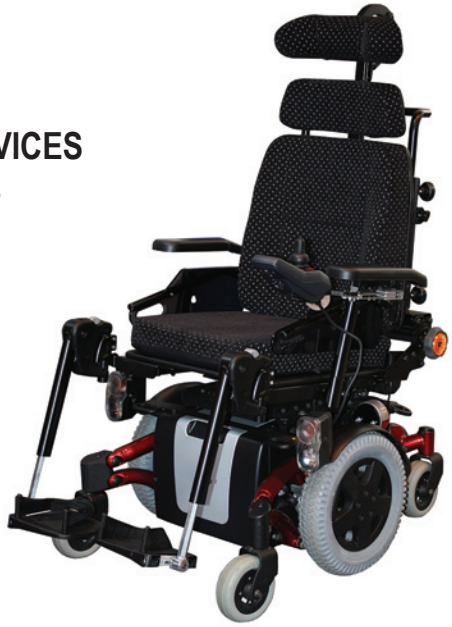
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official Information Health Care Professionals Can Trust



Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements

This fact sheet is designed to provide education on common Comprehensive Error Rate Testing (CERT) Program errors related to Power Mobility Devices (PMDs). It includes information on the documentation needed to support a claim submitted to Medicare for PMDs.

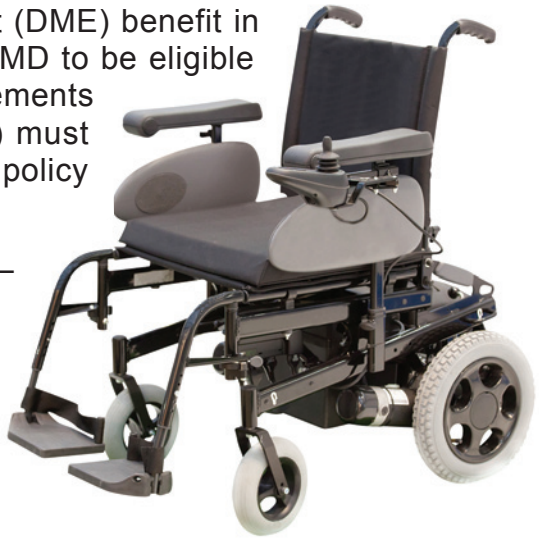
Please note:
The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

The Centers for Medicare & Medicaid Services (CMS) developed the CERT Program to produce a national Medicare Fee-For-Service (FFS) improper payment rate, as required by the Improper Payments Information Act of 2002, as amended by the Improper Payments Elimination and Recovery Improvement Act of 2012. CERT randomly selects a statistically valid, stratified sample of Medicare FFS claims and reviews those claims and related medical records for compliance with Medicare coverage, payment, coding, and billing rules.

To accurately measure the performance of the Medicare claims processing contractors and to gain insight into the causes of errors, CMS calculates a national Medicare FFS improper payment rate and improper payment rates by claim type. The results of these reviews are published annually. This report allows CMS to determine which areas of coverage are most commonly incorrectly billed or documented and create educational materials targeted at those areas. CMS strives to eliminate improper payments in the Medicare Program to maintain the Medicare Trust Fund while protecting patients from medically unnecessary services or supplies.

Overview

PMDs are covered under the Durable Medical Equipment (DME) benefit in the Social Security Act §1861(s)(6). For a beneficiary's PMD to be eligible for reimbursement, the reasonable and necessary requirements stated in related Local Coverage Determinations (LCDs) must be met. Additionally, there are specific statutory payment policy requirements that must also be met.



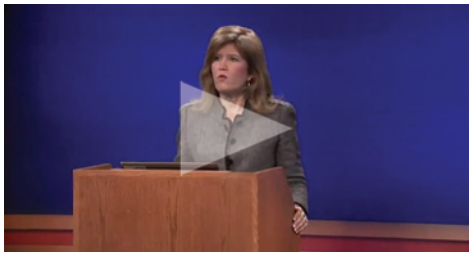
Power Operated Vehicles (POVs) – also known as scooters – and power wheelchairs (PWCs) are collectively classified as PMDs and covered under the Medicare Part B benefit. CMS defines a PMD as a covered DME item that a patient uses in the home. PMDs are part of a class of DME identified as Mobility Assistive Equipment (MAE), including a continuum of technology from canes to PWCs.

