	MEDICAL ASSISTANCE BULLETIN COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE	
	SUBJECT Coverage for Motorized Wheelchairs	BY Eileen M. Schoen Deputy Secretary for Medical Assistance
NUMBER:	Class III 01-87-08, 05-87-02, 19-87-06	
ISSUE DATE:	July 30, 1987	
EFFECTIVE DATE:	July 1, 1987	

PURPOSE:

The purpose of this bulletin is to inform providers that beginning July 1, 1987, the Department will provide coverage for motorized wheelchairs in accordance with established criteria.

SCOPE:

This bulletin is applicable to all physicians, medical suppliers, and pharmacies enrolled in the Medical Assistance Program.

DISCUSSION:

Beginning July 1, 1987, Medical Assistance will pay for motorized wheelchairs prescribed for categorically needy recipients subject to the conditions and limitations described in this bulletin, Chapter 1101 (relating to the general provisions) and Chapter 1123 (relating to medical supplies).

Before the provider may be paid for a motorized wheelchair, the chair must be prior authorized at the State level. All of the following criteria must be met and so certified to the Department to ensure appropriateness of the prescribed wheelchair.

1. The individual must be capable of some activity to which the motorized wheelchair will provide access.

2. The individual must be unable to ambulate.

3. The individual must be unable to propel a manual wheelchair.

4. When seated in the motorized wheelchair, the individual is able to move away from potentially dangerous or harmful situations, independently.

5. The individual has sufficient eye/hand preceptual capabilities to operate the prescribed motorized wheelchair safely.

6. The individual demonstrates the ability to start, stop and guide the prescribed chair within a reasonably confined area.

7. The individual possesses the ability to operate the prescribed chair.

8. The individual's environment is conducive to the use of a motorized wheelchair. The environment should have sufficient door, hallway, and room dimensions for the particular motorized wheelchair unit to turn and exit.

9. The individual possesses sufficient cognitive skills to understand directionality, i.e., left, right, front and back and be able to demonstrate these skills.

PROCEDURE:

The following procedures and related current policies will apply to the expanded coverage for motorized wheelchairs. Please refer to § 1101.67 (relating to prior authorization) and your handbook for specific instructions on how to request prior authorization.

1. The motorized wheelchair must be prescribed by a physician.

2. The attached questionnaire, based on a rehabilitation assessment, must be completed by an accredited rehabilitation facility. An accredited rehabilitation facility is one which as been accredited by either JCAH (Joint Commission on the Accreditation of Hospitals) or CARF (Commission for the Accreditation of Rehabilitation Facilities). The purpose of this assessment will be to evaluate the individual's ability to utilize a motorized wheelchair and to identify any construction modifications or other adaptations which may be required.

3. The Prior Authorization Request must identify any construction modifications or adaptations to the prescribed chair.

4. The assessment/evaluation must be done within 60 days of the date of receipt of the Prior Authorization Request by the

Department.

5. The prescription, the questionnaire and a report of the rehabilitation assessment must be forwarded to the Department along with a completed Prior Authorization Form (MA 97).

6. The Department's payment for a motorized wheelchair will be the lowest of the Medicare fee, the Medical Assistance fee or the provider's usual charge to the general public.

7. Payment for a motorized wheelchair will be limited to one per three years per recipient.

8. Payment will ***not*** be made for modifications to a home, a vehicle, et cetera, in order to accommodate the use of a motorized wheelchair.

9. Second opinions will be requested, when indicated.

10. All other private or governmental health insurance benefits must be utilized before payment will be made by the Medical Assistance Program.

11. All forms, when completed, should be mailed to the following address:

Department of Public Welfare
Office of Medical Assistance
P.O. Box 8188
Harrisburg, PA 17105

The attached question/rehabilitation evaluation form may be photocopied.

Replacement pages to the Medical Assistance Fee Schedule have been issued along with other changes to the MA Fee Schedule.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Bureau of Provider Relations
P.O. Box 8024
Harrisburg, Pennsylvania 17105

Or Call the appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELVARE
OFFICE OF MEDICAL ASSISTANCE

CONSIDERATIONS FOR MOTORIZED WHEELCHAIR PRESCRIPTIONS
(To be completed by the Rehab Facility's evaluator)

Patient's Name:__________ Case Number:______ Telephone Number:________

Yes___ No___ 1. The patient is unable to ambulate.
Yes___ No___ 2. The patient is unable to propel a manual wheelchair.
Yes___ No___ 3. When seated in the wheelchair, the patient is able to move away from potentially dangerous or harmful situations, independently.
Yes___ No___ 4. The patient has sufficient eye/hand perceptual capabilities to operate a motorized wheelchair safely.
Yes___ No___ 5. The patient demonstrates the ability to start, stop and guide the wheelchair within a reasonably confined area.
Yes___ No___ 6. The patient possesses the ability to drive the wheelchair.
Yes___ No___ 7. The patient's environment is conducive to the use of a motorized wheelchair. The environment should have sufficient door, hallway, and room dimensions for the particular motorized wheelchair unit to turn and exit.
Yes___ No___ 8. The patient possesses sufficient cognitive skills to understand directionality, i.e., left, right, front and back and be able to demonstrate those skills.
Yes___ No___ 9. All alternative funding sources have been explored and will not pay for a motorized wheelchair.
Yes___ No___ 10. There is a necessity for motorized mobility.
Yes___ No___ 11. The individual is capable of some activity to which the motorized wheelchair will provide access.
Yes___ No___ 12. The individual is motivated to use a motorized wheelchair.

Frequency of use:________ hours/day________ days/week.

Sitting tolerance in a motorized wheelchair: maximum hours__________

Individual's prognosis over the next three years:__________________________

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Comments:____

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Signature:__________________ Title:_______________ Date:_____________