

Manual Wheelchairs/Cushions Detailed Written Order Prior to Delivery

Patient Name: _____ Account #: _____ DOB: _____ Height: _____ Weight: _____ <input type="checkbox"/> Face Sheet/Demographics Faxed	Order Date: _____ <input type="checkbox"/> Chart Notes Attached Chart notes must include the need for equipment being ordered.
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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 below)	Length of Need: _____ 99 = Lifetime
<input type="checkbox"/> ALS <input type="checkbox"/> Amputation <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> CHF <input type="checkbox"/> Hemiplegia <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Paraplegia <input type="checkbox"/> Quadriplegia <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Other _____

Equipment (check appropriate equipment below)
<input type="checkbox"/> Standard Wheelchair w/ Footrests (K0001) <input type="checkbox"/> Hemi Wheelchair w/ Footrests (K0002) <input type="checkbox"/> Heavy Duty Wheelchair (251 lbs. +) (K0006) <input type="checkbox"/> Extra Heavy Duty Wheelchair (301 lbs. +) (K0007) <input type="checkbox"/> Reclining Back w/ Headrest (E1226) (E0955) <input type="checkbox"/> Seat Belt (E0978) <input type="checkbox"/> Transport Chair w/ Footrests (E1038) <input type="checkbox"/> Heavy Duty Transport Chair (301 lbs. +) (E1039) <input type="checkbox"/> Wheel Lock Extensions (E0961) <input type="checkbox"/> Anti-Tipping Device (E0971) <input type="checkbox"/> Elevating Leg Rest (K0195) <input type="checkbox"/> Oxygen Holder (E2208)

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

<input type="checkbox"/> Lightweight Wheelchair (K0003)	<input type="checkbox"/> Qualifies for a Manual Wheelchair Above and: <input type="checkbox"/> Patient cannot self-propel in a standard wheelchair in the home and <input type="checkbox"/> Patient can and does self-propel in a lightweight wheelchair.
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<input type="checkbox"/> High Strength Lightweight Wheelchair (K0004)	<input type="checkbox"/> Qualifies for a Lightweight Wheelchair Above and: <input type="checkbox"/> Patient engages in frequent activities in the home and Patient requires a seat width, depth or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair.
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<input type="checkbox"/> General Use Foam Seat Cushion (E2601, E2602) <input type="checkbox"/> General Use Foam Back Cushion (E2611, E2612) <input type="checkbox"/> Skin Protection Seat Cushion (E2603, E2604, E2622, E2623)	<input type="checkbox"/> Patient has decubitus ulcers or history of decubitus ulcers on the lower back/sacrum, hip and/or buttock area.
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Prescribing Physician's Information	
Name & Credentials _____ Telephone _____ Signature _____	NPI # _____ Fax _____ Signature Date _____
(Stamped signature not accepted)	

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.

MICHIGAN LOCATIONS **CENTER LINE**

Corporate & Retail
Location
26834 Lawrence
Center Line, MI 48015
586-755-2300
888-BINSONS
Fax: 586-755-2322

EASTPOINTE 21571 Kelly Rd

FARMINGTON HILLS
Tri-Atria Building
32255 Northwestern Hwy

FLINT
G-4433 Miller Rd

LIVONIA
13450 Farmington Rd

LIVONIA
St. Mary Mercy Hospital
36475 5 Mile Rd

ROYAL OAK
30475 Woodward Ave

SAGINAW
5599 Bay Rd

SOUTHGATE
18800 Eureka Rd

STERLING HEIGHTS
43900 Schoenherr Rd

TROY
6475 Rochester Rd

FLORIDA LOCATIONS

LONGWOOD
830 S. Ronald Reagan Blvd
866-928-0003