Universal Health Care
100 Central Avenue #200
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866-690-4842 x 2989
866-420-4842 (fax)

Provision of Mobility Assistive Equipment (Electric Wheelchairs/Scooters) Under Medicare Should Include All Five Points Below:

- **The member's physical limitations (diminished strength, speed, endurance, range of motion, coordination, sensation, and/or deformity) prevent the member from accomplishing mobility-related activities of daily living in the home.**
- **The member's mental capabilities (cognition, orientation, communication, judgment, memory, comprehension, affect, and suitable behavior) are sufficient for safe and adequate performance of mobility-related activities of daily living with the use of mobility assistive equipment.**
- **The member's physical capabilities (strength, speed, endurance, range of motion, coordination, and sensation) are sufficient for safe and adequate performance of mobility-related activities of daily living with the use of mobility assistive equipment.**
- **The characteristics of the member's typical home environment in which the activities of daily living are encountered (surfaces, presence or absence of surface accommodations, obstacles, accessibility, changes in grade, and distance covered) are suitable for the use of the appropriate equipment.**
- **The member demonstrates willingness to use the equipment routinely.**

Please complete the attached questions and fax to Universal Health Care at 1-866-420-4842. Thank you!

Mobility Assistive Equipment (MAE) Questionnaire

1. Does the member have a mobility limitation causing inability to perform one or more mobility-related activities of daily living (MRADL) in the home? ☐YES ☐NO

   A mobility limitation is one that: (check all that apply & explain below)

   ☐ Prevents the member from accomplishing the mobility-related activities of daily living entirely, or

   ☐ Places the member at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform mobility-related activities of daily living, or

   ☐ Prevents the member from completing the mobility-related activities of daily living within a reasonable time frame.

   If yes, please explain: ____

   ____

2. List other conditions that limit the member's ability to perform mobility-related activities of daily living at home? (i.e. significant impairment of cognition or judgment and/or vision.)______________________________

   a. Does this prevent effective use of the MAE or reasonable completion of the tasks, even with a W/C? ☐ YES ☐ NO

3. If these other limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of MAE will be reasonably expected to significantly improve the member's ability to perform or obtain assistance to participate in MRADLs in the home? ☐ YES ☐NO

   a. Is there a caregiver available, willing, and able to safely operate and transfer the member to and from the wheelchair, & to transport the member using the wheelchair? ☐ YES ☐NO

   b. Is the member compliant with all medication(s) and treatment(s)? ☐ YES ☐NO

4. Does the member or caregiver demonstrate the capability & willingness to consistently operate the MAE safely? ☐ YES ☐NO

   a. Is there a history of unsafe behavior in other venues? ☐ YES ☐NO

   Please describe: ____

5. Can the functional mobility deficit be sufficiently and safely resolved by the use of a cane or walker? ☐ YES ☐NO

   a. Can the member safely use a cane or walker? ☐ YES ☐NO

   b. If not, why not? ____

   ____

6. Does the member's typical environment support the use of W/C including scooters/power-operated vehicles (POVs)? ☐ YES ☐NO

   a. Are there factors such as physical layout, surfaces, and obstacles, which may render MAE unusable in the member's home? ☐ YES ☐NO

   Please Describe**:** ____

7. Does the member have sufficient upper extremity function to propel a manual wheelchair in the home to participate in MRADLs during a typical day? The manual wheelchair should be optimally configured for this determination. ☐ YES ☐NO

   a. Are there limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities? List:______________________________ ☐ YES ☐NO

b. Does the member's home provide adequate access, maneuvering space, and surfaces for the operation of a manual wheelchair? ☐ YES ☐NO

c. Can the member safely use a manual wheelchair or if unable to self-propel a manual wheelchair, is there a caregiver who is available, willing, and able to provide assistance? ☐ YES ☐NO

d. If unable to use manual W/C list reason:____

____

8. Does this member have sufficient strength and postural stability to operate a POV/scooter? (A POV is a 3- or 4-wheeled device with tiller steering & limited seat modification capabilities. The member must be able to maintain stability & position for adequate operation.) ☐ YES ☐NO

a. Does the member's home provide adequate access, maneuvering space & surfaces for POV operation? ☐ YES ☐NO

b. Can the member safely use a POV/Scooter? ☐ YES ☐NO

9. Are any extra features provided by a power W/C needed to allow the member to participate in one or more MRADLs? ☐ YES ☐NO

a. Does the member's home provide adequate access, maneuvering space, and surfaces for the operation of a power wheelchair? ☐ YES ☐NO

b. Can the member safely use a power wheelchair? ☐ YES ☐NO

c. If the member is unable to use a power wheelchair, is there a caregiver who is available, willing, and able to provide assistance? ☐ YES ☐NO

d. Is the caregiver able to operate a manual wheelchair? (Why not:_____________________________) ☐ YES ☐NO

10. What is the member's current transfer status? ____

____

11. What is the member current ambulatory status? (include Distance and Devices)

____

Narrative:____

____

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____

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(Please circle below as appropriate)

12. Patient does does not demonstrate medical necessity for a POV/Scooter as opposed to a manual wheel chair for activities of daily living within the home.

___________________________________ ___________________________________

Name of Evaluator (PRINT) Signature of Evaluator

___________________________________ __(   )_____________________________

Date of Evaluation Contact Telephone Number for Evaluator

Member Name: ________________________________ UHC ID #: ___________________________

REV. 08/09/2007