Finding the *SWEET SPOT* in the Wheelchair Evaluation

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Learning Objectives

- Define interprofessional collaboration in healthcare and patient-centered care
- Identify the roles and responsibilities of the ATP and LCMP in documenting the requirements in the policies
- Determine the coverage criteria for mobility assistive equipment and how to use the 9 step algorithm for accurate product selection
- Identify key requirements that must be clearly documented in the wheelchair evaluation with consideration of health insurance reimbursement
- Implement protocol in the wheelchair evaluation documentation to ensure the patient receives the medically necessary product in a timely manner

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ATP and LCMP (PT/OT) - Role and Responsibility

- **ATP** Assessment - Assistive Technology Professional
- **LCMP** – Licensed Certified Medical Professional Wheelchair Evaluation (OT/PT)
- Required for Medicare and those that follow Medicare for complex rehab wheelchairs **(K0835-K0864, K0005 and E1161)**
- An **LMCP** is responsible to perform a wheelchair specialty evaluation **to determine the mobility limitations** and recommend mobility products and accessories to address those limitations
- An **ATP** is responsible to determine the appropriate equipment based on the mobility limitations noted in the LMCP's wheelchair evaluation (trunk and limb measurements, selection of make and model, etc.)

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ATP and LCMP (PT/OT) - Role and Responsibility

- An **ATP** assessment is required to have **direct, in-person involvement** in the wheelchair selection
- The ATP assessment CAN'T be done prior to the specialty evaluation (same date OK or later)
- ATP and LCMP do NOT have to do not have to seen the patient during the same encounter
- The LCMP evaluation can occur before the physician F2F
- A specialty wheelchair evaluation performed by a licensed/certified medical professional **(LCMP)** such as a PT, OT, or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and who documents the medical necessity for the wheelchair and its special features. The PT, OT, or practitioner may have no financial relationship with the supplier

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ATP and LCMP (PT/OT) - Role and Responsibility

- The LCMP and ATP should not restrict equipment recommendations/accessories due to funding
- The beneficiary has a right to know all the equipment options **(RESNA standard)**
- The LCMP should have the advanced knowledge and skills to make appropriate recommendations, and not allow the ATP to make all their decisions about equipment recommendations
- If the LCMP does not have the education and skills to perform the evaluation and make appropriate clinical recommendations, the LCMP should refer the beneficiary to another clinician who does

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ATP and LCMP (PT/OT) - Role and Responsibility

- Formal education for PTs and OTs do not include enough on documentation for mobility products (in the way health insurances want to see it)
- This consumes so much of time and with productivity requirement to see patients, it leads them to have to write or rewrite documentation at nights and on weekends just to get it right
- They either seek **"help"** or are offered **"help"** from equipment suppliers
- ATP must be an employee of the equipment supplier (W2 or 1099) and CAN'T document the medical necessity for any reimbursable item
- LCMP can't have a financial relationship with the equipment supplier
- ATP is sometimes present during the wheelchair evaluation and they know more about coverage criteria and documentation format than the LCMP (they know what works) and are asked or offer to scribe
- **A SCRIBE** is functioning as a "living recorder," documenting in real time the actions and words of the physician/clinician as they are done. If this is done in any other way, it is inappropriate. **Scribes are not providers of items or services.**

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ATP and LCMP (PT/OT) - Role and Responsibility

- If the ATP DOESN"T "HELP" **-** Wheelchair delivery could be delayed or denied due to incomplete documentation
  - Delay in delivery - Patient clearly qualifies for the mobility products ordered but the LCMP just didn't write the documentation in a format or language where it will be covered by insurance (addendum)
  - Supplier doesn't receive reimbursement due to denial (appeal)
- **If the ATP DOES "HELP" -** Ethical and possible Legal implications
  - Patient gets product timely and supplier gets paid timely
  - LCMP received something of value (scribe or worse) which allows them to increase their productivity
  - Was it written word for word or was anything added by the scribe

