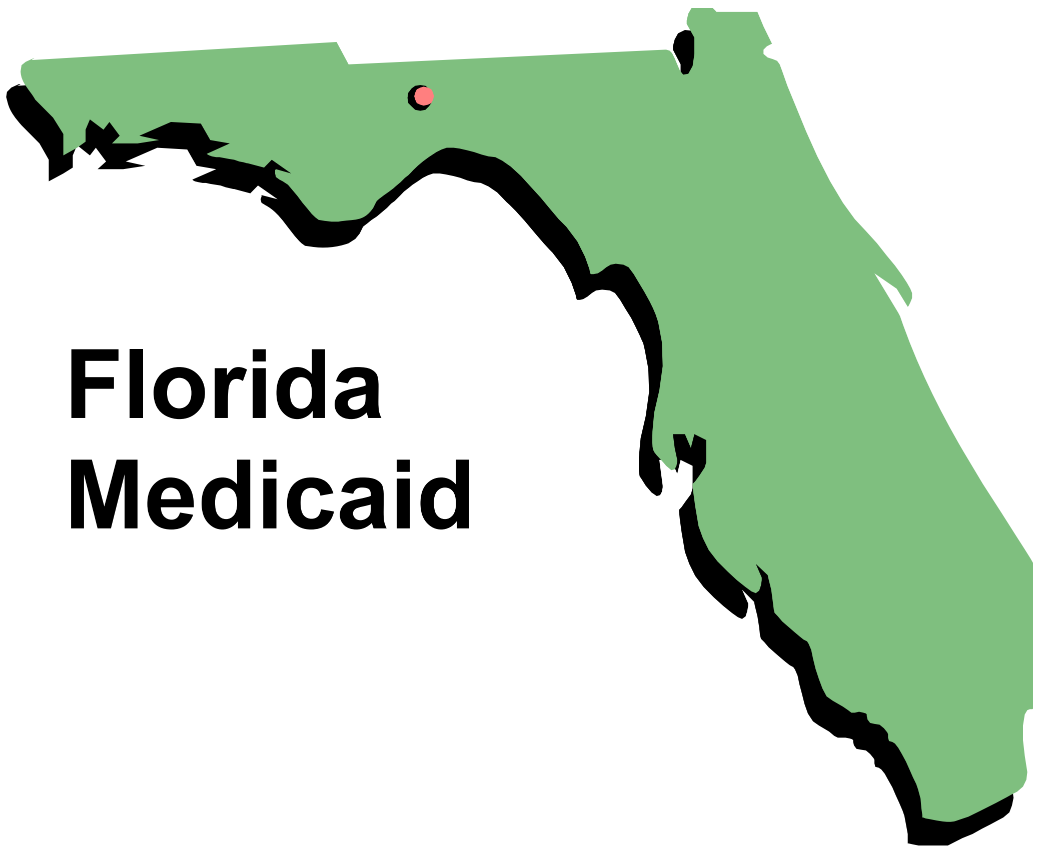

Wheelchairs, Walking Assistance, and Adaptive Durable Medical Equipment and Medical Supplies Services Coverage Policy

Agency for Health Care Administration

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1.0 Introduction

Florida Medicaid wheelchairs, walking assistance, and adaptive durable medical equipment and medical supply (DME) services provide medical equipment and other items to recipients to promote, sustain, or maintain a recipient's mobility at home or in the community.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render wheelchairs, walking assistance, and adaptive DME services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.3 Legal Authority

Florida Medicaid DME services are authorized by the following:

- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR)
- Section 409.906, Florida Statutes (F.S.)

1.4 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to Florida Medicaid's Definitions Policy.

1.4.1 Claim Reimbursement Policy

A policy document found in Rule Division 59G, F.A.C. that provides instructions on how to bill for services.

1.4.2 Coverage and Limitations Handbook or Coverage Policy

A policy document found in Rule Division 59G, F.A.C. that contains coverage information about a Florida Medicaid service.

1.4.3 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C. containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.4.4 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.4.5 Provider

The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.4.6 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary wheelchairs, walking assistance, and adaptive DME services. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance and Copayments

There is no coinsurance or copayment for this service in accordance with section 409.9081, F.S. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid's Copayments and Coinsurance Policy.

3.0 Eligible Provider

3.1 General Criteria

Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid wheelchairs, walking assistance, and adaptive DME services.

