



Group 2 Single Power Option PWCs (K0835 – K0840) and Group 2 Multiple Power Option PWCs (K0841 – K0843)

REQUIRED DOCUMENTATION

Standard Written Order (SWO):

NOTE: Power Mobility Devices (PMDs) require a standard written order prior to delivery (WOPD) for the base item. The WOPD for the base item may only be written after the completion of the face-to-face encounter requirements. The treating practitioner who completes the face-to-face requirements must be the same practitioner who writes the order/prescription for the PMD (base item).

Beneficiary's name or Medicare Beneficiary Identifier (MBI)

Order Date

General description of the item

The description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number

For equipment - In addition to the description of the base item, the SWO may include all concurrently ordered options, accessories or additional features that are separately billed or require an upgraded code (List each separately).

Quantity to be dispensed, if applicable

Treating Practitioner Name or NPI

Treating Practitioner's signature

Practitioner's signature meets **CMS Signature Requirements** for a legible identifier

The SWO for the power mobility device was written by the treating practitioner who conducted the face-to-face encounter

The SWO for the power mobility device was written after the completion of the face-to-face encounter requirements

The SWO for the power mobility device was received prior to delivery

The SWO for all options, accessories, and/or supplies that are separately billed in addition to the base was received prior to claim submission

The treating practitioner who reviews and signs the SWO for separately billable options, accessories, and/or supplies does not need to be the same treating practitioner who completed the WOPD for the PMD base and conducted the face-to-face encounter. In this situation, the treating practitioner who orders the options, accessories, and/or supplies must:

Verify that a qualifying face-to-face encounter occurred within 6-months prior to the date of the WOPD for the base item; and,

Have documentation of the qualifying face-to-face encounter that was conducted for the base item;

Review and sign their order.

Delivery Documentation

Beneficiary's name

Delivery Address

Quantity delivered

A description of the item(s) being delivered. The description can be either a narrative description (e.g., lightweight wheelchair base), a HCPCS code, the long description of a HCPCS code, or a brand name/model number.



Signature of person accepting delivery
Relationship to beneficiary
Delivery date

On-site Home Assessment

Includes information about the home’s physical layout, doorway widths, doorway thresholds, and floor surfaces
Rules out that the beneficiary has adequate access between rooms, maneuvering space and surfaces for the operation of a POV
Verifies that the beneficiary is able to use the wheelchair ordered to assist with MRADLs in the home
If the report notes that the beneficiary cannot access certain rooms necessary to accomplish their MRADLs with the wheelchair, there is an explanation of how that will be mitigated so the beneficiary can complete MRADLs
Date verifies that the home assessment occurred on or before the date the wheelchair was delivered
Signed or initialed by the person completing the assessment

Face-to-Face Medical Encounter

The evaluation was completed BEFORE the treating practitioner completed the SWO
The findings are documented in a detailed narrative note in the format used for other entries
The face-to-face encounter was conducted within six (6) months prior to the order date on the SWO for the PMD (base item).
The face-to-face was completed prior to wheelchair delivery

NOTE: To accommodate the requirements at 42 CFR 410.38, when the treating practitioner sees the beneficiary, regardless of whether a referral to an LCMP is made, that visit date starts the six (6) month timeline for completion of the SWO for the wheelchair base. If the treating practitioner chooses to refer the beneficiary to an LCMP for a mobility evaluation, the treating physician’s co-signature, dating and indicating agreement or disagreement with the LCMP evaluation must occur within this six (6) month timeframe. In cases where the LCMP evaluation is being adopted into the physician’s documentation to substantiate the need for the base item, the SWO may not be written until the LCMP report is signed, dated and agreement/disagreement indicated.

The note clearly indicates that a major reason for the visit was a mobility examination
Author’s signature meets **CMS Signature Requirements** (<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf>) for a legible identifier

The assessment includes information about the following (not all-inclusive, the exam should be tailored to the individual beneficiary):

- 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 beneficiary can walk without stopping
 - Pace of ambulation
 - What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used
 - What has changed to now requires 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 including arm and leg strength and range of motion
- Neurological examination including gait and balance and coordination

The face-to-face evaluation supports that the beneficiary's condition meets all LCD coverage criteria:

- The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) in the home
- Use of a power wheelchair will significantly improve the beneficiary's ability to participate in MRADLs in the home
- The mobility deficit cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker
- The beneficiary 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
- The beneficiary has a physical and/or mental limitation that prevents safe use of a POV in the home **and/or** the beneficiary's home provides inadequate access for operation of a POV
- The beneficiary has the mental and physical capabilities to safely operate the power wheelchair that is provided **or** the beneficiary 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
- The beneficiary's weight is less than or equal to the weight capacity of the PWC that is provided
- The beneficiary has not expressed an unwillingness to use a PWC in the home

Treating practitioner co-signed and dated any portion of the exam that was completed by an LCMP and stated concurrence or any disagreement with that examination

Group 2 Single Power Option PWC (K0835 – K0840) - Additional medical information requirements:

- The beneficiary requires a drive control interface other than a hand or chin-operated standard proportional joystick; **OR**
- The beneficiary meets coverage criteria for a power tilt **or** power recline seating system and the code for only one of these is listed on the SWO:
 - The beneficiary is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; **OR**
 - The beneficiary 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.

