Gammie HomeCare

Compassionate. Knowledgeable. Solutions.

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Standard Wheelchair Insurance Coverage Criteria

1 Prescription of Ordered Item (i.e. Manual Wheelchair)

2 Medical Functional Mobility Evaluation

3 Medical Records Documenting

1. Patient has a mobility limitation that significantly impairs his/her ability to perform mobility related ADLs (toileting, grooming, dressing, bathing etc.)
2. Wheelchair is medically needed **In the home**
3. Mobility limitation cannot be resolved with cane or walker
4. Patient can safely use a manual wheelchair (or caregiver to help with use)
5. Mobility limitation can be resolved with use of the manual wheelchair
6. Patient's height and weight

4 Letter of Medical Necessity
(Form supplied by Gammie HomeCare if documentation qualifies for coverage)

Special Notes:

- Lightweight standard wheelchairs are only covered when a patient cannot self-propel in a standard wheelchair but can self-propel in a lightweight wheelchair
- Reclining Wheelchair is covered when the clinical notes document:
  - Patient has current pressure sores on buttocks / hip / coccyx
  - Patient is at high risk of pressure sores due to inability to functionally weight shift
  - Patient self-catheterizes
    - Note: Reclining Wheelchairs are not covered for the sole purpose of dialysis

Coverage criteria is taken from the CMS Medicare Local Coverage Determination policies. These guidelines are subject to change without notice. Last Updated 8.16.19.

MEDICAL FUNCTIONAL MOBILITY EVALUATION

Name: **Insurance #:** **Birth date:**

Date of Evaluation: _____ ICD-10 Diagnoses: _____ _____ _____ HT: _____WT:_____

Subjective Complaint: _____

_____

Describe any mobility assistive equipment the patient is currently using. Explain why this device is no longer medically appropriate. Document clinical progression, past intervention (if any) and results of those interventions.

_____

_____

Does the patient have limitations of mobility that impair his/her ability to participate in mobility related activities of daily living (MRADL) such as feeding, grooming, toileting, dressing, meal preparation, light housekeeping, and bathing either:

☐ 1. Entirely limited; *or,* ☐ 2. Can accomplish but with risk to safety; *or,* ☐ 3. Can accomplish but not within reasonable time.

Describe limiting symptoms such as dyspnea, weakness, fatigue, pain, imbalance, loss of range of motion, past falls:

_____

_____

Is the patient willing and does he /she have the cognition, judgment and/or vision to participate in MRADLs?

YES ☐ **NO** ☐

If NO (cognition, judgment, visual impairment or other limitations exist), can mobility related activities of daily living be accomplished with the assistance of caregiver (e.g., caregiver pushing the patient in wheelchair)?

YES ☐ **NO** ☐

Describe impairment requiring assistance of caregiver:

_____

_____

Will a cane or walker allow the patient to participate in MRADLs safely and in a timely manner?

YES ☐ **NO** ☐

If *YES,* -Order Cane, crutch or walker.

If NO, describe symptoms preventing use of this type of equipment, including any safety-related issues such as history of, or potential for, falls or environmental barriers (e.g., thick carpet, high thresholds). Be specific.

_____

_____

Considering a manual wheelchair, does the patient have sufficient upper extremity and/or lower extremity strength or the endurance necessary to participate in MRADLs using an optimally configured manual wheelchair?

YES ☐ **NO** ☐

Can the patient self propel in a standard weight wheelchair? YES ☐ **NO** ☐

If NO, would the caregiver be able to use the chair to assist the patient in performing MRADLs? YES ☐ **NO** ☐

Will the patient use the wheelchair within their residence? YES ☐ **NO** ☐

If *YES,* -Order manual wheelchair. Order Lightweight only if patient is able to self propel and cannot in a standard weight wheelchair. If NO, referral may be needed.

Check here if referral for further evaluation made: PT_____OT_____ATP_____

Evaluator Name (Print):_____Signature:_____Date:_____Phone#:_____

Physician Name (Print): _____PROVIDER/NPI #: _____License #:_____Exp date:_____

Street Address: _____ **City:** _____**State:**_____ **Phone #:**_____

Physician's Signature: _____ **Date:** _____

This mobility evaluation must be complete by the treating physician, physical/occupational therapist, or a qualified healthcare practitioner.