Important News for Certain Geographic Areas of the Country

Physicians, non-physician practitioners (NPPs), and suppliers need to know if they are in an area of the country affected by the following two programs applicable to PMDs.

Prior Authorization of PMDs Demonstration

The Medicare Fee-For-Service Prior Authorization of PMD demonstration implements a prior authorization process for POVs and PWCs for people with Medicare who reside in certain states.



Click the Image to Play Video

For more information, visit http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/PADemo.html on the CMS website. For the latest updates, search for the #pmddemonstration topic on https://twitter.com on the Internet. For a video about the demonstration and related documentation requirements, visit http://www.youtube.com/watch?v=I3jDwBDMwp0&feature=youtube or click the image on the left.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding

The Medicare Modernization Act of 2003 (MMA) established requirements for a Competitive Bidding Program for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas, and CMS awards contracts to enough suppliers to meet beneficiary demand for the bid items. For more information, visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid on the CMS website.

Basic Coverage Criteria for All PMDs

The patient must meet **all** of the following three basic coverage criteria, included in the DME MAC LCD, to meet medical necessity requirements:

1. The patient has a mobility limitation that significantly impairs his or her ability to participate in one or more Mobility-Related Activities of Daily Living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is a limitation that:
   - Prevents the patient from accomplishing an MRADL entirely or within a reasonable time frame; or
   - Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL;
2. The patient's mobility limitation cannot be resolved sufficiently and safely by using an appropriately fitted cane or walker; and
3. The patient 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;
   - Limitations of strength, endurance, range of motion or coordination, and presence of pain; or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function; and
   - An optimally configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories.

Additional Coverage Criteria Based on the Specific Type of PMD Provided

In addition to the basic coverage criteria described previously, depending on the type of PMD provided, the patient must meet the following criteria for Medicare to cover the PMD:

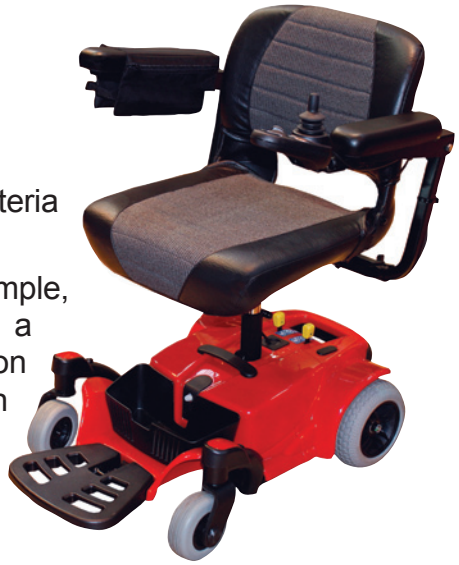
POVs

- The patient is able to:
  - Safely transfer to and from a POV;
  - Safely operate the tiller steering system; and
  - Maintain postural stability and position while operating the POV in the home;
- The patient's mental capabilities (for example, cognition and judgment) and physical capabilities (for example, vision) are sufficient for safe mobility using a POV in the home;
- The patient's weight is less than, or equal to, the weight capacity of the provided POV and greater than, or equal to, 95 percent of the weight capacity of the next lower weight class POV;
- The patient's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the provided POV;
- The patient's use of a POV will significantly improve his or her ability to participate in MRADLs. The patient will use the POV in the home; and
- The patient has not expressed an unwillingness to use a POV in the home.