3.2 Who Can Provide

Services must be rendered by one of the following:

- Durable medical equipment and supply services businesses fully licensed in accordance with Chapter 400, F.S.
- Orthopedic physicians' groups, primarily owned by physicians fully licensed in accordance with Chapter 468, F.S.
- Pharmacies fully licensed in accordance with Chapter 465, F.S.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers the following services in accordance with the American Medical Association's Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS), and the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

- Custom and specialized equipment when a less costly alternative is not available to fulfill the recipient's need
- Equipment maintenance and repair
- Hospital beds and accessories:
  - Manual
  - Electric
  - Semi-electric
  - Heavy duty
- Motorized scooters

- Rent-to-purchase or rental equipment
  - Up to the total of ten monthly claims for rent-to-purchase equipment

  Durable medical equipment and medical supplies provided under a rent-to-purchase agreement between the provider and a recipient becomes the personal property of the recipient at the end of the lease.

- Traction equipment
- Trapeze equipment, fracture frame, and other orthopedic devices
- Walking assistance devices:
  - Canes
  - Crutches
  - Rollabout chair and transfer system
  - Walkers
- Wheelchairs, accessories and power-conversion kits:
  - Amputee
  - Customized or non-customized manual
  - Customized or non-customized power
  - Lightweight and heavy duty
  - Semi and fully reclining
  - Special size
- Used and refurbished equipment

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- Customized wheelchair rentals
- Items listed or identified in a procedure code's description that are billed separately
- Personal comfort, convenience, hygiene, or sanitation items
- Power wheelchair component for standing
- Precautionary-type equipment (e.g., power generators)
- Repairs, replacement, and maintenance of any equipment in cases of misuse, abuse, neglect, loss, or wrongful disposition of equipment by a recipient, a recipient's legal representative, responsible caregiver, or provider
- Replacement parts, repairs, or labor for equipment within the warranty period
- Shipping, handling, labor, measuring, fitting, or adjusting separately
- Transit tie downs

- Travel time and repair assessment time
- Wheelchair power attendant control, lifts, or ramps

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's Recordkeeping and Documentation Policy.

6.2 Specific Criteria

Providers must maintain one of the following in the recipient's file:

- Certificate of Medical Necessity that meets the following requirements:
  - Specifies the type of DME prescribed
  - Is less than 12 months old
  - Is dated within 21 days after the initiation of service
- Current hospital discharge plan that clearly describes the type of DME item or service ordered
- Written prescription

The documentation must be individualized and specify all of the following:

- Type of medical equipment
- Quantity
- Frequency of use
- Length of time the recipient requires DME

Providers must maintain the following documentation in the recipient's file, as applicable:

- Custom Wheelchair Evaluation, AHCA Med Serv Form 015, July 2007, incorporated by reference
- Equipment and supply delivery, pick-up, and return documentation
- Recipient training documentation
- Rental equipment documentation
- Replacement of stolen or destroyed equipment documentation
- Used equipment documentation

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's Authorization Requirements Policy.

7.2 Specific Criteria

Providers must obtain authorization from the quality improvement organization as follows:

- When indicated on the applicable Florida Medicaid fee schedule(s)
- For non-classified procedure codes
- To exceed the coverage limits specified in section 4.0 for recipients age 21 years or older

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Claim Type

Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, incorporated by reference in Rule 59G-4.002, F.A.C.

Providers must include a non-classified procedure code for customized equipment on the claim form.

8.4 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate

For a schedule of rates, incorporated by reference in Rule 59G-4.002, F.A.C., visit AHCA's Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

8.5.1 By Report Claims

Providers must submit medical necessity and product or service documentation to AHCA for pricing.

8.5.2 Rental Equipment

Florida Medicaid reimburses for rental equipment at the prorated daily amount of the monthly rate, per day.

8.5.3 Used and Refurbished Equipment

Florida Medicaid reimburses for used equipment at the lesser of 66% of:

- The provider's usual and customary fee for new equipment
- The maximum rate on the applicable fee schedule

Florida Medicaid reimburses for refurbished equipment at 100% of the maximum rental fee on the applicable fee schedule.

9.0 Appendix

9.1 Custom Wheelchair Evaluation Form

9.1 Custom Wheelchair Evaluation

The intent of this form is to secure sufficient information to determine the medical necessity for a custom wheelchair request submitted for prior approval to Florida Medicaid.
This form must be completed by the licensed therapist or the certified physiatrist performing the evaluation. The evaluator may choose to include additional information that substantiates medical necessity for the equipment requested.

