

**ABSOLUTE  
MEDICAL  
EQUIPMENT, INC.**

Thank you for your recent referral! Our company is excited about providing your patient with the very best in service and home medical equipment. As you know, Medicare regulations are specific about coverage and criteria. Please utilize this check sheet to help verify that we have all of the information needed to get your patient independently mobile quickly!

Please provide:

\_\_\_ **A comprehensive Face-to-Face evaluation** – if this evaluation results in the need for a power device in the home, please indicate so in your chart notes. Information required to be addressed within this evaluation is attached for your review.

\_\_\_ **An order for appropriate equipment** – we must receive this order within 45 days of your Face-to-Face evaluation. Medicare requirements for the information that must be contained in the order is attached for your review.

\_\_\_ **A copy of progress notes from the chart** – this should include any pertinent chart notes from other agencies involved in care such as home health, therapists, laboratories, etc.

We will send for your completion and return:

\_\_\_ **A detailed production description** – please review, sign, date and return this form. This will list equipment description, billing codes, our billable amount, Medicare allowable amount, manufacturer and model number.

Please call should you have any questions. Thank you for your cooperation in allowing us to serve your patients.

**30 East Gordon Road  
Newnan, Georgia 30263  
678-854-9234  
678-854-9238 fax**

**6014 Macon Road  
Columbus, Georgia 31907  
706-562-1600  
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Fayetteville, Georgia 30214  
770-716-3833  
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**FACE-TO-FACE EXAMINATION:**

The report of the face-to-face examination should provide information relating to the following questions.

For POVs and PWCs	What is this patient’s mobility limitation and how does it interfere with the performance of activities of daily living?
For POVs and PWCs	Why can’t a cane or walker meet this patient’s mobility needs in the home?
For POVs and PWCs	Why can’t a manual wheelchair meet this patient’s mobility needs in the home?
For POVs	Does this patient have the physical and mental abilities to transfer into a POV and to operate it safely in the home?
For PWCs	Why can’t a POV (scooter) meet this patient’s mobility needs in the home?
For PWCs	Does this patient have the physical and mental abilities to operate a power wheelchair safely in the home?

**The report should provide pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.**

- History of the present condition(s) and past medical history that is relevant to mobility needs
  - Symptoms that limit ambulation
  - Diagnoses that are responsible for these symptoms
  - Medications or other treatment for these symptoms
  - Progression of ambulation difficulty over time
  - Other diagnoses that may relate to ambulatory problems
  - How far the patient can walk without stopping
  - Pace of ambulation
  - What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used
  - What has changed to now require use of a power mobility device
  - Ability to stand up from a seated position without assistance
  - Description of the home setting and the ability to perform activities of daily living in the home

- Physical Examination that is relevant to mobility needs
  - Weight and height
  - Cardiopulmonary examination
  - Musculoskeletal examination
    - Arm and leg strength and range of motion
  - Neurological examination
    - Gait
    - Balance and coordination

The evaluation should be tailored to the individual patient's conditions. The history should paint a picture of the patient's functional abilities and limitations 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.

Physicians shall document the examination in a detailed narrative note in their charts in the format that they use for other entries. The note must clearly indicate that a major reason for the visit was a mobility examination.

Many suppliers have created forms which have not been approved by CMS which they send to physicians and ask them to complete. Even if the physician completes this type of form and puts it in his/her chart, this supplier-generated form is not a substitute for the comprehensive medical record as noted above. Suppliers are encouraged to help educate physicians on the type of information that is needed to document a patient's mobility needs.

Physicians shall also provide reports of pertinent laboratory tests, x-rays, and/or other diagnostic tests (e.g., pulmonary function tests, cardiac stress test, electromyogram, etc.) performed in the course of management of the patient. Upon request, suppliers shall provide notes from prior visits to give a historical perspective of the progression of disease over time and to corroborate the information in the face-to-face examination.

