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Mobility Assistive Equipment

Funding Guide

Per Medicare guidelines, the provision of mobility assistive equipment (MAE) is complex and involves multiple components that must be completed in order to qualify a patient for coverage and reimbursement. This guide is intended to assist healthcare providers by providing an overview of those components – coverage, coding and documentation. It is NOT a substitute for the policy itself and should only be relied upon as a quick-reference guide. Healthcare providers should acquaint themselves with the actual policy in order to obtain a thorough understanding of the Medicare rules and regulations governing mobility assistive equipment. Medicare's policy for mobility assistive equipment can be found on the Centers for Medicare & Medicaid Services web site at www.cms.hhs.gov/mcd/search.asp

Search by:

- Local Coverage _ Articles (All Articles) & Policies (LMRP/LCD) _ All States
- Keyword Search = Power Mobility (search "title", "all words")

You may also contact your local DME provider or Medicare Part B Contractor (MAC) at: http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml to provide you with copies of the current medical policies.

The Centers for Medicare & Medicaid Services (CMS) has a specific policy regarding mobility assistive equipment (MAE)– walkers, canes, crutches, manual and power wheelchairs and power operated vehicles (commonly called "scooters"). This guide is designed to assist you in documenting the need for MAE. It also includes information about the Medicare requirement for a face-to-face evaluation that must be done specifically for all power mobility devices.

Coverage of MAE will be considered if the equipment is necessary for a patient to perform their mobility-related activities of daily living (MRADLs). MRADLs include activities such as meal preparation, grooming, light housekeeping, toileting and feeding.

The following questions will assist you in making the right choice of equipment for your patient. Each step suggests elements of the patient's history and physical examination that you should document in the medical record; however, the guide is not all-inclusive. Your documentation should be sufficient to

- delineate the history of events that led to the request for the equipment;
- identify the mobility deficits to be corrected by the device ordered;
- establish that other treatments do not obviate the need for the device;
- establish that all other types of lower level equipment have been tried and cannot meet medical needs due to specific documented reasons;
- establish that the beneficiary lives in an environment that supports the use of the equipment; and,
- establish that the beneficiary or caregiver is capable of using or operating the device ordered.

Evaluation

NOTE: *This set of questions should NOT be used as your patient's only medical record. Your normal reporting method must be used to document and support your responses.*

STEP 1 If you are considering a PMD for your patient, Medicare does require an in-office face-to-face visit between you and your patient specifically addressing the patient's mobility needs. A more thorough mobility evaluation may be completed by another medical professional (more details follow). Your prescription (also known as the 7-element order) must be written AFTER the in-person visit has occurred and the mobility evaluation is completed. The following steps will assist in the process.

STEP 2 Does the patient have limitations of mobility that impair his/her ability to participate in mobility related activities of daily living (MRADL) such as feeding, grooming, toileting, dressing, meal preparation, light housekeeping, and bathing either:

1. Entirely limited; or,
2. Can accomplish but with risk to safety; or,
3. Can accomplish but not within reasonable time

DOCUMENT: *Either 1, 2 and/or 3 above as related to their diagnoses and condition; PLUS any limiting symptoms such as dyspnea, weakness, fatigue, pain, imbalance, past history of falls or potential for falls.*

STEP 3 Is the patient willing or does he/she have the cognition, judgment and/or vision to safely participate in mobility related activities of daily living?

❑ YES ❑ NO

If NO (cognition, judgment, visual impairment or other limitations exist), can mobility related activities of daily living be accomplished with the assistance of a caregiver (e.g., caregiver pushing patient in wheelchair)?

❑ YES ❑ NO

If NO, STOP – Review better options to meet your patient's medical needs

DOCUMENT: *Any impairments requiring caregiver assistance for mobility.*

STEP 4 Will a cane or walker allow the patient to participate in MRADLs safely and in a timely manner within the home?

