

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

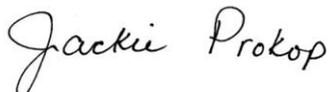
NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.



Director, Program Policy Division
Bureau of Medicaid Policy and Health System Innovation

Project Number:	1222-DME	Comments Due:	August 6, 2012	Proposed Effective Date:	October 1, 2012
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Mail Comments to: Lisa Trumbell
Bureau of Medicaid Policy and Health System Innovation
Medical Services Administration
PO Box 30479
Lansing, MI 48909

Telephone Number: (517) 335-6097 **Fax Number:** (517) 335-5136
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Policy Subject Mobility Standards of Coverage Changes and Revised Evaluation and Medical Justification for Complex Seating and Mobility Devices Form (MSA-1656), New Complex Seating and Mobility Device Prior Authorization Form (MSA-1653-D), Updated Hospital Discharge Waiver Policy

Affected Programs: Medicaid and Children's Special Healthcare Services (CSHCS)

Distribution: Medical Suppliers, Physicians, Outpatient Hospitals, Nursing Facilities, County Medical Care Facilities, Hospital Long Term Care Units, School Based Services, Comprehensive Outpatient Rehabilitation Facilities (CORF), Certified Rehabilitation Agencies, Physical and Occupational Therapists

Policy Summary: Notice of changes to mobility standards of coverage, revised Evaluation and Medical Justification for Complex Seating and Mobility form (MSA-1656), New Complex Seating and Mobility Device Prior Authorization form (MSA-1653-D), and updated Hospital Discharge Waiver policy.

Purpose: To expedite the evaluation and authorization process for mobility and seating items and to align mobility policy closer to Medicare and other insurers.

Proposed Policy Draft

Michigan Department of Community Health Medical Services Administration

Distribution: Medical Suppliers, Physicians, Outpatient Hospitals, Nursing Facilities, County Medical Care Facilities, Hospital Long Term Care Units, School Based Services, Comprehensive Outpatient Rehabilitation Facilities (CORF), Certified Rehabilitation Agencies, Physical and Occupational Therapists

Issued: September 1, 2012 (Proposed)

Subject: Mobility Standards of Coverage Changes and Revised Evaluation and Medical Justification for Complex Seating and Mobility Devices Form (MSA-1656), New Complex Seating and Mobility Device Prior Authorization Form (MSA-1653-D), Updated Hospital Discharge Waiver Policy

Effective: October 1, 2012 (Proposed)

Programs Affected: Medicaid, Children's Special Health Care Services (CSHCS)

To align closer with Medicare and other payers, the Michigan Department of Community Health (MDCH) has revised the mobility standards of coverage listed in the Medical Supplier Chapter of the Medicaid Provider Manual. To assist in expediting the prior authorization (PA) process and provide clinical documentation to support physician orders for mobility and positioning devices, MDCH has revised the Evaluation and Medical Justification for Complex Seating and Mobility Devices form (MSA-1656) formerly referred to as the Mobility, Seating and Positioning Evaluation and Medical Justification form. A Complex Seating and Mobility Device PA form (MSA-1653-D) has been developed specifically for complex seating and mobility devices.

The Mobility evaluation requirements indicated in this bulletin apply to beneficiaries served by fee-for-service (FFS) Medicaid. For beneficiaries enrolled in a Medicaid Health Plan (MHP), the provider must check with the beneficiary's MHP for coverage and clinical evaluation requirements.

Section 1.0 Clarification to the Definition of Durable Medical Equipment (DME):

Durable Medical Equipment is defined as items that:

- Have been approved by the Food and Drug Administration
- Can withstand repeated use
- Are used to serve a medical purpose
- Are not useful to a person in the absence of illness or injury
- Can be used in the beneficiary's home

Section 1.5 Economical Alternative:

For clarification purposes, MDCH considers the most economical alternative to be equipment, supplies, prosthetics, orthotics or accessories that are comprised of features/functions that are the least complex and costly, yet can support the beneficiary in meeting their basic medical/functional needs. The equipment/accessory trial should include various levels of equipment by different manufacturers to determine the most appropriate, least costly alternative.

Section 1.5 New Technology:

MDCH considers coverage of DME, supplies, prosthetics and orthotics, based upon the beneficiary's basic medical/functional needs, ability to use the equipment and the least costly alternative that meets those needs. Medicaid will not authorize coverage of items because the item(s) are the most recent advancement in technology, when the beneficiary's current equipment can meet the beneficiary's basic medical/functional needs. Equipment comprised of features not medical in nature are not covered by Medicaid.

New Terminology:

Mobility Related Activities of Daily Living (MRADLs) have been added to mobility policy to be consistent with Medicare and industry common terminology. MRADLs are defined as daily activities (e.g., grooming, dressing, toileting, etc.) the beneficiary is capable of performing with the aid of mobility equipment.

1.7.A. Prior Authorization Form:

A new PA form has been created for custom seating and mobility devices. The Custom Seating and Mobility Device Prior Authorization form (MSA-1653-D) must be used by DME providers when requesting authorizations for wheelchairs, power operated wheelchairs, custom seating, related mobility accessories and other mobility devices.

Mobility related sections of the Special Services Prior Authorization - Request/Authorization Form (MSA-1653-B) have been removed. DME providers, Medical Suppliers, Orthotists, Prosthetists, Hearing Aid Dealers, Audiologists and Cochlear Manufacturers will continue to request authorizations for non-mobility related items on the MSA-1653-B.

1.7.J. Hospital Discharge Waiver Codes: E0961, E0973, E0990, E1226, K0001, K0002, K0003, K0004, K0195

Standard, standard hemi (low-seat), lightweight or high strength/light weight wheelchairs have been removed from the hospital discharge waiver. These items do not require prior authorization if the standards of coverage and documentation requirements have been met for specific base codes and accessories. Standard wheelchairs include standard arm and foot rests. Refer to the Medical Supplier database and the Wheelchair/Power Operated Mobility Accessory Reimbursement chart on the MDCH website for items included in the wheelchair base.

