### Common Neurologic Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>ICD-9 Code</th>
</tr>
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<tbody>
<tr>
<td>Alzheimer’s disease</td>
<td>331.0</td>
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<tr>
<td>Anterior horn cell disease</td>
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<tr>
<td>Anterior horn cell disease nos</td>
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<tr>
<td>Amyotrophic lateral sclerosis</td>
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<tr>
<td>CNS demyelination nec</td>
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<td>CNS demyelination nos</td>
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<tr>
<td>Cerebral palsy</td>
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<tr>
<td>Congenital Diplegia</td>
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<tr>
<td>Congenital Hemiparesis</td>
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<tr>
<td>Cerebral palsy no</td>
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<td>Cerebellar Ataxia other</td>
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<tr>
<td>Cerebral Lipidosis</td>
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<tr>
<td>Cerebellar degeneration primary</td>
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<td>CIDP (Chronic Inflammatory Demyelinating Polyneuropathy)</td>
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<td>Guillain Barri</td>
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<td>Schilder’s disease</td>
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### Myopathy

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<td>Duchennes</td>
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### Congenital Skeletal Deformity

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<tr>
<td>Kyphoscoliosis Syndrome</td>
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<td>Osteogenesis Imperfecta</td>
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<td>Other congenital anomalies of limbs</td>
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<td>Spina Bifida</td>
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<tr>
<td>Spina Bifida with hydrocephalus</td>
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</table>

*This list is not all-inclusive. In addition, the presence of a specific diagnosis in and of itself does not guarantee coverage of a power mobility device. Providers should document the manifestations of the disease that result in the patient’s inability to accomplish their MPASLA and meet the coverage criteria for the specific device contemplated.*
Physicians may bill Medicare for the power mobility device face-to-face examination through the appropriate evaluation and management (E&M) code corresponding to the history and physical examination of the patient. In addition, in order to recognize the additional physician work related to the documentation, CMS has established an add-on G-code (G0372) that will be paid at a rate equal to the physician fee schedule relative values established for a level 1 office visit for an established patient (CPT Code 99211). The E&M and G-codes must be billed on the same claim.

Use of code G0372 signifies that:
• All of the information necessary to document the power mobility device prescription is included in the medical record, and
• The prescription, along with the supporting documentation, has been received by the power mobility device supplier within 45 days after the face-to-face examination.

Following your evaluation, you may be writing an order for mobility assistive device. If you’re considering a power mobility device, the order must be received, along with the documentation from your face-to-face evaluation and any other pertinent medical information supporting the prescription, within 45 days after the evaluation. (Exception: If the evaluation is performed during a hospital or nursing home stay, the supplier must receive the order and documentation within 45 days after discharge.) The supplier must have both of these items prior to delivering the power mobility device to your patient. When providing this documentation to the medical equipment supplier, you should select only those parts of the medical record that clearly demonstrate medical necessity for the power mobility device.

The order for mobility equipment must contain all of the following elements:
  ✓ Beneficiary name
  ✓ Description of the item ordered – This may be stated in general terms – e.g., “power wheelchair” or may be detailed
  ✓ Date of the face-to-face evaluation (if a power mobility device)
  ✓ Pertinent diagnoses/conditions relating to the need for the MAE
  ✓ Length of need
  ✓ Physician signature
  ✓ Date of physician signature

In most cases, the supplier will send you a detailed prescription outlining the specific device and any options/accessories determined to be necessary for your patient. This detailed order must be reviewed, signed by you and returned to the supplier before the equipment can be dispensed to your patient. The 45-day timeline does not apply to this detailed order; however, prompt return to the supplier will allow timely service for your patient.

The Centers for Medicare & Medicaid Services (CMS) has a new policy for mobility assistive equipment (MAE) – walkers, canes, crutches, manual and power wheelchairs and power operated vehicles (commonly called “scooters”). This guide is designed to assist you in documenting the need for MAE. It also includes information about a new Medicare requirement for a face-to-face evaluation that must be done specifically for power mobility device.