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ATP and LCMP (PT/OT) - Role and Responsibility

- **"HELP" - Ethical and possible Legal implications**
  - LCMP is responsible for their notes and can only use a scribe if the scribe is not a provider of the services (equipment) and the scribe meets scribe requirements
  - LCMP may prefer to use suppliers that scribes for them and doesn't want to work with those that don't
  - Potential **Anti Kickback Violations** in providing something of value (in kind) for a referral for a Medicare covered item

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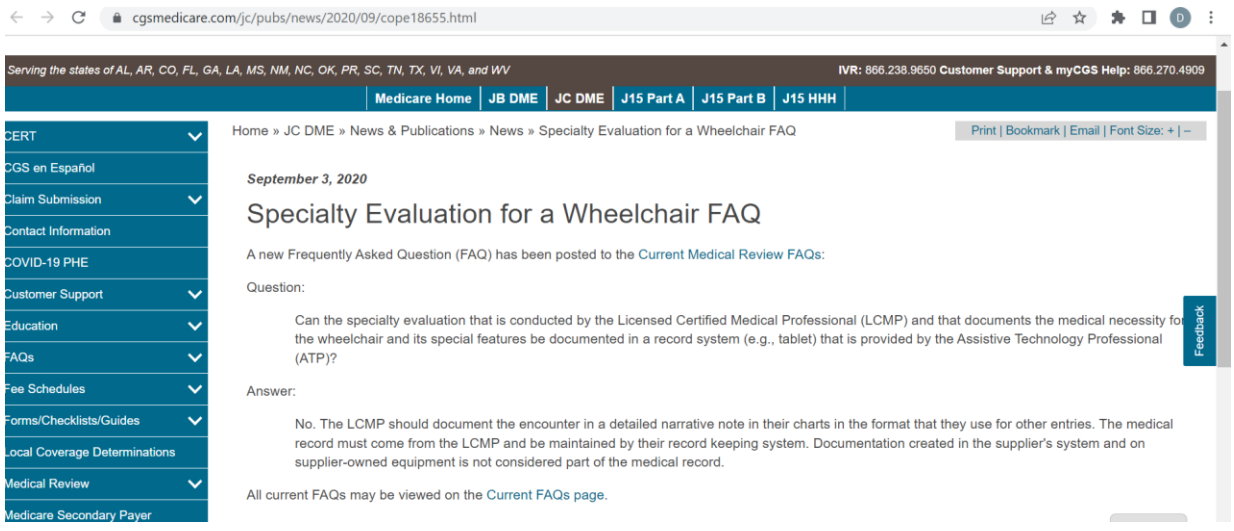

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ATP and LCMP (PT/OT) - Role and Responsibility

Anti Kickback Statute

"Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or ***in kind*** *in return for referring an individual to a person for the furnishing or* ***arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program,*** *or in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,* ***shall be guilty of a felony*** *and upon conviction thereof, shall be fined not more than* ***$25,000*** *or* ***imprisoned for not more than five years, or both****."*

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ATP and LCMP (PT/OT) - Role and Responsibility

- Scribing (writing it) is something of value **in Kind**
- Only working with those that scribe **is a referral for arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program (Medicare / Medicaid)**
- Shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or BOTH"

This arrangement could be considered remuneration **in kind** (a kickback) in return for referring individuals to the supplier for which payment may be made under a Federal health care program (Medicare, Medicaid).

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ATP and LCMP (PT/OT) - Role and Responsibility

Reference

American Occupational Therapy Association.
Occupational Therapy Code of Ethics. American Journal of Occupational Therapy, 69, 6913410030p1–6913410030p8.

