

Dear PMC Members:

Attached below please find the most recent "Fact Sheet" issued by the Centers for Medicare and Medicaid Services (CMS) concerning payment of claims for power mobility devices (PMDs). CMS anticipates that it will release a final rule (in place of the interim final rule) for PMDs on or about April 7th.

MEDICARE FACT SHEET

For Immediate release
CMS Office of Media Affairs
March 31, 2006

Power Mobility Device Regulation and Payment

Today's Actions:

The Centers for Medicare & Medicaid Services (CMS) is issuing a final rule implementing provisions in the Medicare Modernization Act (MMA) affecting Power Mobility Devices (PMDs), which include power operated vehicles (or scooters) and power wheelchairs. This final rule finalizes payment and documentation policies established in an interim final rule published in August. One change from the interim final rule is that this final rule gives physicians and treating practitioners 45 days, rather than 30 days, after the date of the face-to-face examination to provide pertinent parts of the medical record to the durable medical equipment (DME) supplier.

CMS will also pay physicians and other treating practitioners (a physician's assistant, nurse practitioner, or clinical nurse specialist) an add-on payment for the work involved in compiling and transmitting the required documentation to the DME supplier. This payment, which was authorized in the interim final rule, has been held in abeyance until

April 1, 2006, by the fiscal year appropriations legislation, enacted by Congress last December. CMS is attaching to this Fact Sheet an explanation of how physicians and treating practitioners should bill for this add-on payment as well as how to handle collection of beneficiary co-payments.

This final rule is part of a comprehensive overhaul of Medicare policies affecting PMDs that encompasses coverage, prescribing, coding, payment, and claims documentation for these devices. The goal is to ensure that beneficiaries who need assistance with mobility have access to appropriate technologies and that Medicare pays appropriately for these devices.

Background:

Over the past two years, CMS has focused significant attention on power wheelchairs and power scooters. The initial emphasis, growing out of a dramatic rise in claims for the most sophisticated and expensive kind of power wheelchair, was on curbing fraud and abuse by certain unscrupulous suppliers of these devices. CMS then embarked on a comprehensive review of how Medicare covers and pays for PMDs. In a three-pronged initiative announced in April 2004, CMS outlined plans (1) to review the coverage criteria for PMDs; (2) to develop new codes for PMDs that would allow CMS to tailor payment rates for PMDs to the particular features of the specific equipment supplied; and (3) to develop and implement quality standards for suppliers of PMDs.

Through its Mobility Assistive Equipment (MAE) National Coverage Determination (NCD), which includes PMDs, CMS has issued new function-based criteria to replace the historical “bed or chair-confined” standard. CMS believes these criteria, based on expert medical consensus, will help physicians and treating practitioners, as well as suppliers, to better meet patient needs.

In this final rule, CMS adopts many of the policies and procedures in the interim final rule for prescribing, supplying, and billing for PMDs. The MMA provisions expanded the types of health professionals who may order certain types of PMDs and required a face-to-face examination of the patient by the prescribing physician or treating practitioner before a PMD may be prescribed.

Specifics Of The Final Rule:

This final rule delineates the responsibilities of physicians and other treating practitioners, as well as suppliers of PMDs, to ensure that each beneficiary receives the type of power wheelchair or power scooter most suited to his or her needs. It also implements the MMA provision eliminating a requirement that a power scooter could only be prescribed by a specialist in physical medicine, orthopedic surgery, neurology or rheumatology. This new regulation will be effective sixty days from the date of publication in the Federal Register.

This new process provides opportunities for a broader range of health professionals to be more actively involved in deciding whether a beneficiary needs a PMD, and, if so, the appropriate type of PMD. It also gives physicians, other treating practitioners, and suppliers greater certainty regarding Medicare payment by providing more extensive guidance for how PMD claims can be supported with well-documented findings by physicians and other treating practitioners.