❑ YES ❑ NO

If YES, STOP – Order cane, crutch or walker

DOCUMENT: *If NO, describe symptoms preventing use of this type of equipment, including any safety-related issues such as recent history of, or potential for, falls or environmental barriers (e.g., thick carpet, high thresholds). Be specific to the individual patient.*

STEP 5 Considering a manual wheelchair, does the patient have sufficient upper extremity and/or lower extremity strength or the endurance necessary to self-propel an optimally configured manual wheelchair? (Optimally configured means lightest weight, proper wheelbase, appropriate axle position, etc)

❑ YES ❑ NO

If YES, STOP – Order the appropriate manual wheelchair

DOCUMENT: *If NO, describe symptoms preventing use of a manual wheelchair. You do not need to describe symptoms that are the same as those precluding use of a cane, crutch or walker. Just state "See above".*

STEP 6 Considering a POV/Scooter, does the patient have sufficient trunk strength, hand grip, upper extremity function, balance to sit upright, and the ability to stand and pivot? And, does the patient have enough room in their home to maneuver? Given these requirements, in your assessment of this patient and their living environment, is a scooter appropriate?

❑ YES ❑ NO

If YES, STOP – Order Scooter

DOCUMENT: *If NO, describe the reason why a scooter is not an appropriate device to meet your patient's medical needs. Be specific.*

STEP 7 Considering a power wheelchair, does the patient have the functional ability to consistently access a drive control and the cognition, judgment, and visual ability to safely operate a power wheelchair to participate in MRADLs within the home environment?

❑ YES ❑ NO

If YES, STOP – Order power wheelchair

If NO, reconsider answer to Step 2 and consider a device operated by a caregiver (e.g. manual wheelchair).

Once your office visit evaluation is completed (and if applicable, you have reviewed a specialist seating evaluation) you will determine what, if any, MAE is required to meet yor patient's medical needs within the home. If you're considering a power mobility device, a specific order (also known as the 7-element order) must be received by the equipment supplier, along with the documentation from your face-to-face evaluation and any other pertinent medical information supporting the prescription, within 45 days after the full mobility evaluation is completed. (Exception: If the evaluation is performed during a hospital or nursing home stay, the supplier must receive the order and documentation within 45 days after discharge.) When providing this documentation to the medical equipment supplier, you should select only those parts of the medical record that clearly demonstrate medical necessity for the power mobility device.

Prescription

THE ORDER FOR MOBILITY EQUIPMENT MUST CONTAIN ALL OF THE FOLLOWING 7 ELEMENTS:

- ❑ Beneficiary name
- ❑ Description of the item ordered – This may be stated in general terms, such as "power wheelchair", "manual wheelchair", or may be detailed, such as manufacturer name and model.
- ❑ Date of the face-to-face evaluation (only required if a power mobility device is ordered)
- ❑ Pertinent diagnoses/conditions relating to the need for the equipment ordered
- ❑ Length of need
- ❑ Physician printed name and signature
- ❑ Date of physician signature

After this order is completed, the supplier will send you a detailed prescription outlining the specific device and any options/accessories determined to be necessary for your patient and that will be separately billed to Medicare. This detailed order must be reviewed, signed by you and returned to the supplier before the equipment can be dispensed to your patient.

Physicians may bill Medicare for the power mobility device face-to-face evaluation through the appropriate evaluation and management (E&M) code corresponding to the history and physical examination of the patient. In addition, in order to recognize the additional physician work related to the documentation, CMS has established an add-on G-code (G0372) that will be paid at a rate equal to the physician fee schedule relative values established for a level 1 office visit for an established patient (CPT Code 99211). The E&M and G-codes must be billed on the same claim.

Use of code G0372 signifies that:

- All of the information necessary to document the power mobility device prescription is included in the medical record; and,
- The prescription, along with the supporting documentation, has been received by the power mobility device supplier within 45 days after the face-to-face examination.

Maintaining all documentation in your patient's medical record is critical in the event of audit by a 3rd party payer such as Medicare.

In situations where you have referred your patient to a licensed medical professional, such as a physical therapist or occupational therapist with experience in seating and positioning wheelchair evaluations, to perform part of the face-to-face evaluation, you must review their written report and state concurrence or disagreement with the evaluation's findings. In cases where an outside evaluation has been performed, both your evaluation and that of the other licensed professional must be submitted to the supplier prior to their delivery of the device to your patient.

NOTE: *If you choose to refer your patient to another medical professional experienced in seating and positioning, and if you complete your face-to-face examination prior to the specialist evaluation, the date you sign the specialist's report is considered to be the date of completion of the face-to face examination (used on the prescription/7-Element for the PMD).*

Healthcare providers engaged in the evaluation and selection of all types of mobility devices should be aware that the key to Medicare coverage is medical need "in the home." Medicare views the performance of certain devices to be primarily for use outside the home. Therefore, these devices (i.e. Group 4 PWCs) can only be provided to Medicare patients (and some other insurers) as a patient-selected upgrade the item their insurer deems as medically appropriate for use in the home (i.e. Group 3 or Group 2).