Recipient Name:	Date Referred:	Date of Evaluation:
Address:	Phone:	Physician:
	Age: Sex:	OT:
Funding:	Date of Birth:	PT:
Referred By:	Height:	
	Weight:	
Medicaid ID #		

Reason for Referral:

Patient Goals:

Caregiver Goals:

MEDICAL HISTORY:

Dx:	ICD: ICD: ICD: ICD:
Date of injury or onset:	
Prognosis/ Hx:	
Recent / Planned Surgeries:	
Cardio-Respiratory Status: ❐Intact ❐Impaired	Comments:

CURRENT SEATING / MOBILITY: (Type – Manufacturer – Model)

Chair:			Age:
Serial #			
W/C Cushion:	Age:	**W/C Back**:	Age:
Other Positioning Components:			
Reason for ❐Replacement / ❐Repair / ❐Update:			
Funding Source:			

AHCA Med Serv Form 015, July 2007 (incorporated by reference in Rule 59G-4.075, F.A.C.)

HOME ENVIRONMENT:

❒House	❒Apt	❒Asst Living	❒LTCF	❒Alone	❒w/ Family-Caregivers:
Length of time at residence:					
Entrance: ❒Level	❒Ramp	❒Lift	❒Stairs	Entrance Width:	
W/C Accessible Rooms: ❒Yes	❒No	Narrowest Doorway Required to Access:			
Is a caregiver available 24 hours a day: ❒Yes	❒No	If no, how many hours a day is a caregiver available?			
Comments:					
TRANSPORTATION: ❒Car	❒Van	❒Bus	❒Adapted W/C Lift	❒Ramp	❒ Ambulance ❒Other:

COGNITIVE / VISUAL STATUS:

Memory Skills	❒Intact:	❒Impaired:	Comments:
Problem Solving	❒Intact:	❒Impaired:	Comments:
Judgment	❒Intact:	❒Impaired:	Comments:
Attn / Concentration	❒Intact:	❒Impaired:	Comments:
Vision	❒Intact:	❒Impaired:	Comments:
Hearing	❒Intact:	❒Impaired:	Comments:
Other	❒Intact:	❒Impaired:	Comments:

ADL STATUS:	Indep	Assist	Unable	Comments / Other AT Equipment Required
Dressing	❒	❒	❒	
Bathing	❒	❒	❒	
Feeding	❒	❒	❒	
Grooming/Hygiene	❒	❒	❒	
Toileting	❒	❒	❒	
Meal Prep	❒	❒	❒	
Home Management	❒	❒	❒	
Bowel Management:	❒Continent	❒Incontinent		
Bladder Management:	❒Continent	❒Incontinent		

MOBILITY SKILLS:	Indep	Assist	Unable	N/A	Comments
Bed ↔ W/C Transfers	❒	❒	❒	❒	
W/C ↔ Commode Transfers	❒	❒	❒	❒	
Ambulation:	❒	❒	❒	❒	Device:
Manual W/C Propulsion:	❒	❒	❒	❒	
Operate Power W/C w/ Std. Joystick	❒	❒	❒	❒	
Operate Power W/C w/ Alternative Controls	❒	❒	❒	❒	
Ability to Stand	❒	❒	❒	❒	
Able to Perform Weight Shifts	❒	❒	❒	❒	Type:
Hours Spent Sitting in W/C Each Day:			Comments:		

AHCA Med Serv Form 015, July 2007 (incorporated by reference in Rule 59G-4.075, F.A.C.)

SENSATION:

❐Intact ❐Impaired ❐Absent	Hx of Pressure Sores ❐Yes ❐No
Current Pressure Sores ❐Yes ❐No	Location/Stage
Comments:	

CLINICAL CRITERIA / ALGORITHM SUMMARY

Is there a mobility limitation causing an inability to safely participate in one or more Mobility Related Activities of Daily Living (MRADL) in a reasonable time frame? ❐Yes ❐No
Explain:

Are there cognitive or sensory deficits (awareness, judgment, vision, etc..) that limit the user's ability to safely participate in one or more MRADL's or ADL's? ❐Yes ❐No
If yes, can they be accommodated or compensated for to allow use of a mobility assistive device to participate in MRADL's? ❐Yes ❐No
Explain:

Does the user demonstrate the ability or potential ability and willingness to safely use the mobility assistive device? ❐Yes ❐No
Explain:

Can the mobility deficit be sufficiently resolved with only the use of a cane or walker? ❐Yes ❐No
Explain:

Does the user's environment support the use of a ❐ MANUAL WHEELCHAIR ❐ POV ❐POWER WHEELCHAIR: ❐Yes ❐No
Explain:

If a manual wheelchair is recommended, does the user have sufficient function or abilities to use the recommended equipment? ❐Yes ❐No ❐N/A
Explain:

If a POV is recommended, does the user have sufficient stability and upper extremity function to operate it? ❐Yes ❐No ❐N/A
Explain:

