Lake Region HOME MEDICAL SUPPLY

Physician's Order for Manual Wheelchair

Acct: _____

Date of Order: _____

Patient Name: _____ DOB: _____

Date of Face-to-Face (F2F) Examination: _____ Height: _____ Weight: _____

(must be done by treating physician within 6 months prior to order)

Diagnosis Code(s) supporting need for wheelchair: _____

If a wheelchair is needed for use in the home to help complete daily activities, ***please refer your patient to a qualified therapist for a wheelchair evaluation if any of the following also apply:***

A. The patient has a long-term (over 6 months) or progressive diagnosis that is affecting their mobility
B. The patient will be seated in the wheelchair over 4 hours per day

Manual Wheelchair Coverage Criteria that MUST BE DOCUMENTED IN F2F EXAM AND/OR THERAPY EVALUATION:

1. Patient has a **mobility limitation** that affects ability to perform one or more mobility-related Activities of Daily Living (MRADLs) such as toileting, feeding, dressing, grooming or bathing in the home (specify those affected)
2. The patient's mobility limitation **cannot be sufficiently resolved** by the use of a CANE or WALKER
3. The patient's **home provides adequate access** for use of the wheelchair
4. Use of a manual wheelchair will **improve patient's ability to participate in MRADLs** and the patient will use it on a regular basis in the home
5. Patient **has not expressed an unwillingness** to use the manual wheelchair in the home
6. The patient has **sufficient upper extremity function** and other physical and mental capabilities needed to safely self-propel the wheelchair ***OR*** has a **caregiver who is able to provide assistance** with the wheelchair

- If wheelchair evaluation done by therapist, the treating physician must document in F2F note that he/she has seen, and concurs with, therapist recommendations OR must cosign the therapy evaluation.
- The F2F exam MUST be part of physician progress note; a letter written by physician is not valid documentation.
- The order form is not considered to be part of the medical record and cannot be used to document the F2F exam.

Physician Order

Start Date (if different from Date of Order): _____

Length of Need: ☐ 12 months ☐ Lifetime ☐ Other: _____

Wheelchair and Accessories (check all appropriate):

- ☐ Standard Wheelchair (K0001) *Patient weight up to 250 lbs*
- ☐ Hemi Wheelchair (K0002) *Patient weight up to 250 lbs and requires lower seat height (17" to 18") because of short stature or to enable the patient to place his/her feet on the ground for propulsion*
- ☐ Lightweight Wheelchair (K0003) *Patient weight up to 250 lbs and can't self-propel in standard wheelchair*
- ☐ Heavy Duty Wheelchair (K0006) *Patient weight 251 – 300 lbs or has severe spasticity*
- ☐ Extra Heavy Duty Wheelchair (K0007) *patient weight 301 - 450 lbs*
- ☐ Other: _____

☐ Foot Rest (K0045) ☐ General Seat Cushion (E2601) ☐ Anti Tip Back Device (E0971)
☐ Leg Rest (K0195) ☐ General Back Cushion (E2611) ☐ Anti Roll Back Device (E0974)
☐ Other: _____

Physician Signature: _____ **Date:** _____

Physician Name: (please print) _____ **NPI:** _____

Fax back to: 320-231-4941