PWCs

- The patient does **not** meet the coverage criteria for a POV;
- The patient's mental (for example, cognition and judgment) and physical capabilities (for example, vision) are sufficient to safely operate the provided PWC (or, if the patient is unable to safely operate the PWC, the patient's caregiver is available, willing, and able to safely operate the provided PWC but is unable to adequately propel an optimally configured manual wheelchair);
- The patient's weight is less than, or equal to, the weight capacity of the provided PWC and greater than, or equal to, 95 percent of the weight capacity of the next lower weight class of PWC;
- The patient's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the provided PWC;
- Using a PWC will significantly improve the patient's ability to participate in MRADLs and the patient will use the PWC in the home (for patients with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver);
- The patient has not expressed an unwillingness to use a PWC in the home; and
- Any coverage criteria pertaining to the specific wheelchair type are met.

PWCs Group 2 Single Power Option and Above



- The patient **meets** the coverage criteria for a PWC;
- The patient meets any specific wheelchair base coverage criteria listed in the LCD;
- A Licensed/Certified Medical Professional (LCMP) (for example, Physical Therapist [PT], Occupational Therapist [OT], or a physician with specific training and experience in rehabilitation wheelchair evaluations) must perform a specialty evaluation on the patient. The evaluation documents the medical necessity for the wheelchair and its special features. The PT, OT, or physician must not have any financial relationship with the supplier;
- A supplier that provides the wheelchair must employ a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified Assistive Technology Professional (ATP). The supplier must specialize in wheelchairs and have a direct, in-person relationship with the patient in selecting his or her wheelchair; and
- One of the following:
  - The patient requires a drive control interface other than a hand or chin-operated standard proportional joystick (for example, head control, sip and puff, switch control); **or**
  - The patient meets coverage criteria for a power tilt or a power recline seating system, and the system is being used on the wheelchair.

NOTE: All four DME MACs offer voluntary Advanced Determination of Medicare Coverage (ADMC) of customized PMDs to determine in advance of delivery of an item whether payment for a PMD may be made.

Common CERT Errors

Supporting documentation is essential for Medicare coverage. The provider and supplier must work together to ensure all documentation is correct and meets coverage guidelines. A provider must provide the supplier with documentation of:

- A face-to-face examination;
- A written prescription (7-element order);
- A receipt of the records of the face-to-face examination; and
- Consideration of other items of MAE.

Most often, the CERT Program identifies issues with meeting PMD coverage documentation requirements. Table 1 provides information about common PMD errors and methods for preventing the errors.

Table 1. Common Pitfalls Leading to PMD Documentation Errors

Mistake	How to Prevent
Invalid or Incomplete 7-Element Order	Always write orders that contain all 7 elements: 1. Patient's name; 2. Description of item that is ordered. This description may be general (for example, "power operated vehicle," "power wheelchair," or "power mobility device") or more specific; 3. Date of completion of the face-to-face examination; 4. Pertinent diagnoses/conditions that relate to the need for a PMD; 5. Length of need; 6. Physician/NPP's signature; and 7. Date of physician/NPP's signature. **NOTE:** The supplier must use a date stamp or equivalent to document the receipt date.
Incomplete Progress Notes – Missing Clinical Information Example A: Progress note fails to document that the beneficiary's **mobility needs could not be met with an optimally configured manual wheelchair (or by a cane, walker, wheeled walker, or POV)**. Example B: Progress note fails to document the need for **any mobility aid**.	Always fully document **why** the beneficiary's mobility needs could not be met with an optimally configured manual wheelchair or other mobility aid. Checking "no" on a template is not sufficient information.
Incomplete Progress Notes – Missing Technical Requirement Example A: Progress note is missing a signature. Example B: Progress note is missing a date.	Always sign and date progress notes.
Physician chooses to use an LCMP to assist in completing the face-to-face examination but the submitted documentation fails to include a signed and dated **attestation that the LCMP has no financial relationship with the supplier**.	Always submit the financial attestation with the initial additional documentation request (ADR).

NOTE: The prior authorization demonstration aims to reduce the number of PMD documentation errors. For more information on how to correct a mistake using the prior authorization demonstration process, refer to "Common Pitfalls to Avoid in PMD Prior Authorization Requests (PAR)" at http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/CommonPitfallsinPMDPARs_v3_08282012.pdf on the CMS website.