Group 2 Multiple Power Option PWC (K0841 – K0843) - Additional medical information requirements:

- The beneficiary uses a ventilator which is mounted on the wheelchair; **OR**
- The beneficiary meets coverage criteria for a power tilt **and** power recline seating system and the code for both of these is listed on the SWO:
 - The beneficiary is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; **OR**
 - The beneficiary 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.



Supplier Attestation Statement

File includes a signed statement from the supplier (or the LCMP) stating that there is no financial relationship between the LCMP(s) completing portions of the face-to-face examination and the supplier

ATTENTION!

Many suppliers have created forms which have not been approved by CMS which they send to practitioners and ask them to complete. Even if the practitioner 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. Suppliers are encouraged to help educate practitioners on the type of information that is needed to document a beneficiary's mobility needs.

The information that the supplier must obtain before submitting a claim to the DME contractor is described in detail in the Power Mobility Devices LCD and Policy Article. However, if the DME MAC or other Medicare Contractor asks for documentation on individual claims, additional documents (e.g., notes from prior visits, test reports, etc.) shall also be obtained from the treating practitioner to provide a historical perspective that reflects the beneficiary's condition in the continuum of care, corroborating the information in the face-to-face examination, painting a picture of the beneficiary's condition and progression of disease over time.

Specialty Evaluation

Performed by licensed/certified medical professional such as PT or OT or physician who has specific training and experience in rehabilitation wheelchair evaluations.

Documents the medical necessity for the wheelchair and its special features

Documents the beneficiary's seating and positioning needs

Provides detailed information explaining why each specific option or accessory is needed to address the beneficiary's mobility limitation

Person performing the evaluation has no financial relationship with the supplier

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Supplier ATP Appraisal

Copy of RESNA certificate or screen-print/printout of credential verification from RESNA website (<https://www.resna.org>) verifying that the supplier employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs

Evidence of "direct, in-person involvement" by the supplier's ATP in the selection of the wheelchair and accessories (e.g. evaluation conducted by the supplier's ATP clearly documented inclusion of the supplier's ATP name as an active participant in the specialty evaluation conducted by the treating practitioner or other LCMP)

REMINDERS

- All new rental series claims for HCPCS Codes K0813-K0829, K0835-K0843, and K0848-K0864 with a date of delivery on or after July 22, 2019 must be associated with a prior authorization request as a condition of payment.
- If the requirements related to a face-to-face examination have not been met, the GY modifier **must** be added to the codes for the wheelchair and all accessories.
- If the wheelchair that is provided is only needed for mobility outside the home, the GY modifier **must** be added to the codes for the item and all accessories.
- A KX modifier may be added to the code for a wheelchair and all accessories only if all of the coverage criteria have been met for the product that is provided.
- If the requirements for use of the KX modifier or GY modifier are not met, the GA or GZ modifier **must** be added to the code. When there is an expectation of a medical necessity



denial, suppliers **must** enter GA on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or GZ if they have not obtained a valid ABN.

- Claim lines billed without a KX, GA, GY, or GZ modifier will be **rejected** as missing information.
- Items with no physician or other licensed health care provider order must be submitted with an “EY” modifier added to each affected HCPCS code.

ONLINE RESOURCES

- **Power Mobility Web Resources**
 - **JB:** https://www.cgsmedicare.com/jb/mr/power_mobility_resources.html
 - **JC:** https://www.cgsmedicare.com/jc/mr/power_mobility_resources.html
- **Condition of Payment Required Prior Authorization Program**
 - **JB:** https://www.cgsmedicare.com/jb/mr/pmd_prior_auth.html
 - **JC:** https://www.cgsmedicare.com/jc/mr/pmd_prior_auth.html
- **Power Mobility Devices LCD and Policy Article**
 - **JB:** <https://www.cgsmedicare.com/jb/coverage/lcdinfo.html>
 - **JC:** <https://www.cgsmedicare.com/jc/coverage/lcdinfo.html>

DISCLAIMER

This document was prepared as an educational tool and is not intended to grant rights or impose obligations. This checklist may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either written law or regulations. Suppliers are encouraged to consult the *DME MAC Supplier Manual* and the Local Coverage Determination/Policy Article for full and accurate details concerning policies and regulations.