Coverage of MAE will be considered if the equipment is necessary for a patient to perform their mobility-related activities of daily living (MRADLs). MRADLs include activities such as meal preparation, grooming, light housekeeping, toileting and feeding.

The evaluation of a patient with mobility deficits is a complex process. Often other modalities of treatment may ameliorate the need for MAE. The first question you should ask yourself is “Do I have the expertise necessary to evaluate and prescribe the appropriate therapy for this patient?” If you cannot answer “Yes” to this question, you should refer your patient to a rehabilitation professional. For certain groups of power wheelchairs (i.e., Group 2 rehab seat and higher), the Medicare policy requires an evaluation by a physical or occupational therapist or a physician with training and experience in rehabilitation wheelchair evaluations. Your medical equipment supplier can provide you with the names of qualified professionals in your area.

The following questions will assist you in making the right choice of equipment for your patient. Each step suggests elements of the patient’s history and physical examination that you should document in the medical record; however, the guide is not all-inclusive. Your documentation should be sufficient to:
• delineate the history of events that led to the request for the equipment;
• identify the mobility deficits to be corrected by the device ordered;
• establish that other treatments do not obviate the need for the device;
• establish that the beneficiary lives in an environment that supports the use of the equipment; and,
• establish that the beneficiary or caregiver is capable of using or operating the device ordered.

Step 1

Does the patient have limitations of mobility that impair his/her ability to participate in mobility-related activities of daily living (MRADLs) such as feeding, grooming, toileting, dressing, meal preparation, light housekeeping, and bathing either:

1. Entirely limited; or,
2. Can accomplish but with risk to safety; or,
3. Can accomplish but not within reasonable time

DOCUMENT: Either 1, 2 or 3 above PLUS any limiting symptoms such as dizziness, weakness, fatigue, pain, imbalance, past history of falls or potential for falls.

Step 2

Is the patient willing or does he/she have the cognition, judgment and/or vision to participate in mobility-related activities of daily living?

YES NO

If NO (cognition, judgment, visual impairment or other limitations exist), can mobility related activities of daily living (MRADLs) be accomplished

If YES, – Order Cane, crutch or walker.

DOCUMENT: If no, describe symptoms preventing use of this type of equipment. If NO, reconsider answer to Step 2 and consider a device operated by a caregiver (e.g., manual wheelchair).

Step 3

Will a cane or walker allow the patient to participate in MRADLs safely and in a timely manner?

YES NO

If YES, – Order Cane, crutch or walker.

DOCUMENT: If NO, describe symptoms preventing use of this type of equipment, including any safety-related issues such as history of, or potential for, falls or environmental barriers (e.g., thick carpet, high thresholds). Be specific.

Step 4

Considering a manual wheelchair, does the patient have sufficient trunk strength, hand grip, and upper extremity function, balance to sit upright, requires the ability to stand and pivot and may require more space in the home to maneuver. Given these requirements, in your assessment of this patient and their living environment, is a scooter appropriate?

YES NO

If YES, – Order Manual wheelchair.

DOCUMENT: At least one of the following elements:
• establish that the beneficiary lives in an environment that supports the use of the equipment; and,
• establish that the beneficiary or caregiver is capable of using or operating the device ordered.

Step 5

Scooter use requires a patient to have sufficient trunk strength, hand grip, and upper extremity function, balance to sit upright, requires the ability to stand and pivot and may require more space in the home to maneuver. Given these requirements, in their assessment of this patient and their living environment, is a scooter appropriate?

YES NO

If YES, – Order Scooter.

DOCUMENT: At least one of the following elements:
• establish that other treatments do not obviate the need for the scooter;
• identify the mobility deficits to be corrected by the scooter ordered;
• delineate the history of events that led to the request for the scooter;
• establish that the beneficiary lives in an environment that supports the use of the scooter.

Step 6

Considering a power wheelchair, does the patient have the functional ability to consistently access a drive control and the cognition, judgment, and visual ability to safely operate a power wheelchair to participate in MRADLs within the home environment?