1.10 Noncovered Items:

The following items have been added to Section 1.10 Noncovered items:

- Padded footplates
- Custom seating for secondary and/or transport chairs

MOBILITY POLICY UPDATES

2.46 PA Requirements:

PA is no longer required for walkers when the Standards of Coverage and documentation requirements have been met. PA is required for the walker if attachments (e.g., seat attachments, platform attachments, etc.) are needed or if requesting replacement within five years for beneficiaries 21 years of age and older or within two years for beneficiaries under 21 years of age.

2.46 Walkers Documentation:

Required documentation must be kept in the beneficiary file and be available upon request.

Additions to Documentation requirements:

- Duration of need and frequency of use
- Identifying other specific economic alternatives considered
- Identifying make, model, serial number and warranty information
- Statement of medical need for the specific walker requested

For each walker type, the following must be included:

1. Standard Walker (E0130, E0135, E0141, E0143):
Medical/functional reason a cane would not meet the beneficiary's ability to perform MRADLs.
2. Walker with trunk support (E0140):
Medical/functional reason a standard walker would not meet the beneficiary's ability to perform MRADLs.

3. Enclosed Walker with posterior seat (E0144):
Medical/Functional reason a standard walker would not meet the beneficiary's ability to perform MRADLs.
4. Heavy Duty Walker (E0147 – E0149):
Medical/functional reason for a heavy-duty walker (e.g., obesity, severe neurological disorder, or restricted use of hands).

2.47 Wheelchairs, Pediatric Mobility and Positional Medical Devices, and Seating Systems:

Manual Wheelchair Standards of Coverage Codes: E1161, E1229, E1231 – E1238, K0001 – K0007:

2.47.B Standards of Coverage:

Additions:

- Must be able to use the wheelchair in the home environment (e.g., wheelchair must be able to fit through doorways and cross thresholds)
- Must identify other economic alternatives considered
- For a heavy-duty standard wheelchair, include patient weight in the beneficiary's file
- For extra heavy-duty standard wheelchair, patient's weight must exceed 300 pounds. Include patient weight in the beneficiary's file

2.47.C Prior Authorization for Purchase, Rentals, Repairs, and/or Replacement of Mobility Devices:

PA is required for all power wheelchairs, power-operated vehicles, custom seating, positioning and accessories. Standard wheelchairs with specified accessories/add-ons do not require PA if the standards of coverage and documentation requirements have been met. Accessories/attachments for standard wheelchairs (other than standard arm and legs rests), require PA. Consult the Medical Supplier Database and the Wheelchair/Power Operated Mobility Accessory Reimbursement chart on the MDCH website for items included in the wheelchair base.

Section 1.7.B Clinical Documentation/Evaluation:

The MSA-1656 must be completed for standard wheelchairs that need accessory/attachment add-ons (excluding standard arm and standard legs rests), power wheelchairs, power operated vehicles, custom seating, positioning devices, scooters, tilt-n-space features, gait trainers, strollers, car seats and standers. Standard wheelchairs that do not need accessory/attachment add-ons do not require PA if the standards of coverage and documentation requirements are met.

The MSA-1656 serves as a baseline evaluation used to substantiate the basic medical and functional needs of the beneficiary for consideration of requested mobility and positioning equipment. The form assists the clinical evaluator(s) in determining the most appropriate and cost effective equipment that will address those needs. The MSA-1656 and applicable addendum(s) are to be completed by any of the following licensed professionals: physical therapist, occupational therapist, physiatrist or rehabilitation registered nurse. The MSA-1656 is completed only once and accompanies the MSA-1653-D and applicable addendum(s) that relate to the requested equipment. A new MSA-1656 is completed only when a change occurs in the beneficiary's basic medical/functional needs.

Addendums A and B:

The evaluator(s) must complete Addendums A and B to clarify the beneficiary's ability to use the requested equipment, list equipment the beneficiary currently owns/rents and indicate if that equipment is under warranty. The addendums accompany the MSA-1656 for the initial evaluation. The evaluator only completes the specific addendum and section(s) of the addendum that relates to the mobility/seating item requested. For future PA requests if the beneficiary's medical/functional status has not changed, the evaluator completes only the applicable addendum for any new or replacement equipment and sends the addendum to the durable medical equipment provider to submit with the prior authorization request (MSA-1653-D).

The Addendum A: Mobility and Seating form must be completed and submitted with the MSA-1656 and/or MSA-1653-D when requesting complex seating, a manual wheelchair with accessory add-ons, power wheelchairs, scooters and power accessories. The evaluator completes only the sections that apply to the requested equipment and accessories.

The Addendum B form must be completed and submitted with the MSA-1656 and/or MSA-1653-D when requesting strollers, gait trainers, standers and children's positioning chairs. The evaluator(s) completes only the sections that apply to the requested equipment and accessories.

The attached documents detail the revised policy:

Attachment A – Revised “Evaluation and Medical Justification for Complex Seating and Mobility Devices (MSA - 1656) for all beneficiaries”

Attachment B – Addendum A: Mobility and Seating

Attachment C – Addendum B: Strollers, Gait Trainers, Standers and Children's Positioning Chairs

Attachment D – Revised Special Services Prior Authorization – Request Authorization Form (MSA-1653-B)

Attachment E – New Complex Seating and Mobility Device Prior Authorization Form (MSA-1653-D)

The forms above are available on the MDCH website and have electronic fill-in capacity. The fields have unlimited text space.

Prior to submitting the MSA-1656, Addendums and the MSA-1653-D, the applicable standards of coverage and documentation requirements listed in the Medicaid Provider Manual must be met.

References:

The “Wheelchair/Power Operated Mobility Accessory Reimbursement Table,” has been updated and is posted on the MDCH website.