*Recently, **AOTA** was informed about questionable practices surrounding wheelchair evaluations conducted by occupational therapists in certain states. These practices impact recommendations and reimbursement and raise potential ethical as well as legal issues. These concerns involved questions about appropriate documentation, the role of the DME supplier, and what is viewed as a complete and compliant power wheelchair evaluation as intended by the Centers for Medicare & Medicaid Services (CMS) regulations and related guidance.*

Q: Can I perform a power wheelchair evaluation but have the wheelchair supplier do the documentation if I am there to sign off on it?

A: NO. When you as the therapist sign off on documentation, you are effectively attesting that these are your notes; the content is accurate and reflects your clinical judgment.

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ATP and LCMP (PT/OT) - Role and Responsibility

Medical Suppliers and Medicare Power Wheelchair Evaluation and Documentation

APTA American Physical Therapy Association

Physical therapists providing complex seating and wheeled mobility evaluations must have a high level of competency, and they require adequate time to determine the appropriate assistive technology and to complete the documentation required to support the recommendations. The purpose of a physical therapist providing the evaluation and making skilled recommendations is to best meet the specific needs of the individual and avoid recommending, providing, or billing for equipment that is not medically necessary or will not adequately meet the patient's needs. The physical therapist frequently works collaboratively with a multidisciplinary team including physicians, other health care providers, assistive technology professionals, the patient, and caregivers.

Medical Suppliers Cannot Be Scribes

When you sign off on documentation, you are attesting that these are your notes, that the content is accurate, and that they reflect your clinical judgment.

APTA has been informed about concerns with a supplier's employed assistive technology professional acting as a scribe for the physical therapist during the specialty evaluation. An ATP is someone certified to analyze patient's need, help select the appropriate technology, and train the patient in its use. The Durable Medical Equipment Medicare Administrative Contractors (currently Noridian and CGS) prohibit an ATP from acting as the physical therapist's scribe, as there is an inherent conflict of interest. The supplier and the medical professional, in this case the ATP and the physical therapist, cannot have any financial relationship, and scribing for the physical therapist is providing in-kind value, which violates the MACs' local coverage determinations. This can also lead to a possible anti-kickback violation.

This isn't to say that organizations cannot have relationships with specific vendors; it's common practice. However, from an ethical perspective, any relationship you and your vendor have must be collaborative and unbiased by any incentives the vendor may provide. These include not only potential financial incentives but also the vendor's equipment-related expertise based on the clinical information you give them about patients' abilities, barriers to performance, and functional use of the wheelchair. You should not delegate recommendation decisions or writing the evaluation to the vendor; it is your ethical and professional responsibility to personally document and sign clinical evaluations and notes to ensure accuracy and regulatory compliance.

This means you should record the visit and mobility evaluation in your usual medical record-keeping format — not on a form that the supplier may provide. Those forms may create the impression that they are a sufficient record, but CMS requires more extensive documentation than the supplier-provided form typically includes. Deficient documentation may result in equipment denials or delays, which will impede your patient's progress and potential outcomes. A better idea is to collaborate with DME suppliers to get familiar with evaluation report language that accurately reflects your clinical judgment regarding the individual's status, needs, and abilities.

13

ATP and LCMP (PT/OT) - Role and Responsibility

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ATP and LCMP (PT/OT) - Role and Responsibility

RESNA Rehabilitation Engineering and Assistive Technology Society of North America

Code of Ethics

RESNA Code of Ethics are a public statement of principles used to promote and maintain high standards of conduct within the multidisciplinary profession of Assistive Technology. These are important to our profession because they promote and guide the professional practice of RESNA members, certificants, certificant candidates, and students who must:

1. Hold paramount the welfare of persons served professionally.
2. Practice only in their area(s) of competence.
3. Maintain the confidentiality of privileged or confidential information.
4. Disclose all conflicts of interest.
5. Know and comply with the laws, regulations, and policies that guide professional practice.
6. Act in a manner that positively reflects upon the assistive technology profession.

