of the earlier requirement that only specialists in physical medicine, orthopedic surgery, neurology, and rheumatology could prescribe a POV, unless no such specialist is reasonably accessible to the beneficiary. This earlier limitation, however, did not apply to a prescription for a power wheelchair. In an earlier CMS rule, the agency expressed concerns about the safety of POVs and developed more restrictive criteria with respect to those who could write prescriptions for POVs. Those concerns have been resolved. The new rule clarifies that any physician or treating practitioner who conducts a face-to-face examination of the patient can prescribe PMD, including POVs.
A supplier is defined in the new rule as an entity with a valid Medicare supplier number, including a mail order supplier. The supplier must maintain the prescription and supporting documentation provided by the physician or treating practitioner and must make this information available to CMS and its agents upon request, including any further documentation to support and/or substantiate the medical necessity for the PMD. Suppliers may not dispense a PMD to a beneficiary until they have received the PMD prescription and the supporting documentation from the physician or treating practitioner. This documentation must be received by the supplier within 45 days after the face-to-face examination.

Medicare will pay for a PMD only if the physician or treating practitioner meets the following conditions:

- Conducts a face-to-face examination of the beneficiary for the purpose of evaluating and treating the beneficiary for his or her medical condition and determining the medical necessity for the PMD as part of an overall treatment plan;

- Writes a prescription that is provided to the beneficiary or supplier, and is received by the supplier within 45 days after the face-to-face examination; and

- Provides supporting documentation, including pertinent parts of the beneficiary’s medical record that supports the medical necessity for the power mobility device, which is received by the supplier within 45 days after the face-to-face examination.

Beneficiaries discharged from a hospital do not need to receive a separate face-to-face examination as long as the physician or treating practitioner who performed the face-to-face examination of the beneficiary in the hospital issues a PMD prescription and supporting documentation that is received by the supplier within 45 days after the date of discharge. Accessories for PMDs may be ordered by the physician or treating practitioner without conducting a face-to-face examination of the beneficiary.

In general, the new rule makes the procedural process of obtaining a PMD less worrisome. There is significant emphasis on the face-to-face examination, including the clarification that a beneficiary coming out of the hospital need not have a separate face-to-face examination. The time frame of 45 days to get the prescription to the supplier from the time of the face-to-face evaluation will likely keep the process moving in a relatively timely fashion. In addition, the rule sets out examples of the pertinent parts of the beneficiary’s medical record that should accompany the prescription: history, physical examination, diagnostic tests, summary of findings, diagnoses, treatment plans and/or other information as may be appropriate.


For further discussion of access to Medicare-covered POVs and other PMDs, contact Alfred Chiplin (achiplin@medicareadvocacy.org) in the Center for Medicare Advocacy’s Washington, DC office at (202) 216-0028.

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