Further, the new process includes specific payments to physicians and other treating practitioners for providing documentation, and it eliminates the burden for physicians and other treating practitioners to provide potentially duplicative information on multiple forms. In particular, the interim final rule announced the elimination of the need for a physician or other treating practitioner to complete and sign a Certificate of Medical Necessity (CMN) to accompany the order for a PMD. CMS' experience has been that the CMN did not work as well as originally hoped because it did not accurately reflect the contents in the medical record. The beneficiary's physician or treating practitioner is in the best position to evaluate and document the beneficiary's clinical condition and medical needs, and good medical practice requires that this evaluation be adequately documented. Thus, to minimize the documentation requirements for providers while assuring that documentation is adequate, physicians and treating practitioners will now submit copies of relevant existing documentation from the beneficiary's medical record, rather than having to transcribe medical record information onto a CMN.

Physicians' and Other Treating Practitioners' Role and Responsibilities:

- Face-to-face examination: The MMA requires as a condition for payment for PMDs that the equipment be prescribed by a physician or other treating practitioner who has conducted a face-to-face examination of the beneficiary. A beneficiary who has had a face-to-face examination during an inpatient hospital stay will not need a separate face-to-face examination, as long as the physician or treating practitioner who performed the face-to-face examination during the hospital stay prescribes the PMD within 45 days after the date of discharge. The face-to-face examination requirement does not apply when only accessories for PMDs are being ordered.

- Written prescription: The physician or treating practitioner must submit a written prescription for the PMD to the supplier. This prescription must be received by the supplier within 45 days after the face-to-face examination, or in the case of a recently hospitalized beneficiary, within 45 days after the date of discharge from the hospital. The written prescription must include the beneficiary's name, the date of the face-to-face examination, the diagnoses and conditions that support the claim for the PMD, a description of the specific type of PMD required, and the expected length of time the beneficiary will need the equipment. The prescription must be signed and dated by the physician or treating practitioner.

- Supporting documentation: The physician or treating practitioner who performed the face-to-face examination must submit to the DME supplier the written prescription accompanied by supporting documentation of the beneficiary's need for the PMD in the home (a standard required by statute for all durable medical equipment). The supporting documentation will include pertinent parts of the medical record that clearly support the medical necessity for the PMD in the beneficiary's home, which may include the history, physical examination, diagnostic tests, summary of findings, diagnoses, and treatment plans. It may also include information from other examinations, as well as relevant reports from other consultants and practitioners. This supporting documentation must be received by the supplier within 45 days after the face-to-face examination, or in the case of a recently hospitalized beneficiary, within 45 days after the date of discharge from the hospital.

This combination of a written prescription and supporting documentation replaces the CMN that was previously required in ordering such equipment.

- Billing and payment: The physician or treating practitioner will bill Medicare under the Physician Fee Schedule for the appropriate level of office or hospital visit for the face-to-face examination. In addition, as noted above, CMS has established an add-on G code that will allow the physician or treating practitioner to be paid for the work and resources involved in compiling and submitting the required documentation from the medical record. The payment amount for this new G code for 2005 is \$21.60, adjusted by the geographic area where the service is provided.

DME Supplier's Role and Responsibilities:

- Prior to dispensing a PMD, the DME supplier must have received within 45 days after the face-to-face examination, or in the case of a recently hospitalized beneficiary, within 45 days of discharge from the hospital, the written prescription and supporting documentation from the physician or treating practitioner who performed the face-to-face examination. The supplier must identify the specific type of PMD to fill the prescription.

Implementation And Outreach:

The Durable Medical Equipment Regional Contractors (DMERCs) have issued a series of articles, as well as a draft local coverage determination (identical across all four DMERCs) providing guidance to suppliers on the types of documentation from the

beneficiary's medical record that will be needed to establish the medical necessity of the prescribed equipment.

As physicians, treating practitioners, and suppliers become acclimated to their new roles and responsibilities, the DMERCs will carefully monitor billing trends to identify extraordinary situations where further intervention is warranted to ensure that claims are submitted accurately.

CMS believes this final rule and implementing efforts will increase claims processing consistency, while ensuring that beneficiaries receive the most clinically appropriate mobility equipment. In sum, all stakeholders — physicians, treating practitioners, patients, and suppliers — will benefit from this comprehensive set of reforms.

