

DOCUMENTATION CHECKLIST

POVS: HCPCS CODES K0800 – K0802 AND K0812

REQUIRED DOCUMENTATION

7-Element Order

Personally completed (handwritten or electronic) by the physician/practitioner who completed the face-to-face requirements

Contains **ALL** of the following elements:

Beneficiary's name

Description of the item (may be general – e.g., “power mobility device” or may be more specific)

Date of completion of the face-to-face examination

Pertinent diagnoses/conditions that relate to the need for the power mobility device

Length of need

The prescribing physician/practitioner's signature

The date the prescription was written

Was received after completion of the face-to-face evaluation

A date stamp or equivalent documents the date the order was received from the physician

The order was received within 45 days after completion of the face-to-face exam (or 45 days after discharge if the examination was performed during a hospital or nursing home stay) and prior to delivering the POV to the beneficiary

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

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf>

Detailed Product Description

Specifies the order date

Includes a separate listing for the base and each option/accessory that is billed

Has sufficient detail (narrative description or brand name & model number) to verify correct coding

Signed and dated by physician

A date stamp or equivalent documents supplier's receipt date

Physician's signature meets CMS signature requirements for a legible identifier

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



Confirms 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 POV 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 POV, 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 POV was delivered

Signed or initialed by the person completing the assessment

Face-to-Face Medical Evaluation

The evaluation occurred BEFORE the physician completed the 7-element written order

The findings are documented in a detailed narrative note in the format used for other entries

The supplier received the written report of the face-to-face exam within 45 days after completion of the exam or 45 days after hospital/SNF discharge

The face-to-face was completed prior to POV delivery

The face-to-face contains a date stamp or equivalent documenting the supplier's receipt date

The note clearly indicates that a major reason for the visit was a mobility examination

Author's signature meets CMS signature requirements 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 POV 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 is able to safely transfer to and from a POV, operate the tiller steering system and maintain postural stability and position while operating the POV in the home

The beneficiary's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home

The beneficiary's weight is less than or equal to the weight capacity of the POV that is provided

The beneficiary has not expressed an unwillingness to use a POV in the home

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

Date stamp or equivalent documents date supplier received a copy of the face-to-face exam

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

REMINDERS

Many suppliers have created forms which have not been approved by CMS which they send to physicians and ask them to complete. Even if the physician 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 physicians 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 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 physician 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.

GROUP 2 POVs (K0806 – K0808)

Group 2 POVs have added capabilities that are not needed for use in the home. Therefore, if a Group 2 POV is provided it will be denied as not reasonable and necessary.

REMINDERS

- 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 POV and all accessories.
- If the POV 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 POV and all accessories only if all of the coverage criteria have been met for the product that is provided.



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- 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 Resources**

- **JB:** https://www.cgsmedicare.com/jb/mr/power_mobility_resources.html
- **JC:** https://www.cgsmedicare.com/jc/mr/power_mobility_resources.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.