Note that other funding sources consider needs both inside and outside the home and provide coverage for devices categorized as Group 4 products. Questions about what product is appropriate for your patient should be addressed to a rehabilitation equipment specialist in your area. These rehab professionals can assist you in determining which power wheelchair best meets the needs of your patient.

PWC Code Groupings		PWC Weight Capacity		Seating System/Power Options
Group 1	K0813- K0816	Standard	<300 lbs.	Captains Seat
Group 2	K0820 - K0843	Heavy Duty	301 - 450 lbs	Rehab Seat
Group 3	K0848 - K0864	Very Heavy Duty	451 - 600 lbs	Single Power Option
Group 4	K0868 - K0886	Extra Heavy Duty	>601 lbs	Multi Power Option
Group 5	K0890 - K0891			Portable/Non-Portable

Coding & Coverage of PMDs

BASIC POWER MOBILITY DEVICE (PMD) COVERAGE CRITERIA

Patient has mobility limitation that significantly impairs MRADL abilities.

- Prevents ability to accomplish
- Can't accomplish safely
- Can't accomplish in reasonable time
- Limitation cannot be resolved by cane or walker
- Limitation cannot be resolved by optimally configured manual wheelchair
- Home is accessible for PMD
- PMD significantly improves participation in MRADLs

ALL POWER OPERATED VEHICLES (POV)

Patient meets basic PMD coverage criteria and all below criteria. Patient able to:

- Transfer to/from POV
- Operate tiller system
- Maintain postural stability while operating POV in home
- Patient weight is within limit of device
- Patient is willing to use POV

ALL POWER WHEELCHAIRS (PWC)

Patient meets basic PMD coverage criteria and all below criteria.

- Patient does not meet coverage criteria for POV
- Patient or caregiver has ability to operate PWC
- Patient weight is within limit of device
- Patient is willing to use PWC

CAPTAIN VS. REHAB SEAT

Rehab seating for a PWC typically has a solid or sling seat and back and requires the use of a separate seat and/or back cushion. Patients that require seat or back cushioning but do not meet the criteria for a skin protection and/or positioning cushion are appropriate for a captains seat. Patients who need a skin protection and/or positioning cushion must meet the criteria outlined in the Wheelchair Seating policy.

For skin protection:

Current pressure ulcer (707.03, 707.04, 707.05) or past history of a pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface OR Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1), other spinal cord disease (336.0-336.3), multiple sclerosis (340), other demyelinating disease (341.0-341.9), cerebral palsy (343.0-343.9), anterior horn cell diseases including amyotrophic lateral sclerosis (335.0-335.21, 335.23-335.9), post polio paralysis (138), traumatic brain injury resulting in quadriplegia (344.09), spina bifida (741.00-741.93), childhood cerebral degeneration (330.0-330.9), Alzheimer's disease (331.0), Parkinson's disease (332.0).

For positioning:

The patient has any significant postural asymmetries that are due to one of the diagnoses listed in criterion 2b above or to one of the following diagnoses: monoplegia of the lower limb (344.30-344.32, 438.40-438.42) or hemiplegia (342.00-342.92, 438.20-438.22) due to stroke, traumatic brain injury, or other etiology, muscular dystrophy (359.0, 359.1), torsion dystonias (333.4, 333.6, 333.71), spinocerebellar disease (334.0-334.9).

CRITERIA FOR POWER TILT OR POWER RECLINE SEATING SYSTEM

The patient is at high risk for development of a pressure ulcer AND is unable to perform a functional weight shift; OR the patient utilizes intermittent catheterization for bladder management AND is unable to independently transfer from the wheelchair to bed; OR the power seating system is needed to manage increased tone or spasticity.

