INSURANCE REQUIREMENTS FOR MANUAL WHEELCHAIR

PHYSICIAN REQUIREMENTS

STANDARD WHEELCHAIRS

- ***Standard Written Order (SWO) that contains:***
    - Beneficiary's name
    - Physician's name
    - Physician's NPI number
    - Length of need
    - Diagnosis that is relevant to the need for the wheelchair
    - Specific type of manual wheelchair that is to be ordered
    - Each option/accessory that is separately billed
    - Physician's signature and date (must be dated the same day or after the face to face exam).

Chart notes or patient progress notes written by the **Physician** that document the following:

- Physician had a **Face to Face Exam** with the patient for the purpose of evaluating medical necessity for the wheelchair.

Face to face Exam instructions

- **Describe** the patients 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:
- **Describe** how the mobility limitation prevents the beneficiary from accomplishing an MRADL entirely; or
- **Describe** how the mobility deficit places patient at a reasonably determined risk secondary to the attempts to perform an MRADL; or
- **Describe** how the mobility deficit prevents the patient from completing an MRADL within a reasonable amount of time; **and**
- **Describe** why the mobility limitation cannot be sufficiently and safely resolved by use of appropriately fitted cane or walker; **and**
- **Document** that the patients home provides adequate access between rooms, maneuvering space and surfaces for use of the wheelchair that is to beprovided; **and**
- **Document** that the use of a manual wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and patient will use it on a regular basis; **and**
- **Document** that the patient has not expressed an unwillingness to use the wheelchair.
- **Document** that 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; **or**
- **Document** beneficiary has a caregiver who is available, willing and able to provide assistance with the wheelchair.

Mobility & More
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Medicare Requirements for Manual Wheelchairs

SPECIAL WHEELCHAIRS

Lightweight wheelchair

- **Document** that the patient cannot self-propel in a standard wheelchair; **and** can and does self-propel in a lightweight wheelchair.

High strength lightweight wheelchair

- **Document** that the patient self-propels the high-strength lightweight wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair; **and** spends at least two hours per day in the wheelchair.

Heavy-duty wheelchair

- Provide documentation that the patient weighs more than 250 pounds; **or**
- Has severe spasticity.

ACCESSORIES

Elevating leg rests

- **Document** in the chart notes why the patient needs elevating leg rests. Add elevating leg rests to the prescription.

Cushion

- **Document** in the chart notes why the patient needs a cushion .
  Cushions are recommended for all patients who use their wheelchair daily.

Please fax all forms attached including the chart notes to 704-821-7777.

If you have any questions contact Mobility & More at 704-821-7777.

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DME STANDARD WRITTEN ORDER (SWO)

ORDER DATE:			Name of Practice / Facility:	
Person completing this form:			Phone #:	
PATIENT DEMOGRAPHICS				
FIRST NAME:	***LAST NAME:***	M.I.	***PHONE:***	
Street Address:		City:	State:	Zip:
DOB:	Sex: M F	Ht:	Wt:	2nd Contact/Phone:
Primary Insurance: ❑ Medicare ❑ Medicaid ❑ Other			**Secondary Insurance:** ❑ Medicare ❑ Medicaid ❑ Other	
Name:			Name:	
Address:			Address:	
Phone:			Phone:	
MBI/Policy #:			Policy #:	

SUPPORTING ICD-10 CODES / NARRATIVE DIAGNOSIS

1.	2.	3.	4.

The patient named above is being treated under a comprehensive plan of care. I, the undersigned treating physician certify that the below prescribed is medically necessary for the patient. I believe that the following products are both reasonable and necessary for the overall patient's wellbeing, condition and/or rehabilitation. I certify that the patient's medical records reflect the need for the item ordered and will be sent to the DME provider along with this SWO.

❑ ***Standard Folding Walker***	❑ ***Hospital Bed***	❑ ***Adult Briefs / Pull Ups***	❑ ***Bedside Commode***
❑ ***Walker w/Wheels***	❑ ***Patient Lift***	❑ ***Under Pads / Gloves***	❑ ***Shower Chair***
❑ ***Rollator (walker w/wheels, seat & brakes)***	❑ ***Trapeze Bar***	❑ ***Wrist / Carpel Tunnel Brace***	❑ ***Transfer Bench***
❑ ***Transport Wheelchair***	❑ ***Gel Overlay***	❑ ***Ankle Brace Support***	❑ ***Raised Toilet Seat***
☑ ***Manual Wheelchair***	❑ ***Low Airloss Mattress***	❑ ***Back Brace Support***	❑ ***Breast Pump***
☑ ***Wheelchair Seat Cushion***	❑ ***Diabetic Shoes***	❑ ***Knee Brace Support***	❑ ***Urological Supplies***
☑ ***Wheelchair Back Cushion***	❑ ***Compression Stockings***	❑ ***Other:***	
❑ ***Motorized Wheelchair / Powerchair***	❑ ***Mobility Scooter / POV***	❑ ***Other:***	
☑ ***Elevating Leg Rest*** ☑ ***Adj. Ht. Armrest*** ☑ ***Seat Belt*** ☑ ***Heel Loops*** ☑ ***Brake Extensions*** ☑ ***Anti-Tippers***		***QUANITY TO BE DISPENSED:*** 1 ***LENGTH OF NEED:*** 99	
❑ ***Motorized Wheelchair / Scooter Repairs*** – repairs as needed to support continued patient's mobility needs in their home			

PHYSICIANS NAME:		***NPI #:***	
Street Address:	City:	State:	Zip
Contact:	Phone:	Fax:	

PHYSICIANS SIGNATURE: _____ ***DATE:*** _____

INFO

FAX this SWO to 704-821-7777 or email to ~~orders~~@mobility-more.com