



DETAILED WRITTEN ORDER

Homecare Dimensions

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

Rev.: **B**

Title: **Wheelchair**
K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0195

Page #: **1 of 5**

Initial Date of Medical Necessity: _____

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 hemi-wheelchair 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.



DETAILED WRITTEN ORDER

Homecare Dimensions

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

Rev.: B

Title: **Wheelchair**
K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0195

Page #: 2 of 5

ORDERED	CODE	DETAILED DESCRIPTION OF ORDERED ITEMS
	K0009	Other manual wheelchair/base: Medical records justifying medical necessity of the item that <i>might</i> include: Diagnosis Abilities and limitations as they relate to the equipment Duration of the condition Expected prognosis Past experience using similar equipment
	K0195	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: _____

Continue on Following Page



DETAILED WRITTEN ORDER

Homecare Dimensions

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

Rev.: B

Title: **Wheelchair**
K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0195

Page #: 3 of 5

Mobility Related Activities of Daily Living

Patient: _____

Medicare #: _____ HCD Account #: _____

Mobility related activities of daily living are defined as feeding, toileting, dressing, grooming, and bathing in customary locations of the patient's home.

A mobility limitation is defined as:

- 1) Inability to complete the MRADL entirely
- 2) Patient is at heightened risk of morbidity or mortality when performing the MRADL or
- 3) Is prevented from completing the MRADL in a reasonable amount of time

Please 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. |

Treating Physician Signature: _____ Date: _____

Treating Physician Name: _____ NPI: _____



DETAILED WRITTEN ORDER

Homecare Dimensions

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

Rev.:
B

Title:

Wheelchair

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

Page #:

4 of 5

Continue on Following Page



DETAILED WRITTEN ORDER

Homecare Dimensions

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

Rev.: **B**

Title: **Wheelchair**
K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009, K0195

Page #: **5 of 5**

Medicare Mobility Assistive Equipment Policy

Patient: _____

Medicare #: _____ HCD Account #: _____

The MAE uses an algorithmic approach to determine which piece of equipment, if any, is “reasonable and necessary” to assist a Beneficiary in performing the Mobility-Related Activities of Daily Living (MRADL) within the home.

Please answer the following questions in order to determine which piece of equipment is “reasonable and necessary.” Circle **Yes** or **NO** for 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 Physician Signature: _____ Date: _____

Treating Physician Name: _____ NPI: _____

Document Complete