360 DEGREE Patient Care

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Script for Manual Wheelchair

Patient Name: _____DOB: _____ Height: _____Weight: _____

ICD 10 Diagnosis code_____Length of need_____(99Lifetime)

Standard (K0001): ____ Lightweight (K0003): ___Heavy Duty (K0006 Over 250lbs): _____ X-Heavy Duty (K0007 Over 300lbs): ____

General use back:_____Comfort cushion:____Elevating Leg Rests: ____ Standard Foot Rests _____

1) Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility related activities of daily living (MRADL'S) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home? _____Yes _____No

Explain mobility limitation(s): _____

How far can the patient walk? (be quantitative) _____feet

2) Can the patient's mobility limitation be sufficiently resolved by the use of an appropriately fitted cane, or walker? _____Yes _____No

3) Does the patient home provide adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided? _____Yes _____No

4) Will the use of a manual wheelchair significantly improve the patient's ability to participate in MRADL's and the patient will use it on a regular basis within the home? _____Yes _____No

5) Has the patient expressed willingness to use the manual wheelchair within the home? _____Yes ____No

6) Is the patient able to adequately self-propel (without being pushed) in a standard (45lb) wheelchair? _____Yes _____No

7) If NO, would the patient be able to adequately self-propel (without being pushed) in a lightweight (34lb) wheelchair? ____Yes ____No

8) If ordering Leg Rests, does the patient have a cast, brace, or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that require Elevating Leg Rests? _____Yes _____No

9) How many hours a day will the patient be in the manual wheelchair: _____

*****If the patient is not able to self-propel a standard wheelchair then you MUST document. "Patient is able and will to self-propel a lightweight wheelchair but they were not able to self-propel a standard wheelchair in their home setting.******

Ordering Provider signature:_____Date_____

Physician Name: _____NPI: _____

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A manual wheelchair is covered if:
a) Criteria A, B, C, D and E are met; and
b) Criterion F or G is met

Additional Coverage criteria for specific devise are listed below.
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 patient from accomplishing an MRADL entirely, or
2. Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform and MRADL; or
3. Prevents the patient 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 patient will use it on a regular basis in the home.
E. The patient has not expressed an unwillingness to use the manual wheelchair that is provided in the home.
F. 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.

- Limitation 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 Patient has a caregiver who is available, willing and able to provide assistance with the wheelchair.

* If the manual wheelchair is only for use outside the home, it will be denied as not reasonable and necessary.

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The office visit note must have this information documented in order for Medicare to pay for the wheelchair. If this is not documented, then Medicare will deny the claim for the wheelchair. This cannot be fill-in-the-blank; it must be documented by the Dr or APRN.

I saw____Patient name_____today in regards to their need for a lightweight wheelchair due to _____. The wheelchair will allow them to complete their ADLS safely and timely. They are unable to use a cane or walker due to_____. They were willing and able to self propel in a lightweight wheelchair but they were not able to self propel in a standard wheelchair.

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