YES NO

If YES, – Order power wheelchair.

If NO, reconsider answer to Step 2 and consider a device operated by a caregiver (e.g., manual wheelchair).

Maintenance all documentation in your patient’s medical record is critical in the event of audit by a 3rd party payer such as Medicare. In situations where you have referred your patient to another licensed professional, such as a physical therapist or occupational therapist, to perform part of the face-to-face evaluation, you must review their written report and state concurrence or disagreement with the evaluation’s findings. In cases where an outside evaluation has been performed, both your evaluation and that of the other licensed professional must be submitted to the supplier prior to their delivery of the device to your patient.
Although Medicare has created a myriad of new codes to describe the various types of power wheelchairs, they are categorized into 5 groups based on performance characteristics. The key to prescribing the proper wheelchair for your patient is a thorough assessment of the environment in which they will use their power wheelchair throughout the typical day. Is there a need to traverse curbs? Drive longer distances or climb steep inclines or ramps? These are all questions that are important to consider when prescribing a power wheelchair for your patient. Healthcare providers engaged in the evaluation and selection of a power mobility device should be aware that despite the changes to Medicare’s rules, there is still a Medicare requirement that the device be used “in the home.” Medicare views the performance of Group 4 devices to be primarily for use outside the home. Therefore, if a Group 4 device is provided, Medicare will reimburse based on a code that is medically appropriate for use in the home (i.e. Group 3 or Group 2). Note that other funding sources such as Medicaid or private insurers will consider reimbursement for both indoor and outside the home and provide coverage for devices categorized as Group 4 products. Questions about what product is appropriate for your patient should be addressed to a rehabilitation equipment specialist in your area. These rehab professionals can assist you in determining which power wheelchair best meets the needs of your patient.

Coding & Coverage

Basic Power Mobility Device (PMD) Coverage Criteria
Patient has mobility limitation that significantly impacts MRADL abilities
• Pneumata ability to accomplish
• Can’t accomplish safely
• Can’t accomplish in reasonable time
• Limitation not resolved by cane or walker
• Limitation not resolved by optimally configured manual wheelchair

All Power Operated Vehicles (POV)
Patient meets basic PMD coverage criteria and all below criteria. Patient able to:
• Transfer from bed to POV
• Operate tilt system
• Maintain postural stability while operating POV in home
• Patient weight is within limit of device
• Patient is willing to use POV

All Power Wheelchairs (PWC)
Patient meets basic PMD coverage criteria and all below criteria
• Patient does not meet coverage criteria for POV
• Patient or caregiver has ability to operate POV
• Home is accessible to PWC
• Patient weight is within limit of device
• PWC significantly improves MRADL participation
• Patient is willing to use PWC

Power Wheelchair Group 1
Coverage Criteria
• Patient meets basic coverage criteria for PMD AND
• Patient meets additional criteria for PWC

Power Wheelchair Group 2 Captains Seat & Rehab Seat
Coverage Criteria
• Patient meets basic coverage criteria for PMD AND
• Patient meets additional criteria for PWC

Power Wheelchair Group 2 Single Power Option
Coverage Criteria
• Patient meets Group 2 criteria AND
• Patient requires an alternate drive control interface OR
• Patient meets coverage criteria for a power tilt or power recline seating system AND
• Evaluation performed by PT, OT, Physician with specific training/experience in rehabilitation wheelchair evaluations

Power Wheelchair Group 3
Coverage Criteria
• Patient meets basic coverage criteria for PMD AND
• Patient meets additional criteria for PWC

Power Wheelchair Group 3 Single Power Option
Coverage Criteria
• Patient meets Group 3 criteria AND
• Patient meets coverage criteria for a power tilt or power recline seating system AND
• Evaluation performed by PT, OT, Physician with specific training/experience in rehabilitation wheelchair evaluations

