TO: Nursing Home Administrators

FROM: Susan J. Tucker, Executive Director
      Office of Health Services

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal

RE: Reimbursement for Power Wheelchairs and Power Wheelchair Repairs

Under COMAR 10.09.10.10N, nursing home providers may be reimbursed for the cost of power wheelchairs and power wheelchair repairs. The procedure is as follows:

- Providers request preauthorization by the Long Term Care and Community Support Services Administration for a power wheelchair or wheelchair repair, in a format designated by the Administration. Please see the preauthorization request format attached to this transmittal.\(^1\) Completed requests should be sent to:

  The Division of Long Term Care Services
  201 West Preston Street, Room 120-G
  Baltimore, Maryland 21201

- The Administration determines:
  - The medical necessity of the wheelchair or wheelchair repair.
  - Whether the nursing home is conducive to wheelchair traffic.
  - The maximum allowable cost of the wheelchair or wheelchair repair.

- The Administration sends a preauthorization letter to the provider approving or denying the wheelchair or wheelchair repair.

Upon approval of the wheelchair or wheelchair repair, the nursing home:

\(^1\) In addition to the form, information regarding the cost of the equipment or repair may be required.
- Purchases or rents the wheelchair, or has the wheelchair repaired.
- May request an interim rate revision in the capital cost center (in accordance with COMAR 10.09.10.07A) by submitting documentation of increased costs.
- Reports the cost of the wheelchair or wheelchair repair on the bottom of Schedule H of the Nursing Home Uniform Cost Report.
- Must provide the preauthorization letter and invoice for each wheelchair purchased or repaired during the period as part of the cost report verification.
- Will have the lower of the preauthorized maximum allowable cost, defined as the maximum reimbursement pursuant to COMAR 10.09.12, or the actual cost of each wheelchair or wheelchair repair included in the total allowable reimbursement amount during cost report settlement.

Retroactive Authorization

Regulatory provisions allowing reimbursement for power wheelchairs were adopted effective October 1, 2007. In order to permit providers to receive payment for power wheelchairs and power wheelchair repairs back to October 1, 2007, the Program will accept retroactive requests for authorization as long as the request is received by the Program no later than April 30, 2009.

Please submit any questions regarding this transmittal to the Nursing Home Program at 410 767-1736.

SJT/seh
Attachments

cc: Nursing Home Liaison Committee
MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL ASSISTANCE PROGRAM
PREAUTHORIZATION REQUEST
POWER WHEELCHAIRS FOR NURSING HOME RESIDENTS
INCLUDING REPAIRS

Section I – Recipient Information
MA Number
Last Name First Name DOB Sex
Is discharge anticipated? Yes No If yes, approximate discharge date

Section II – Facility Information
Facility Name Provider Number
Address
Request Date Contact Telephone

Section III – Requested Equipment/Repairs

<table>
<thead>
<tr>
<th># Units</th>
<th>HCPCS</th>
<th>Description</th>
<th>Program Use Only</th>
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For repairs only: was the equipment for which repair is requested purchased before the recipient entered the nursing home? Yes No

Section IV – Medical/Functional Information
Attending Physician Name
Diagnoses related to need for power wheelchair

<table>
<thead>
<tr>
<th>Dx Code</th>
<th>Description</th>
<th>Dx Code</th>
<th>Description</th>
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Recipient’s ability to walk with or without the use of a cane or brace (check one in each column)

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<thead>
<tr>
<th>Description</th>
<th>In Room</th>
<th>On Unit</th>
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<tbody>
<tr>
<td>Independent (occasional or no assistance needed)</td>
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<td>Supervision (oversight, encouragement, cuing)</td>
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<td>Limited assistance (recipient highly involved, primarily needs non-weight-bearing physical help)</td>
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<td>Extensive assistance (some involvement by recipient, usually needs weight-bearing support, occasional full staff performance)</td>
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<td>Total dependence (full staff performance)</td>
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ADL support needed for walking with or without the use a cane or brace (check one in each column)

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<tr>
<th>Description</th>
<th>In Room</th>
<th>On Unit</th>
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<tbody>
<tr>
<td>No setup or physical help from staff</td>
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<tr>
<td>Setup help only</td>
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<td>One person physical assist</td>
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<td>Two + person physical assist</td>
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Furthest distance recipient able to walk without sitting down (check one):
- □ Less than 10 ft
- □ 10 - 25 ft
- □ 25 - 50 ft
- □ 51 - 149 ft
- □ 150+ ft

Is the recipient able to self-propel a manual wheelchair? □ Yes □ No
If no, please detail the medical and/or functional problems that prevent the recipient from being able to independently propel a manual wheelchair.

Is the recipient able to independently operate the controls of a power wheelchair in a safe manner? □ Yes □ No
If no, describe the medical and/or functional problems that prevent the recipient from being able to independently operate a power wheelchair.

Additional information to support medical necessity for equipment

IMPORTANT! Please attach a copy of the physician’s order. The request will not be considered without a valid physician’s order that specifies each equipment item requested.

I certify that the above information is true to the best of my ability. I also certify that the facility in which this equipment is to be used can safely accommodate the use of the wheelchair.

Signature ___________________________ Printed Name ___________________________ Title ___________________________ Date ___________________________