Required Face-to-Face Examination and Documentation

Payment will only be made for a PMD when a Medicare-enrolled physician* (M.D. or D.O.) or NPP* (physician assistant, nurse practitioner or clinical nurse specialist) has completed and documented the following statutory requirements:

- Conducted a face-to-face examination of the patient; and
- Written a prescription (7-element order) for the item prior to delivery of the PMD to the patient.

* For more information on authorized providers, refer to the Medicare Learning Network® (MLN) Matters® Article MM8239, "Denial for Power Mobility Device (PMD) Claim from a Supplier of Durable Medical, Orthotics, Prosthetics, and Supplies (DMEPOS) When Ordered By a Non-Authorized Provider" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8239.pdf on the CMS website.

Face-to-Face Examination

A **face-to-face examination** must be conducted by the ordering physician/NPP **before** the prescription (7-element order) is written and must consist of:

- An **in-person visit** between the ordering physician/NPP and the patient that includes the reason for the visit was a mobility examination. This visit must document the decision to prescribe a PMD; and
- A **medical evaluation** performed by the ordering physician/NPP. The evaluation must clearly document the patient's functional status with attention to conditions affecting the patient's mobility and his or her ability to perform MRADLs within the home. This may be done all, or in part, by the ordering physician/NPP. If all or some of the medical examination is completed by another medical professional, the ordering physician/NPP must sign off on the report and incorporate it into his or her records.

The physician/NPP may refer the patient to an LCMP, such as a PT or OT who has experience and training in mobility evaluations, to perform part of the face-to-face examination. LCMPs should clearly document all information and include it as part of the complete medical record to sufficiently demonstrate medical need.

If the patient was referred by the LCMP before visiting the physician/NPP, then once the physician/NPP has received and reviewed the written report of this examination, the physician/NPP must see the patient and perform any additional examination that is needed. The report of the visit must state concurrence or any disagreement with the LCMP examination. In this situation, the physician/NPP must provide the supplier with a copy of both examinations. The PT, OT, or physician/NPP may have no financial relationship with the supplier.

Table 2 indicates what questions the face-to-face examination should answer.

Table 2. Summary of Face-To-Face Examination

Type of PMD	Face-To-Face Examination Should Answer…
POVs and PWCs	What is this patient's mobility limitation and how does it interfere with the performance of activities of daily living?
POVs and PWCs	Why can't a cane or walker meet this patient's mobility needs in the home?
POVs and PWCs	Why can't a manual wheelchair meet this patient's mobility needs in the home?
POVs	Does this patient have the physical and mental abilities to transfer into a POV and to operate it safely in the home?
PWCs	Why can't a POV (scooter) meet this patient's mobility needs in the home?

Documentation of the Face-to-Face Examination

The face-to-face examination should be tailored to the individual patient's conditions. **The medical history should contain a well-documented description of your patient's functional abilities and limitations on a typical day. It should contain as much objective data as possible.** The physical examination should focus on the body systems that cause the patient's ambulatory difficulty or impact the patient's ambulatory ability. While the physician/NPP should fully evaluate the patient during the face-to-face examination, note that not all elements listed may apply to every patient. Professional discretion is necessary to determine if these items are required as part of the face-to-face examination.

Do not record the information from the physical examination in vague and subjective terms (for example, weak, breathless, tired), but instead, provide quantifiable, objective measures or tests of the abnormal characteristic (for example, range of motion, manual muscle test scores, heart rate/respiratory rate/pulse oximetry). Each medical record must be individualized to the unique characteristics of the patient. Include in **all** physical examinations a detailed description of the patient's **observed** ability or inability to transfer and/or walk.