15

ATP and LCMP (PT/OT) - Role and Responsibility

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Pay $13,500,000 To Resolve Alleged False Claims For Custom Wheelchairs

PRESS RELEASE

[redacted] Agrees to Pay $13,500,000 to Resolve Alleged False Claims for Custom Wheelchairs

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ATP and LCMP (PT/OT) - Role and Responsibility

Contact certification@resna.org with any questions.

List of Suspended Certified Professionals

List of Suspended Certified Professionals

First Name	Last Name	Credentials	Suspension Start Date	Suspension End Date
Dalia	Morales	ATP	6/25/2024	6/25/2026
Vern	Nielsen	ATP	03/17/2025	03/17/2029
Michael	Peterlin	ATP	05/01/2025	-
Stephen	Pikus	ATP	05/01/2025	-
David	Cingano	ATP	05/01/2025	08/05/2025

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What's the Goal with Rehabilitation

- Rehabilitate patients to not require medical equipment
- Select the most appropriate Mobility Assistive Equipment (MAE) for the patient's needs
- **Provide documentation for third party payers** (Medicare, Medicaid, etc.) in order for patient to receive medically necessary equipment in a timely manner with the least amount of financial liability as possible
- NEED to be **EFFICIENT**/effective in providing the required documentation
  - For productivity
  - For timely delivery of necessary product (provider CAN'T deliver unless it is RIGHT)
  - Patient isn't held financially liable OR are not able to retain the medically necessary equipment
  - Equipment supplier could receive payment for their services to be able to continue servicing patients in the future

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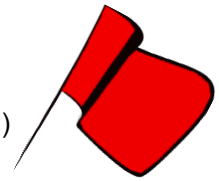
18

Addendum / Amendment

- The DME provider obtains the documentation for a mobility device (physician chart note and the therapist evaluation) but something is missing?
- The provider contacts the physician / therapist and explains that the documentation provided does not justify the need for the items ordered.
- The physician / therapist says, “What do you need, please tell me and I’ll write and **Addendum** OR can you write it for me?
- This is **WORST CASE SCENARIO**!
- Medicare and other payer do NOT like addendums (immediate **RED FLAG**)
- AND it’s **INEFFICIENT TO REDO WORK**



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Addendum / Amendment

If an addendum is necessary, please follow these recording keeping principals so the addendum is accepted:

CMS’ Recordkeeping Principles

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to MACs, CERT, Recovery Auditors, and ZPICs containing amendments, corrections or addenda must:

1. **Clearly and permanently identify any amendment, correction or delayed entry as such, and**
2. **Clearly indicate the date and author of any amendment, correction or delayed entry, and**
3. **Clearly identify all original content, without deletion.**

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20

Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Least Costly Alternative

- Authorize the least costly medically appropriate alternative to the item being ordered.
- All items that cost less must be tried and failed OR considered and ruled out.

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Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Medical Necessity

- Unsafe or unreasonable and the reason why (be specific)
- The WHY is CRITICAL
- All least costly alternatives either **tried and failed** (with reason) OR
- C**onsidered and ruled out** (with reason)

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Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Medical Necessity Documentation

Treating Practitioner (Face to Face Exam)

- Diagnosis responsible for the mobility limitation
- Symptoms affecting mobility
- MRADLs that are being affected by the mobility limitation
- Ambulatory status
- Routine physical exam (height, weight, vitals)

Wheelchair Evaluation (LCMP) / Treating Practitioner

- Addressing ALL least costly alternatives (cane/walker, manual wheelchairs, scooters, power wheelchairs) with objective measurements (manual muscle test, ROM, SAT, pain, endurance, etc.)
- AND document the medical necessity for ALL accessories (tilt and or recline, upgraded electronics, skin / positioning cushion, swing away mounting hardware, etc.)

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Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Step 1

Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living in the home?

A mobility limitation is one that:

a. Prevents the beneficiary from accomplishing the mobility-related activities of daily living entirely, or

b. Places the beneficiary at reasonably determined **heightened risk of morbidity or mortality** secondary to the attempts to participate in mobility-related activities of daily living, or

c. Prevents the beneficiary from completing the mobility-related activities of daily living within a **reasonable time frame**.