POWER WHEELCHAIR GROUP 1, GROUP 2 CAPTAINS SEAT & REHAB SEAT

Coverage Criteria

- Patient meets basic coverage criteria for PMD
  AND
- Patient meets additional criteria for PWC

POWER WHEELCHAIR GROUP 2 SINGLE POWER OPTION (TILT OR RECLINE)

Coverage Criteria

- Patient meets Group 2 criteria
  AND
- Patient meets coverage criteria for a power tilt or a power recline seating system
  OR
- Patient requires an alternate drive control interface
  AND
- Evaluation performed by a medical professional with specific training/experience in complex rehabilitation wheelchair evaluations*

POWER WHEELCHAIR GROUP 2 MULTIPLE POWER OPTION (TILT OR RECLINE)

Coverage Criteria

- Patient meets Group 2 criteria
  AND
- Patient meets coverage criteria for 2 or more power seating systems
  OR
- Patient uses a ventilator which is mounted on the wheelchair
  AND
- Evaluation performed by a medical professional with specific training/experience in complex rehabilitation wheelchair evaluations*

POWER WHEELCHAIR GROUP 3

Coverage Criteria

- Patient meets basic coverage criteria for PMD
  AND
- Patient meets additional criteria for PWC
  AND
- Patient limitation due to neurologic, myopathic or congenital skeletal abnormality
  AND
- Evaluation performed by a medical professional with specific training/experience in complex rehabilitation wheelchair evaluations*

POWER WHEELCHAIR GROUP 3 SINGLE POWER OPTION (TILT OR RECLINE)

Coverage Criteria

- Patient meets Group 3 criteria
  AND
- Patient meets coverage criteria for a power tilt or a power recline seating system
  OR
- Patient requires an alternate drive control interface
  AND
- Evaluation performed by a medical professional with specific training/experience in complex rehabilitation wheelchair evaluations*

POWER WHEELCHAIR GROUP 3 MULTIPLE POWER OPTION (TILT OR RECLINE)

Coverage Criteria

- Patient meets Group 3 criteria
  AND
- Patient meets coverage criteria for 2 or more power seating systems
  OR
- Patient uses a ventilator which is mounted on the wheelchair
  AND
- Evaluation performed by a medical professional with specific training/experience in complex rehabilitation wheelchair evaluations*

POWER WHEELCHAIR GROUP 4

Coverage Criteria– NONE

Medicare considers Group 4 devices to have additional capabilities that are not necessary for use within the home (e.g. speed 6 mph, curb climb 75 mm, range 16 miles/charge...). Group 4 products billed to Medicare– standard (captain's and sling/rehab seat, single power option, multi-power option and all weight ranges) will be denied. If your patient chooses, and any of their other funding sources allow, they can upgrade to this type of PWC. This could mean they will have additional out-of-pocket expenses.

POWER WHEELCHAIR GROUP 5 (PEDIATRIC PWCS)

Coverage Criteria

- Patient meets basic coverage criteria for PMD
  AND
- Patient meets additional criteria for PWC
  AND
- Patient is expected to grow, and weight is ≤ 125 lbs
  AND
- Evaluation performed by PT, OT, Physician with specific training/experience in rehabilitation wheelchair evaluations*

POWER WHEELCHAIR GROUP 5 SINGLE POWER OPTION (TILT OR RECLINE)

Coverage Criteria

- Patient meets Group 5 criteria
  AND
- Patient meets coverage criteria for a power tilt or a power recline seating system
  OR
- Patient requires an alternate drive control interface
  AND
- Evaluation performed by a medical professional with specific training/experience in complex rehabilitation wheelchair evaluations*

POWER WHEELCHAIR GROUP 5 MULTIPLE POWER OPTION (TILT OR RECLINE)

Coverage Criteria

- Patient meets Group 5 criteria
  AND
- Patient meets coverage criteria for 2 or more power seating systems
  OR
- Patient uses a ventilator which is mounted on the wheelchair
  AND
- Evaluation performed by a medical professional with specific training/experience in complex rehabilitation wheelchair evaluations*

* AND a certified ATP employed by the medical equipment supplier must be a part of the wheelchair selection process.

It is critical that physicians understand the distinction between the National Coverage Decision (NCD) for Mobility Assistive Equipment and the Centers for Medicare & Medicaid Services (CMS) Final Rule for the face-to-face evaluation. These are two separate rules governing the provision of mobility assistive equipment. The NCD outlines the coverage criteria for all mobility assistive equipment – canes, crutches, walkers, power operated vehicles (POVs or "scooters"), manual and power wheelchairs. The Final Rule requiring a face-to-face examination and a 45 day timeline for providing the order and supporting documentation to the medical equipment supplier applies ONLY to power mobility devices – POVs and power wheelchairs.