The face-to-face examination must be relevant to the patient's mobility needs and include the following elements:

- History of present condition and relevant past medical history, including:
  - Signs/symptoms that limit ambulation;
  - Diagnoses responsible for these signs/symptoms;
  - Medications or other treatment for these signs/symptoms;
  - Progression of ambulation difficulty over time;

- Other diagnoses that may relate to ambulatory problems;
- Distance the patient can ambulate without stopping and with what assistive device (for example, cane, walker);
- Pace of ambulation;
- History of falls, including frequency, circumstances leading to falls, what ambulatory assistance (for example, cane, walker, wheelchair) is currently used, and why it is not sufficient;
- What changed in the patient's condition that now requires a PMD;
- Reason for inability to use a manual wheelchair, such as assessment of upper body strength;
- Reason the patient needs a PWC rather than successive levels of MAE (for example, cane, walker, optimally configured manual wheelchair, POV) and reasons that the patient should not or could not use a cane, walker, optimally configured manual wheelchair, or POV in the home to satisfy his or her needs; and
- Description of the home setting, including the ability to perform MRADLs in the home, as well as the ability to use the PMD in the home; and

- Physical examination relevant to mobility needs, including:
  - Height and weight;
  - Trunk stability (sitting/standing);
  - Cardiopulmonary examination; and
  - Musculoskeletal examination, including arm and leg strength and range of motion; and
- Neurological examination, including:
  - Gait;
  - Balance and coordination; and
  - If the patient is capable of walking, a documented observation of ambulation (with use of a cane or walker as appropriate).

NOTE: For more information on the face-to-face examination, a sample checklist for the face-to-face examination, and examples of insufficient and sufficient documentation, refer to the MLN Matters® Special Edition Article SE1112, "Power Mobility Device Face-to-Face Examination Checklist" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1112.pdf on the CMS website.

NOTE: The face-to-face examination is not required when ordering only accessories for PMDs.

CAUTION

Many suppliers create forms which are sent to physicians/NPPs who are then asked to complete them. Even if the physician/NPP 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.

Written Prescription (7-Element Order)

The treating physician/NPP must write a prescription (7-element order) for a PMD **after** the face-to-face examination that includes the following seven elements:

1. Patient's name;
2. Description of item that is ordered. This description may be general (for example, "power operated vehicle," "power wheelchair," or "power mobility device") or more specific;
3. Date of completion of the face-to-face examination;
4. Pertinent diagnoses/conditions that relate to the need for a PMD;
5. Length of need;
6. Physician/NPP's signature; and
7. Date of physician/NPP's signature.

This must be a handwritten or an electronic signature. Stamp signatures are acceptable in limited situations. For more information, refer to "Complying with Medicare Signature Requirements" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf on the CMS website.

Documentation Provided to Supplier

In addition to prescribing the PMD, the physician/NPP must provide the supplier with supporting documentation of the face-to-face examination and the written prescription (7-element order) within 45 days of the completion of the face-to-face examination. This documentation should include portions of the medical record that support medical necessity for the PMD in the patient's home. The medical record must contain sufficient information to show that the coverage criteria for a PMD are met. This information must directly relate to the patient's use of a PMD.

Detailed Written Product Description: Physician/NPP Signature

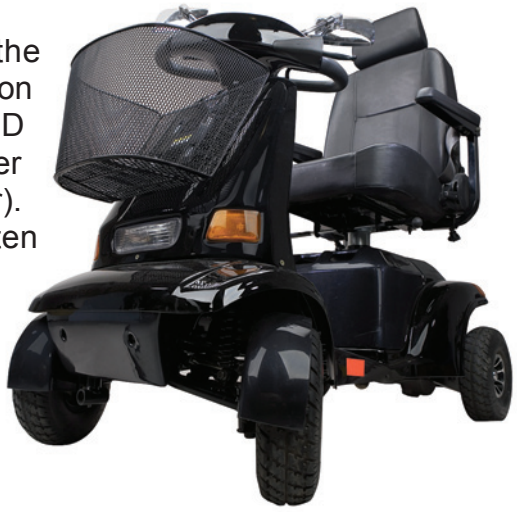
Once the supplier determines the power mobility device that is appropriate for the patient based on the order, the supplier must prepare a written detailed product description and **the treating physician/NPP must review, sign, and date** the description.

Required Supplier Documentation

For Medicare to cover a PMD, the supplier must have the following documentation:

- The **written prescription (7-element order)** accompanied by supporting documentation:
  - Within 45 days of a face-to-face examination by the treating physician, or discharge from a hospital or nursing home; and
  - Before delivering the PMD;
- The **detailed product description**;
- **Home assessment** documented in a written report; and
- **Proof of delivery**.

