

Power Wheelchairs and POVs – Policy Clarification and Medical Review Strategy

In a joint release by the Centers for Medicare and Medicare Services (CMS) and the Office of the Inspector General (OIG) on September 9, 2003, the Department of Health and Human Services announced a 10 point initiative to address the explosive growth of Medicare payments for power wheelchairs over the past few years. Two of the points in the plan were a clarification of the Local Medical Review Policy (LMRP) for Power Wheelchairs and the adoption of a consistent approach to medical review of power wheelchair claims by all four DMERCs. This article outlines steps that are being taken to address these two points.

The national policy on power wheelchairs and power operated vehicles (POVs) is found in the Medicare Coverage Issues Manual section 60-9. It states that a wheelchair is covered “if the patient’s condition is such that without the use of a wheelchair he would otherwise be bed or chair confined.” A power wheelchair or power operated vehicle (POV) is covered if, in addition, “...the patient is unable to operate the wheelchair manually.”

The following information is a clarification of national policy. All DMERCs are strictly enforcing these coverage criteria and applying them to all claims reviewed regardless of the date of service or date of submission. Power wheelchairs or POVs (hereafter referred to as just power wheelchairs) are covered only for patients who are nonambulatory. If a patient can bear weight to transfer from a bed to a chair or wheelchair, the patient is considered nonambulatory. However, if the patient is able to walk either without any assistance or with the assistance of an ambulatory aid, such as a walker, the power wheelchair is denied as not medically necessary. If the patient is nonambulatory and qualifies for a wheelchair, a power wheelchair is covered only if the patient is unable to self-propel a manual wheelchair within their home. Medicare coverage of durable medical equipment is limited to items that are necessary for use within the home. Although a power wheelchair may be useful to allow the beneficiary to move extended distances, especially outside the home, Medicare statute and national policy do not currently provide coverage for those uses.

The DMERCs are pursuing an aggressive medical review strategy aimed at identifying suppliers who are providing power wheelchairs that do not meet Medicare coverage criteria. Through a variety of data analysis techniques, the DMERCs identify suppliers for medical review. Potential errors are validated through probe reviews. This review may be done on either a pre-pay basis (i.e., at the time of the initial claim determination) or a post-pay basis (i.e., after the claim has been paid). In accordance with the Progressive Corrective Action approach, the DMERCs will notify the supplier if a supplier-specific review is being conducted.

All claims for power wheelchairs must continue to include a Certificate of Medical Necessity (CMN). However, CMNs have never provided all of the information required to document that the coverage criteria for power wheelchairs have been met. Rather, they

serve as medical review screening tools that allow the DMERCs to review some but not all of the coverage criteria for a particular item through automated edits. For claims that are subjected to manual medical review, the claims will be developed to the supplier asking for copies of the patient's medical record which contains information verifying that the coverage criteria have been met. Evaluations that are used to document coverage must have been performed and recorded prior to the delivery of the power wheelchair.

The information needed by the DMERCs to make a medical necessity determination includes, but is not limited to, the following elements:

- The distance that the patient can walk (a) independently and (b) with the assistance of a walker or other ambulatory aid;
- Strength and function of the upper and lower extremities (including tone, range of motion limitations, etc.);
- The diagnosis that is associated with the limitations.

If the power wheelchair is being provided to a patient who has received a Medicare-covered manual or power wheelchair within the past 5 years, the DMERCs will need information from the patient's medical record that documents that there has been a significant change in the patient's medical condition that necessitates the different type of equipment.

The following items must be submitted for all claims that are developed:

- Relevant portions of the patient's medical record containing evaluations performed and recorded prior to the delivery of the power wheelchair;
- A copy of the delivery slip;
- Product information including manufacturer, make, model, etc.;
- A photocopy of the original, signed CMN that was used to create the electronic CMN if it was transmitted electronically.

If the relevant portions of the patient's medical record are not provided, the claim will be denied as not medically necessary. Other than the CMN, there is no requirement that the documentation be received on any specific form.

For purposes of review of wheelchair claims, the patient's medical record consists of some or all of the following:

- 1) Physician notes from the office, inpatient or outpatient hospital, or nursing home;
- 2) Nonphysician clinician notes from the physician's office, inpatient or outpatient hospital, nursing home, or Medicare-covered home health agency visit;
- 3) Nonphysician clinician (e.g., physical therapist or occupational therapist) evaluations that meet all of the following criteria:
 - a) Performed on referral from the treating physician; and,
 - b) Performed "in person" and not conducted by telephone; and
 - c) Performed by a Medicare provider or employee of a Medicare provider; and,
 - d) Clinicians are not employees of or otherwise paid by the wheelchair supplier.

Other types of information are not sufficient by themselves to document that the coverage criteria have been met, even if they are signed or initialed by the treating physician. That

is because they are not considered to be part of the patient's medical record. However, the supplementary information that they contain will be given consideration if it is corroborated by the medical record. This applies to documents created either before or after delivery of the power wheelchair. Some examples, not all-inclusive, of these type documents are:

- 1) Evaluations performed by PTs, OTs, or other individuals employed by or otherwise paid by the supplier;
- 2) Forms (either narrative or check-off) devised by the supplier and completed by the physician;
- 3) Summaries of the patient's medical condition prepared by the supplier or physician;
- 4) Forms (either narrative or check-off) developed by suppliers and completed by the patient or caregiver.

These medical review guidelines will not only be applied to new reviews, but will also be applied to any provider-specific reviews that are currently being conducted by the DMERCs.

Depending on the extent of errors found on a probe review, the DMERCs have a number of options that may be used for follow-up, including but not limited to: supplier-specific education, conducting a follow-up audit, placing the supplier on 100% pre-pay review, conducting a statistically valid random sample post-pay review. Any evidence of fraud will be referred to the Benefit Integrity department. The DMERCs will be particularly on the alert for suppliers who switch their billing of power wheelchairs to another of their locations/ supplier numbers when a probe or other medical review is conducted on a different office location.

The DMERCs will provide suppliers with additional updates and clarifications through our web sites, list serve, and bulletins. The DMERCs will also provide information to the local carriers for publication in their bulletins to help educate physicians on the coverage criteria for power wheelchairs.