For ALL mobility assistive equipment, the physician or treating practitioner must document the medical necessity for the item prescribed and why other treatments are not appropriate. This follows the algorithmic approach or step-wise therapy common to many diagnostic and therapeutic considerations. Per Medicare guidelines, you "should record your visit and mobility evaluation in your usual medical record-keeping format". For power mobility devices, CMS provides additional guidance for documenting critical elements of the face-to-face examination. The supporting documentation must include pertinent parts of the medical record that clearly support the medical necessity for the PMD in the beneficiary's home, which may include the history, physical examination, diagnostic tests, summary of findings, diagnoses, and treatment plans. It may also include information from other examinations, as well as relevant reports from other consultants and practitioners. When providing this documentation to the medical equipment supplier, the physician or treating practitioner should select only those parts of the medical record that clearly demonstrate medically necessity for the PMD.

Documentation

THE PARTS OF THE MEDICAL RECORD SELECTED SHOULD BE SUFFICIENT TO:

- ❑ Delineate the history of events that led to the request for the equipment;
- ❑ Identify the mobility deficits to be corrected by the device ordered;
- ❑ Establish that other treatments do not obviate the need for the device;
- ❑ Establish that all other types of lower level equipment have been tried and cannot meet medical needs due to specific documented reasons;
- ❑ Establish that the beneficiary lives in an environment that supports the use of the equipment; and,
- ❑ Establish that the beneficiary or caregiver is capable of using or operating the device ordered.

BASICS OF DOCUMENTATION

- Consistency
  - "Mental image" of patient is consistent from document to document and physician to physician
- Understand that the reviewers are not allowed to infer medical need. The clinical documentation must clearly support the need for each individual patient.
- Description of progression
  - Why a walker 6 months ago and now a power wheelchair? What has changed clinically?
  - Why a lower level device is not appropriate (Stepped Approach)

WHAT REVIEWERS ARE LOOKING FOR

- Quantifiable information about your patient's mobility limitation(s) – strength, neurological impairment, range of motion limitations
- Description of time taken to accomplish mobility-related ADLs (MRADLs)
- Documentation of how co-morbid conditions impact ability to perform MRADLs such as:
  - Congestive Heart Failure
    - Shortness of breath
    - Fatigue
    - Chest pain with exertion
  - History of Stroke and the resultant neurologic or cognitive impairments
  - Diabetes
    - Neuropathy
    - Peripheral Vascular Disease (claudication)
- Safety – History of falls, imbalance, coordination
- Compliance with device use and willingness of caregiver to assist beneficiary

CANES, CRUTCHES AND WALKERS

- Documentation of sufficient upper extremity strength to use the device.
- Description of coordination and balance necessary to safely ambulate in their home environment, taking into consideration floor coverings, thresholds and steps/ramps
- If the patient has symptoms from co-morbid conditions such as congestive heart failure, diabetes or chronic obstructive pulmonary disease that affect endurance, are these described in quantifiable detail?
- Has a lower extremity condition such as osteoarthritis of the knees, paraplegia or weakness been documented, including the impact of these impairments on the use of one of these devices?

MANUAL WHEELCHAIRS

- Upper extremity function – Document strength, range of motion, sensory deficits
- Conditions affecting an upper extremity such as osteoarthritis of the shoulder, wrists or hands or carpel tunnel syndrome that preclude use of a cane, walker or manual wheelchair
- Quantifiable endurance (walks XX feet before becoming SOB) if symptoms from co-morbid conditions such as congestive heart failure, diabetes or chronic obstructive pulmonary disease cause selection of higher level device.
- If some of these "softer" impairments exist (i.e., endurance factors), have other technologies such as an ultra-lightweight wheelchair or a manual wheelchair with power assist wheels been considered?

POWER OPERATED VEHICLES ("SCOOTERS")

- Can the patient independently stand and pivot? This action is required to enter and exit a scooter safely.
- Does the patient have sufficient shoulder mobility, strength and coordination to use the tiller-type control used on a scooter?
- Does the patient have the trunk stability to sit in a seat without the need for external support? Most scooters have a captain's seat style seating system.
- Many scooters have a longer wheelbase than power wheelchairs, requiring more room for maneuverability. Consider your patient's mobility needs within their home environment to determine whether a POV will meet your patient's needs. The equipment supplier's home environmental assessment may assist you in determining whether the patient's home will accommodate a POV.

POWER WHEELCHAIRS

- Clear evidence the beneficiary fails to meet any of the physical requirements necessary to utilize a lower level device
- Can the patient physically use a scooter but their home environment is unsuitable for such a device?
- Does the patient have the visual and/or eye-hand coordination skills necessary to operate a joystick-controlled device?

