

Universal Health Care
100 Central Avenue #200
St Petersburg, FL 33701
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: _____

(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 #: _____