	K0005 – Ultra Lightweight W/C **Coverage Criteria and Documentation Requirements**
	Coverage Criteria:
1	a.) 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. b.) The patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. c.) The patient must be a full time wheelchair user d.) The patient must require individualized fitting and adjustment for one or more features such as, but not limited to, axle configuration, wheel camber, or seat and back angles, and which cannot be accommodated by a lower level wheelchair (K0001 through K0004).
	Documentation Required:
2	Must have patient height & weight documented
3	Must IDENTIFY at least one MRADL that the patient is unable to accomplish with their **current equipment** (cane/walker/lesser level manual wheelchair) and describe the specific limitation. • Bathing, Dressing, Toileting, Meal preparation/feeding, Grooming What specific medical event (change in medical condition) occurred to render the current equipment no longer appropriate?
4	Must document why the patient is unable to ambulate with a **cane or walker** (identify specific reasons) to complete one or more MRADLs in a timely manner
5	Must document specific reasons why the patient cannot propel him/herself in a standard, lightweight, or high strength lightweight **manual wheelchair**, but is able to independently propel him/herself in an ultra lightweight wheelchair (possibly through a trial) and the use of an ultra lightweight wheelchair will allow them to accomplish the MRADL in a safe or timely manner
6	Must document that the patient is a **full time manual wheelchair user**
7	Must document a description of the patient's **routine activities** that he/she participates in on a daily basis, and whether the patient is fully independent in the use of the wheelchair.
8	The medical documentation must include a description of the **features of the ultra lightweight wheelchair that are not available on a high strength lightweight wheelchair (K0004)** o The center of the wheel may be positioned for stability, safety and efficient propulsion. • Axle position forward for improved propulsion efficiency and decreased effort to propel for a full time wheelchair user. • Axle position higher on frame to lower rear seat to floor height compared to front seat to floor height to allow gravity to assist the user with postural stability o Wheel Camber improves maneuverability and lateral stability o Back angle • A open angle (slight recline) can help compensate for a weakened trunk or reduced hip range • A closed angle (forward bend) can help to move the center of gravity forward to improve safety (prevent the chair from tipping backwards). o The frame of the chair allows for a seat height not available on a lower level chair. • Lower than a super low hemi height to allow for foot propulsion.
9	Must document the patient has sufficient UE function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, ROM, or coordination, presence of pain, or deformity or absence of one or both UE's are relevant to the assessment of the UE function.

Notes:

Ultra Lightweight (K0005) Wheelchair
Functional Mobility Evaluation/LMN

Patient Name: **Date:**

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

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

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

Medical History:

Medical Diagnoses: (as related to the need for wheelchair and accessories)
Written Description/ICD-10 Codes

Patient name:

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:

MRADL: ☐ **Dressing** ☐ **Toileting** ☐ **Bathing** ☐ **Feeding/meal prep** ☐ **Grooming**
Specific mobility limitation:

Please describe what specific changes in the patient's medical condition have occurred that prevent the patient from accomplishing this MRADL with their current mobility assistive device:

Medicare uses an algorithmic approach for identifying which mobility assistive device/equipment is the most appropriate for your patient. Please describe the reason all lower level items (cane, walker, standard/lightweight wheelchair, and any other equipment that was considered and ruled out) will not allow your patient to complete the MRADL safely or in a timely manner: (must be in objective and measurable terms):

Cane/ Walker:

Standard/Lightweight wheelchairs:

Patient name:

Is the patient a full time wheelchair user? ☐ **Yes** ☐ **No**

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

Sitting Balance:

Spinal Posture:

Skin Integrity (past or current pressure ulcers):

UE ROM & STRENGTH	☐ **ROM WFL's**
LE ROM & STRENGTH	☐ **ROM WFL's**

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

Patient name:

Edema:

Pain Location (and rating of 0-10):

How does pain limit the patient's ability to participate in an MRADL with their current mobility assistive device?

Transfer ability and independence/assistance/equipment needed:

Please describe/list the type of activities the patient frequently encounters on a daily routine:

Additional information:

Patient name:

What specific frame configurations that are not available on a lower level chair (K0001-K0004) are required by the patient through individual fitting and adjustment and why?

<u>Axle configuration</u> - Medical Justification:

Wheel camber - Medical Justification:

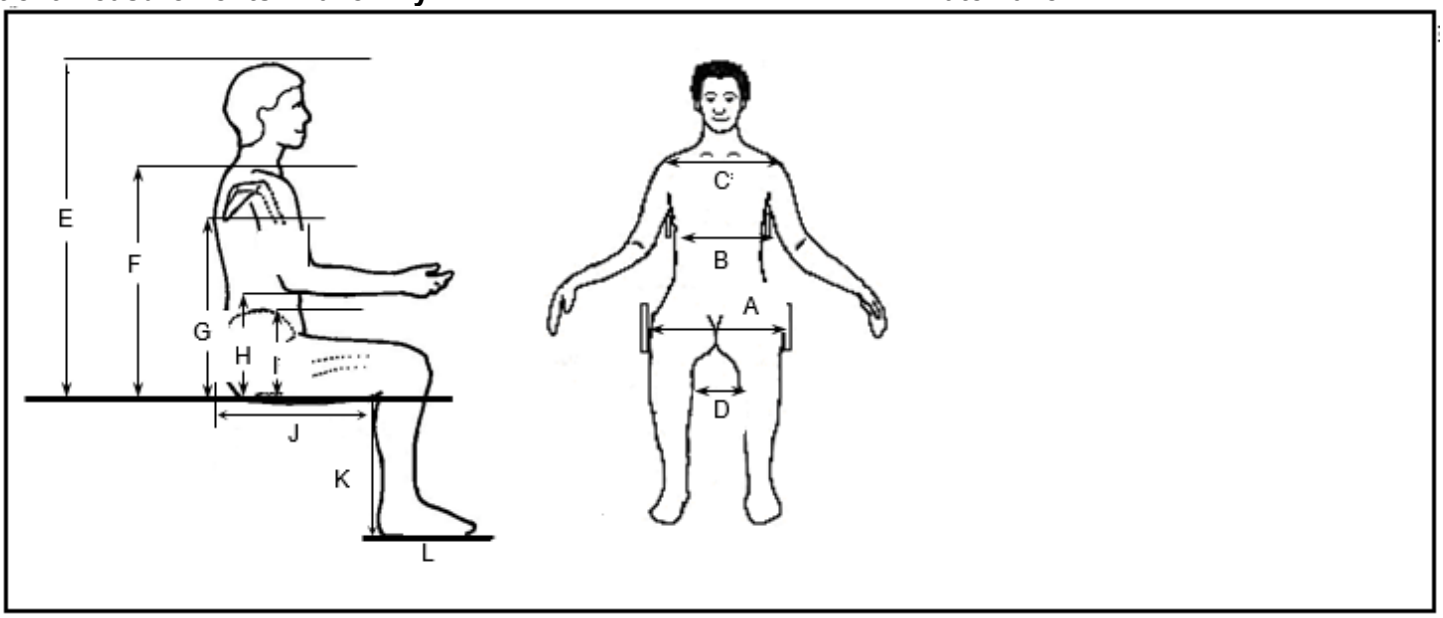
<u>Seat and/or back angles</u> - Medical Justification:

<u>Seat to floor height</u> - Medical Justification:

How will the requested wheelchair aid the patient in participating/completing MRADL's within their home?

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:

Equipment/Accessories	Medical Justification

Patient name:

Equipment/Accessories	Medical Justification

Patient name:

Equipment/Accessories	Medical 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.