L23613 Power Mobility Devices POV

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Provider No. 6385310001

PHYSICIAN: _____

_____

_____

UPIN _____ **NPI** _____

Phone _____

PATIENT: _____

_____

_____

Phone _____

DOB _____

Policy: _____

Initial Date _____

Revised Date _____

Recertification

Length of Need : _____

DIAGNOSIS

ICD-9 Code	**Description**
_____	_____
_____	_____

EQUIPMENT/SERVICES

Qty	**Proc. Code**	**Item Name/Narrative**
1	_____	POWER WHEELCHAIR

BASIC CRITERIA (A-C) MUST BE MET FOR POWER MOBILITY DEVICE

A.) 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 (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home? ☐ Y ☐ N

B.) Can the patient's mobility limitation NOT be sufficiently and safely resolved by the use of an appropriately fitted cane or walker? ☐ Y ☐ N

C.) Does the patient NOT have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day? ☐ Y ☐ N

IN ADDITION TO CRITERIA (A-C), POWER OPERATED VEHICLE (POV) IS COVERED IF CRITERIA (D-I) ARE ALSO MET

D.) Is the patient able to (i) safely transfer to and from a POV, and (ii) operate the tiller steering system, and (iii) maintain postural stability and position while operating the POV in the home? ☐ Y ☐ N

E.) Are the patient's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) sufficient for safe mobility using a POV in the home? ☐ Y ☐ N

F.) Does the patient's home provide adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided? ☐ Y ☐ N

G.) How much does the patient weigh? _____ lbs (Note that the patient's weight must less than or equal to the weight capacity of the POV/PWS that will be provided)

H.) Will use of a POV (Power Operated Vehicle) significantly improve the patient's ability to participate in MRADLs and the patient will use it in the home? ☐ Y ☐ N

I.) Has the patient expressed a willingness to use a POV in the home? ☐ Y ☐ N

IN ADDITION TO CRITERIA (A-C), PATIENT DID NOT MEET D, E OR F FOR A POV. POWER WHEEL CHAIR (PWC) IS COVERED IF CRITERION (J OR K) IS MET AND CRITERIA (L-O) ARE MET

J.) Does the patient have the mental and physical capabilities to safely operate the PWC that is provided? ☐ Y ☐ N or

K.) If the patient is unable to safely operate the power wheelchair, does the patient have a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the PWC that is provided? ☐ Y ☐ N and

L.) Does the patient's home provide adequate access between rooms, maneuvering space, and surfaces for the operation of the PWC that is provided? ☐ Y ☐ N

M.) How much does the patient weigh? _____ lbs (Note that the patient's weight must less than or equal to the weight capacity of the PWC that will be provided)

N.) Will use of a PWC significantly improve the patient's ability to participate in MRADLs and the patient will use it in the home? ☐ Y ☐ N

O.) Has the patient expressed a willingness to use a PWC in the home? ☐ Y ☐ N

Clinician Signature _____ **Date** _____