FREEDOM MOBILITY
Complex Rehab Technology

Statement Of Medical Necessity (MWC)

Section A	PATIENT & PHYSICIAN INFORMATION
PATIENT NAME:	**PHYSICIAN NAME:**
DATE OF BIRTH:	NPI:
ADDRESS:	ADDRESS:
CITY/STATE/ZIP:	CITY/STATE/ZIP:
PHONE:	PHONE:

Section B — DIAGNOSIS

ICD-10 CODES	DESCRIPTIVE DIAGNOSIS
☐☐☐.☐☐☐☐	
☐☐☐.☐☐☐☐	
☐☐☐.☐☐☐☐	

Length of Need:	☐☐ months *(99=lifetime)*	HEIGHT:	WEIGHT:

Section C-1 — MEDICAL NECESSITY FOR MWC

#	Answer	Question
1.	❑ Yes ❑No	Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs in the home? *(MRADL = Mobility-Related Activities of Daily Living: Toileting, Feeding, Dressing, Grooming, or Bathing)*
2.	❑ Yes ❑ No	Will the Manual Wheelchair significantly improve the patient's ability to perform MRADLs?
3.	❑ Yes ❑ No	Is there a consistent caregiver available to assist the patient with the use of the manual wheelchair?
4.	❑ Yes ❑ No	Is the patient (or caregiver) willing to operate the wheelchair safely?
5.	❑ Yes ❑ No	Can the mobility limitation be resolved with the use of an appropriately fitted **CANE** or **WALKER**?
6.	❑ Yes ❑ No	Does the patient's Typical Home Environment support the use of maneuvering a manual wheelchair?
7.	❑ Yes ❑ No	Does the patient have sufficient use of their Upper Extremities to self propel a manual wheelchair?
8.	❑ Yes ❑ No	**Standard Wheelchair (K0001)** - Can your patient adequately self-propel a STANDARD K0001 Manual Wheelchair? *(requires most strength)*
9.	❑ Yes ❑ No	**Standard Hemi-Wheelchair (K0002)** – Does your patient require 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?
10.	❑ Yes ❑ No	**Lightweight Wheelchair (K0003)** – Is your patient unable to self-propel in a standard wheelchair in the home AND can and does he/she self-propel in a lightweight wheelchair? *(requires less strength than standard)*
11.	❑ Yes ❑ No	**High-Strength Wheelchair (K0004)** - Does your patient require a NON-STANDARD seat width, depth, or height AND spends at least 2 hours per day in the wheelchair?
12.	❑ Yes ❑ No	**High-Strength Wheelchair (K0004)** - Does your patient frequently engage in activities within the home that CANNOT be accomplished with a Standard K0001 or a Lightweight K0003 manual wheelchair?
13.	❑ Yes ❑ No	**Heavy Duty Wheelchair (K0006)** - Does your patient weight more than 250lbs or have severe spasticity?
14.	❑ Yes ❑ No	**Extra Heavy Duty Wheelchair (K0007)** - Does your patient weigh more than 300lbs?