Power Wheelchair Group 4
Coverage Criteria
• Patient meets Group 3 criteria AND
• Patient requires an alternate drive control interface OR
• Patient meets coverage criteria for a power tilt or power recline seating system AND
• Evaluation performed by PT, OT, Physician with specific training/experience in rehabilitation wheelchair evaluations

Power Wheelchair Group 5
Coverage Criteria
• Patient meets Group 5 criteria AND
• Patient uses a ventation which is mounted on the wheelchair OR
• Patient meets coverage criteria for power tilt or a power recline seating system AND
• Evaluation performed by PT, OT, Physician with specific training/experience in rehabilitation wheelchair evaluations

Power Wheelchair Group 5 Multiple Power Option
Coverage Criteria
• Patient meets Group 5 criteria AND
• Patient requires an alternate drive control interface OR
• Patient meets coverage criteria for a power tilt or power recline seating system AND
• Evaluation performed by PT, OT, Physician with specific training/experience in rehabilitation wheelchair evaluations

Performance Characteristics for PWC

Group 1
- Minimum Top End Speed: 3 mph
- Minimum Range: 5 miles
- Minimum Obstacle Climb: 20 mm
- Dynamic Stability Incline: 6 degrees

Group 2
- Minimum Top End Speed: 3 mph
- Minimum Range: 7 miles
- Minimum Obstacle Climb: 40 mm
- Dynamic Stability Incline: 6 degrees

Group 3
- Minimum Top End Speed: 4.5 mph
- Minimum Range: 12 miles
- Minimum Obstacle Climb: 60 mm
- Dynamic Stability Incline: 7.5 degrees

Group 4
- Minimum Top End Speed: 6 mph
- Minimum Range: 16 miles
- Minimum Obstacle Climb: 75 mm
- Dynamic Stability Incline: 9 degrees

Group 5
- Minimum Top End Speed: 4 mph
- Minimum Range: 12 miles
- Minimum Obstacle Climb: 40 mm
- Dynamic Stability Incline: 9 degrees
- Crash Testing: Passed

PWC Code Groupings
Group 1: K0813 - K0816
Group 2: K0820 - K0843
Group 3: K0848 - K0864
Group 4: K0868 - K0886
Group 5: K0890 - K0891

PWC Weight Capacity
PWC Weight Capacity

Group 2
- Group 2 Standard: ≤300 lbs
- Group 2 Heavy Duty: 301 - 450 lbs
- Group 2 Very Heavy Duty: 451 - 600 lbs
- Group 2 Extra Heavy Duty: >600 lbs

PWC Seating System

Captains Seat
Rehab Seat
Single Power Option
Multi Power Option
Portable/Non-Portable

Seating System/Power Options

Climb 75 mm, range 16 miles/charge...). Group 4 products billed to either Group 2 or Group 3, depending on which Group 2 or Group 3 coverage criteria are met.

Power Wheelchair Group 6
Coverage Criteria
• Patient meets basic coverage criteria for PMD AND
• Patient meets additional criteria for PWC

Power Wheelchair Group 7
Coverage Criteria
• Patient meets Group 2 criteria AND
• Patient requires an alternate drive control interface OR
• Patient meets coverage criteria for a power tilt or power recline seating system AND
• Evaluation performed by PT, OT, Physician with specific training/experience in rehabilitation wheelchair evaluations

Power Wheelchair Group 8
Coverage Criteria
• Patient meets Group 5 criteria AND
• Patient requires an alternate drive control interface OR
• Patient meets coverage criteria for a power tilt or power recline seating system AND
• Evaluation performed by PT, OT, Physician with specific training/experience in rehabilitation wheelchair evaluations

Power Wheelchair Group 9
Coverage Criteria
• Patient meets Group 5 criteria AND
• Patient requires an alternate drive control interface OR
• Patient meets coverage criteria for a power tilt or power recline seating system AND
• Evaluation performed by PT, OT, Physician with specific training/experience in rehabilitation wheelchair evaluations