For clarification purposes, MDCH will post a power point titled “Evaluation and Medical Justification for Complex Seating and Mobility Devices, MSA-1656,” on the MDCH website. This tool clarifies the roles of the physician, the physical therapist, occupational therapist, Rehab RN and the DME provider in completing the MSA-1656.

The above documents can be found at www.michigan.gov/medicaidproviders >>Billing and Reimbursement >> Provider Specific Information >> Medical Suppliers.

Evaluation and Medical Justification for Complex Seating and Mobility Devices Completion Instructions

This form should be completed for **NEW** or **REPLACEMENT** mobility device(s) and seating systems. It must be submitted with the **Complex Seating and Mobility Device Prior Approval - Request/Authorization (MSA-1653-D)**. The evaluation and justification must be submitted within **90 days** of the evaluation date.

The appropriate Addendum(s) must accompany the **MSA-1656 & MSA-1653-D**.

BENEFICIARY INFORMATION: Complete beneficiary name, date of birth, sex, **mihealth** number, ordering physician and physician specialty. The beneficiary name and **mihealth** number must be entered at the top of each subsequent page.

SECTION 1 THROUGH SECTION 11 MUST BE COMPLETED BY A LICENSED/CERTIFIED MEDICAL PROFESSIONAL. In each section, check the boxes and supply the information requested as it applies to the beneficiary.

NOTE: A licensed/certified medical professional means an occupational or physical therapist, a physiatrist or rehabilitation RN who has at least two years' experience in rehabilitation seating; and is not an employee of, or affiliated in any way with, the Medical Supplier with the exception of hospitals with integrated delivery models that include the supplier of the equipment and the provider of the clinical evaluation. (PTA, OTA may not evaluate for, complete or sign this document.)

SECTION	INSTRUCTIONS																																																
1	Indicate the beneficiary name, mihealth number, ordering physician and physician specialty. Enter date of evaluation, evaluator's name, title, telephone number, place of employment and address. If team evaluation, in Section 11, list all participants and titles.																																																
2	Medical history is used to gather information in regards to the beneficiary's physical status and progression of disease. Estimate weight if unable to weigh at time of evaluation. The abbreviation "WFL" means "within functional limits."																																																
3	Home Environment questions reflect the current setting in which the beneficiary lives.																																																
4	Community Activities of Daily Living (ADL) reflects the beneficiary's transportation situation to the community and/or school, if applicable. Indicate if the wheelchair fits into the vehicle and if the family can lift the wheelchair.																																																
5	This information reflects the need for pressure relief. If the beneficiary has current decubiti, the evaluator should indicate the stage as defined by the National Pressure Ulcer Advisory Panel (NPUAP) at: www.npuap.org .																																																
6	Mandatory for all requests. Describes the beneficiary's ADL functional ability without mobility devices. The abbreviation "UE" means "upper extremity." Only answer the items regarding visual perception, problem solving and comprehension if requesting a power mobility item.																																																
7	<p>Mat Evaluation includes measurements of the beneficiary. Relevant measures include adjustments for clothing. Complete the Manual Muscle Test (MMT) for hand only if requesting a power wheelchair (this measurement should be of the appropriate hand/digits that will be used to control the power wheelchair).</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="4" style="text-align: left;">Manual muscle evaluation</th> <th colspan="4" style="text-align: left;">Modified Ashworth Scale</th> </tr> </thead> <tbody> <tr> <td style="text-align: right;">100%</td> <td style="text-align: center;">5</td> <td style="text-align: center;">N</td> <td style="text-align: left;">Normal</td> <td style="text-align: right;">Complete ROM against gravity with full resistance</td> <td style="text-align: right;">50%</td> <td style="text-align: center;">3</td> <td style="text-align: center;">F</td> <td style="text-align: left;">Fair</td> <td style="text-align: right;">Complete ROM against gravity</td> </tr> <tr> <td style="text-align: right;">75%</td> <td style="text-align: center;">4</td> <td style="text-align: center;">G</td> <td style="text-align: left;">Good</td> <td style="text-align: right;">Complete ROM against gravity with some resistance</td> <td style="text-align: right;">25%</td> <td style="text-align: center;">2</td> <td style="text-align: center;">P</td> <td style="text-align: left;">Poor</td> <td style="text-align: right;">Complete ROM with gravity eliminated</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td style="text-align: right;">10%</td> <td style="text-align: center;">1</td> <td style="text-align: center;">T</td> <td style="text-align: left;">Trace</td> <td style="text-align: right;">Evidence of contractibility but no joint motion</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td style="text-align: right;">0%</td> <td style="text-align: center;">0</td> <td style="text-align: center;">O</td> <td style="text-align: left;">Zero</td> <td style="text-align: right;">No evidence of contractility</td> </tr> </tbody> </table> <p style="text-align: center;">C = Complete; IC = Incomplete; * = Pain</p>	Manual muscle evaluation				Modified Ashworth Scale				100%	5	N	Normal	Complete ROM against gravity with full resistance	50%	3	F	Fair	Complete ROM against gravity	75%	4	G	Good	Complete ROM against gravity with some resistance	25%	2	P	Poor	Complete ROM with gravity eliminated						10%	1	T	Trace	Evidence of contractibility but no joint motion						0%	0	O	Zero	No evidence of contractility
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SECTION	INSTRUCTIONS	
8	Check all items that apply for mobility goals. Complete section for wheelchair and seating systems.	
9	Section is to be used if evaluator has any other comments to establish medical need, functional goals, etc. Evaluator should list all equipment the beneficiary currently owns or uses. Include Brand, Model, Serial Number, Description and Date Purchase.	
10	To be completed if beneficiary is in a nursing facility. This section should be completed and signed by the Director of Nursing, Facility Administrator or Ordering Physician, PA or NP. The attestation page must accompany the MSA-1653-B and appropriate Addendum(s) when submitting to the MDCH Program Review Division.	
11	To be signed by the evaluator, and, if applicable, all team members involved in the evaluation. The attestation page must accompany the MSA-1653-B and appropriate Addendum(s) when submitting to the Michigan Department of Community Health (MDCH) Program Review Division.	
Notes	The applicable addendums must accompany the MSA-1656 & MSA-1653-B when requesting the authorization. Failure to include the appropriate addendum(s) may cause a delay in the authorization process.	
	Addendum A: To be completed when requesting new or replacement manual wheelchairs with accessories, power mobility devices, and/or seating systems.	Addendum B: To be completed when requesting new or replacement strollers, standers, gait trainers and children's positioning chairs.
	Note: For beneficiaries residing in a nursing facility, return the completed MSA-1656, addendum(s) and MSA-1653-B to the requesting nursing facility. For beneficiaries in the community, the MSA-1656, addendum(s) and MSA-1653-B are forwarded to the ordering physician for their review.	