Written Prescription (7-Element Order)



A PMD **cannot** be delivered based on a verbal order. If the supplier delivers the item prior to getting the written prescription (7-element order), Medicare will deny the claim for the PMD as "noncovered." Payment will not occur even if the supplier subsequently gets the written prescription (7-element order). The supplier should document the date on which the written order was received.

Detailed Product Description

Once the **supplier** determines the power mobility device that is appropriate for the patient based on the order, the supplier must prepare a written detailed product description that needs to contain the following information:

- Specific Healthcare Common Procedure Coding System (HCPCS) codes for base and all options and accessories that will be separately billed;
- Narrative description of the items;
- Manufacturer name and model name/number;
- Physician/NPP signature and date signed; and
- Date stamp to document receipt date.

NOTE: After the supplier completes the detailed product description, the treating physician/NPP must review, sign, and date it.

Home Assessment

The supplier must complete a home assessment at, or prior to, delivery. It must:

- Verify that the patient can adequately maneuver the device, considering:
  - Physical layout;
  - Doorway width;
  - Doorway thresholds; and
  - Surface; and
- Be documented in a written report.

Proof of Delivery

- The patient must sign a delivery ticket;
- The supplier must provide a copy of the supplier's standards to the patient for review; and
- The delivery of the PMD must be within 120 days following completion of the face-to face examination;
  - **EXCEPTION:** For PWCs that go through the ADMC process and receive an affirmative determination, the delivery must be within 6 months following the determination.

Billing

- The date of service on the claim must be the date the supplier furnishes the PMD to the patient; and
- The supplier must keep the patient's signature, authorizing submission of a Medicare claim, on file.

