
## What's needed for a new referral:

- Demographics
- Detailed Written Order Signed/Dated by physician
- Most recent Face-To-Face note discussing the item the patient is needing as well as the diagnosis

In addition to the "reasonable and necessary" criteria contained in this LCD there are other payment rules, which are discussed in the following documents that must also be met prior to Medicare reimbursement:

- The LCD-related Standard Documentation Requirements Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- The LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- Refer to the Supplier Manual for additional information on documentation requirements.
- Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

---

For the items addressed in this LCD, the "reasonable and necessary" criteria, 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:
   A. Prevents the beneficiary from accomplishing an MRADL entirely, or
   B. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
   C. 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")

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.

Light weight w/c

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):

- Cannot self-propel in a standard wheelchair in the home; and
- The beneficiary can and does self-propel in a lightweight wheelchair.

Still has to qualify for standard w/c 1st

A high strength lightweight wheelchair (K0004) is covered when a beneficiary meets the criteria in (1) or (2):

The beneficiary self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair.

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).

An ultra lightweight manual wheelchair (K0005) is covered for a beneficiary if criteria (1) or (2) is met and (3) and (4) are met:

1. *The beneficiary must be a full-time manual wheelchair user.*
2. The beneficiary must require individualized fitting and adjustments for one or more features such as, but not limited to, axle configuration, wheel camber, or seat and back angles, and which cannot be accommodated by a K0001 through K0004 manual wheelchair.
3. The beneficiary must have a specialty evaluation that was performed by a licensed/certified medical professional (LCMP), such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The LCMP may have no financial relationship with the supplier.
4. The wheelchair is provided by a Rehabilitative Technology Supplier (RTS) that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

*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.

because of short stature or to enable the beneficiary to propel himself/herself independently for propulsion.

HD Wheelchair

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 high strength lightweight wheelchair (K0004) 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).

An ultra lightweight manual wheelchair (K0005) is covered for a beneficiary if criteria (1) or (2) is met and (3) and (4) are met:

1. The beneficiary must be a full-time manual wheelchair user.
2. The beneficiary must require individualized fitting and adjustments for one or more features such as, but not limited to, axle configuration, wheel camber, or seat and back angles, and which cannot be accommodated by a K0001 through K0004 manual wheelchair.
3. The beneficiary must have a specialty evaluation that was performed by a licensed/certified medical professional (LCMP), such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The LCMP may have no financial relationship with the supplier.
4. The wheelchair is provided by a Rehabilitative Technology Supplier (RTS) that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

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.

A manual wheelchair with tilt in space (E1161) is covered if the beneficiary meets the general coverage criteria for a manual wheelchair above, and if criteria (1) and (2) are met:

1. The beneficiary must have a specialty evaluation that was performed by a licensed/certified medical professional (LCMP), such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features (see Documentation Requirements section). The LCMP may have no financial relationship with the supplier.
2. The wheelchair is provided by a Rehabilitative Technology Supplier (RTS) that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

A custom manual wheelchair base (K0008) is covered if, in addition to the general coverage criteria above, the specific configuration required to address the beneficiary's physical and/or functional deficits cannot be met using one of the standard manual wheelchair bases plus an appropriate combination of wheelchair seating systems, cushions, options or accessories (prefabricated or custom fabricated), such that the individual construction of a

ELR's

In addition to the "reasonable and necessary" criteria contained in this LCD there are other payment rules, which are discussed in the following documents, that must also be met prior to Medicare reimbursement:

- The LCD-related Standard Documentation Requirements Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- The LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.

---

- Refer to the Supplier Manual for additional information on documentation requirements.
- Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

For the items addressed in this LCD, the "reasonable and necessary" criteria, based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

Options and accessories for wheelchairs are covered if the beneficiary has a wheelchair that meets Medicare coverage criteria and the option/accessory itself is medically necessary. Coverage criteria for specific items are described below.

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

ARM OF CHAIR:

Adjustable arm height option (E0973, K0017, K0018, K0020) is covered if the beneficiary requires an arm height that different from that available using nonadjustable arms and the beneficiary spends at least 2 hours per day in the wheelchair.

An arm trough (E2209) is covered if the beneficiary has quadriplegia, hemiplegia, or uncontrolled arm movements.

FOOTREST/ LEGREST:

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

NONSTANDARD SEAT FRAME DIMENSIONS:

A nonstandard seat width and/or depth for a manual wheelchair (E2201-E2204) is covered only if the beneficiary's physical dimensions justify the need.

WHEELS/TIRES FOR MANUAL WHEELCHAIRS:

gear reduction drive wheel (E2227) is covered if all of the following criteria are met:

1. The beneficiary has been self-propelling in a manual wheelchair for at least one year; and

MED medical equipment

DETAILED PHYSICIANS ORDER
DURABLE MEDICAL EQUIPMENT

Patient: _____ Date of Order: _____ HT: ____ WT: _____

Address: _____ DOB: _____ Length of Need: 99

_____ Diagnosis Codes: _____

**Equipment Needed:**

____ E1038 Transport chair (weight <= 300 lbs.)
____ K0001 Standard Manual Wheelchair
____ K0003 Lightweight Manual Wheelchair
____ K0004 High Strength Lightweight Manual Wheelchair
____ K0006 HD Manual Wheelchair (weight > 250 lbs.)
____ K0007 Extra HD Manual Wheelchair (weight > 300 lbs.)

Additional Accessories for K0001 – K0007 wheelchairs
Non Standard Seat Width
____ E2201 (>=20"-<24") ____ E2202 (24"-27")
____ Seat Cushion – Please specify:
E2601, E2602, E2603*, E2604*, E2622*, E2623*
____ Back Cushion – Please specify:
E2611, E2612
____ Heel Loops/ Standard leg rests (E0951) ___Right ____ Left
____ Elevating Leg rests (K0195) ___Right ___ Left
____ Articulating Leg rests (K0053)
____ Anti-Tippers (E0971) ___ Right ___ Left
____ Brake extensions (E0961) ___ Right ___ Left
____ Height adjustable arms (E0973) ___ Right ___ Left
____ Arm Trough (E2209)* ___ Right ___ Left
____ Amputee support (E1020)* ___ Right ___ Left
____ Swing away Hardware (E1028) ___ Right ___ Left
____ 1 arm drive attachment (E0958) ___ Right ___ Left
____ Lap tray (E0950)
____ Oxygen tank holder (E2208)
*Verify covered diagnosis*

____ E0260 Semi-electric hospital bed w/ mattress
____ E0261 Semi-electric hospital bed w/o mattress
____ E0265 Full electric hospital bed (ABN required)
____ E0303 HD hospital bed extra wide (350-600 lbs)
____ E0143 Standard Walker (No wheels)
____ E0143 Wheeled walker
____ E0143 Wheeled walker with seat (Rollator)
____ E0156 Walker Seat for Rollator
____ E0100 Cane-Standard Aluminum
____ E0105 Quad Cane (sm or lg)

____ **If other please specify:**

_____
_____
_____
_____
_____
_____

Physicians
Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Physicians
Signature: _____
(Original no stamps please)

Date: _____

NPI: _____

Showroom location for new patients and walk-ins:
1005 N Kingshighway Ste 12 Cape Girardeau ph. 573-803-2390 fax. 573-803-1247