SUBMIT TO:

**Michigan Department of Community Health
Program Review Division
PO Box 30170
Lansing, Michigan 48909**

Fax: (517) 335-0075

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

Evaluation and Medical Justification for Complex Seating and Mobility Devices

This form must be completed by physical therapist, occupational therapist, physiatrist, or rehabilitation registered nurse. Incomplete information will result in the form being returned to the evaluator for completion.

SECTION 1: BENEFICIARY INFORMATION

Beneficiary Name: _____	mihealth Number: _____
Ordering/Referring Physician: _____	NPI: _____
Physician Specialty: _____	

SECTION 2: MEDICAL HISTORY

Primary Diagnosis (ICD-9-CM): _____	Secondary Diagnosis (ICD-9-CM): _____
Onset date: _____	Onset date: _____
If spinal cord injury or spina bifida indicate the level of injury: _____	
Relevant past and future surgeries: _____	
Bowel Mgmt: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy (Indicate type): _____	
Bladder Mgmt: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter (Indicate type): _____	
Cardio Status: <input type="checkbox"/> WFL <input type="checkbox"/> Impaired	Neuro Status: Seizures <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, Frequency/Duration: _____ / _____
Balcofen pump present? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, date Implanted: _____	Respiratory Status: <input type="checkbox"/> WFL <input type="checkbox"/> Impaired
Botox? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, date of last injection: _____	Sip 'N Puff controller requested: <input type="checkbox"/> YES <input type="checkbox"/> NO
Other explain: _____	If YES, additional information maybe be required.
Height: _____ Weight: _____	Explain recent changes or trends in weight: _____
List medication(s) currently prescribed: _____	
How does the management or severity of the above conditions/impairments affect the need for the equipment requested? _____	

SECTION 3: HOME ENVIRONMENT

Beneficiary resides in: <input type="checkbox"/> House <input type="checkbox"/> Condo/town home <input type="checkbox"/> Apartment <input type="checkbox"/> Assisted Living /AFC/Group Home <input type="checkbox"/> Nursing Facility
Does beneficiary live alone? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, does beneficiary have a caregiver? <input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, who provides the care? <input type="checkbox"/> Family member <input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> Other (explain)
How many hours per day are provided by the caregiver? _____

SECTION 4: COMMUNITY ADL (Transportation)

What is beneficiary's mode of transportation? (Check all that apply.) <input type="checkbox"/> Car <input type="checkbox"/> Van/SUV <input type="checkbox"/> Van w/ Lift <input type="checkbox"/> Truck <input type="checkbox"/> Taxi Cab <input type="checkbox"/> Bus <input type="checkbox"/> School Bus <input type="checkbox"/> Ambulance <input type="checkbox"/> Other
Does the beneficiary attend school or work? <input type="checkbox"/> YES <input type="checkbox"/> NO
Is the beneficiary transported in the current or requested wheelchair? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, explain why the beneficiary cannot be transported in the current or requested chair? Explain: _____

SECTION 5: SENSATION AND SKIN ISSUES

Sensation <input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> Absent <input type="checkbox"/> Hypersensitive	Pressure Relief <input type="checkbox"/> Dependent <input type="checkbox"/> Independent <input type="checkbox"/> Type of assistance needed How does the beneficiary perform pressure relief? _____	
Does beneficiary have a history of skin decubiti and/or Flap surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, indicate location: _____	Does beneficiary have a current decubiti? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, describe: _____	Does beneficiary have other skin issues? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, describe: _____

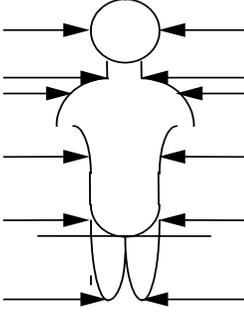
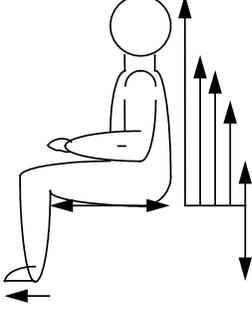
Beneficiary Name: _____ mihealth Number: _____

SECTION 6: MOBILITY ASSESSMENT (Mandatory for all requests)

