Valley Mission Homecare Pharmacy
12509 E Mission, Ste 103
Spokane Valley, WA 99216
valleymissionrx.com
Phone (509) 928-6400 **Fax (509) 928-6441**

WHEELCHAIRS AND TRANSPORT CHAIRS (NON-POWERED)

Eligibility Assessment & Order Guidance Tool

- **This guidance is based on requirements for <u>traditional Medicare Beneficiaries</u>. Although other insurers may have less or more stringent requirements -including potential need for prior authorization - CMS policies serve as the reference standard. For questions, please call Valley Mission Homecare Pharmacy[†] at (509) 928-6400.**

STEP 1: Verify the patient's medical condition meets Medicare coverage criteria – All below are REQUIRED and must be <u>explicitly</u> referenced in the clients chart record:

- **Patient has a <u>mobility limitation</u> with a qualifying diagnosis that significantly impairs the the ability to participate in mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming and bathing.**
- **Patient has been evaluated <u>face-to-face</u> for MRADL-related medical concerns within the past 6 months and has a care plan for ongoing evaluation at least every 6 months**
- **The medical condition must result in significant challenge or difficulty that the resulting mobility limitation cannot be sufficiently resolved by the use of a properly fitted cane or walker.**
- **The use of a wheelchair or transport chair is expected to significantly *<u>improve</u>* the patient's ability to be more successful with *<u>MRADLs</u>* in the *<u>home</u>* and the patient is expected to be a willing participant in the *<u>regular</u>* use of the equipment. *Importantly, coverage cannot be justified if the intended use is solely for outside the home, nor if the equipment is primarily for the benefit of a caregiver.***
- ***<u>For Wheelchair</u>*: The patient has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair in the home during a typical day.**
- ***<u>For Transport Chair</u>*: The patient is <u>unable</u>, due to insufficient upper body strength or other physical or mental capacity, to self-operate a manual wheelchair in a typical fashion in the home and therefore mobility needs are better achieved with a transport chair, <u>AND</u> the patient has an available, willing caregiver who provides assistance.**
- ***<u>Typical equipment variations</u>***
  - ***"Light-weight":* The patient is <u>unable</u> to self-propel standard version of the equipment in the home but is expected to successfully self-propel a lightweight version.**
  - ***"Hemi":* The patient requires a lower seat height (17-18") because of short stature or to place feet on the ground for propulsion.**
  - ***"Heavy Duty":* The patient weighs more than 250 pounds or has severe spasticity.**

STEP 2: Complete all sections of the Wheelchair/Transport Chair (non-powered) Detailed Written Order (see page 2)

STEP 3: Print and Fax the following documents to (509) 928-6441:

1. **The most recent face-to-face visit summary pertaining to mobility -related medical assessment. This must include documentation of required qualifications outlined in STEP 1 above.**
2. **Demographic face-sheet for the patient.**

[†] ***Valley Mission Homecare Pharmacy specializes in the provision of Durable Medical Equipment (DME) and Supplies to Medicare beneficiaries. Information provided here is intended solely to facilitate communication between the Ordering Provider and the DME Supplier to help ensure medical criteria are sufficient for presumptive coverage. This does NOT in any manner replace formal guidance located in the relevant Local Coverage Determination (LCD) specified by the Medicare Administrative Contractor.***

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Detailed Written Order

Patient Information

Last Name	First Name	Middle Name	Date of Birth

Physical Address	City	State	Zip Code
Billing Address (if different)	**City**	**State**	**Zip Code**

Phone	Alternate Phone

Prescriber Information

Last Name	First Name	Credential Type	NPI

Practice Location Address	City	State	Zip Code	Tax ID

Practice Location Phone	Practice Location Fax	Supervising Provider Name and NPI if applicable

Order Detail

Rx (i.e., Wheelchair or Transport Chair)
Length of Need
Diagnosis (ICD-10) – list all codes pertinent to mobility impairment

Patient Height	Patient Weight

Additional information/instruction

I certify that I am the ordering prescriber specified above and hereby attest that information on this page is true, accurate and complete to the best of my knowledge and that the patient has suitable medical criteria documented in his/her patient record indicating medical necessity for the items listed above. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil or criminal liability. The patient (and his/her caregivers, when applicable) is capable of using this equipment and has successfully completed or will be trained on the proper use of the products prescribed on this order.

Prescriber Signature	Date