Indiana Health Coverage Programs

P R O V I D E R B U L L E T I N

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To: **All Indiana Health Coverage Programs Durable Medical Equipment Providers, Home Health Care Providers, Hospitals, Medical Clinics, and Physicians**

Subject: **Nonmotorized Wheelchair or Motorized Wheelchair Purchase**

Overview

Purchase of a nonmotorized wheelchair or motorized wheelchair is covered by the Indiana Health Coverage Programs (IHCP), and is subject to prior authorization (PA) review. Requests for purchase of both nonmotorized and motorized wheelchairs require submission of medical clearance forms. Effective **November 16, 2001**, the revised medical clearance form for nonmotorized or motorized wheelchair purchase must be submitted with the request for PA.

This bulletin addresses the revised medical clearance form information that will be used to make PA determinations for purchase of nonmotorized or motorized wheelchairs.

The new forms will replace the forms currently in the *IHCP Provider Manual*, in *Chapter 6: Prior Authorization*. The new forms will also be available on the IHCP Web site at www.indianamedicaid.com.

Prior Authorization Criteria

Nonmotorized or motorized wheelchairs will be authorized when medically necessary. Coverage may be considered in the following specific instances.

Motorized vehicles are covered only when the member is enrolled in a school, sheltered workshop, or work setting, or if the member is left alone for significant periods of time. It must be documented that the member can safely operate the vehicle and that the member does not have the upper extremity function necessary to operate a nonmotorized wheelchair. *(405 IAC 5-19-9)*

Requests for wheelchairs or similar motorized vehicles require that a completed medical clearance form be submitted with the PA request before the request is reviewed.

Documentation Requirements

The PA request must be accompanied by the following information:

- A diagnosis that supports the medical necessity
- A completed IHCP Medical Clearance form for purchase of a nonmotorized or motorized wheelchair. Health Care Excel (HCE) has updated the forms to reflect current policy and to address medical necessity. Examples of the revised forms are included in this bulletin. Medical necessity for nonmotorized and motorized wheelchair purchase must be clearly documented on the form in the section, *Functional Status*.
- A completed IHCP Medical Clearance for Motorized Wheelchair Purchase that includes the motorized wheelchair criteria.

Further Information

Questions about this bulletin can be directed to the Health Care Excel Prior Authorization department at (317) 347-4500.

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Medical Clearance for Non-Motorized Wheelchair Purchase

Member Name: _____ **RID#** _____

Primary and Secondary Diagnoses: _____ **Length of illness:** _____

Height: **Weight:**

405 IAC 5-19-9 (a) – Medicaid reimbursement is available for wheelchairs or similar motorized vehicles, subject to the restrictions in this section, and requires prior authorization. (c) Requests for wheelchairs or similar motorized wheelchairs require a completed medical clearance form submitted with the prior authorization request before the request shall be reviewed.

1. Does the member currently have a wheelchair? _____ What brand and model? _____
2. What is the condition of the current chair? _____
3. Why is this chair no longer effective for this member? Explain

   _____

   _____
4. Can it be repaired? Estimated cost? Will this chair be a second chair for this person?

Functional Status

Please provide the functional status of the member that warrants the use of the wheelchair and accessories.

1. Upper extremities (be specific) _____
2. Lower extremities (be specific) _____
3. Hand function (be specific) _____
4. Contractures (be specific) _____
5. Neck/spine (be specific) _____
6. Static/dynamic sitting balance (be specific) _____
7. Ambulation (be specific) _____
8. Transfer/bed mobility (be specific) _____
9. ADLS (be specific) _____

   _____

   _____
10. Medical problems that require special positioning equipment (be specific) _____

    _____
11. Other _____

    _____

The provider may submit an Occupational Therapy or Physical Therapy evaluation if the above information is not sufficient for review.

Residence

Where does the member reside? ☐ Home ☐ Group Home ☐ Nursing Facility ☐ ICF/MR

Nursing Facility or ICF/MR

405 IAC 5-19-3 (b) DME and associated repair costs for the usual care and treatment of members in long term care facilities are reimbursed in the facility's per diem rate and may not be billed to Medicaid by the facility, pharmacy, or other provider. Nonstandard or custom/special equipment and associated repair costs require prior authorization by the office, and may be billed separately to Medicaid, when authorized.