Functional Ability Without Mobility Device(s)																																																								
Sitting: <table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Static</td> <td style="text-align: center;">Dynamic</td> </tr> <tr> <td>WFL</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Uses UE for balance</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Contact guard assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Standby assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Minimum assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Moderate assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Maximum assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Dependent/unable</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Static	Dynamic	WFL	<input type="checkbox"/>	<input type="checkbox"/>	Uses UE for balance	<input type="checkbox"/>	<input type="checkbox"/>	Contact guard assist	<input type="checkbox"/>	<input type="checkbox"/>	Standby assist	<input type="checkbox"/>	<input type="checkbox"/>	Minimum assist	<input type="checkbox"/>	<input type="checkbox"/>	Moderate assist	<input type="checkbox"/>	<input type="checkbox"/>	Maximum assist	<input type="checkbox"/>	<input type="checkbox"/>	Dependent/unable	<input type="checkbox"/>	<input type="checkbox"/>	Standing: <table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Static</td> <td style="text-align: center;">Dynamic</td> </tr> <tr> <td>WFL</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Uses UE for balance</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Contact guard assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Standby assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Minimum assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Moderate assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Maximum assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Dependent/unable</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Static	Dynamic	WFL	<input type="checkbox"/>	<input type="checkbox"/>	Uses UE for balance	<input type="checkbox"/>	<input type="checkbox"/>	Contact guard assist	<input type="checkbox"/>	<input type="checkbox"/>	Standby assist	<input type="checkbox"/>	<input type="checkbox"/>	Minimum assist	<input type="checkbox"/>	<input type="checkbox"/>	Moderate assist	<input type="checkbox"/>	<input type="checkbox"/>	Maximum assist	<input type="checkbox"/>	<input type="checkbox"/>	Dependent/unable	<input type="checkbox"/>	<input type="checkbox"/>	Transfers: <input type="checkbox"/> Independent <input type="checkbox"/> Type of assistance needed How does beneficiary transfer: <input type="checkbox"/> Pivot <input type="checkbox"/> Sliding <input type="checkbox"/> Mechanical Lift <input type="checkbox"/> Other: (Explain)
	Static	Dynamic																																																						
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Moderate assist	<input type="checkbox"/>	<input type="checkbox"/>																																																						
Maximum assist	<input type="checkbox"/>	<input type="checkbox"/>																																																						
Dependent/unable	<input type="checkbox"/>	<input type="checkbox"/>																																																						
	Static	Dynamic																																																						
WFL	<input type="checkbox"/>	<input type="checkbox"/>																																																						
Uses UE for balance	<input type="checkbox"/>	<input type="checkbox"/>																																																						
Contact guard assist	<input type="checkbox"/>	<input type="checkbox"/>																																																						
Standby assist	<input type="checkbox"/>	<input type="checkbox"/>																																																						
Minimum assist	<input type="checkbox"/>	<input type="checkbox"/>																																																						
Moderate assist	<input type="checkbox"/>	<input type="checkbox"/>																																																						
Maximum assist	<input type="checkbox"/>	<input type="checkbox"/>																																																						
Dependent/unable	<input type="checkbox"/>	<input type="checkbox"/>																																																						
Ambulation within 1 minute: <input type="checkbox"/> Independent > or = 150 ft. <input type="checkbox"/> Unable to ambulate <input type="checkbox"/> Ambulates with Assist > or = 150 ft. <input type="checkbox"/> Limited due to endurance - Explain: Explain type of assistance: _____ <input type="checkbox"/> Ambulates with Device > or = 150 ft. <input type="checkbox"/> Ambulates short distance only ____ ft. Explain how this affects equipment ordered? _____																																																								
Complete only if power mobility is ordered (e.g., power wheelchair, scooter, power assisted wheels, etc.)																																																								
Visual perception: Has visual acuity and perception that permits safe and independent operation of the equipment requested. <input type="checkbox"/> YES <input type="checkbox"/> NO																																																								
Problem solving: Has problem solving skills appropriate to operate requested power mobility. If beneficiary is unable, who will complete? Explain: <input type="checkbox"/> YES <input type="checkbox"/> NO																																																								
Comprehension: Understands and is able to follow directions and conversations that are complex or abstract; understands either spoken or written language. If NO, explain: <input type="checkbox"/> YES <input type="checkbox"/> NO																																																								

SECTION 7: EVALUATION INFORMATION

See Instructions for Modified Ashworth Scale and Manual Muscle Evaluation.

Width at the: 	Height: 	<table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">L</td> <td style="text-align: center;">R</td> </tr> <tr> <td>Crown:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Occiput:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Shoulder:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Axilla:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Elbow:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Seat Depth:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Leg Length:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Foot Length:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </table>		L	R	Crown:	_____	_____	Occiput:	_____	_____	Shoulder:	_____	_____	Axilla:	_____	_____	Elbow:	_____	_____	Seat Depth:	_____	_____	Leg Length:	_____	_____	Foot Length:	_____	_____
	L	R																											
Crown:	_____	_____																											
Occiput:	_____	_____																											
Shoulder:	_____	_____																											
Axilla:	_____	_____																											
Elbow:	_____	_____																											
Seat Depth:	_____	_____																											
Leg Length:	_____	_____																											
Foot Length:	_____	_____																											
Primitive reflexes present: <input type="checkbox"/> Asymmetrical Tonic Neck Reflex <input type="checkbox"/> Symmetrical Tonic Next Reflex <input type="checkbox"/> Startle Reflex <input type="checkbox"/> Other; Explain: _____	Explain how this relates to equipment ordered: _____																												

Beneficiary Name: _____

mihealth Number: _____ ATTACHMENT A

Head & Neck	<input type="checkbox"/> Maintains upright without support <input type="checkbox"/> Rotated	<input type="checkbox"/> Maintains upright with support <input type="checkbox"/> Laterally Flexed	<input type="checkbox"/> Flexed <input type="checkbox"/> Cervical Hyperextension	<input type="checkbox"/> Extended <input type="checkbox"/> Absent head control
	ROM (Range of Motion) <input type="checkbox"/> AROM <input type="checkbox"/> AAROM <input type="checkbox"/> PROM	MMT/O (Manual Muscle) <input type="checkbox"/> Test <input type="checkbox"/> Observation	TONE	Explain how this affects equipment ordered:
	Left	Right		
Shoulder	_____ Flexion _____ _____ Abduction _____ _____ Internal Rotation _____ _____ External Rotation _____	_____ Flexion _____ _____ Abduction _____ _____ Internal Rotation _____ _____ External Rotation _____	<input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia Modified Ashworth Scale: _____ <input type="checkbox"/> Hypotonia	
Elbow	_____ Flexion _____ _____ Extension _____ _____ Pronation _____ _____ Supination _____	_____ Flexion _____ _____ Extension _____ _____ Pronation _____ _____ Supination _____	<input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia Modified Ashworth Scale: _____ <input type="checkbox"/> Hypotonia	
Wrist	_____ Flexion _____ _____ Extension _____	_____ Flexion _____ _____ Extension _____	<input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia Modified Ashworth Scale: _____ <input type="checkbox"/> Hypotonia	
Hand	_____ Grip Strength _____ _____ Pinch Strength _____			
Knee	_____ Flexion _____ _____ Extension _____	_____ Flexion _____ _____ Extension _____	<input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia Modified Ashworth Scale: _____ <input type="checkbox"/> Hypotonia	
Ankle & Foot	_____ Dorsiflexion _____ _____ Plantarflexion _____ _____ Inversion _____ _____ Eversion _____	_____ Dorsiflexion _____ _____ Plantarflexion _____ _____ Inversion _____ _____ Eversion _____	<input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia Modified Ashworth Scale: _____ <input type="checkbox"/> Hypotonia Clonus: <input type="checkbox"/> Left <input type="checkbox"/> Right	