This final rule went on public display at the office of the *Federal Register* on March 31, 2006 for publication on April 5, 2006.

APPENDIX A
APPENDIX B

APPENDIX A

DOCUMENTING MEDICAL NECESSITY

POINTERS FOR PHYSICIANS AND OTHER TREATING PRACTITIONERS

When prescribing a power wheelchair or power scooter the physician or other treating practitioner must provide the DME supplier with documentation of the medical necessity of the device prescribed. This should include pertinent parts of the medical record and include the documentation of the beneficiary's face-to-face examination including information such as the history, physical examination, diagnostic tests, summary of findings, diagnoses, and treatment plans.

The physician or treating practitioner should select only those parts of the medical record that clearly demonstrate medical necessity for the PMD.

The parts of the medical record selected should be sufficient to:

- delineate the history of events that led to the request for the PMD;
- identify the mobility deficits to be corrected by the PMD;
- establish that other treatments do not obviate the need for the PMD,

- establish that the beneficiary lives in an environment that supports the use of the PMD; and
- establish that the beneficiary or caregiver is capable of operating the PMD.

In most cases, the information recorded at the face-to-face examination will be sufficient. However, there may be some cases where the physician or treating practitioner has treated a patient for an extended period of time and the information recorded at the face-to-face examination refers to previous notes in the medical record. In this instance, those previous notes would also be needed.

The physician, treating practitioner or supplier that is a HIPAA- covered entity should make sure to remove or edit any materials that may be contained within the medical record that are not necessary to support the prescription. For example, a gynecologic report would not be needed in the records submitted for a beneficiary whose clinical need for a PMD is based solely on disability secondary to a stroke.

APPENDIX B

Obtaining Payment for Prescribing Power Mobility Devices (PMDs)

On March 10, 2006, CMS instructed the carriers and fiscal intermediaries (FI) to hold claims billed with code G0372 that were submitted after December 30, 2005, through March 31, 2006.

Physicians billing a Medicare carrier had three options for submitting the evaluation and management (E/M) code used to bill for the face-to-face appointment with the beneficiary and the G0372 code for services between December 30, 2005 and March 31, 2006. With the expiration of the statutory moratorium on paying for the G0372 code, the following procedures will apply.

Physicians who submitted both the E/M and the G0372 immediately on the same claim and whose claims were required to be held by their carriers through March 31, 2006, will begin receiving payment without further action by the physician. Payment will be made in a lump sum, and will be accompanied by a Remittance Advice specifying the payment on each claim.

- Physicians who held all claims containing the G0372 code until after March 31, 2006 should now submit these claims to the carrier for normal claims processing.

- Physicians who split their claims, submitting the claim for the E/M service for payment immediately, and holding the claim for the G0372 code for submission separately after March 31, 2006, should now submit the claims for the G0372, and should collect any additional co-payments due from the beneficiary.

- Physicians submitting claims on and after April 1, 2006, must bill the E/M and the G0372 code on the same claim.

Method II Critical Access Hospitals (CAH) billing a Medicare Fiscal Intermediary (FI) have the following options for submitting the G0372 code and the E/M code:

- CAHs that submitted both the claims for the office visit and the G0372 code Fiscal intermediaries were to hold payment for these claims through July 2, 2006. After July 2, the fiscal intermediaries will pay the claim with no further action required of the CAH.

- Hold all claims containing the G0372 code until after July 2, 2006. After July 2, 2006, the CAH should submit the claims for the office visit and G0372 on the same claim form. These claims will be processed in the normal way.

- Submit the E/M service now and bill the G0372 code after July 2, 2006. The E/M service will be paid now. The provider may choose to submit two separate claims for the individual services. (Providers will not be penalized for splitting the billing of these services).

- Method II CAHs submitting claims on and after July 2, 2006, must bill the E/M and the G0372 code on the same claim.

- On July 3, 2006, FIs will begin releasing the payments for the claims that were held with code G0372.