If a power wheelchair is recommended, does the user have sufficient function or abilities to use the recommended equipment? ❐Yes ❐No ❐N/A
Explain:

RECOMMENDATION / GOALS:

❐ **MANUAL** WHEELCHAIR ❐ **POV** ❐**POWER** WHEELCHAIR: ❐**POSITIONING SYSTEM**(TILT/RECLINE) ❐**SEATING**

MAT EVALUATION: (NOTE IF ASSESSED SITTING OR SUPINE)

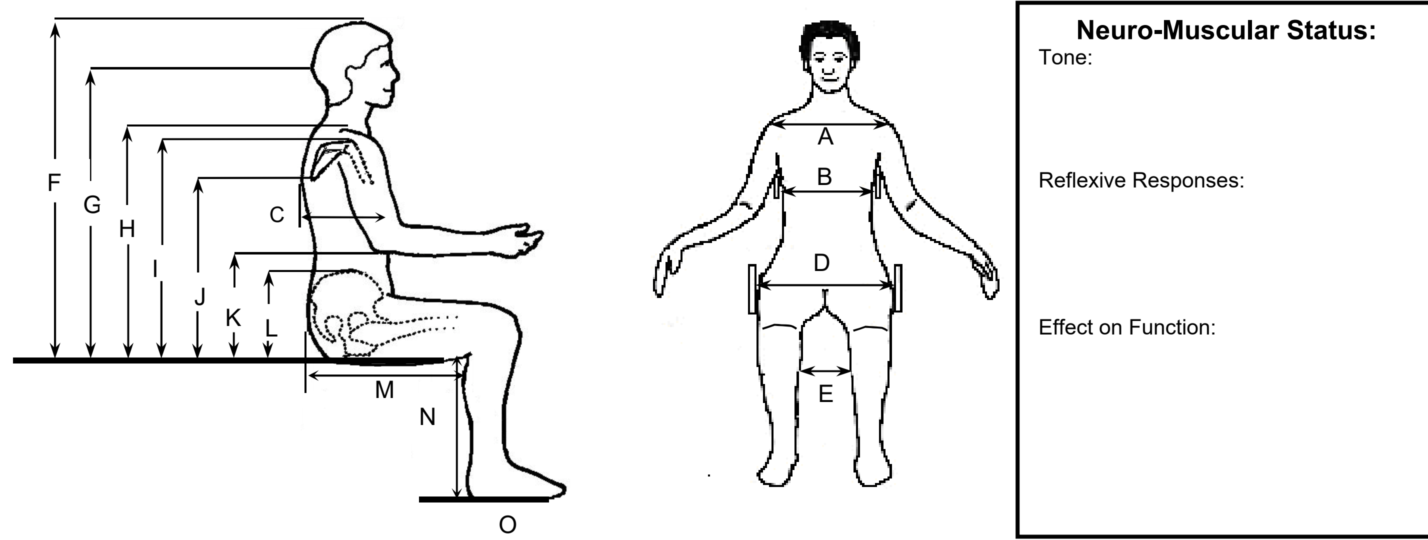
	POSTURE:	FUNCTION:	COMMENTS:	SUPPORT NEEDED
HEAD & NECK	❐ Functional ❐ Flexed ❐ Extended ❐ Rotated ❐ Laterally Flexed ❐ Cervical Hyperextension	❐ Good Head Control ❐ Adequate Head Control ❐ Limited Head Control ❐ Absent Head Control ❐ Tone/ Reflex		

AHCA Med Serv Form 015, July 2007 (incorporated by reference in Rule 59G-4.075, F.A.C.)

UPPER EXTREMITY	**SHOULDERS** **Left**: ❒WFL ❒Elev / dep ❒Pro / retract ❒Subluxed **Right**: ❒WFL ❒Elev / dep ❒Pro / retract ❒Subluxed	**R.O.M.** **Strength:** **Tone/Reflex:**		
	ELBOWS **Left**: ❒Impaired ❒WFL **Right**: ❒ Impaired ❒ WFL	**R.O.M.** **Strength:** **Tone/Reflex:**		
WRIST & HAND	**Left**: ❒Impaired ❒WFL **Right**: ❒Impaired ❒WFL	**Strength / Dexterity:**		
TRUNK	**Anterior / Posterior** ❒ WFL ❒ ↑ Thoracic Kyphosis ❒ ↑ Lumbar Lordosis ❒ Fixed ❒ Flexible ❒ Partly Flexible ❒ Other	**Left Right** ❒ WFL ❒ Convex Left ❒ Convex Right ❒ Fixed ❒ Flexible ❒ Partly Flexible ❒ Other	**Rotation** ❒ Neutral ❒ Left Forward ❒ Right Forward ❒ Fixed ❒ Flexible ❒ Partly Flexible ❒Other	
PELVIS	**Anterior / Posterior** ❒ Neutral ❒ Posterior ❒ Anterior ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	**Obliquity** ❒ WFL ❒ Left Lower ❒ Rt. Lower ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	**Rotation** ❒ WFL ❒ Right ❒ Left ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	

AHCA Med Serv Form 015, July 2007 (incorporated by reference in Rule 59G-4.075, F.A.C.)