Medical equipment suppliers are healthcare professionals entrusted with providing care for your patient. If you have ordered the equipment or supplies as part of your patient's treatment plan, providing records to the supplier in support of the medical necessity helps insure that the treatment plan will be carried out. Confirming that the services provided to your patient meet payor guidelines is just one facet of the equipment supplier's responsibility. Obtaining the clinical records that support medical necessity of the equipment, options and accessories ordered is inherent in this responsibility. Their business and ultimately, the care of your patient, depend on you.

The following is a list of diagnoses and their corresponding ICD-9 codes for Group 3 PWCs. Please note that this list is not all-inclusive. In addition, the presence of a specific diagnosis in and of itself does not guarantee coverage of a power mobility device. Providers should document the manifestations of the disease that result in the patient's inability to accomplish their MRADLs and meet the coverage criteria for the specific device contemplated.

Group 3 Reference ICD-9 CODES

COMMON NEUROLOGIC CONDITIONS

Alzheimer's disease 331.0
Anterior horn cell disease 335
Anterior horn cell disease nos 335.9
Amyotrophic lateral sclerosis 335.20
CNS demyelination nec 341.8
CNS demyelination nos 341.9
Cerebral Palsy
- Congenital diplegia 343.0
- Congenital hemiplegia 343.1
- Congenital quadriplegia 343.2
- Congenital monoplegia 343.3
- Infantile hemiplegia 343.4
- Cerebral palsy nos 343.9

Cerebellar Ataxia other 334.3
Cerebral Lipidosis 330.1
Cerebral degeneration child 330.3
Cerebellar degeneration primary 334.2
CIDP (Chronic Inflammatory Demyelinating Polyneuropathy) 356.9
Encephalitis, myelitis, and encephalomyelitis 323
Friedricks Ataxia 334
Guillian Barre 357.0
Hemiplegia / Hemiparesis
- Flaccid hemiplegia unspecified side 342.00
- Flaccid hemiplegia dominant side 342.01
- Flaccid hemiplegia non-dominant side 342.02
- Spastic hemiplegia unspecified side 342.10
- Spastic hemiplegia dominant side 342.11
- Spastic hemiplegia non-dominant side 342.12
- Hemiplegia 342
- Hemiplegic 343.1

Hereditary spastic paraplegia 334.1
Huntington's chorea 333.4
Idiopathic torsion dystonia 333.6
Kugelberg-Welander disease 335.11
Leukodystrophy 330
Myelopathy in other disease 336.3
Motor neuron disease nec 335.29
Multiple Sclerosis 340
Parkinson's Disease 332.0
Progressive muscular atrophy 335.21
Pseudo bulbar palsy 325.23
Primary lateral sclerosis 335.24
(Post polio) Late Effect Acute Polio 138
Schilder's disease 341.1
Spinal Cord Injury
- quadriplegia, unspecified 344.00
- quadriplegia, C1 - C4– complete 344.01
- quadriplegia, C1 - C4– incomplete 344.02
- quadriplegia, C5 - C7– complete 344.03
- quadriplegia, C5 - C7– incomplete 344.04
- other quadriplegia 344.09
- paraplegia nos 344.1
- diplegia of upper extremity 344.2

Spinocerebellar disease 334
Spinal muscular atrophy 335.1
Symptomatic torsion dystonia 333.7
Spinocerebellar disease nec 334.8
Spinocerebellar disease nos 334.9
Syringomyelia 336.0
Traumatic Brain Injury– quadriplegia 344.09
Vascular myelopathies 336.1
Werdnig-Hoffman's disease 335.0

MYOPATHY

Congenital myopathy 359.0
Dermatomyositis (Wagners) 710.3
Myasthenia gravis 358.00
Myotonia congenital 359.2
Myositis Ossificans 728.12
Muscular Dystrophy
- Beckers 359.1
- Duchennes 359.1

Polymyositis 710.4
Polymyositis Ossificans 728.19
Rheumatic Myositis 729.1

CONGENITAL SKELETAL DEFORMITY

Congenital Hip Dislocation 754.3
Klinefelters Syndrome 758.7
Osteogenesis Imperfecta 756.51
Other congenital anomalies of limbs 755
Spina Bifida 741
Spinal Bifida with hydrocephalus 741.0

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