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Quick Pulse

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CMS Issues New Rules for Power-Operated Vehicles

On August 25, 2005, the Centers for Medicare & Medicaid Services (CMS) issued an interim final rule on the prescribing, supplying, and reimbursement for power operated vehicles ("scooters") and power wheelchairs. CMS appears to be trying to clamp down on overly aggressive druable medical equipment (DME) suppliers without denying the legitimate claims. CMS Administrator Dr. Mark McClellan told reporters that the new rule is designed to provide Medicare recipients with access to these devices while also eliminating both unnecessary administrative burdens and inappropriate Medicare spending.

In February 2005 CMS announced a national coverage decision for mobility assistive equipment (MAE), from simple canes and walkers to sophisticated power wheelchairs and scooters. The coverage criteria use a function-based determination of medical necessity. This determination looks at the ability of the beneficiary to safely accomplish mobility-related activities of daily living, such as toileting, grooming, and eating, with and without the use of mobility equipment, such as a wheelchair.

The interim final rule on power-operated vehicles was published in the ***Federal Register*** on August 26, 2005, and will become effective for services on or after October 25, 2005. Comments will be accepted until November 25, 2005, and a final rule will be published at a later date. The new rule:

- **Eliminates the requirement for a Certificate of Medical Necessity** (CMN), signed by the prescribing physician or other treating practitioner, to accompany any claim for power wheelchairs and scooters.
- **Broadens who can prescribe the devices.** It eliminates a restriction that allowed only a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology to prescribe a power scooter. The new rule allows any physician or treating practitioner (i.e., physician assistant, nurse practitioner, clinical nurse specialist) to prescribe a power wheelchair or power scooter.
- **Institutes a 30-day timeframe.** The rule mandates that suppliers obtain a written prescription within 30 days of the face-to-face examination before billing Medicare.
- **Requires documentation in the patient's medical record** of the beneficiary's need for assistance with mobility **in the home**, as well as the type of technology needed.

- **Specifies that a face-to-face examination of the patient be performed** by the physician or treating practitioner before a power wheelchair or power scooter can be prescribed. Dr. McClellan said, "This is what constitutes clinical practice today. Performing a clinical evaluation is absolutely intrinsic in the face-to-face requirement. It is a key part of our current national coverage decision – to make sure people who need power mobility are getting the treatment they need." Another CMS official said, "One of the things we will be asking is that when physicians document patient encounters, they need to decide the patient's clinical condition – disease progression, change in health status, living situation (e.g., caregivers), medical history, current condition, etc. Our guidance clearly lays out that these are the things we are looking at, and it is that information that our contractors would use in evaluating claims for payment."

- **Requires that DME suppliers obtain clinical documentation along with the written prescription before delivering a vehicle to a Medicare beneficiary**. That documentation must be in a patient's medical record and must demonstrate the need for assistance with mobility as well as the type of technology needed. Only the prescription has to be submitted to CMS, but the documentation for each claim must be kept on file and must be produced when and if CMS requests it. A CMS official said, "We do expect documentation…of the medical necessity to be kept on file by each of the suppliers for all of the prescriptions they fill. They shouldn't be filling prescriptions without that documentation. We won't ask for that routinely, but it must be on hand…And having it on hand when a prescription is filled will help ensure that clinical need and the type of device being prescribed are properly matched."

- **Establishes new billing codes** for power wheelchairs and power scooters to allow Medicare to differentiate among types of equipment with different features and pay more accurately based on the characteristics of the particular chair/scooter.

Physicians (and other treating practitioners) will get an additional fee of $21.60 (adjusted geographically) from Medicare for preparing and providing the required documentation to the equipment supplier. To receive this payment, the physician or treating practitioner must include a special billing code on the claim for the office visit. Dr. McClellan said, "I don't know that doctors are assuming more responsibility…The physician or treating practitioner is in the best position to determine what the beneficiary's needs are...So, we are adding in a new payment to help assure the documentation is there and gets to the supplier. The point is not to create new burdens for the physicians. Rather, this is an existing responsibility for health professionals, and we want to be sure we are supporting them in providing this information."

It is not clear yet how physicians, suppliers, and Medicare recipients will respond to these changes. A spokesperson for the Advanced Medical Technology Association said she hadn't seen all the details of the new rules, commenting, "The devil is in the details, and we need to contact our members to get a consensus on this."

CMS plans a campaign to educate physicians, and other practitioners who prescribe power wheelchairs and power scooters as well as suppliers about the new criteria and the new documentation requirements. CMS will also provide billing instructions for suppliers before the implementation date. The contractors who process DME claims also will issue specific guidance about what information from the beneficiary's medical record is needed to demonstrate the medical necessity of the equipment. CMS officials said this guidance will underscore that an appropriate coverage determination for these products will take into account:

- The patient's medical history.
- Elements of a physical assessment, such as strength and range of motion.
- A functional needs assessment, as documented in the medical record.
- The availability of other types of devices.

This interim final rule is just the latest action by CMS in its effort to implement the Power Wheelchair Initiative, which was first announced in April 2004. That initiative is focused on improving coverage, payment policies, and the quality of the suppliers of power wheelchairs and power scooters.

In early September 2005, CMS will hold a special Open Door Forum to address power wheelchair and power scooter issues. This is intended as an opportunity for physicians, suppliers, and other interested parties to discuss Medicare policies with senior staff.

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