Caretaker vs. Rehab Seat
Rehab seating for a PWC typically has a solid or sling seat and back and requires the use of a separate seat and/or back cushion. Patients that require seat or back cushioning but do not meet the criteria for a skin protection and/or positioning cushion are appropriate for a caretaker seat. Patients who need a skin protection and/or positioning cushion must meet the criteria outlined in the Wheelchair Seating policy

For skin protection:
Current pressure ulcer (707.03, 707.04, 707.05) or past history of a pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface OR Abnormal or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.3), other spinal cord disease (338.0-338.3), multiple sclerosis (340.0), demyelinating disease (341.0-341.9), central palsy (343.0-343.9), anterior horn cell disease including amyotrophic lateral sclerosis (333.0-333.9), post-polio syndrome (335.23-335.25), traumatic brain injury resulting in quadriplegia (344.09), spina bifida (741.00-741.93), childhood cerebral degeneration (330.03-330.9), Ataxia disease (331.0), Parkinson's disease (332.0).

For posturing:
The patient has any significant postural asymmetries that are due to one of the diagnoses listed in criterion 2a above or to one of the following diagnoses: monoplegia of the lower limb (340.30-340.32), hemiplegia (342.00-342.32), 438.20-438.22) due to stroke, traumatic brain injury, or other disorder, esophageal dysfunction (530.20-530.29), kyphoscoliosis (332.0-332.93), spina bifida (333.0-333.9), kyphoscoliosis (333.0-333.93), and hemiplegia (342.00-342.32), 438.20-438.22) due to stroke, traumatic brain injury, or other disorder, spinal cord injury resulting in paraplegia (344.00-344.3), other spinal cord disease (338.0-338.3), multiple sclerosis (340.0), demyelinating disease (341.0-341.9), central palsy (343.0-343.9), anterior horn cell disease including amyotrophic lateral sclerosis (333.0-333.9), post-polio syndrome (335.23-335.25), traumatic brain injury resulting in quadriplegia (344.09), spina bifida (741.00-741.93), childhood cerebral degeneration (330.03-330.9), Ataxia disease (331.0), Parkinson's disease (332.0).

Criteria for Power Tilt or Power Recline Seating System
The patient at high risk for development of a pressure ulcer (707.03, 707.04, 707.05) or in need to perform a functional weight shift OR the patient utilizes intermittent catheterization for bladder management AND is unable to independently transfer from the wheelchair to bed.

OR the power seating system is needed to manage increased tone, or spasticity.
It is critical that physicians understand the distinction between the National Coverage Decision (NCD) for Mobility Assistive Equipment and the Centers for Medicare & Medicaid Services (CMS) Final Rule for the face-to-face evaluation. These are two separate rules governing the provision of mobility assistive equipment. The NCD outlines the coverage criteria for all mobility assistive equipment – canes, crutches, walkers, power operated vehicles (POVs or “scooters”), manual and power wheelchairs. The Final Rule requiring a face-to-face examination and a 45 day timeline for providing the order and supporting documentation to the medical equipment supplier applies ONLY to power mobility devices – POVs and power wheelchairs.

For all mobility assistive equipment, the physician or treating practitioner must document the medical necessity for the item prescribed and why other treatments are not appropriate.

This follows the algorithmic approach or step-wise therapy common to many diagnostic and therapeutic considerations. For power mobility devices, CMS provides additional guidance for documenting critical elements of the face-to-face examination. The supporting documentation must 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. When providing this documentation to the medical equipment supplier, the physician or treating practitioner should select only those parts of the medical record that clearly demonstrate medically 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 equipment;
- Identify the mobility deficits to be corrected by the device ordered;
- Establish that other treatments do not obviate the need for the device;
- Establish that the beneficiary or caregiver is capable of using or operating the device ordered.