SECTION 8: GOALS

Check all that apply.

- Independence with mobility in the home and motor related ADLs (MRADLs) in the community (independence is - no help or oversight provided, and has physically demonstrated independence in operating requested equipment)
- Assisted mobility/occasional assistance with wheelchair propulsion (e.g., verbal cueing, pushing up a ramp or onto a bus, over curbs, etc.)
- Dependent mobility
- Optimize pressure relief
- Proper positioning and/or correction of a physiological condition. Explain: _____
- Other: (Explain) _____

SECTION 9: LIST EQUIPMENT PRESENTLY OWNED OR USED BY THE BENEFICIARY

Brand	Model	Serial Number	Description	Date of Purchase

Evaluation and Medical Justification for Complex Seating and Mobility Devices Addendum A: Mobility/Seating

This form must be completed by a physical therapist, occupational therapist, physiatrist, or rehabilitation registered nurse. The Evaluator must complete requested and/or current equipment, warranty information and economic alternative information.

Incomplete information will result in the form being returned to the Evaluator for completion.

NOTE: Only complete sections that apply to the requested equipment/accessories. If requesting an equipment/accessories complete Current/None area of the section.

Beneficiary Name: _____ Mihealth Number: _____

SECTION(s)	Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Manual wheelchair with accessory add-ons.	<input type="checkbox"/> Propels a wheelchair 60 feet, turns around, maneuvers the chair to a table, bed, toilet, negotiates at least a 3% grade, maneuvers on rugs and over door sills <input type="checkbox"/> Cannot propel manual wheelchair without caregiver assist. <input type="checkbox"/> Cannot propel manual wheelchair, used for transport only. <input type="checkbox"/> Medical reason for power assisted wheels: <input type="checkbox"/> Tilt <input type="checkbox"/> Tilt & Recline Medical reasons for function indicated: Hours of continuous wheelchair use per day: <input type="checkbox"/> > 4 hours <input type="checkbox"/> < 4hours; if < 4 hours, how many? _____	Specify current brand and model number, age of base: Under Warranty: <input type="checkbox"/> Yes <input type="checkbox"/> No Where is or will this device be used? (<i>i.e., home, school, community</i>)
Power wheelchair with standard joystick	<input type="checkbox"/> Able to propel manual wheelchair _____ feet. <input type="checkbox"/> YES <input type="checkbox"/> NO Beneficiary is able to drive a power wheelchair independently _____ feet, turns around, maneuvers the chair to a table, bed, toilet, negotiates at least a minimum of a 3% grade, maneuvers on rugs and over door sills. If NO, please explain: Power functions requested: (<i>Check all that apply.</i>) <input type="checkbox"/> Recline <input type="checkbox"/> Elevating seat <input type="checkbox"/> Center mount elevating leg rests <input type="checkbox"/> Tilt <input type="checkbox"/> Tilt & Recline <input type="checkbox"/> Elevating leg rests <input type="checkbox"/> YES <input type="checkbox"/> NO Able to perform, manipulate or work all seat functions without assistance? <input type="checkbox"/> YES <input type="checkbox"/> NO Requires verbal and/or physical assistance to manipulate seat functions? <input type="checkbox"/> YES <input type="checkbox"/> NO Has pressure relief plan of care with equipment? (explain) Hours of continuous wheelchair use per day: <input type="checkbox"/> > 4 hours <input type="checkbox"/> < 4hours; if < 4 hours, how many? _____	Specify current brand and model number, age of base: Under Warranty: <input type="checkbox"/> Yes <input type="checkbox"/> No Where is or will this device be used? (<i>i.e., home, school, community</i>) Manual functions requested: <input type="checkbox"/> Tilt <input type="checkbox"/> Tilt & Recline