CONTINUE QUESTIONS ON NEXT PAGE ⇨

PATIENT NAME: First Name Last Name
DOB: Client Info\DOB

FAX TO: My Phone 2

Section C-2	MEDICAL NECESSITY FOR ACCESSORIES TO MWC
15. ❑ Yes ❑ No	**Height Adjustable Arms x2 (E0973) -** Does your patient require an arm height that is different than those available using nonadjustable arms and does the patient spend at least 2 hours a day in the wheelchair?
16. ❑ Yes ❑ No	**Heel Loops (E0951) -** Does your patient exhibit lower leg weakness and is the patient at risk for their foot sliding off the footplate?
17. ❑ Yes ❑ No	**O2 Holder (E2208) -** Is your patient on oxygen and requires an oxygen tank holder for the manual wheelchair? If yes, how much 02 is patient using? ___________ and how often does your patient use it? ____________. Attach medical records supporting 02 usages.
18. ❑ Yes ❑ No	**Elevating Leg Rest X2 (E0990) –** Does your patient have lower extremity edema or a leg cast where the leg(s) needs to remain elevated?
19. ❑ Yes ❑ No	**Wheel Lock Brake Extensions X2 (E0961) -** Does your patient have any physical limitation that requires them to have wheel lock extensions? (This would allow the patient to safely engage the brakes, which is important when transferring)
20. ❑ Yes ❑ No	**Safety Lap Belt (E0978) –** Did you answered yes to questions 1, 2, 4, 6, NO to 5, and yes to EITHER 3 or 7? If yes, then your patient meets medical necessity for a manual wheelchair and automatically qualifies for a Safety Lap Belt which provides safety from a patient falling out of the chair and causing injury to oneself.
21. ❑ Yes ❑ No	**Anti Tip Safety Wheels X2 (E0971) –** Did you answered yes to questions 1, 2, 4, 6, NO to 5, and yes to EITHER 3 or 7? If yes, then your patient meets medical necessity for a manual wheelchair and automatically qualifies for Anti Tip Safety Wheels which provide safety from a patient tipping backwards and causing injury to oneself.
22. ❑ Yes ❑ No	**General Use Back Cushion (E2611 <22"/E2612 >=22") -** Did you answered yes to questions 1, 2, 4, 6, NO to 5, and yes to EITHER 3 or 7? If yes, then your patient meets medical necessity for a manual wheelchair and automatically qualifies for a general use back cushion. A standard manual wheelchair used without the minimum support of a general use back cushion lacks support and may cause discomfort, rubbing, chafing and skin breakdown.
23. ❑ Yes ❑ No	**General Use Seat Cushion (E2601 <22"/E2602 >=22") -** Did you answered yes to questions 1, 2, 4, 6, NO to 5, and yes to EITHER 3 or 7? If yes, then your patient meets medical necessity for a manual wheelchair and automatically qualifies for a general use seat cushion. A standard manual wheelchair used without the minimum support of a general use seat cushion lacks support and may cause discomfort, rubbing, chafing and skin breakdown
24. ❑ Yes ❑ No	**Cushion for Skin Protection (E2624 <22"/E2625 >=22") –** Does your patient have either of the following: A. Current pressure ulcer or past history of a pressure ulcer on area of contact with the seating surface; or b. Absent of impaired sensation in the area of contact with the seating surface or inability to carry out functional weight shift due to one of the following diagnoses; SCI resulting in quadriplegia or paraplegia, other spinal cord disease, MS, other demyelinating disease, Cerebral Palsy, anterior horn cell disease including ALS, post polio paralysis, TVI resulting in quadriplegia, spina bifida, childhood cerebral degeneration, alzheimer's disease, or Parkinson disease?
25. ❑ Yes ❑ No	**Cushion Seat for Positioning (E2605 <22"/E2606 >=22") –** Does your patient have any significant postural asymmetries or one of the following diagnoses: monoplegia of the lower limb, hemiplegia (due to stroke, TBI, or other etiology), MD, Torsion dystonias, or spinocerebellar Disease?
26. ❑ Yes ❑ No	**Cushion for Back Positioning (E2613 <22"/E2614 >=22") -** Does your patient have any significant postural asymmetries or one of the following diagnoses: monoplegia of the lower limb, hemiplegia (due to stroke, TBI, or other etiology), MD, Torsion dystonias, or spinocerebellar Disease?

Section D — PHYSICIAN ATTESTATION, SIGNATURE, AND DATE

I certify that I am the treating physician identified in section A of this form. I certify the medical necessity information in section B and C is true, accurate and complete, to the best of my knowledge. I hereby incorporate this document into my patient's medical records.

PHYSICIAN'S SIGNATURE: ____ **DATE:** __________________________________

FAX TO: My Phone 2