1. Walkers & Rollators

Medicare pays for walkers with or without wheels if a patient has

- a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home;
- the patient is able to safely use the walker and
- the functional mobility deficit can be sufficiently resolved with use of a walker.

A heavy duty walker is covered for patients who meet coverage criteria for a standard walker and who weigh more than 300 pounds.

Medicare pays for Rollators up to $130 (keep in mind that Medicare pays 80% of allowable, 20% must be paid by patient or secondary payer). The difference between the cost of the Rollator and Medicare paid amount is patient’s responsibility. Please note that if you have received a regular walker from Medicare and now need a Rollator, Medicare will not pay for it because it will be considered same or similar equipment and change in condition will not justify the new equipment.

The U Step walker will be reimbursed if the patient has a neurological disorder or other condition restricting the use of one hand.

Knee walkers or walker accessories are not covered by Medicare.

2. Manual Wheelchairs

Medicare pays for standard/lightweight manual wheelchairs and transport wheelchairs on a capped rental basis. This means that the equipment is rented for 13 months and is the property of Advanced Medical Concepts and must be returned to us if the patient is no longer in need of the equipment, has moved into a Skilled Nursing Facility or has passed away. After Medicare pays for the 13 months rental, the equipment will become the beneficiaries. If repairs or maintenance is required on patient owned equipment, Medicare may pay for the repairs. Because the equipment is a rental for the initial 13 months, Advanced Medical Concepts can only rent within our service area and cannot bill Medicare for manual wheelchairs or transport wheelchairs purchased online.

If you live within our rental area please read below for manual wheelchair coverage

A manual wheelchair is covered if:

- Criteria A, B, C, D, and E are met; and
- Criterion F or G is met.

Additional coverage criteria for specific devices are listed below.

A) The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living 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 places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
2. 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’s home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.
D) Use of a manual wheelchair will significantly improve the patient’s ability to participate in MRADLs and the patient will use it on a regular basis in the home.
E) The patient has not expressed an unwillingness to use the manual wheelchair that is provided in the home.
F) The patient has sufficient upper extremity 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, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.*
G) The patient has a caregiver who is available, willing, and able to provide assistance with the wheelchair.
   If the manual wheelchair will be used inside the home and the coverage criteria are not met, it will be denied as not medically necessary.
   If the manual wheelchair will only be used outside the home, it will be denied as not medically necessary.
   A standard hemi-wheelchair (K0002) is covered when the patient requires a lower seat height (17" to 18") because of short stature or to enable the patient to place his/her feet on the ground for propulsion.

A lightweight wheelchair (K0003) is covered when a patient:

1. The patient self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard wheelchair.
2. The patient requires a seat width, depth, or height that cannot be accommodated in a standard, and spends at least two hours per day in the wheelchair. A high strength lightweight wheelchair is rarely medically necessary if the expected duration of need is less than three months (e.g., post-operative recovery).

A heavy duty wheelchair (K0006) is covered if the patient weighs more than 250 pounds or the patient has severe spasticity.

An extra heavy duty wheelchair (K0007) is covered if the patient weighs more than 300 pounds.

Coverage of an ultra-lightweight wheelchair (K0005) and manual tilt in space wheelchair (E1161) are determined on an individual consideration basis. Ultra-lightweight wheelchairs and tilt in space wheelchairs are paid for as a purchase because they must be custom ordered based on patient’s specifications and needs - pending Advance Determination of Medical Coverage. Patient’s medical records can be submitted to Medicare to determine coverage. This can take up to 30 days after the necessary documentation has been provided by the physician and other clinicians. Please contact Advanced Medical Concepts for more detailed coverage determination.

**Sport wheelchairs and bathroom wheelchairs are not covered by Medicare.**

### 3. Seat and Back Cushions for Wheelchairs

A general use seat cushion and a general use wheelchair back cushion are covered for a patient
who has a manual wheelchair or a power wheelchair with a sling/solid seat/back which meets Medicare coverage criteria. If the patient does not have a covered wheelchair, then the cushion will be denied as not medically necessary. If the patient has a scooter or a power wheelchair with a captain's chair seat, it will be denied as not medically necessary.