NO 

Patient DOES NOT Qualify for MAE

YES GO

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Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Step 2

Are there other conditions that limit the beneficiary's ability to participate in MRADLs at home?

Some examples are significant impairment of cognition or judgment and/or vision.

For these beneficiaries, the provision of MAE might not enable them to participate in MRADLs if the comorbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with MAE.

NO → GO

YES → GO Caution → Answer Step 3

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25

Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Step 3

If these other limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of MAE will be reasonably expected to significantly improve the beneficiary's ability to perform or obtain assistance to participate in MRADLs in the home?

The beneficiary has the mental and physical capabilities to safely operate the power wheelchair that is provided; OR

If the beneficiary is unable to safely operate the power wheelchair, the beneficiary has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair that is provided; and

NO → STOP → Patient DOES NOT Qualify for MAE

YES → GO

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26

Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Step 4

Does the beneficiary or caregiver demonstrate the capability and the willingness to consistently operate the MAE safely?

Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.

A history of unsafe behavior in other venues may be considered.

NO 

Patient DOES NOT Qualify for MAE

YES GO

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Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Step 5 – Cane and Walker

Can the functional mobility deficit be sufficiently resolved by the prescription of a cane or walker? (IN THE HOME)

*Assess the beneficiary's ability to **safely** use a cane or walker.*

YES 

Patient May Qualify for Cane / Walker

NO GO

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28

Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Step 6

Does the beneficiary's typical environment support the use of wheelchairs including scooters/power-operated vehicles (POVs)?

Determine whether the beneficiary's environment will support the use of these types of MAE. (DME Supplier)

Keep in mind such factors as physical layout, surfaces, and obstacles, which may render MAE unusable in the beneficiary's home. (DME Supplier)

*ON SITE **HOME** ASSESSMENT (REQUIRED FOR ALL WHEELCHAIRS AND SCOOTERS*

NO STOP Patient DOES NOT Qualify for MAE

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YES GO

29

Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Step 6

DME is covered by **Medicare Part B** when needed in the HOME

What is considered HOME according to Medicare?

- SNF (31/32) - Yes or No
- Hospital – Yes or No
- Assisted Living Facility (13) – Yes or No
- Group Home (14) – Yes or No
- Custodial Care (33) – Yes or No
- Intermediate Care Facility (54) – Yes or No
- Homeless Shelter (4) – Yes or No

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Step 6

SNF Can NEVER be considered the HOME regardless of who is paying for the stay

Section 1861(n) of the Act limits Part B coverage under the DME benefit to those items that are furnished for use in a patient's home. This provision further specifies that any institution meeting the basic definition of a hospital in Section 1861(e)(1) of the Act, or of an SNF in Section 1819(a)(1) of the Act, cannot be considered a patient's "home" for this purpose. Section 1819(a)(1) (formerly Section 1861(j)(1)) of the Act, in turn, defines an "SNF" broadly as any institution that is primarily engaged in providing skilled nursing (clause (A)) or rehabilitation services (clause (B)) to its residents.

This expansive SNF definition omits the specific, more restrictive elements contained in the remainder of Sections 1819(a)-(d) of the Act, which list the detailed requirements that an institution must meet in order to participate in the Medicare program as a *certified* SNF. Thus, in excluding Part B coverage for DME furnished in "SNFs" as defined broadly in Section 1819(a)(1) of the Act, Congress intended for this exclusion to encompass not only all *Medicare-participating* SNFs, but also any other institutions which, though not participating in Medicare, do provide the type of care described in that section of the law. This policy is also reflected in the regulations in title 42 of the Code of Federal Regulations (42 CFR) at §410.38(b), and in Chapter 15, Section 110.1.D of the *Medicare Benefit Policy Manual*, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html on the CMS website.