Basics of Documentation

- Consistency
  - “Mental image” of patient is consistent from document to document and physician to physician
- Ability for reviewers to infer need for item (e.g., history of stroke – reviewer might reasonably infer that it resulted in a neurologic deficit that would require the use of a cane or walker)
- Description of progression
  - Why a walker 6 months ago and now a power wheelchair? What changed?
  - Why a lower level device is not appropriate (Stepped Approach)

What Reviewers Are Looking For

- Quantifiable information about your patient’s mobility limitation(s) – strength, neurological impairment, range of motion limitations
- Description of time taken to accomplish mobility-related ADLs (MRADLs)
- Documentation of how co-morbid conditions impact ability to perform MRADLs such as:
  - Congestive Heart Failure
    - Shortness of Breath
  - Fatigue
  - Chest Pain with Exertion
- History of Stroke and the resultant neurologic or cognitive impairments
- Diabetes
  - Neuropathy
  - Peripheral Vascular Disease (claudication)
- Safety – History of falls, imbalance, coordination
- Compliance with Device Use and Willingness of Caregiver to Assist Beneficiary

Documentation

Canes, Crutches and Walkers - Document

- Documentation of sufficient upper extremity strength to use the device
- Description of coordination and balance necessary to safely ambulate in their home environment, taking into consideration floor coverings, thresholds and step/stairs
- If the patient has symptoms from co-morbid conditions such as congestive heart failure, diabetes or chronic obstructive pulmonary disease that affect endurance, are these described in quantifiable detail?
- Has a lower extremity condition such as osteoarthritis of the knees, paraplegia or weakness been documented, including the impact of these impairments on the use of one of these devices?

Manual Wheelchairs - Document

- Upper extremity function – Document strength, range of motion, sensory deficits
- Conditions affecting an upper extremity such as osteoarthritis of the shoulder, wrists or hands or carpal tunnel syndrome that preclude use of a cane, walker or manual wheelchair
- Quantifiable endurance (walks XX feet before becoming SOB) if symptoms from co-morbid conditions such as congestive heart failure, diabetes or chronic obstructive pulmonary disease cause selection of a higher level device.
- If some of these “softer” impairments exist (i.e., endurance factors), have other technologies such as a lightweight wheelchair or a manual wheelchair with power assist wheels been considered?

Power Operated Vehicles (“Scooters”) - Document

- Can the patient independently stand and pivot? This action is required to enter and exit a scooter safely.
- Does the patient have sufficient shoulder mobility, strength and coordination to use the tiller-type control used on a scooter?
- Does the patient have the trunk stability to sit in a seat without the need for external support? Most scooters have a captain’s seat style seating system.
- Many Scooters have a longer wheelbase than power wheelchairs, requiring more room for maneuverability. Consider your patient’s mobility needs within their home environment to determine whether a POV will meet your patient’s needs. The equipment supplier’s home environmental assessment may assist you in determining whether the patient’s home will accommodate a POV.

Power Wheelchairs – Document

- Clear evidence the beneficiary fails to meet any of the physical requirements necessary to utilize a lower level device
- Can the patient physically use a scooter but their home environment is unsuitable for such a device?
- Does the patient have the visual and/or eye-hand coordination skills necessary to operate a joystick-controlled device?

Documenting Progressive Diseases

Medicare will cover certain customized power wheelchairs and accessories for patients with definable progressive diseases such as amyotrophic lateral sclerosis (ALS) or multiple sclerosis (MS). This allows a patient to be approved for a power mobility device that has capabilities necessary in the near future (i.e., next 6-12 months) as a result of their disease progression. To qualify for coverage, the patient must have:

- A definable progressive disease
- Clearly documented disease progression in the medical records

- Near term (i.e., next 6-12 months) need for more advanced device or accessory

Medical equipment suppliers are healthcare professionals entrusted with providing care for your patient. If you have ordered the equipment or supplies as part of your patient’s treatment plan, providing records to the supplier in support of the medical necessity helps ensure that the treatment plan will be carried out. Confirming that the services provided to your patient meet payer guidelines is just one facet of the equipment supplier’s responsibility. Obtaining the clinical records that support medical necessity of the equipment, options and accessories ordered is inherent in this responsibility. Their business and ultimately, the care of your patient, depend on you.