	E1161 – Manual Tilt in Space W/C Coverage Criteria and Documentation Requirements
	Coverage Criteria
1	The patient must 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. A mobility limitation is one that: 1. Prevents the patient from accomplishing an MRADL entirely, or 2. Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or 3. Prevents the patient from completing an MRADL within a reasonable time frame. The patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
	Documentation Required:
2	Must have patient height & weight documented
3	Must document why the patient is unable to ambulate with a cane or walker due to risk of falling or inability to complete one or more MRADLs in a timely manner
4	Must IDENTIFY at least one MRADL that the patient is unable to accomplish with a cane/walker/lesser level manual wheelchair and describe the specific limitation. • Bathing, dressing, toileting, meal preparation/feeding, grooming
5	Current equipment: • It must be identified why the patient's current equipment is no longer appropriate for them to participate in MRADLs. • What specific medical event (change in medical condition) occurred to render the current equipment no longer appropriate? • What other equipment was either trialed or considered and ruled out and WHY? o ALL less costly alternatives must be ruled out
6	Must document that the patient cannot propel him/her-self in a standard, lightweight, high strength lightweight wheelchair and an ultra lightweight wheelchair and **how the recommended tilt in space chair will allow the patient to participate in MRADLs**, and
7	Any current or past history of skin breakdown must be documented with date and staging of the wound. (this is particularly important when requesting a skin protection cushion (E2603/E2604, E2607/E2608, E2622/E2623, or E2624/E2625), and
8	A specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT) or physician who has specific training and experienced in rehabilitation wheelchair evaluations documents the patient's seating and positioning needs. This evaluation must be in a narrative format, not a simple check box and must individually address the patient's seating needs. The PT, OT, or physician may have no financial relationship with the supplier; and
9	Must Document that the patient is at high risk for development of a pressure ulcer and is ***unable to perform a functional weight shift***; (The documentation must also identify the patient's ability to transfer and demonstrate that the patient requires more than "supervision" to accomplish a transfer – which would supplement that the patient is unable to perform a "functional weight shift"), and
10	Must Document that the patient utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed (more appropriate for a reclining back than tilt in space), and
11	Must document that the patient has a caregiver who is available, willing, and able to provide assistance with the wheelchair for participation in MRADLs (bathing, dressing, feeding, and toileting).

Notes :

Manual Tilt Wheelchair Functional Mobility Evaluation/LMN

Patient Information:

Name: **Date:**

Address: **City:** **State:**

Phone #: **Date of Birth:** **Zip:**

Insurance: **Ht:** **Wt:**

Medical History:

Medical Diagnoses:
Written Description/ICD-10 Code(s)

What is the current mobility equipment that the patient is using and specifically why does it not allow the patient to complete one or more MRADLs completely, safely, or in a timely manner (please identify which MRADL is limited and quantify that limitation):
Current device:

Which MRADL does this affect?

MRADL: Dressing Toileting Bathing Feeding/meal prep Grooming

Patient name:

Describe the specific mobility limitation with their current equipment:

Describe what changes in their medical condition occurred that necessitated a new chair?

Describe current ambulation status: **Non ambulatory**

UE ROM WFL's	UE Strength
LE ROM WFL's	LE Strength

Describe Functional Strength, Endurance, or pain limitations in relation to mobility related activities of daily living (MRADLs):

Patient name:

Seating & Positioning:
Pelvic position:

Level **Obliquity** **Pelvic tilt** **(sacral sitting/posterior pelvic tilt)**

Head control and spinal posture:

Skin integrity/condition:
Current pressure injury **(location(s) and stage):**

Past history of pressure injury **(location(s) and stage):**

Sensation: **Intact** **Impaired - Explain:**

Muscle tone, spasticity, spasms, trunk strength that impairs posture:

Transfers (Method & Assistance Required):

Is patient dependent for mobility? **Yes** **No - Describe:**

Patient name:

Describe the reason why the following mobility assistive equipment does not meet the patient's mobility needs to accomplish the MRADL identified on page 1:
Cane/Walker:

Appropriately configured manual wheelchair:

<u>Tilt and/or recline seating systems</u>

Is the patient at high risk for development of pressure sores? Yes No

Is the patient able to perform a functional weight shift Yes No

Does the patient use intermittent catheterization for bladder management and/or is unable to independently transfer? Yes No

Is the seating required to manage increased tone or spasticity? Yes No
If yes, please explain

<u>Tilt</u>, please explain if required:

Patient name:

Tilt and/or recline seating systems (continued):

Recline, please explain why recline is required:

If the patient requires a molded seat or back:
Does the patient have skeletal and/or physical deformities/abnormalities that require custom molded seating system: (explain?)

Does the patient have significant postural asymmetries? (explain):

Explain why the patient's needs cannot be met by standard seating components?

