BLACKBURN'S

REHAB

NEW MEDICARE POLICY AFFECTS MEDICAL RECORD DOCUMENTATION

WHAT EQUIPMENT IS AFFECTED BY THE NEW POLICY?

Canes	Scooters*
Walkers	Power Wheelchairs *
Manual Wheelchairs	*see reverse for power requirements

WHAT IS THE NEW POLICY?

The new policy replaces the previous Certificate of Medical Necessity (CMN) and relies soley on the medical record to justify the need for ordered equipment. There are two key components to the policy that must be documented in the medical record:

1. **Establish the Mobility Related Activity of Daily Living (MRADL)** that the patient needs the equipment to accomplish (Bed or Chair Confinement is no longer considered). Examples of MRADLs include, but are not limited to: toileting, feeding, dressing, grooming, bathing.

Medicare will cover the equipment for the patient to use OR for a caregiver to use in order to help the patient accomplish the MRADL. Please remember that Medicare will only cover the equipment for use IN THE HOME.

2. **Use Medicare's Algorithm** to determine the appropriate level of equipment. (see attached algorithm) Please document in the medical record that a lesser piece of equipment will not suffice due to one of the following:

   a. the patient is **NOT SAFE** using a lesser piece of equipment, or
   b. the patient cannot accomplish the MRADL within a **REASONABLE TIMEFRAME** using a lesser piece of equipment.

WHAT COMPRISES THE MEDICAL RECORD?

Physician Progress Notes	Discharge Planning Notes
Clinical PT Notes – OT Notes	Laboratory Notes
Home Health Clinical Notes	Hospital – Rehab Facility Notes
Pathology Reports	Skilled Nursing Facility Notes

WHAT ABOUT HIPAA?

As a supplier, BLACKBURN'S is required by Medicare to retain the portion of the medical record that corroborates the need for equipment ordered. HIPAA allows this action under the "covered entity" rule.

WHAT SHOULD BE INCLUDED IN AN ORDER?

Start date of order
Patient name
Address or Medicare Health Insurance Claim Number
Diagnosis
Specific Product
Length of Need
Physician PRINTED name
Physician signature and date

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POWER MOBILITY DEVICE (PMD) DOCUMENTATION REQUIREMENTS

FACE-TO-FACE EXAM

For a Scooter (POV) or Power Wheelchair (PWC) to be covered by Medicare, the physician or treating practioner must conduct a face-to-face exam with the patient and the supplier must receive the written order within 45 days of that exam.

EVALUATION PERFORMED BY PHYSICIAN OR TREATING PRACTITIONER

(physician assistant, nurse practitioner or clinical nurse specialist)

Medical Documentation to include:

Identified Mobility Related deficit
How the PMD will help achieve one or more of the Mobility Related Activities of Daily Living (MRADL)
MRADLs include, but are not limited to: toileting, grooming, dressing, feeding, bathing, etc.
Symptoms
Related Diagnoses
History
Height & Weight
How long the condition has been present
Clinical progression
Interventions that have been tried and the results
Past use of walker, manual wheelchair, POV or PWC and results

CLINICAL EVALUATION

If a physician is unable to determine and document all necessary information, a referral for an OT/PT Clinical Evaluation can be initiated to document need. PLEASE FAX ORDER FOR EVALUATION TO BE SCHEDULED.

Following the Clinical Evaluation, a copy of the Clinical Evaluation Report will be forwarded for the physician's review. The physician must note that he AGREES or DISAGREES with the outcomes and sign and date the report.

If a face-to-face exam was completed PRIOR to the Clinical Evaluation, the signed Clinical Evaluation Report with concurring statement must be forwarded to the supplier WITHIN 45 DAYS of the SIGNATURE DATE.

If a face-to-face exam WAS NOT COMPLETED PRIOR TO OR DURING the Clinical Evaluation, it must be completed following the evaluation, with all information forwarded to the supplier WITHIN 45 DAYS of the FACE-TO-FACE EXAM DATE.

PHYSICIANS CAN BILL WITH NEW "G" CODE

Code G0372 has been established to recognize the additional physician service and resources required to establish and document the need for PMDs. The new G code is only payable if all of the information necessary to document the PMD prescription is included in the medical record after a face-to-face examination of the beneficiary, and the prescription is received by the PMD supplier within 45 days after the face-to-face.

The Centers for Medicare and Medicaid Services (CMS) will pay an additional $21.60 above and beyond the standard office visit with use of the G0372 code.

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