

SILVER SPORT FULL RECLINING

PRICE LIST AND ORDER FORM

Patient Name: _____ D.O.B: _____ Date: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Medicare/Insurance Policy #: _____

Diagnosis (Dx): _____

PRECONFIGURED AND READY TO SHIP VIA DRIVE MEDICAL RAPID DELIVERY PROGRAM - RDP

SSP16RBDDA	16" Full Reclining Back w/ Detachable Desk Arm, Silver Vein	SSP18RBDFA	18" Full Reclining Back w/ Detachable Full Arm, Silver Vein
SSP16RBDFA	16" Full Reclining Back w/ Detachable Full Arm, Silver Vein	SSP20RBDDA	20" Full Reclining Back w/ Detachable Desk Arm, Silver Vein
SSP18RBDDA	18" Full Reclining Back w/ Detachable Desk Arm, Silver Vein	SSP20RBDFA	20" Full Reclining Back w/ Detachable Full Arm, Silver Vein

FRAME WIDTH AND DEPTH

		MSRP	HCPCS
<input type="checkbox"/> 16"	16 x 16	\$795.50	K0001/ E1266
<input type="checkbox"/> 18"	18 x 16	\$795.50	K0001/ E1266
<input type="checkbox"/> 20"	20 x 16	\$829.75	K0001/ E1266

ARM TYPES

<input type="checkbox"/> STDS4Y4705R	Right	Standard
<input type="checkbox"/> STDS4Y4705L	Left	Standard

REPLACEMENT FRONT RIGGINGS

Covered if the patient has a musco-skeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; or the patient has significant edema of the lower extremities that requires an elevating legrest; or the patient meets the criteria for and has a reclining back on the wheelchair

<input type="checkbox"/> STDS4Y4706	Swing-Away Elevating Legrest, Silver Vein, Tool Free	\$185.99	E0990
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GENERAL USE SEAT CUSHION

A general use seat cushion and a general use back cushion is covered for a patient who has a manual wheelchair which meets Medicare's coverage criteria

<input type="checkbox"/> 14880	16" (w) x 16" (d) x 1.75" (h)	\$60.02	E2601
<input type="checkbox"/> 14907	16" (w) x 18" (d) x 2 (h)	\$60.02	E2601
<input type="checkbox"/> 14887	18" (w) x 16" (d) x 1.75" (h)	\$60.02	E2601
<input type="checkbox"/> 14908	18" (w) x 18" (d) x 2 (h)	\$60.02	E2601
<input type="checkbox"/> 14888	18" (w) x 16" (d) x 2" (h)	\$72.76	E2601
<input type="checkbox"/> 14881	20" (w) x 16" (d) x 1.75" (h)	\$80.04	E2601
<input type="checkbox"/> 14909	20" (w) x 18" (d) x 2 (h)	\$80.04	E2601

SEAT BELTS

Covered if the patient has weak upper body muscles, upper body instability or muscle spasticity which requires use of this item from proper positioning

		MSRP	HCPCS
<input type="checkbox"/> STDS850	Auto Clasp Type	\$33.77	E0978
<input type="checkbox"/> STDS851	Velcro® Type Closure	\$29.50	E0978
<input type="checkbox"/> STDS855	Bariatric Auto Clasp Type	\$35.90	E0978
<input type="checkbox"/> STDS856	Bariatric Velcro® Type Closure	\$31.50	E0978

ANTI FOLD BAR

<input type="checkbox"/> STDS806	\$54.60
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WHEELCHAIR CANE/CRUTCH HOLDER

<input type="checkbox"/> STDS1034	\$25.66	E2207
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HEEL LOOPS

Required to maintain wheelchair users feet safely on the footplates due to spasticity, paralysis, or another physical condition. Reduces injury by preventing feet from being caught in front casters. Required to maintain proper lower extremity alignment while using the wheelchair

<input type="checkbox"/> STDS831	\$62.50	E0951
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WHEEL LOCKS

<input type="checkbox"/> STDS4Y4703R	Right	Standard
<input type="checkbox"/> STDS4Y4703L	Left	Standard

ANTI-TIPPERS

Required for safety to prevent wheelchair from tipping backward resulting in user injury.

<input type="checkbox"/> STDS4Y4712	\$79.99	E0971
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GENERAL USE BACK CUSHION

A general use seat cushion and a general use back cushion is covered for a patient who has a manual wheelchair which meets Medicare's coverage criteria

<input type="checkbox"/> 14889	18" x 17"	\$90.24	E2611
<input type="checkbox"/> 14920	20" x 17"	\$112.24	E2611

Physician's Name: _____ Physician's Signature: _____

Address: _____ Phone Number: _____

Facility Name: _____ UPIN#: _____

A Wheelchair is covered if: Criteria 1, 2, 3, 4, 5, 6, are met; & Criterion 6 or 7 is met
The following criteria is 6 basic things needed to qualify for a manual wheelchair:

1. The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRDAL) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.

PLUS A mobility limitation is one that: Prevents the patient from accomplishing an MRADL entirely, or places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or Prevents the patient from completing an MRADL within a reasonable time frame.

2. The patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

3. The patient's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.

PLUS 4. Use of a manual wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home.

5. The patient has not expressed an unwillingness to use the manual wheelchair that is provided in the home.

PLUS 6. The patient has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day.

OR Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

7. The patient has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

If the manual wheelchair will be used inside the home and the coverage criteria are not met, it will be denied as not medically necessary. If the manual wheelchair will only be used outside the home, it will be denied as not medically necessary.

K0001 and E1226

To qualify for a manual fully reclining back option (E1226), the beneficiary has one or more of the following conditions: The beneficiary is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or the beneficiary utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed.

Accessories qualifying criteria

The following criteria shows what is needed to qualify for each:

Seat and Back Cushions - E2601 & E2611

- A general use seat cushion and a general use back cushion is covered for a patient who has a manual wheelchair which meets Medicare's coverage criteria

Adjustable Arms - E0973

- Adjustable height arm is covered if the patient requires an arm height that is different than that available using non-adjustable arms and the patient spends at least 2 hours per day in the wheelchair.

Elevating Legrests - E0990

- Covered if the patient has a musco-skeletal condition or the the presence of a cast or brace which prevents 90 degree flexion at the knee; or
- The patient has significant edema of the lower extremities that requires an elevating legrest; or
- The patient meets the criteria for and has a reclining back on the wheelchair

Safety Belt - E0978

- Covered if the patient has weak upper body muscles, upper body instability or muscle spasticity which requires use of this item from proper positioning.

Miscellaneous Code

E0971 Anti Tippers

- Required for safety to prevent wheelchair from tipping backward resulting in user injury.

E0961 Wheel Lock Extensions

- Allows wheelchair user to independently operate wheel locks due to upper extremity weakness, decreased range of motion, spasticity, or hemiplegia.

E0951 Heel Loops

- Required to maintain wheelchair: users feet safely on the footplates due to spasticity, paralysis, or another physical condition.
- Reduces injury by preventing feet from being caught in front casters
- Required to maintain proper lower extremity alignment while using the wheelchair

Typical User: The patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, & spend at least two hours per day in the chair

Qualifying Wheelchair(s): Silver Sport Full Reclining

Silver Sport Full Reclining Qualifying Accessories:

Seat Cushions: 14880, 14887, 14881, 14907, 14908, 14909, 14888

Auto Clasp Seat Belt: STDS850, bariatric - STDS855

Velcro Seat Belt: STDS851, bariatric - STDS856

Anti Tippers: STDS4Y4712

Heel Loops: STDS831

Elevating Legrest: LELRSV-TF