Beneficiary Name: _____

Mihealth Number: _____ ATTACHMENT B

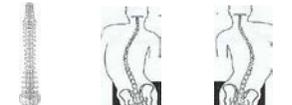
Requested		<input type="checkbox"/> Current <input type="checkbox"/> None
Equipment	Beneficiary's ability to use	
Power wheelchair with alternate controls	<input type="checkbox"/> Able to propel manual wheelchair _____ feet. <input type="checkbox"/> YES <input type="checkbox"/> NO Beneficiary is able to drive a power wheelchair independently _____ feet, turns around, maneuvers the chair to a table, bed, toilet, negotiates at least a minimum of a 3% grade, maneuvers on rugs and over door sills. If NO, please explain:	Specify current brand and model number, age of base: Under Warranty: <input type="checkbox"/> Yes <input type="checkbox"/> No Where is or will this device be used? (<i>i.e., home, school, community</i>)
	Power functions requested: (<i>Check all that apply.</i>) <input type="checkbox"/> Recline <input type="checkbox"/> Elevating seat <input type="checkbox"/> Center mount elevating leg rests <input type="checkbox"/> Tilt <input type="checkbox"/> Tilt & Recline <input type="checkbox"/> Elevating leg rests <input type="checkbox"/> YES <input type="checkbox"/> NO Able to perform, manipulate or work all seat functions without assistance? <input type="checkbox"/> YES <input type="checkbox"/> NO Requires verbal and/or physical assistance to manipulate seat functions? <input type="checkbox"/> YES <input type="checkbox"/> NO Has pressure relief plan of care with equipment? (explain)	Manual functions requested: <input type="checkbox"/> Tilt <input type="checkbox"/> Tilt & Recline
	Specify control needed: Medical need for control indicated: Indicate the beneficiary's ability to use in their environment: Hours of continuous wheelchair use per day: <input type="checkbox"/> > 4 hours <input type="checkbox"/> < 4 hours; if < 4 hours, how many? _____	
Requested		<input type="checkbox"/> Current <input type="checkbox"/> None
Power wheelchair standing feature	<input type="checkbox"/> Beneficiary has a history of pressure ulcers on pelvis, buttocks, hips or back <input type="checkbox"/> Will be used for pressure relief in lieu of tilt, recline, tilt/recline, and custom seating <input type="checkbox"/> Pressure relief is done by the beneficiary without assistance If assistance is required, indicate amount and frequency needed:	Specify current brand and model number, age of base: Under Warranty: <input type="checkbox"/> Yes <input type="checkbox"/> No Where is or will this device be used? (<i>i.e., home, school, community</i>)
	Indicate current pressure relief plan of care (including frequency and duration): Beneficiary/caregiver compliant with current pressure relief plan of care? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, explain:	
Requested		<input type="checkbox"/> Current <input type="checkbox"/> None
Scooter	<input type="checkbox"/> Able to propel manual wheelchair _____ feet. <input type="checkbox"/> Independent trunk balance <input type="checkbox"/> Adequate bilateral hand functions to work tiller.	Specify current brand and model number, age of base: Under Warranty: <input type="checkbox"/> Yes <input type="checkbox"/> No Where is or will this device be used? (<i>i.e., home, school, community</i>)

Beneficiary Name: _____ Mihealth Number _____

Growth adaptability of device REQUIRED	Requested	Current
	Seat width: _____	Seat width: _____
	Seating system height: _____	Seating system height: _____
	Seat depth: _____	Seat depth: _____
	Frame adaptability: _____	Frame adaptability: _____

SEATING SYSTEM

Medical Reason
<input type="checkbox"/> New growth > 3 inches depth and/or > 2 inches width of frame <input type="checkbox"/> Change in width; specify: _____ <input type="checkbox"/> Orthopedic change; specify: _____ <input type="checkbox"/> Needs corrective forces to assist with maintaining or improving posture. <input type="checkbox"/> Accommodate beneficiary's posture (current seating postures are not flexible . . . , etc.) <input type="checkbox"/> Other medical changes that affect the need for new positioning; specify: _____

POSTURE:				COMMENTS:
	Lateral View	AP View	Superior View	
TRUNK	Anterior / Posterior  <input type="checkbox"/> WFL Kyphosis <input type="checkbox"/> ↑ Thoracic Lordosis <input type="checkbox"/> ↑ Lumbar <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	Left Right  <input type="checkbox"/> WFL <input type="checkbox"/> Convex Left <input type="checkbox"/> Convex Right <input type="checkbox"/> c-curve <input type="checkbox"/> s-curve <input type="checkbox"/> multiple <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	Rotation-shoulders and upper trunk  <input type="checkbox"/> Neutral <input type="checkbox"/> Left anterior <input type="checkbox"/> Right anterior <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	<input type="checkbox"/> Hypertonia <input type="checkbox"/> Hypotonia
	Anterior View	Superior View	ROM	MMT/O
HIPS	Position  <input type="checkbox"/> Neutral <input type="checkbox"/> Abduct <input type="checkbox"/> Adduct <input type="checkbox"/> Fixed <input type="checkbox"/> Subluxed <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Dislocated <input type="checkbox"/> Flexible	Windswept  <input type="checkbox"/> Neutral <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	Hip Flexion/Extension Limitations: (PROM in Degrees) Hip Internal/External Range of Motion Limitations:	

Beneficiary Name: _____ Mihealth Number _____

POSTURE:				COMMENTS:
	Lateral View	AP View	Superior View	
PELVIS	Anterior / Posterior	Obliquity	Rotation-Pelvis	If spinal curvature present, indicate degree.
	<input type="checkbox"/> Neutral <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior	<input type="checkbox"/> WFL <input type="checkbox"/> R elev <input type="checkbox"/> L elev	<input type="checkbox"/> WFL <input type="checkbox"/> Right Anterior <input type="checkbox"/> Left Anterior	
	<input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	<input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	<input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	

Requested Seating System		Current Seating System <input type="checkbox"/> None	
Under warranty: <input type="checkbox"/> Yes <input type="checkbox"/> No		Include warranty: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mobility device to be used with:		Mobility device is used with:	
<input type="checkbox"/> Standard	<input type="checkbox"/> Custom	<input type="checkbox"/> Standard	<input type="checkbox"/> Custom
Manufacturer:	Type:	Manufacturer:	Type:
Date provided:	Date provided:	Date provided:	Date provided:
Components include:	Components include:	Components include:	Components include:
<input type="checkbox"/> Seat only <input type="checkbox"/> Back only <input type="checkbox"/> Back and Seat	<input type="checkbox"/> Seat only <input type="checkbox"/> Back only <input type="checkbox"/> Back and Seat	<input type="checkbox"/> Seat only <input type="checkbox"/> Back only <input type="checkbox"/> Back and Seat	<input type="checkbox"/> Seat only <input type="checkbox"/> Back only <input type="checkbox"/> Back and Seat
Lateral Components Include:	Lateral Components Include:	Lateral Components Include:	Lateral Components Include:
<input type="checkbox"/> Trunk <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Abductor <input type="checkbox"/> Anti-thrust	<input type="checkbox"/> Trunk <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Abductor <input type="checkbox"/> Anti-thrust	<input type="checkbox"/> Trunk <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Abductor <input type="checkbox"/> Anti-thrust	<input type="checkbox"/> Trunk <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Abductor <input type="checkbox"/> Anti-thrust

