Medical Necessity and Home Environment Evaluation Form for Manual Wheelchair, Power-Operated Vehicle, Accessories and Repairs

Mass Advantage Premiere (PPO), Mass Advantage Basic (HMO), and Mass Advantage Plus (HMO) Plans review provider requests on behalf of members for the initial purchase and delivery of a wheelchair and accessories, and wheelchair accessories, batteries, replacement parts or repair item (batteries, tubes, tires, etc) purchases more than one year from initial wheelchair delivery. Providers should complete and submit this form if the members' condition and/or mobility needs change.

This form complies with the benefits plans and medical necessity requirements in our Mass Advantage Medicare Advantage Plans, cited above, and aligns with the Centers for Medicare and Medicaid (CMS) National Coverage Determination (NCD) policies, the Original Medicare guidance in Medicare manuals, and Massachusetts Medicare Administrative Contractors Local Coverage Determination (LCD) policies.

Instructions

1) Complete each question on this form and fax to 888-656-7783 or call 866-312-8467.
2) Include all medical record documentation that supports your request.
3) For the initial purchase of the Wheelchair and Accessories, complete the top portion of the form. For Accessories (batteries, repairs, etc) after the initial one-year Wheelchair installation, complete the questions at the bottom of the form.
4) Note that with the current Public Health Emergency (PHE) in effect, the Medicare requirement for a Face -to-Face and Detailed Written Order that requires practitioners (MD, DO, DPM, PA, NP, CNS) to examine the Medicare beneficiary within 6 months for certain DME items is suspended. When the PHE is lifted and Medicare resumes this Face to Face and Detailed Written Order requirement, Mass Advantage will comply with the requirement.

Requesting Provider Contact Information

Name of Provider: ________________ NPI Number_________________

Address (Street, State, Zip Code):

____

Phone Number: _____________________ Fax Number: ________________

Patient Demographic Information

Beneficiary / Patient Name: ______________________________ Date of Birth: ___________

Relationship to Patient:

____

Patient ID Number: __________________________ Group Number: ___________________

Patient Address (Street, State, Zip Code):

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Patient Clinical Information

Height: _______________ Weight: ______________ Gender: ______________

Referral Number, if applicable: ____

Primary Diagnosis: ____________________ Date: _____________ Acute Chronic

Secondary Diagnosis: __________________ Date: _____________ Acute Chronic

Date you examined your patient (if applicable):____________________________________

Medical Necessity and Home Evaluation

1) Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home? Y N

2) What has changed in your patient's medical condition that now impairs the patient's mobility?

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3) What was the patient's mode of mobility in the home prior to this request?

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4) Why would a manual wheelchair not meet the patient's mobility needs in the home?

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5) Where will the patient primarily use the mobility device?

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6) Does the patient's home provide adequate access between rooms and doorways, adequate maneuvering space, and appropriate floor surfaces for use of the requested mobility device? Y N

7) Will the patient need the mobility device for longer than 6 months? Y N

8) Does the patient have mental capabilities (judgment, cognition) and physical capabilities (vision, trunk control) to safely operate the mobility device? Y N

9) Can the patient safely transfer in and out of the mobility device? Y N

10) Has the patient / caregiver demonstrated the ability to use the wheelchair correctly?
Y N

11) What wheelchair accessories, not included within the base code, (see LCD L33788 Manual Wheelchair Bases and LCD L33789 Power Mobility Devices) do you anticipate the patient requiring and why? Please discuss your request for each HCPCS code.

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Complete To Request Wheelchair Accessories, Repairs, Equipment *After One Year From Initial Delivery*

1) Has anything changed in your patient's medical condition or has the patient changed provider?

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2) What wheelchair accessories or repairs are required and why? Please discuss your request for each HCPCS code.

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Provider Attestation and Signature

The provider attests that a face-to-face examination and evaluation of the patient and home have been conducted, and that the equipment being requested is medically necessary and appropriate for the patient. The provider further attests that the home environment supports the safe and successful operation of the wheelchair and that the questions above have been completed honestly and accurately.

Provider Signature:

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Provider Name: ________________________________ **Date:** ____________