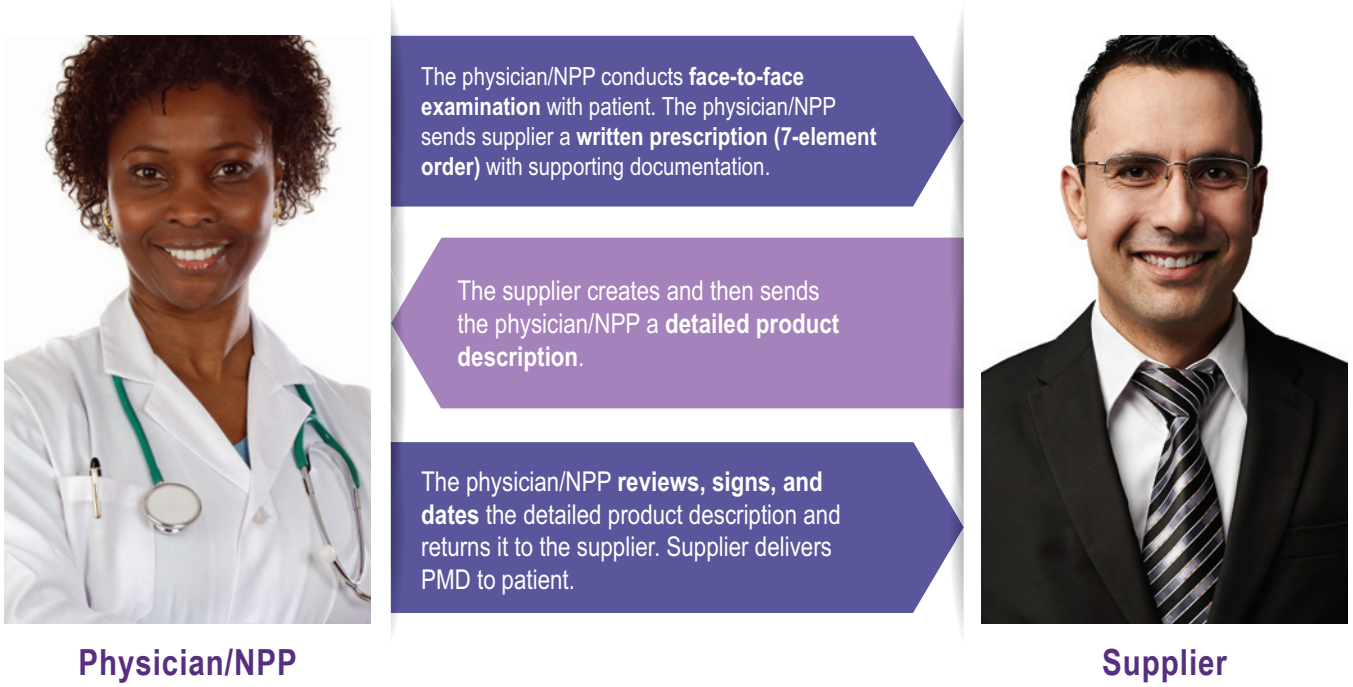
Documentation Submission

- Upon request, suppliers must submit to CMS, or its agents, the PMD prescription (7-element order) and supporting documentation received from the treating physician/NPP; and
- If requested, suppliers must also submit documentation to support medical necessity, which may include physician office records, hospital records, nursing home records, home health agency records, records from other health professionals, and test reports.

Physician/NPPs and suppliers should contact the DME MAC for coverage instructions related to specific items.

The physician/NPP and the supplier must work together to ensure a patient's PMD is covered by Medicare. Figure 1 shows how the physician/NPP may cooperate.

Figure 1. Physician/NPP and Supplier



Patient Costs

PWCs

Medicare pays for the PWC on a rental basis for up to 13 months. On the first day after the 13th rental month, the supplier must transfer the equipment title to the patient. For complex, rehabilitative PWCs (for example, PWCs with power seating systems and/or special controls needed by patients who cannot use a standard joystick control), the supplier must offer the patient the option to obtain the item on a lump sum purchase basis when the item is initially furnished. If the patient does not elect the purchase option, the supplier is paid based on the capped rental rules.

The patient may choose to get a replacement PWC, if medically necessary, when the current PWC has been used continuously for 5 years. For certain patient-owned equipment, such as a PWC for which the title transferred to the patient after 13 continuous months of rental, the supplier must replace the equipment free of charge if it does not last the full 5-year period (that is, it is no longer serviceable or needs substantial repairs). This replacement equipment does not need to be "new." For more information, refer to 42 Code of Federal Regulations (CFR) Section 414.210(e)(4) at http://www.gpo.gov/fdsys/pkg/CFR-2013-title42-vol3/pdf/CFR-2013-title42-vol3-sec414-210.pdf on the Internet.

POVs

Patients can rent or purchase a POV. If they choose a rental option, the supplier retains ownership of the POV, and Medicare limits its total rental payments to the purchase price. Therefore, if the patient needs the POV for an extended period, purchase is a preferable option. The patient may choose to get a replacement POV, if medically necessary, when the POV has been used continuously for 5 years.

Patient Costs Summary

Table 3 summarizes the patient costs for purchasing or renting a PWC or POV.

Table 3. Summary of Patient Costs

If the patient...	Then Medicare Part B pays...*	And the patient pays...**
Chooses to purchase the PWC, if applicable, or POV…	80% of the allowed purchase price in one lump sum payment…	20% of the allowed purchase price.
Chooses to rent the PWC…	80% of the allowed rental price for months 1 through 13…	20% of the allowed rental charge.
Chooses to rent the POV…	80% of the allowed rental price. Total Medicare payments cannot exceed 80% of the allowed purchase price…	20% of the allowed rental charge.

* The Medicare payment is based on 80% of the allowed amount minus any unmet Part B deductible.

** Patient costs increase when obtaining wheelchairs from suppliers that do not accept assignment.

NOTE: If the patient is enrolled in a Medicare Advantage (MA) Plan, the patient needs to contact the MA Plan to determine the costs and coverage. The MA Plan may also require preauthorization and have a limited number of participating DME suppliers.

NOTE: If the PWC or POV is purchased, Medicare pays 80 percent of the allowable service and maintenance charge each time the equipment is actually serviced.

