

# Medical Suppliers and Medicare Power Wheelchair Evaluation and Documentation



Physical therapists providing complex seating and wheeled mobility evaluations must have a high level of competency, and they require adequate time to determine the appropriate assistive technology and to complete the documentation required to support the recommendations. The purpose of a physical therapist providing the evaluation and making skilled recommendations is to best meet the specific needs of the individual and avoid recommending, providing, or billing for equipment that is not medically necessary or will not adequately meet the patient's needs. The physical therapist frequently works collaboratively with a multidisciplinary team including physicians, other health care providers, assistive technology professionals, the patient, and caregivers.

## Medical Suppliers Cannot Be Scribes

When you sign off on documentation, you are attesting that these are your notes, that the content is accurate, and that they reflect your clinical judgment.

APTA has been informed about concerns with a supplier's employed assistive technology professional acting as a scribe for the physical therapist during the specialty evaluation. An ATP is someone certified to analyze patient's need, help select the appropriate technology, and train the patient in its use. The Durable Medical Equipment Medicare Administrative Contractors (currently Noridian and CGS) prohibit an ATP from acting as the physical therapist's scribe, as there is an inherent conflict of interest. The supplier and the medical professional, in this case the ATP and the physical therapist, cannot have any financial relationship, and scribing for the physical therapist is providing in-kind value, which violates the MACs' local coverage determinations. This can also lead to a possible anti-kickback violation.

This isn't to say that organizations cannot have relationships with specific vendors; it's common practice. However, from an ethical perspective, any relationship you and your vendor have must be collaborative and unbiased by any incentives the vendor may provide. These include not only potential financial incentives but also the vendor's equipment-related expertise based on the clinical information you give them about patients' abilities, barriers to performance, and functional use of the wheelchair. You should not delegate recommendation decisions or writing the evaluation to the vendor; it is your ethical and professional responsibility to personally document and sign clinical evaluations and notes to ensure accuracy and regulatory compliance.

This means you should record the visit and mobility evaluation in your usual medical record-keeping format — not on a form that the supplier may provide. Those forms may create the impression that they are a sufficient record, but CMS requires more extensive documentation than the supplier-provided form typically includes. Deficient documentation may result in equipment denials or delays, which will impede your patient's progress and potential outcomes. A better idea is to collaborate with DME suppliers to get familiar with evaluation report language that accurately reflects your clinical judgment regarding the individual's status, needs, and abilities. See Mobility Device Clinical Documentation for more guidance.

## Support Your Evaluation of Medical Necessity

There are numerous CMS and other statutory and regulatory requirements that must be met to justify payment for a power mobility device, wheelchair options and accessories, and wheelchair seating.

The general documentation requirements for DMEPOS items include the following:

- Standard written order.
- Medical record information (including the patient's continued need and use, if applicable).
- Correct coding.
- Proof of delivery.

The DME MAC Local Coverage Article: Power Mobility Devices – Policy Article states that payment may not be made for a motorized or power wheelchair unless the treating practitioner (physician, physician assistant, nurse practitioner, or clinical nurse specialist) conducts the face-to-face encounter and writes the standard written order. The treating practitioner may have another qualified medical professional perform part of this encounter, such as a physical therapist who has experience and training in mobility evaluations. This person is not permitted to have a financial relationship with the supplier, unless the supplier is owned by a hospital in which the PT practices in the inpatient or outpatient hospital setting.

For a complete list of documentation requirements for these specific DME, see these articles in the CMS Medicare Coverage Database:

- [Local Coverage Article: Standard Documentation Requirements For All Claims Submitted to DME MACs.](#)
- [Local Coverage Determination: Power Mobility Devices.](#)
- [Wheelchair Options/Accessories – Policy Article.](#)

In addition, you can find guidance on completing the Certificate of Medical Necessity form in the [Medicare Claims Processing Manual Chapter 20 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies](#). Section 100.2.1(2) goes into detail about “Section B,” which may be completed by a nonphysician clinician but must be reviewed by the treating physician. This section includes components of the Certificate of Medical Necessity including the estimated length of need, diagnosis codes, and other clinical information regarding the client's condition.

## Stay Current

In addition to the sub-regulatory guidance found in the Medicare Manuals, you can stay up to date by reviewing the [National Coverage Determination for Mobility Assistive Equipment](#) and your DME MAC's LCDs and policy articles.

To access your specific LCD DME policies, perform a policy search within the [CMS Medicare Coverage Database](#) or refer directly to your MAC's website, where you may find more useful tools including checklists, FAQs, and resources issued for providers. See:

- [Noridian Power Mobility Devices](#)
- [CGS Power Mobility Resources](#)

CMS also provides a [Power Mobility Devices MLN Booklet](#).

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