	Position	Windswept	Range of Motion	
HIPS	❒ Neutral ❒ ABduct ❒ ADduct ❒ Fixed ❒ Subluxed ❒ Partly Flexible ❒ Dislocated ❒ Flexible	❒ Neutral ❒ Right ❒ Left ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	Left / Right Flex: _____° _____° Ext: _____° _____° Int R: _____° _____° Ext R: _____° _____°	
KNEES & FEET	Knee R.O.M. Left: ❒ WFL ❒ Flex_____° ❒ Ext _____° Right: ❒ WFL ❒ Flex_____° ❒ Ext _____°	Strength: Hamstring ROM Limitations: (Measured at ___° Hip Flex) Left______ Right______ Orthosis? Prosthetic?	Foot Positioning ❒ WFL ❒L ❒R ❒ Dorsi-Flexed ❒L ❒R ❒ Plantar Flexed ❒L ❒R ❒ Inversion ❒L ❒R ❒ Eversion ❒L ❒R	Foot Positioning Needs:
MOBILITY	Balance Sitting Balance: ❒ WFL ❒ Min Support ❒ Mod Support ❒ Unable Standing Balance: ❒ WFL ❒ Min Support ❒ Mod Support ❒ Unable	Transfers ❒ Independent ❒ Min Assist ❒ Max Assist ❒ Sliding Board ❒ Lift or Sling Required	Ambulation ❒ Unable to Ambulate ❒ Ambulates with Assistance ❒ Ambulates with Device ❒ Independent without Device ❒ Indep. Short Distance Only	



Neuro-Muscular Status:

Tone:

Reflexive Responses:

Effect on Function:

AHCA Med Serv Form 015, July 2007 (incorporated by reference in Rule 59G-4.075, F.A.C.)

	Measurements in Sitting:	Left	Right	
	A: Shoulder Width			
	B: Chest Width			**H:** Top of Shoulder
	C: Chest Depth (Front – Back)			**I:** Acromium Process (Tip of Shoulder)
	D: Hip Width			**J:** Inferior Angle of Scapula
	** Asymmetrical Width			**K:** Elbow
	E: Between Knees			**L:** Iliac Crest
	F: Top of Head			**M:** Sacrum to Popliteal Fossa
	G: Occiput			**N:** Knee to Heel
				O: Foot Length

Additional Comments and please add Trunk and Pelvic width with brace/ Orthosis, when applicable.
** Asymmetrical Width: i.e., windswept or scoliotic posture; measure widest point to widest point

REQUESTED EQUIPMENT:

Requested Frame (make and model):
Dimensions:
Amount of growth available:

SIGNATURE:

As the evaluating therapist, I hereby attest that I have personally completed this five page evaluation form and that I am not an employee of, or working under contract to, the manufacturer(s) or the provider(s) of the durable medical equipment recommended in my evaluation. I further attest that I have not and will not receive remunerations of any kind from the manufacturer(s) or the Medicaid Durable Medical Equipment provider(s) for the equipment I have recommended with this evaluation. I accept the responsibility of performing a follow-up evaluation at the time of the initial fitting and delivery of the recommended equipment and will be available for a follow-up evaluation six months after the equipment was delivered to recommend any additional adjustments, if a six-month follow up evaluation is needed.

I am currently enrolled as a Medicaid provider and my provider number is: ☐

or, I am not currently enrolled as a Medicaid Provider and have attached a copy of my current license, as follows: (double click on appropriate box and select: Checked):

	License #
☐ Physical Therapy license	
☐ Occupational Therapy license	
☐ Physiatrist board certification	

Signature, as it appears on license or certification ______ ***Date*** ______ ***Daytime contact number(s)*** ______

Fax Number ______ ***Email Address*** ______ ***Cell phone number (optional)*** ______

Optional:

Physician: I have read & concur with the above assessment ______ **Date:** ______ **Phone:** ______

AHCA Med Serv Form 015, July 2007, (incorporated by reference in Rule 59G-4.075, F.A.C.)