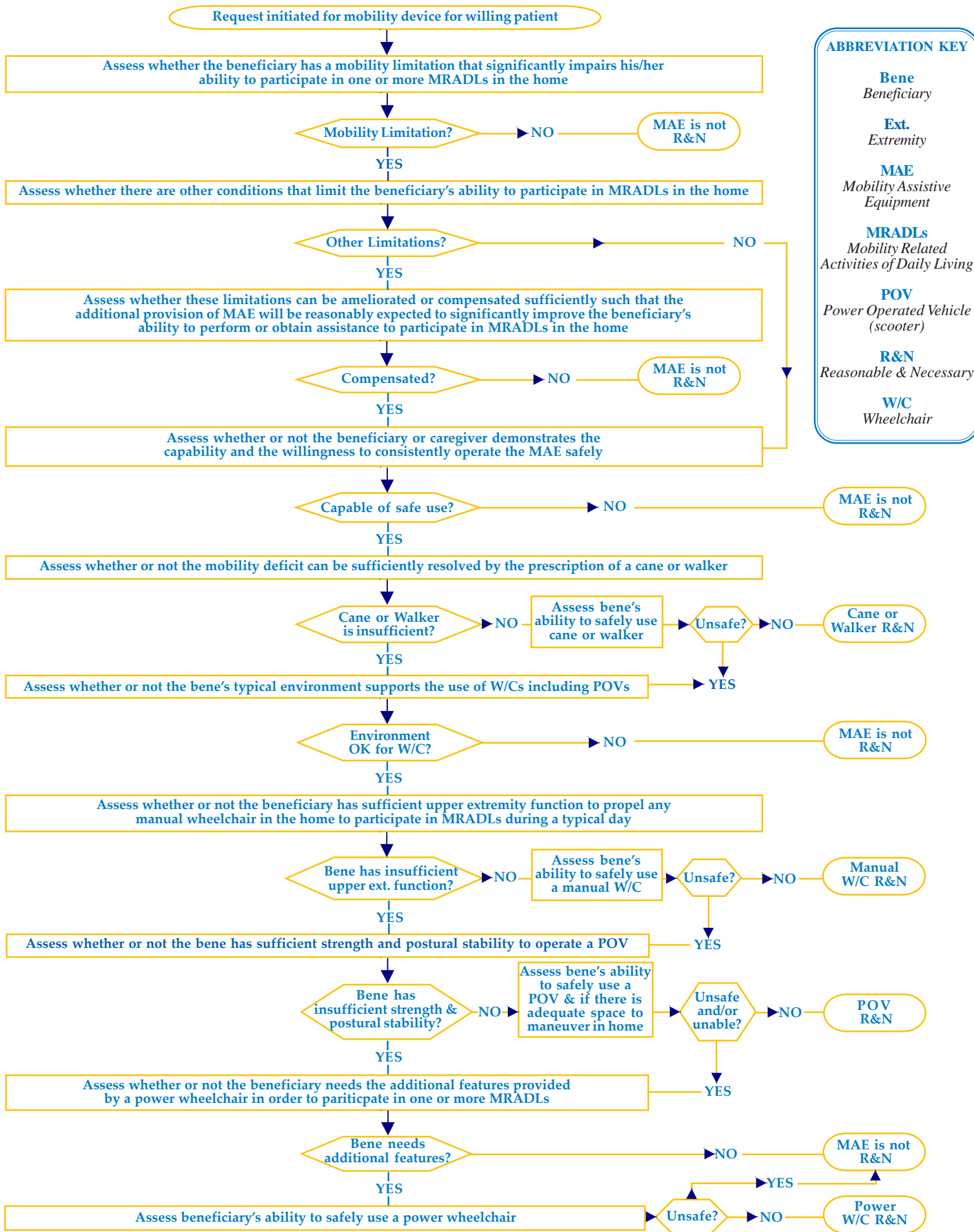


# Medicare's Clinical Criteria Algorithm For Prescribing Mobility Assistive Equipment



**ABBREVIATION KEY**

- Bene**  
Beneficiary
- Ext.**  
Extremity
- MAE**  
Mobility Assistive Equipment
- MRADLs**  
Mobility Related Activities of Daily Living
- POV**  
Power Operated Vehicle (scooter)
- R&N**  
Reasonable & Necessary
- W/C**  
Wheelchair

## Care Medical & Rehabilitation Equipment Is Your “Partner In Care”

Medicare has recently implemented changes to their documentation requirements for Mobility Assistive Equipment (MAE). The algorithm on the reverse side explains the specific points Medicare expects the medical record to address. The following are explanations of Medicare’s documentation requirements.

### THE HOME ASSESSMENT

Medicare any many other payers require an in-person home assessment be completed by either Care Medical Equipment or a medical professional. This assessment is intended to ensure that the recommended MAE will truly meet the patient’s needs “inside the home”. This could, for instance, be an opportunity to recognize that a patient needs to install a ramp to their front door or that a motorized wheelchair will turn from the hallway to the bedroom, but a scooter will not.

### THE MEDICAL RECORD

Many payers including Medicare require that the patient’s medical record contain as much documentation as needed to ensure that coverage criterion for an item has been met. The medical record may include: physician’s office records; hospital records; skilled nursing facility records; home health agency records; PT/OT records; other healthcare professional’s records; and test results (for example: x-rays, lab results, sleep study results, etc.). *It is important to note that the medical record does not include justifications written by the supplier.*

### THE FACE-TO-FACE EXAMINATION

Medicare requires that the physician complete an in-person physical examination and functional assessment of the patient. This examination may be completed by the physician alone or in conjunction with a Licensed/Certified Medical Practitioner (LCMP). An LCMP is typically a PT or OT with experience in mobility seating and positioning. In the case of a chronically progressive diagnosis (CHF, COPD, diabetes, etc.) this face-to-face examination may occur over the course of several physician visits. In the case of an acute diagnosis (SCI, CVA, amputation, etc.) this face-to-face examination may occur during the course of an in-patient hospitalization or skilled nursing facility stay. Components which Medicare requires to be present in the face-to-face examination include the following; however, each component would not necessarily need to be addressed in every evaluation:

#### ◆ Symptoms

#### ◆ Related Diagnoses

#### ◆ History

- How long the condition has been present
- Clinical progression
- Interventions that have been tried
- Other equipment that has been tried

#### ◆ Physical Exam

- Weight
- Impairments of strength, range of motion, sensation, coordination
- Presence of abnormal tone or deformity
- Neck, trunk, and pelvic posture and flexibility
- Sitting and standing balance

#### ◆ Functional Assessment

- Transferring between bed, chair, and PMD
- Walking around their home to bathroom, kitchen, living room

Many manufacturers and suppliers have created forms that have not been approved by CMS. These forms are sent to the physician with instructions to complete, sign and date. Even if the physician completes this type of form and puts it in his/her chart, the supplier-generated form is not a substitute for the face-to-face exam.

### THE DETAILED WRITTEN ORDER

Medicare requires multiple elements be present on the detailed written order. Some of these elements (procedure code, allowables, supplier’s charge) must be provided by Care Medical Equipment. Medicare also requires that Care Medical Equipment receive this detailed written order signed from the physician within **45-days** of the face-to-face examination.

### ADD-ON CODE G0372

Medicare recognizes that these new documentation requirements will be more costly to physicians; therefore, Medicare will pay \$22.60 in addition to the physician’s regular examination fee when billed under the add-on code G0372 (physician service required to establish and document need for a power mobility device).

*For further information or assistance, please contact your local  
Care Medical & Rehabilitation Equipment Representative*

[www.caremedical.com](http://www.caremedical.com)