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Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Step 6

Considerations

- If the patient lives in an assisted living facility (ALF), distance they have to walk to the dining room
- Do they eat all their meals in the dining room?
- Do they have a kitchen or small kitchenette in their apartment where they only make their breakfast only, but have lunch and dinner in the dining room?
- Many ALFs do not allow scooters in the dining room. The patient has to park their scooter outside the dining room and walk in using their cane or walker.

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32

Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Step 7 = Manual Wheelchair Bases

Does the beneficiary have sufficient upper extremity **function** to propel a manual wheelchair **in the home (assisted living POS 14/33 is considered home)** to participate in MRADLs during a typical day? The manual wheelchair should be optimally configured (seating options, wheelbase, device weight, and other appropriate accessories) for this determination.

Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.

*Assess the beneficiary's ability to **safely** use a manual wheelchair.*

***NOTE:** If the beneficiary is unable to self-propel a manual wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair may be appropriate.*

YES

NO → SKIP to Step 8

- Patient May Qualify for a Manual Chair → Continue to Step 7

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Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Step 7 – Manual Wheelchair Bases

Standard Manual wheelchair **(K0001) CR**

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 CR

A **lightweight wheelchair (K0003)** is covered when a beneficiary meets both criteria: Cannot self-propel in a standard wheelchair in the home; and the beneficiary can and does self-propel in a lightweight wheelchair CR

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Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Step 7 – Manual Wheelchair Bases

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 CR

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).

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Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Step 7 – Manual Wheelchair Bases

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

1. The beneficiary must be a full-time manual wheelchair user OR
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.

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Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Step 7 – Manual Wheelchair Bases

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

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.

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Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Step 8 - Scooter / POV

Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter? IRP

A POV is a 3- or 4-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation.

The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a POV.

*Assess the beneficiary's ability to **safely** use a POV/scooter.*

NO

SKIP to Step 9

YES - Patient May Qualify for a Scooter

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Continue with Step 8

38

Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Step 8 – Scooter / POV

A POV (K0800-K0802) is covered if all of the basic coverage criteria have been met.

The patient is able to:

- Safely transfer to and from a POV, and
- Operate the tiller steering system, and
- Maintain postural stability and position while operating the POV in the home.
- The patient's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home.
- The patient's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided.
- The patient has not expressed an unwillingness to use a POV in the home.

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Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Step 9 – Power Wheelchair Base

Are the additional features provided by a power wheelchair needed to allow the beneficiary to participate in one or more MRADLs?

The pertinent features of a power wheelchair compared to a POV are typically control by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.

***NOTE:** If the beneficiary is unable to use a power wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair is appropriate. A caregiver's inability to operate a manual wheelchair can be considered in covering a power wheelchair so that the caregiver can assist the beneficiary.*

NO

Patient DOES NOT Qualify for Power Chair

YES Proceed to Determine Appropriate Power Chair

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40

Mobility Assistive Equipment 9 Step Algorithm (coverage criteria)

Step 9 – Power Wheelchair Base

Captains seat – Can't support cushions
Solid seat – Support cushions
No power – No power functions, power ELRs, power seat elevation
Single power – Tilt OR Recline OR Alternative Drive (head array, sip and puff, etc)
Multiple power – Tilt and Recline / Vent on the chair

Group 2 bases – Non complex and Complex (tilt, recline)

Group 3 bases – Neurological, myopathy or congenital skeletal deformity condition causing the mobility limitation

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Accessories

Once the base has been determined the LCMP must address medical necessity for all separately provided accessories such as (not all inclusive)

- Cushion and back
- Power positioning (tilt, recline, tilt and recline, seat elevation, power legs)
- Swing away mounting hardware
- Angle adjustable footplate

Each separate accessory MUST be justified in order for insurance to pay for these!

Make the note as clear as possible the reason this specific patient requires the accessory and NOT only the accessory's purpose.

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42

Thank You for Attending

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