**ORDERS:**

The order that the supplier must receive within 45 days after completion of the face-to-face examination must contain all of the following elements:

- 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 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

Once the supplier has determined the specific power mobility device that is appropriate for the patient based on the physician's order, the supplier must prepare a written document (termed a detailed product description) that lists the wheelchair base and all options and accessories that will be separately billed. For the wheelchair base and each option/accessory, the supplier must enter all of the following:

- HCPCS code
- Narrative description of the HCPCS code
- Manufacturer name and model name/number
- Supplier's charge
- Medicare fee schedule allowance

If there is no fee schedule allowance, the supplier must enter "not applicable". The physician must sign and date this detailed product description and the supplier must receive it prior to delivery of the PWC or POV. A date stamp or equivalent must be used to document receipt date. The detailed product description must be available on request.

It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

## Important Medicare Coverage and Criteria Information

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity.

The term power mobility device (PMD) includes power operated vehicles (POVs) and power wheelchairs (PWCs).

### What's the Difference?

Power Wheelchair (PWC) is a device configured as wheelchair with batteries, operated by a joystick  
Power Operated Vehicle (POV) is a scooter-type device, operated by battery and controlled with handle bar type steering

### BASIC COVERAGE CRITERIA:

All of the following basic criteria (A-C) must be met for a power mobility device to be covered. Additional coverage criteria for specific devices are listed below.

**A)** The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:

- Prevents the patient from accomplishing an MRADL entirely, or
- Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
- Prevents the patient from completing an MRADL within a reasonable time frame.

**B)** The patient's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.

**C)** The patient does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.

- Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
- An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.

**POWER OPERATED VEHICLES:**

A POV is covered if all of the basic coverage criteria (A-C) have been met and if criteria D-I are also met.

**D)** The patient is able to:

- Safely transfer to and from a POV, and
- Operate the tiller steering system, and
- Maintain postural stability and position while operating the POV in the home.

**E)** The patient's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home.

**F)** The patient's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided.

**G)** The patient's weight is less than or equal to the weight capacity of the POV that is provided.

**H)** Use of a POV will significantly improve the patient's ability to participate in MRADLs and the patient will use it in the home.

**I)** The patient has not expressed an unwillingness to use a POV in the home.

If a POV will be used inside the home and coverage criteria A-I are not met, it will be denied as not medically necessary.

## **POWER WHEELCHAIRS :**

A power wheelchair is covered if:

- a. All of the basic coverage criteria (A-C) are met; and
- b. The patient does not meet coverage criterion D, E, or F for a POV; and
- c. Either criterion J or K is met; and
- d. Criteria L, M, N, and O are met; and
- e. Any coverage criteria pertaining to the specific wheelchair type are met.

J) The patient has the mental and physical capabilities to safely operate the power wheelchair that is provided; or

K) If the patient is unable to safely operate the power wheelchair, the patient has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair that is provided; and

L) The patient's weight is less than or equal to the weight capacity of the power wheelchair that is provided.

M) The patient's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is provided.

N) Use of a power wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it in the home. For patients with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver.

O) The patient has not expressed an unwillingness to use a power wheelchair in the home.

If the PWC will be used inside the home and coverage criteria (a)-(e) are not met but the criteria for a POV are met, payment will be based on the allowance for the least costly medically appropriate alternative.

If the PWC will be used inside the home and coverage criteria (a)-(e) are not met and the criteria for a POV are not met, it will be denied as not medically necessary.

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**Motorized Wheelchair/Scooter Order Form**

Dear Physician,

If your evaluation has resulted in the determination that your patient's mobility needs will be best met by a Power Mobility Device such as a power wheelchair or scooter, please complete the following order in full and fax to the local office, numbers listed above, attn: Power Mobility Department. Thank you.

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Length of need: *(99 indicates lifetime)* \_\_\_\_\_

Date of Face-to-Face Evaluation: \_\_\_\_\_

Equipment Ordered: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ NPI#: \_\_\_\_\_

**X** \_\_\_\_\_ Date: \_\_\_\_\_

*Physician Signature*