A skin protection seat cushion is covered for a patient who meets both of the following criteria:

1) The patient has a manual wheelchair or a power wheelchair with a sling/solid seat/back and the patient meets Medicare coverage criteria for it; and
2) The patient has either of the following:
   a) Current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface; or
   b) Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.1), other spinal cord disease (336.0-336.3), multiple sclerosis (340), other demyelinating disease (341.0-341.9), cerebral palsy (343.0-343.9), anterior horn cell diseases including amyotrophic lateral sclerosis (335.0-335.21, 335.23-335.9), post polio paralysis (138), traumatic brain injury resulting in quadriplegia (344.09), spina bifida (741.00-741.93), childhood cerebral degeneration (330.0-330.9), Alzheimer's disease (331.0), Parkinson's disease (332.0).

A positioning seat cushion and positioning back cushion is covered for a patient who meets both of the following criteria:

1) The patient has a manual wheelchair or a power wheelchair with a sling/solid seat/back and the patient meets Medicare coverage criteria for it; and
2) The patient has any significant postural asymmetries that are due to one of the diagnoses listed in criterion 2b above or to one of the following diagnoses: monoplegia of the lower limb (344.30-344.32, 438.40-438.42) or hemiplegia (342.00-342.92, 438.20-438.22) due to stroke, traumatic brain injury, or other etiology, muscular dystrophy (359.0, 359.1), torsion dystonias (333.4, 333.6, 333.71), spinocerebellar disease (334.0-334.9).

A headrest is also covered when the patient has a covered manual tilt-in-space wheelchair, manual semi or fully reclining back on a manual wheelchair, a manual fully reclining back on a power wheelchair, or power tilt and/or recline power seating system.

If the patient has a mobility scooter or a power wheelchair with a captain's chair seat, a headrest or other positioning accessory will be denied as not medically necessary.

A combination skin protection and positioning seat cushion is covered for a patient who meets the criteria for both a skin protection seat cushion and a positioning seat cushion.

A seat or back cushion that is provided for use with a transport wheelchair (E1037, E1038) will be denied as not medically necessary.

The effectiveness of a powered seat cushion (E2610) has not been established. Claims for a powered seat cushion will be denied as not medically necessary.

To determine which category the cushion you want falls under please contact us at 800-860-3185.

4. Power Wheelchairs

Advanced Medical Concepts will guide you through the entire process of obtaining a power wheelchair through Medicare. We work directly with Medicare and your physician to obtain the necessary documentation to get pre-approved for the prescribed equipment.
The Phone Call
The process begins with your call or e-mail to request information about Power Wheelchairs. Our Mobility Specialists will answer every question you have and gather the necessary information (address, phone number, medical problems, insurance info, etc.) to create your confidential file.

The Doctor’s Visit
The next step is meeting with your doctor for your mobility evaluation. Medicare requires a doctor’s prescription for Power Wheelchairs coverage. (If you plan to use Medicare for payment, it is important to schedule your doctor’s appointment right away.) This doctor’s visit must be specifically for your face-to-face mobility evaluation, not a general appointment. During the mobility evaluation, your doctor will ask you a series of questions to determine if a power mobility product is medically necessary. If your doctor prescribes a power mobility device, we work with your doctor to complete the Medicare paperwork. Print Medicare Coverage Criteria and take to your doctor.

The Paperwork
We work with Medicare to complete the paperwork process. We have several years experience working with Medicare and can help you get the right equipment for you.

The Right Chair
We fit your power wheelchair to your body measurements for complete comfort. We guarantee your new power wheelchair will fit your body proportions and will work in your home.

Delivery and Training
We deliver our power wheelchairs right to your home with no delivery fees. At delivery, we teach you how to operate your new power wheelchair throughout your home. Based on Medicare guidelines, we are responsible for delivery, setup, and training of equipment; therefore we cannot provide service for Medicare beneficiaries that live outside of our area.