Resources

DME MACs serving Jurisdictions A, B, C, and D provide detailed education in a variety of formats including: self-paced online tutorials, supplier manuals, podcasts, video education, and webinars. Each DME MAC jurisdiction staffs a Regional CERT Coordinator who can assist you with various CERT-related questions and/or concerns, such as:

- General CERT information;
- Detailed review results of a CERT claim;
- Explanation of a CERT-related overpayment;
- How to request a review of a CERT overpayment;
- Clarification of the type of documentation requested by CERT; and
- Explanation of why you continue to receive request letters for medical records when you already submitted the documentation.

For more information about PMD requirements, refer to your DME MAC LCD. Additional information is included in the DME MAC's Supplier Manual. You can find DME MAC jurisdiction, website addresses, and Regional CERT Coordinator contact information in Table 4.

Table 4. Website Addresses and Regional CERT Coordinators for Each DME MAC

Jurisdiction	Website Address	Regional CERT Coordinator
Jurisdiction A: NHIC, Corp.	http://www.medicarenhic.com/dme	Alina Jimenez 323-432-7840 alina.jimenez@hp.com
Jurisdiction B: National Government Services (NGS)	http://www.ngsmedicare.com/ngs/portal/ngsmedicare/welcome	Stacie McMichel 317-841-4612 Stacie.McMichel@wellpoint.com
Jurisdiction C: CGS	http://www.cgsmedicare.com/jc	Brenda Normandia 615-782-4485 Brenda.Normandia2@cigna.com
Jurisdiction D: Noridian Healthcare Solutions, LLC	https://www.noridianmedicare.com/dme	Jennifer Huber 701-433-3064 jennifer.huber@noridian.com and Melissa Gordon 701-433-3092 melissa.gordon@noridian.com

For more information on Medicare PMD coverage, refer to the resources listed in Table 5.

Table 5. Resources

Resources	Website and Description
CMS Internet-Only Manual, "Medicare Claims Processing Manual" (Publication 100-04), Chapter 20	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf The "Medicare Claims Processing Manual" describes basic billing requirements. Chapter 20 focuses on DME billing.
Medicare Coverage Database	http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx The Medicare Coverage Database permits searching of National Coverage Determinations (NCDs), LCDs, and DME MAC provider education articles regarding coverage policies.
MLN Guided Pathways (GPs)	The MLN GPs help providers gain knowledge on resources and products related to Medicare and the CMS website. For more information applicable to you, refer to the section about your provider type in the "MLN Guided Pathways: Provider Specific Medicare Resources" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website. For all other GPs, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Guided_Pathways.html on the CMS website.
MLN Products	http://go.cms.gov/MLNProducts The MLN Products web page provides a complete listing of all national educational products related to provider compliance, including CERT.
Power Mobility Device (PMD) Demonstration Operational Guide	The purpose of the "Power Mobility Device (PMD) Demonstration Operational Guide" is to interpret and clarify the documentation responsibilities for Medicare participating suppliers and providers when ordering a PMD for Medicare beneficiaries in the PAR Demonstration area. http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/PMD_DemonstrationOperationalGuide_v15_04242013.pdf
Provider Compliance	For more information about provider compliance, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html on the CMS website, or scan the Quick Response (QR) code on the right with your mobile device.

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This fact sheet was prepared as a service to the public and is not intended to grant rights or impose obligations. This fact sheet 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 the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

The Medicare Learning Network® (MLN), a registered trademark of CMS, is the brand name for official information health care professionals can trust. For additional information, visit the MLN's web page at http://go.cms.gov/MLNGenInfo on the CMS website.

Your feedback is important to us and we use your suggestions to help us improve our educational products, services and activities and to develop products, services and activities that better meet your educational needs. To evaluate Medicare Learning Network® (MLN) products, services and activities you have participated in, received, or downloaded, please go to http://go.cms.gov/MLNProducts and in the left-hand menu click on the link called 'MLN Opinion Page' and follow the instructions. Please send your suggestions related to MLN product topics or formats to MLN@cms.hhs.gov.

Check out CMS on: