

Rolling the Right Way: The Physician's Role In Wheelchair Prescription

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Ms. Rholing, a 45-year old mother of 2 with primary progressive multiple sclerosis, presented to the wheelchair clinic at Southern New England Rehabilitation Center for evaluation of her mobility status. Two years ago, with a prescription from her well-intentioned doctor, this unfortunate woman obtained a simple power chair that no longer meets her needs. Like 177,000 other Rhode Islanders, Ms. Rholing has Medicare as her primary insurer.¹ Due to her physician's lack of awareness of stringent Medicare guidelines and documentation requirements, she is now precluded from obtaining a new, more appropriate, wheelchair. In an era of advanced medical technology, wheelchair prescription remains a misunderstood and undervalued service. Had Ms. Rholing initially been evaluated at a wheelchair clinic by a team of experts including a physical therapist, an occupational therapist, and a qualified medical supplier, the outcome would have been much different. In this article we offer a model for a comprehensive wheelchair and mobility evaluation. Ideally, the evaluation should include:

- Medical history
- Current medical issues
- Psychosocial history, including architectural/community barriers
- Musculoskeletal structure/function
- Neurologic structure/function
- Postural assessment
- Functional mobility/activities of daily living
- Skin integrity/sitting tolerance
- Equipment history
- Trial of new equipment

Once this process is concluded, the therapists formulate a detailed letter of medical necessity, highlighting the required equipment and justification for each component. This letter is forwarded to the medical supplier and the referring physician for review and signature. Given the progressive nature of Ms. Rholing's diag-

nosis, a skilled clinic team would have prescribed an adaptable wheelchair with advanced electronics and seating options, capable of addressing the client's deteriorating functional capacities. Medicare expects that a wheelchair base will meet the client's needs for a minimum of five years. During that time, Medicare will reimburse upgrades but historically has not approved an entirely new seating system.

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With the latest Medicare documentation requirements for specialized manual and power wheelchairs, the burden of proof lies with the referring physician. These guidelines, intended to alleviate fraud and abuse, were implemented as a result of a 350% increase in Medicare payments for power wheelchairs from 1999-2003.² Last year, Medicare denied 80% of audited power wheelchair requests because of the lack of compliance with documentation requirements.³ For power mobility devices, like the one needed by Ms. Rholing, Medicare requires the following specific process for approval. The referring physician writes a prescription for a wheelchair assessment, which enables the client to attend a specialty seating and positioning clinic. After equipment recommendations are finalized, the referring physician must perform a face-to-face "mobility evaluation" to document the client's functional capabilities and challenges on a typical day.⁴ The report generated from this visit must reflect the following:

- Reasons why patient's current mobility equipment is no longer effective
- Impact of mobility limitations on **mobility-related activities of daily living (MRADL)** within the home
- Cognitive and physical capabilities to utilize the recommended power mobility device
- Rationale for why a less costly device (cane, walker, manual wheelchair, scooter) would not meet the client's needs⁵
- A statement that the physician has "reviewed and agrees with the PT/OT evaluation"

This equipment prescription process may seem tedious, but it is crucial in order to serve patients with a variety of disabilities. The level of detail outlining mobility limitations must be specific to the home environment. Medicare will not reimburse equipment necessary for use exclusively outside of the home.⁶ MRADLs are defined as toileting, feeding, grooming, dressing, and bathing.⁶ For instance, if the client is incontinent due to her inability to mobilize to the bathroom in a timely fashion, Medicare will approve an appropriate device. However, if the patient is functional within the home but limited with community mobility to access her pharmacy or grocery store, a request for a power mobility device of any type would be denied.

Medicare further requires the physician to complete a "seven element order" for the power mobility device.⁷ Many medical suppliers provide a template for the physician's convenience. This form can be completed quickly and easily by the doctor or office staff and must include: beneficiary's name, detailed description of device, date of completion of the face-to-face exam, diagnosis/conditions warranting the need for the mobility device, length of need (lifetime), physician's signature with NPI # and the date of physician's signature. Once the progress notes from the face-to-face exami-

nation, signed wheelchair clinic evaluation, and the seven element order are received by medical suppliers, they will send a "detailed written order" outlining the specific equipment recommendations, with associated HCPCS codes, to the physician for signature. All of this documentation is time-sensitive as the medical supplier only has 45 days to gather this information. It is therefore imperative that all requests for documentation are immediately completed and returned.

Once the physician's role is complete, the supplier must ensure that the prescribed equipment is medically necessary as outlined by Medicare guidelines, verifying that the documentation and justification are complete. The equipment is then ordered and delivered. The supplier bills for the equipment electronically, with coded item descriptions corresponding to equipment and filed documentation.⁸ Medicare cannot be billed until the user receives the equipment. Medicare also reserves the right to audit the patient's file at any time to verify supporting documentation, and may withdraw reimbursement from the supplier if guidelines are not met. Therefore the supplier, who cannot repossess the client's equipment, takes on a sig-

nificant financial risk in providing expensive power wheelchairs to clients without proper documentation or true medical need. Whether Medicare is the primary or secondary insurer, the same documentation requirements are necessary. Most other insurers are starting to follow these same guidelines. Unlike Medicare, other insurers will actually review the supporting documentation and issue a prior authorization, allowing the supplier to provide the equipment without risk.

The seating clinic at Southern New England Rehabilitation Center seeks to streamline the process for physicians and clients, ensuring that people like Ms. Rholing will receive the most appropriate and cost-effective wheelchair. At the outpatient clinic at Saint Joseph Hospital for Specialty Care, the PT and OT staff are Assistive Technology Professionals and have provided specialty evaluation services for seating and positioning for the past decade.

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Pediatric Rehabilitation Day Treatment For Children With Brain Injury and Neurodevelopmental Disorders

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The pediatric rehabilitation literature offers many studies on models of care for autistic children with medical, behavioral and psychiatric co-morbidities as well as adolescent brain injury victims with cognitive and physical impairments.^{1,2} This article describes a day treatment program at a comprehensive outpatient medical rehabilitation center specializing in neurological disorders. Sargent Rehabilitation Center has an adolescent **traumatic brain injury (TBI)** unit and a private day school for children with special needs who are diagnosed primarily with **autism spectrum disorder (ASD)**.

Legislative federal and state initiatives in maternal health, child care, and education have defined the need to develop community systems and delivery service

models for children with special needs, which includes TBI and ASD.^{3,4,5,6,7} Developing a continuum of care to address the severe problems of these children has challenged medical, psychosocial, rehabilitation, and education professionals. Likewise, selecting appropriate programs of service has challenged families, physicians, public/private referrers, and purchasers of service.

More than one million children in the US suffer closed head injuries annually, with acute and persistent impairments.⁸ With an incidence of ASD of 1 per 150 births, the prevalence of childhood autism in the US could reach 4 million in the next decade.⁹ Although school systems have traditionally not focused on rehabilitation, the continuum

of public and private programs should provide levels of care based on the severity of the condition.

PHILOSOPHY, FEATURES, AND THE PYRAMID OF TRANSITIONAL CARE

Sargent Rehabilitation Center's programs for children and young adults are offered six hours daily, 230 days a year. Both the TBI and ASD programs are located in specially equipped rehabilitation settings, with vocational training areas. Clients are treated as "whole persons" who live with their families in the community. The impact of a clinical problem will often arise or change with developmental stages. Care needs to be readily accessible, coordinated, and continuously provided by an experienced interdisciplinary team.