

DETAILED WRITTEN ORDER

Homecare Dimensions

Document #: 09.DWO.HCD.15b Effective: 09/15/2009

В

Rev.:

Title:

Wheelchair

K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0195

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Initial Date of Medical Nece					
Patient Name:			Medicare #:		
Address:		City:		ST:	Zip:
Phone #:	Cell #:		DOB:		
Email:			Length of Need	:	(99 = Lifetime
Diagnosis Code:					

Medical records: The Medical Records will need to document that **ALL** of the following coverage criteria are met:

Patient has mobility limitation that significantly impairs his/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; **AND**

Mobility limitation cannot be sufficiently and safely resolved by use of appropriately fitted cane or walker; **AND**The patient's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided; **AND**

Use of a manual wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home; **AND**

The patient has not expressed an unwillingness to use the manual wheelchair that is provided in the home; **AND**The patient has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day; **AND**

The patient has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

Equipment Ordered: All wheelchairs are billed using the specific codes listed in the Local Coverage Determination.

ORDERED	CODE	DETAILED DESCRIPTION OF ORDERED ITEMS
	K0001	Standard wheelchair
	K0002	Standard hemi-wheelchair: Medical record supports patient requires a lower seat height (17"-18") because: Short stature, or Need to place feet on ground for propulsion
	K0003	Lightweight wheelchair: Medical record supports that patient: Cannot self-propel in a standard wheelchair using arms and/or legs; and Can and does self-propel in a lightweight wheelchair.
	K0004	High strength lightweight wheelchair: Medical record supports that patient: Self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair; and/or Requires seat width, depth, height that cannot be accommodated in a standard, lightweight, or hemiwheelchair and spends at least two hours per day in the wheelchair.
	K0005	Ultra lightweight wheelchair: Payment is determined on an individual consideration basis. Documentation must include: Description of patient's routine activities; and Types of activities patient frequently encounters; and Information concerning whether or not patient is fully independent in use of the wheelchair; and Description of the K0005 features that are needed compared to the K0004 base.
	K0006	Heavy-duty wheelchair: Medical record supports that patient: Weighs more than 250 pounds; and Has severe spasticity.
	K0007	Extra heavy-duty wheelchair: Medical record supports patient weighs more than 300 pounds.



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K	0009	Other manual wheelchair/base: Medical records justifying medical necessity of the item that <u>might</u> include: Diagnosis
		Abilities and limitations as they relate to the equipment Duration of the condition
		Expected prognosis
K	0195	Past experience using similar equipment Elevating leg rests, pair: Medical records support that patient:
		The patient has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; or The patient has significant edema of the lower extremities that requires an elevating leg-rest; or The patient meets the criteria for and has a reclining back on the wheelchair.
Treating Physician Signature: Date:		
Treating Physician Name: NPI:		n Name: NPI:

DETAILED DESCRIPTION OF ORDERED ITEMS

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Mobility Related Activities of Daily Living

Patier	nt:		
Medic	are #: _		HCD Account #:
	•		activities of daily living are defined as feeding, toileting, dressing, grooming, and ary locations of the patient's home.
A mob	1) Ina 2) Pat	bilit tien	on is defined as: by to complete the MRADL entirely t is at heightened risk of morbidity or mortality when performing the MRADL or wented from completing the MRADL in a reasonable amount of time
Please	e circle	yes	or no.
YES	NO	1.	The patient has a mobility limitation that significantly impairs her ability to participate in one or more mobility- related activities of daily living.
YES	NO	2.	The patient's mobility limitation cannot be sufficiently resolved with the use of an appropriately fitted cane or walker.
YES	NO	3.	The patient's home provides adequate access between rooms, maneuvering space, and surfaces for use of manual wheelchair is provided.
YES	NO	4.	Use of manual wheelchair will significantly improve the patient's ability to participate in MRADL and the patient will use it on a regular basis in the home.
YES	NO	5.	The patient had not expressed an unwillingness to use the manual wheelchair that is provided in the home.
YES	NO	6.	Patient cannot self propel in a standard wheelchair in the home.
YES	NO	7.	The patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.
Treati	ng Phys	sicia	an Signature: Date:
			an Name: NPI:



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Medicare Mobility Assistive Equipment Policy

Patien	t:		
Medica	are#:		HCD Account #:
	ary" to a		algorithmic approach to determine which piece of equipment, if any, is "reasonable and t a Beneficiary in performing the Mobility-Related Activities of Daily Living (MRADL) within
			ollowing questions in order to determine which piece of equipment is "reasonable and necessary. questions:
			 1 thru 5: If you are ordering a Walker, Cane or Crutches 1 thru 7: If you are ordering a Manual Wheelchair 1 thru 8: If you are ordering a Power Operated Vehicle (POV) 1 thru 9: If you are ordering a Power Wheelchair (PWC)
YES	NO	1.	Does the patient have mobility limitation(s) that significantly impairs their ability to perform one or more MRADLs within their home?
YES	NO	2.	Are there other conditions that limit the patient's ability to participate in MRADLs at home?
YES	NO	3.	If limitations exist, can they be compensated sufficiently such that the provisions of MAE will be reasonably expected to significantly improve the patient's ability to perform or obtain assistance to participate in MRADLs in the home?
YES	NO	4.	Does the patient or caregiver demonstrate the capability and willingness to consistently operate the MAE safely?
YES	NO	5.	Can the functional mobility deficit be sufficiently resolved by the prescription of a cane or walker?
YES	NO	6.	Does the patient's home environment support the use of wheelchairs including scooter/power-operated vehicles (POV)?
YES	NO	7.	Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair in the home to participate in MRADLs during a typical day?
YES	NO	8.	Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?
YES	NO	9.	Are the additional features, provided by a power wheelchair, needed to allow the beneficiary to participate in one or more MRADLs?
Treating	g Physic	ian S	Signature: Date:
Treating	g Physic	ian N	lame: NPI: