BINSON'S Medical Equipment & Supplies Since 1953

Longwood, FL
Fax: 407-691-3021

BECN 15306034478

reset form

Manual Wheelchairs/Cushions/Accessories Detailed Written Order Prior to Delivery

Patient Name: _____
Account #: _____ DOB: _____
Height: _____ Weight: _____
☐ ***Face Sheet/Demographics Faxed***

Order Date: _____
☐ ***Chart Notes Attached***
Chart notes must include the need for equipment ordered.

☒ I, the Physician, have seen this patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers. I have documented the following information and the need for this equipment in the patient's most recent chart notes. **Date of visit prior to order: _____**

DIAGNOSIS (check appropriate diagnosis from list below)

☐ ALS	☐ Hemiplegia	☐ Paraplegia
☐ Amputation	☐ Multiple Sclerosis	☐ Quadriplegia
☐ Cerebral Palsy	☐ Muscular Dystrophy	☐ Rheumatoid Arthritis
☐ CHF	☐ Osteoarthritis	☐ Other _____

Length of Need _____ 99 = Lifetime

Necessity for Wheelchair Equipment

☐ Patient's limitation greatly impairs ability to participate in mobility related activities of daily living ***and***
☐ Patient's mobility limitation cannot be sufficiently resolved by the use of a cane or walker ***and***
☐ Patient's home provides adequate access and maneuvering space for use of the wheelchair ***and***
☐ Use of a wheelchair will improve the patient's ability to participate in mobility related activities of daily living ***and***
☐ Patient is willing to use the wheelchair in the home ***and***
☐ Patient is physically and mentally capable of safely propelling the wheelchair within the home ***or***
☐ Patient has a caregiver who is available, willing and able to provide assistance with the wheelchair.

Equipment (check appropriate equipment below)

☐ Standard Wheelchair w/ Footrests (K0001)
☐ Hemi Wheelchair w/ Footrests (K0002)
- To enable the patient to place his/her feet on the ground for propulsion ***or***
- Male: Less than or equal to 5' 5" - Female: Less than or equal to 5'

Seat Width _____ Seat Depth _____
(Optional/If Known)

☐ Heavy Duty Wheelchair (251 lbs. +) (K0006)
☐ Extra Heavy-Duty Wheelchair (301 lbs. +) (K0007)
☐ Transport Chair w/ Footrests (E1038)
☐ Heavy Duty Transport Chair (301 lbs. +) (E1039)
☐ Lightweight Wheelchair (K0003)

Qualifies for a Manual Wheelchair Above and:
☐ Patient cannot self-propel in a standard wheelchair in the home ***and***
☐ Patient can and does self-propel in a lightweight wheelchair.

☐ High Strength Lightweight Wheelchair (K0004)

Qualifies when beneficiary meets at least one of the criteria below:
☐ Patient self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair.
☐ 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.

Accessories (check appropriate accessories listed below

☐ Anti-Tipping Device (E0971)	☐ Oxygen Holder (E2208)
☐ Elevating Leg Rest (K0195)	☐ Reclining Back w/ Headrest (E1226) (E0955)
☐ Heel Loops (E0951)	☐ Seat Belt (E0978)
☐ Height Adjustable Arms (E0973) ***	☐ Transfer Board (E0705)
☐ One Arm Drive Attachment (E0958) ☐ L ☐ R	☐ Wheel Lock Extensions (E0961)
☐ Residual Limb Support (E1020) ☐ L ☐ R	☐ Non-Standard Seat Frame width 20-24" (E2201)

***Beneficiary requires an arm height that is different from that available using nonadjustable arms and the beneficiary spends at least 2 hours per day in chair.

Cushions

☐ General Use Foam Seat Cushion (E2601, E2602) ☐ General Use Foam Back Cushion (E2611, E2612)

Patient has decubitus ulcers or history of decubitus ulcers on the lower back/sacrum, hip and/or buttock area.
☐ Skin Protection Seat Cushion (E2603, E2604, E2622, E2623)

Prescribing Physician's Information

Name & Credentials	NPI #
Telephone	Fax
Signature	Signature Date

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If filled out completely, this form serves as the Detailed Written Order (DWO) and proof that patient was seen by the physician within 6 months prior to the date of order. This must be received by supplier before equipment is dispensed.

A manual wheelchair for use inside the home is covered if:

- Criteria A, B, C, D, and E are met; and
- Criterion F or G is met.

A. The beneficiary has a 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. A mobility limitation is one that:
   1. Prevents the beneficiary from accomplishing an MRADL entirely, or
   2. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
   3. Prevents the beneficiary from completing an MRADL within a reasonable time frame.

B. The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

C. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.

D. Use of a manual wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home.

E. The beneficiary has not expressed an unwillingness to use the manual wheelchair that is provided in the home.

F. The beneficiary 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. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

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

In addition to the general manual wheelchair criteria above, the specific criteria below must be met for each manual wheelchair.

A transport chair is covered as an alternative to a standard manual wheelchair and if basic coverage criteria A-E and G above are met.

A standard hemi-wheelchair is covered when the beneficiary requires a lower seat height (17" to 18") because of short stature or to enable the beneficiary to place his/her feet on the ground for propulsion.

A lightweight wheelchair is covered when a beneficiary meets both criteria (1) and (2):

1. Cannot self-propel in a standard wheelchair in the home; and
2. The beneficiary can and does self-propel in a lightweight wheelchair.

A high strength lightweight wheelchair is covered when a beneficiary meets the criteria in (1) or (2):

1. The beneficiary self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair.
2. The beneficiary 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.

A high strength lightweight wheelchair is rarely reasonable and necessary if the expected duration of need is less than three months (e.g., post-operative recovery).

If the manual wheelchair will be used inside the home and the coverage criteria are not met, it will be denied as not reasonable and necessary.

If the manual wheelchair will only be used outside the home, see NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section of the related Policy Article for information concerning statutory coverage requirements.

If the manual wheelchair base is not covered, then related accessories will be denied as not reasonable and necessary.

MISCELLANEOUS

Payment is made for only one wheelchair at a time. Backup chairs are denied as not reasonable and necessary. One month's rental for a standard manual wheelchair (K0001) is covered if a beneficiary-owned wheelchair is being repaired.

Medicare requires that it is a physician (MD, DO, or DPM), physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) perform the office visit examination with the beneficiary. The chart note from the office visit exam must be signed and dated by the author of the note. If completed by a PA, NP, or CNS, the physician (MD, DO or DPM) must cosign and date the note.