1. If the member resides in a nursing facility or ICF/MR, what modifications are currently on the per diem wheelchair or previously used on the per diem wheelchair to improve the member's function? _____

   _____

   _____

   _____

(Continued)

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2. If these modifications to the per diem wheelchair failed, please explain why. _____

3. If no modifications were added to the per diem wheelchair, please explain why. _____

Wheelchair Specifications

1. Specify the Brand and Model of the requested wheelchair.
2. What are the special features of the above-mentioned wheelchair that are needed by the member?

Special Feature		Body Measurements	
a.	Hemi height	Knee to heel	_____
b.	Seat depth	Femur length	_____
c.	Seat width	Hip width	_____
d.	Other		_____

Wheelchair Accessories

List the accessories needed to make this wheelchair functional for the member and the corresponding problem that will be corrected or will be prevented from worsening. Use an additional page if more items need to be listed.

Accessory	Member Specific Problem Corrected

Comments:

Signature and Title _____ **Date** _____

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Medical Clearance for Motorized Wheelchair Purchase

Member Name: _____ **RID#** _____

Primary and Secondary Diagnoses: _____ **Length of illness:** _____

Height: **Weight:**

405 IAC 5-19-9 (a) – Medicaid reimbursement is available for wheelchairs or similar motorized vehicles, subject to the restrictions in this section, and requires prior authorization.

Motorized vehicles are covered only when the member is enrolled in a school, sheltered workshop, or work setting, or if the member is left alone for significant periods of time. It must be documented that the member can safely operate the vehicle and that the member does not have the upper extremity function necessary to operate a manual wheelchair.

(c) Requests for wheelchairs or similar motorized wheelchairs require a completed medical clearance form submitted with the prior authorization request before the request shall be reviewed.

1. Does the member currently have a wheelchair? _____ What brand and model? _____
2. What is the condition of the current chair? _____
3. Why is this chair no longer effective for this member? Explain _____
4. Can it be repaired? Estimated cost? Will this chair be a second chair for this person?

Functional Status

Please provide the functional status of the member that warrants the use of the wheelchair and accessories.

1. Upper extremities (be specific) _____
2. Lower extremities (be specific) _____
3. Hand function (be specific) _____
4. Contractures (be specific) _____
5. Neck/spine (be specific) _____
6. Static/dynamic sitting balance (be specific) _____
7. Ambulation (be specific) _____
8. Transfer/bed mobility (be specific) _____
9. ADLS (be specific) _____
10. Medical problems that require special positioning equipment (be specific) _____
11. Other _____

The provider may submit an Occupational Therapy or Physical Therapy evaluation if the above information is not sufficient for review.

Residence

Where does the member reside? ☐ Home ☐ Group Home ☐ Nursing Facility ☐ ICF/MR

Motorized Wheelchair Criteria

1. Does the member live alone or have caregivers? If the member has a caregiver/family, how long is the member left alone? Explain _____

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2. Does the member have a caregiver in the home who is physically capable of assisting the member? Explain.

3. Is the member employed or attending a vocational or sheltered workshop? If so, where?

4. Does the member attend school? If so, where?

5. How does the member get to and from work, workshop, or school?

6. Can the member operate a manual wheelchair? If so, how far?

7. Does the member have the upper extremity function necessary to operate a motorized wheelchair? Explain.

8. Can the member safely operate the motorized wheelchair? Explain?

Wheelchair Specifications

1. Specify the Brand and Model of the requested wheelchair.

2. What are the special features of the above-mentioned wheelchair that are needed by the member?

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1. Specify the Brand and Model of the requested wheelchair. _____

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	Special Feature	Body Measurements	
a.	Hemi height	Knee to heel	_____
b.	Seat depth	Femur length	_____
c.	Seat width	Hip width	_____
d.	Other		_____

Wheelchair Accessories

List the accessories needed to make this wheelchair functional for the member and the corresponding problem that will be corrected or will be prevented from worsening. Use an additional page if more items need to be listed.

Accessory	Member Specific Problem Corrected

Comments:

Signature and Title **Date**