Service
We have in-home as well as in-store service for your convenience. Most service issues can even be solved over the phone or in your home.

5. Medicare Coverage Criteria

Orders:
For a power wheelchair (PWC) to be covered, we must receive from the treating physician a written order containing all of the following elements:

1. Beneficiary’s name
2. Description of the item that is ordered. This may be general – e.g., "power wheelchair", "power operated vehicle", or "power mobility device" – or may be more specific.
3. Date of the face-to-face examination
4. Pertinent diagnoses/conditions that relate to the need for the power wheelchair
5. Length of need
6. Physician’s signature
7. Date of physician signature

This order must be received by Advanced Medical Concepts within 45 days after completion of the physician’s face-to-face examination and prior to delivery of the device. (Exception: If the examination is performed during a hospital or nursing home stay, we must receive the order
within 45 days after discharge.)

**Face-to-face examination:**

For a power wheelchair to be covered, the treating physician must conduct a face-to-face examination of the patient before writing the order and submit to Advanced Medical Concepts within 45 days of the face-to-face examination and prior to delivery of the device. If this requirement is not met, the claim will be denied as non-covered.

The report of the face-to-face examination shall provide information relating to the following questions:

- What is this patient’s mobility limitation and how does it interfere with the performance of activities of daily living?
- Why can’t a cane or walker meet this patient’s mobility needs in the home?
- Why can’t a manual wheelchair meet this patient’s mobility needs in the home?
- If a powered wheelchair is provided, why can’t a mobility scooter meet this patient’s mobility needs in the home?
- Does this patient have the physical and mental abilities to operate a power wheelchair or mobility scooter safely in the home?
- Is the patient willing and motivated to use the power wheelchair or mobility scooter?

The report shall provide pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.

- Symptoms
- Related diagnoses
- History
- How long the condition has been present
- Clinical progression
- Interventions (including medications) that have been tried and the results
- Past use of walker, manual wheelchair, mobility scooter or power wheelchair and the results
- Physical exam
- Weight
- Impairment of strength, range of motion, sensation, or coordination of arms and legs
- Presence of abnormal tone or deformity of arms, legs, or trunk
- Neck, trunk, and pelvic posture and flexibility
- Sitting and standing balance
- Functional assessment – any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person
- Transferring between a bed, chair, and power wheelchair
- Walking around their home – to bathroom, kitchen, living room, etc. – provide information on distance the patient is able to walk without stopping, speed, and balance

The elements that are addressed will depend on the diagnoses that are responsible for the mobility deficit. For example, for patients with COPD, heart failure, or arthritis, the major emphasis will be on symptoms and history of the progression of their condition rather than on the physical examination. Functional assessment is important for all patients.

Physicians shall also provide reports of pertinent laboratory tests, x-rays, and/or other diagnostic tests (e.g., pulmonary function tests, cardiac stress test, electromyogram, etc.) performed in the course of management of the patient.

Physicians shall document the evaluation in a detailed narrative note in their charts in the format that they use for other entries. The note must clearly indicate that a major reason for the visit
6. Physician Fee for Face-To-Face evaluation

Due to the MMA requirement that the physician or treating practitioner create a written prescription and a regulatory requirement that the physician or treating practitioner prepare pertinent parts of the medical record for submission to the durable medical equipment supplier, the Centers for Medicare & Medicaid Services (CMS) has established the new G Code (G0372) to recognize additional physician services and resources required to establish and document the need for a PMD.

CMS believes that the typical amount of additional physician services and resources involved is equivalent to the physician fee schedule relative values established for a level 1 office visit for an established patient (Current Procedural Terminology (CPT) code 99211). The payment amount for such a visit is $21.60

Code G0372 indicates that:

- All of the information necessary to document the PMD prescription is included in the medical record.
- The prescription, along with the supporting documentation, has been received by the PMD supplier within 45 days after the face-to-face examination.

Effective October 25, 2005, G0372, will be used to recognize additional physician services and resources required to establish and document the need for the PMD, and are added to the Medicare physician fee schedule.