



Medicare Payment for Documenting the Medical Necessity of Power-Operated Wheelchairs and Scooters

Medicare pays a fee to physicians to communicate to a durable medical equipment (DME) supplier that they certify that a patient needs a power-operated scooter or power wheelchair, a class of DME known as power mobility devices. The payment is for completing the form, not for completing the assessment of the patient.

Background

In August 2005, the Centers for Medicare and Medicaid Services (CMS) announced rules pertaining to Medicare coverage and payment for power mobility devices, including several changes from the previous rules. These changes:

- Allow all physician specialties, as well as physician assistants, nurse practitioners and clinical nurse specialists, to prescribe medically necessary power mobility devices. Before this change, only certain physician specialties—including physical medicine, orthopedic surgery, neurology and rheumatology—had the authority to prescribe these devices for Medicare patients.
- Require physicians and other treating practitioners to examine the patient face-to-face to evaluate the medical necessity of a power mobility device. Medicare pays physicians for that face-to-face examination through the appropriate evaluation and management (E/M) code for the level of service rendered.
- Require physicians to submit supporting medical record documentation, including documentation of the face-to-face examine, that justifies their written prescription. This new submission of medical record documentation requirement replaces the certificate of medical necessity (CMN) power mobility devices—physicians no longer have to submit this CMN form. CMS determined that CMN was not as effective as it was originally designed to be. The new requirement of submitting medical record copies as confirmation of medical necessity, which the physician already needs to maintain, avoids imposing a new paperwork burden. The CMS hopes that replacing the certificate of medical necessity submission requirement with both the face-to-face examination and documentation submission requirements will reduce fraudulent billing by DME suppliers. The new regulations prohibit suppliers from delivering power mobility devices to beneficiaries without receipt of a written prescription and supporting medical record documentation.

- Implement an add-on payment to reimburse physicians for the time and resources used to complete and submit the required medical record documentation to a DME supplier.

Billing Codes

Use Healthcare Procedure Coding System (HCPCS) code G0372 to bill for the time and resources used to complete and submit the required medical record documentation to DME suppliers. The code is defined:

G0372 - Physician service required to establish and document the need for a power mobility device (use in addition to primary evaluation and management code)

Physicians can report G0372 in addition to the E/M code for the actual face-to-face examination.

Medicare Payment

Payment for the G0372 is equal the physician fee schedule amount for the lowest level established patient office visit, Current Procedural Terminology (CPT) 99211.

In 2006, Medicare pays \$21.60 for code G0372. The payment rate represents the national average. Payment may vary slightly by area to reflect geographic differences.

Documentation

Physicians should submit all pertinent medical record information that clearly supports the medical necessity for a power mobility device to the DME supplier. According to the CMS, the progress note recorded during the face-to-face examination would serve as sufficient documentation of medical necessity in most cases. You must submit the supporting documentation, along with the written prescription, to the supplier within 30 days of the face-to-face examination.

Exceptions to the Face-to-Face Examination Requirement

The Medicare rules do allow exceptions to the face-to-face examination requirement. A beneficiary discharged from a hospital does not require a separate face-to-face examination if the physician that performed the face-to-face examination during the hospital stay issues the prescription and supporting documentation to the supplier within 45 days after the date of discharge. Also, the face-to-face examination is not required when the physician is only ordering accessories for power mobility devices.