How many hours per day will the patient utilize the wheelchair:

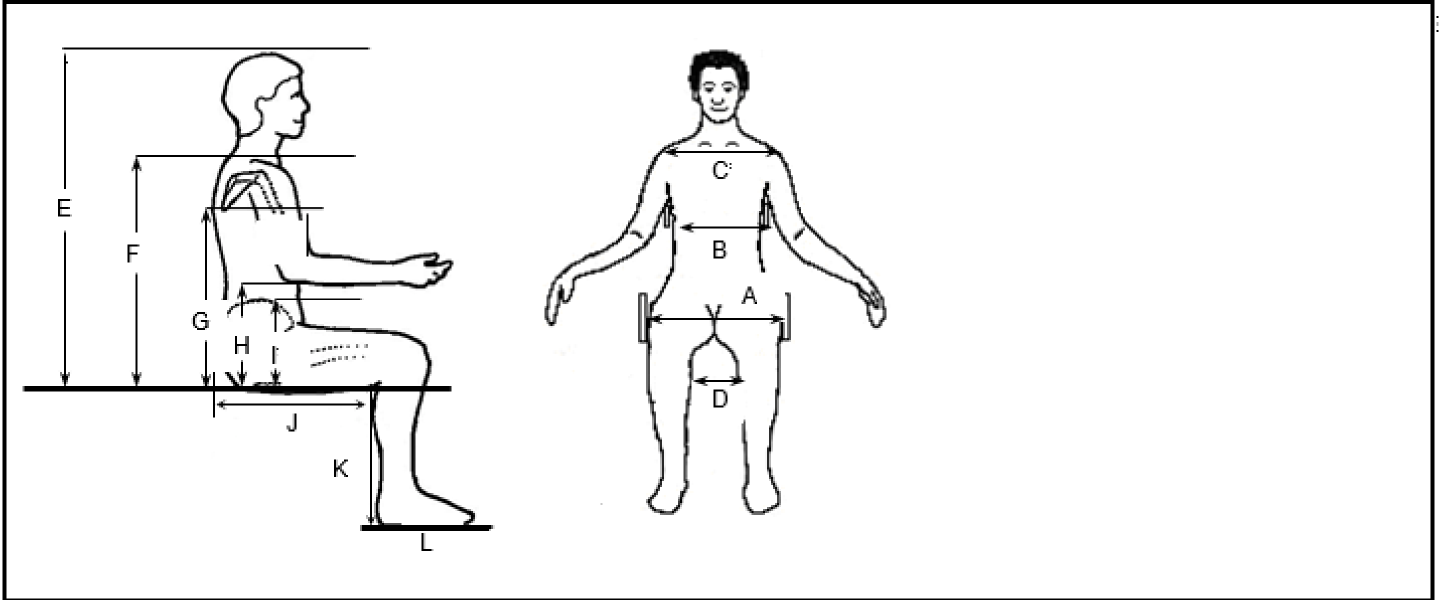
Alternate equipment trialed or considered and ruled out and why?

Does the patient have a caregiver who is able to provide assistance with the wheelchair?
Yes: No:

If yes, who is it?

Patient name:

Patient Measurements: Taken By: **Date Taken:**



	Measurements in Sitting:	**Left**	**Right**	
	A: Hip Width			**F: Seat to Top of Shoulder**
	Overall Width (asymmetrical)			**G: Seat to Axilla**
	B: Chest Width			**H: Seat to Elbow**
	Chest Depth			**I: Seat to PSIS**
	C: Shoulder Width			**J: Upper Leg Length**
	D: Abduction			**L: Lower Leg Length**
	E: Seat to Top of Head			**M: Foot Length**

COMMENTS:

Patient name:

Additional information:

EQUIPMENT	JUSTIFICATION

Patient name:

EQUIPMENT	JUSTIFICATION

Patient name:

EQUIPMENT	JUSTIFICATION

Patient name:

EQUIPMENT	JUSTIFICATION

Patient name:

EQUIPMENT	JUSTIFICATION

Therapist:

Therapist name:____________________________________ **License #:** __________________

Company name: ____

Address: ____ **Phone #:**____________________

City:____**State:**____________**Zip:**______________

Signature: ____ **Date:** _______________________

My signature affirms that I completed each section of this evaluation based upon my own clinical knowledge, training and evaluation of the person's medical condition. I attest that there is no financial relationship between the supplier and me.

Physician:

By signing below I certify that the equipment being requested is reasonable and necessary and I agree with this assessment. I also agree to include this evaluation as part of my medical records to substantiate the need for the wheelchair.

Physician name: ____________________________________ **NPI:**_________________________

Address:____ **Phone #:**____________________

City:____**State:**____________**Zip:**______________

Signature: ____________________________________ **Date:** __________________

My signature affirms that I concur with the findings of this therapy evaluation and will agree to make this assessment part of my medical record for this patient.

Please attach a copy of the patient's medical record (physician office/chart notes) that reflects the need for the wheelchair per Medicare guidelines.