WHEELCHAIR PROCESS FOR MD-MART-*PLEASE READ THOROUGHLY*

Basically what Medicare is looking for is the face to face **FIRST**(Criteria A to E **AND** Criteria F **OR** G to be met). **ALL** criteria must be met in order to qualify for the wheelchair. It must be in narrative form in patient's medical record. Just think of it as an interview for the patient and evaluating patient to see if he/she needs a wheelchair. Medicare is trying to prevent fraud due to past issues. Here is a small example since we are not allowed to guide the doctor on what needs to be written. Just keep in mind that Medicare only pays for equipment inside the home. If the doctor states patient is using wheelchair for doctor's appointment or community outings then it will not qualify.

Example of Face to Face: The patient has a mobility limitation that significantly impairs his/her ability to participate in MRADLs such as toileting, feeding, dressing, grooming and bathing due to (**DIAGNOSIS**). The patient has tried a walker and a cane but (**REASON)**. The patient has adequate room in his home to maneuver wheelchair.....etc etc etc.....(use the attach "GENERAL COVERAGE CRITERIA" as a guide)

******KEEP IN MIND THERE IS NO FORM FOR THE FACE TO FACE******

AFTER the face to face the doctor can then write a prescription. We request at least 4 office visit records as well or any records pertaining to the patient that can help qualify he/she for the wheelchair. When we get the face to face, the prescription and office visit records we will send the doctor a DETAILED WRITTEN ORDER which the doctor will need to fill out in it's entirety and send back to our office. From there we will go through all documents to make sure there are no contradictions to qualify patient. If all documents are in order, we will then notify patient and schedule equipment delivery. If you have any questions on our process, please feel free to contact us. We would be happy to assist you.

Thank you,

MD-Mart

Local Coverage Determination (LCD) for Manual Wheelchair Bases (L11454)

Coverage Indications, Limitations and/or Medical Necessity
For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this local coverage determination, the criteria for "reasonable and necessary", based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations, and/or medical necessity.

GENERAL COVERAGE CRITERIA

A manual wheelchair for use inside the home (E1037 - E1039, E1161, K0001 – K0009) 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.

ADDITIONAL CRITERIA FOR SPECIFIC MANUAL WHEELCHAIRS (E1037, E1038, E1039, E1161, K0002 – K0008)

In addition to the general manual wheelchair criteria above, the specific criteria below must be met for each manual wheelchair. If the specific criteria are not met, the manual wheelchair will be denied as not reasonable and necessary.

A transport chair (E1037, E1038 or E1039) is covered as an alternative to a standard manual wheelchair (K0001) and if basic coverage criteria A-E and G above are met.

A standard hemi-wheelchair (K0002) 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 (K0003) 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 heavy duty wheelchair (K0006) is covered if the beneficiary weighs more than 250 pounds or the beneficiary has severe spasticity.

An extra heavy duty wheelchair (K0007) is covered if the beneficiary weighs more than 300 pounds.

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

A safety belt/pelvic strap (E0978) is covered if the beneficiary has weak upper body muscles, upper body instability or muscle spasticity which requires use of this item for proper positioning.

A manual fully reclining back option (E1226) is covered if the beneficiary has one or more of the following conditions:

1. The beneficiary is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or
2. The beneficiary utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed.

If these criteria are not met, the manual reclining back will be denied as not reasonable and necessary.

- Elevating legrests (E0990, K0046, K0047, K0053, K0195) are covered if:

1. The beneficiary has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; or
2. The beneficiary has significant edema of the lower extremities that requires an elevating legrest; or

The beneficiary meets the criteria for and has a reclining back on the wheelchair

MISCELLANEOUS

Payment is made for only one wheelchair at a time. Backup chairs are denied as not reasonable and necessary.

Prescription (order) Requirements

These items require a written order prior to delivery (WOPD). A WOPD is the standard Medicare detailed written order, which must be completed and in the DMEPOS supplier's possession BEFORE the item can be delivered. The prescription (order) for the DME must meet all requirements for a WOPD and include all of the items below:

- Beneficiary's name,
- Physician's Name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item
- The prescribing practitioner's National Provider Identifier (**NPI**),
- The signature of the ordering practitioner
- Signature date

For any of the specified items provided on a periodic basis, including drugs, the written order must include:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration, if applicable
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills, if applicable

Note that prescriptions for these specified DME items require the National Provider Identifier to be included on the prescription. Prescriptions for other DME items do not have this NPI requirement.

Date and Timing Requirements

There are specific date and timing issues:

- The date of the F2F must be on or before the date of the written order (prescription) and may be no older than **6 months prior to the prescription date**.
- The date of the F2F must be on or before the date of delivery for the item(s) prescribed.
- The date of the written order must be on or before the date of delivery (DOS).
- ALL DMEPOS suppliers must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.