Requested Seating System		Current Seating System <input type="checkbox"/> None	
<input type="checkbox"/> Standard	<input type="checkbox"/> Custom	<input type="checkbox"/> Standard	<input type="checkbox"/> Custom
Manufacturer:	Type:	Manufacturer:	Type:
Other Components - List:	Other Components - List:	Additional Components: <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Components: <input type="checkbox"/> Yes <input type="checkbox"/> No
		If Yes, describe:	If Yes, describe:

Beneficiary Name: _____ Mihealth Number _____

Requested Seating System		Current Seating System <input type="checkbox"/> None	
<input type="checkbox"/> Planar (contoured)	<input type="checkbox"/> Custom	<input type="checkbox"/> Planar (contoured)	<input type="checkbox"/> Custom
If requesting custom seating, specify why Planar does not meet beneficiary's medical needs.			

Equipment	Device Type <i>(attach additional page(s) if necessary)</i>	Medical Reason
All Accessories / Add Ons	<input type="checkbox"/> Head & Neck Type:	
	<input type="checkbox"/> Arms <input type="checkbox"/> Special Trough [describe]	
	<input type="checkbox"/> Special pad [describe]	
	<input type="checkbox"/> Feet <input type="checkbox"/> Footbox [describe]	
<input type="checkbox"/> Other - Describe		
Medical Reason	Specify Medical Reason for brand(s) and model(s) requested for this beneficiary:	

EVALUATOR (PT, OT, PHYSIATRIST OR REHAB RN) ATTESTATION AND SIGNATURE/DATE

I certify that I conducted the evaluation and have completed the information in the appropriate Sections of the MSA-1656-Addendum A and that there is no financial arrangement with the selected durable medical equipment provider and/or the evaluating clinician. I certify that the equipment requested is the most economical alternative that meets the beneficiary's basic medical and functional needs. I certify that the information contained in this form is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

[Click here to enter text.](#)

Evaluation Date

[Click here to enter text.](#)

Evaluator Name/Title (Print)

[Click here to enter text.](#)

Place of Employment and Address

[Click here to enter text.](#)

NPI

[Click here to enter text.](#)

Phone Number

[Click here to enter text.](#)

Evaluator Signature

Date

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

**Evaluation and Medical Justification for Complex Seating and Mobility Devices
Addendum B: Stroller, Gait Trainers, Stenders and Children's Positioning Chairs**

This form must be completed by a physical therapist, occupational therapist, physiatrist, or rehabilitation registered nurse. The Evaluator must complete requested and/or current equipment, warranty information and economic alternative information.

Incomplete information will result in the form being returned to the evaluator for completion.

NOTE: Only complete sections that apply to the requested equipment/accessories. If requesting an equipment/accessories complete Current/None area of the section.

Beneficiary Name: _____ Mihealth Number: _____

SECTION	Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Equipment	Beneficiary's ability to use	
Stroller	<input type="checkbox"/> Transport only <input type="checkbox"/> Primary mobility device Indicate medical special needs for use and adaptations needed:	Specify brand, model number, and age of device:
		Under Warranty: <input type="checkbox"/> Yes <input type="checkbox"/> No
		Where is or will this device be used? (i.e., home, school, community)
	Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Gait trainer (if less than age 21)	<input type="checkbox"/> Is independent with gait trainer. <input type="checkbox"/> Requires assistance with mobility using gait trainer. How many times per day will beneficiary use gait trainer: How far can beneficiary ambulate with gain trainer/device? _____ ft. How much assistance does beneficiary require? Indicate the expected performance in the requested equipment:	Specify brand, model number, and age of device:
		Under Warranty: <input type="checkbox"/> Yes <input type="checkbox"/> No
		Where is or will this device be used? (i.e., home, school, community)
		Beneficiary/caregiver compliant with current mobility plan of care? <input type="checkbox"/> Yes <input type="checkbox"/> No
		If No, explain:
	Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Children's positioning chairs (if less than age 21) e.g., feeder seat, high/low seat, activity chair, etc.	<input type="checkbox"/> Home inaccessible to mobility device. <input type="checkbox"/> Beneficiary is > 40 lbs. with limited head and trunk control <input type="checkbox"/> Beneficiary has current active seizures <input type="checkbox"/> Beneficiary is unable to eat or be safely fed in current mobility device <input type="checkbox"/> Crown to hip measurement on Mat evaluation is > 26"	Specify brand, model number, and age of device:
		Under Warranty: <input type="checkbox"/> Yes <input type="checkbox"/> No
		Where is or will this device be used? (i.e., home, school, community)
		If beneficiary is < 40 lbs. or < 26", explain why commercially available products or other mobility devices will not meet the beneficiary's medical needs:

Beneficiary Name: _____ Mihealth Number: _____

		Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Equipment	Beneficiary's ability to use	Where device is used	
Car seat	Indicate medical special needs for use and adaptations needed:	Specify brand, model number, and age of device:	
		Under Warranty: <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Where is or will this device be used? (i.e., home, school, community)	
		Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Stander (If less than age 21)	<input type="checkbox"/> Is dependent with standing <input type="checkbox"/> Walks with assistive device <input type="checkbox"/> Walks with gait trainer <input type="checkbox"/> Required for post-op care Specify treatment plan and state any surgical or other interventions that affect standing:	Specify brand, model number, and age of device:	
		Under Warranty: <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Where is or will this device be used? (i.e., home, school, community)	
	Indicate current standing plan of care (including how many times per day and how long):		
	Is the beneficiary/caregiver compliant with standing plan of care? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, explain:		
Growth adaptability of device	Requested	<input type="checkbox"/> Current <input type="checkbox"/> None	
	Seat width: _____	Seat width: _____	
	Seating system height: _____	Seating system height: _____	
	Seat depth: _____	Seat depth: _____	
	Frame adaptability: _____	Frame adaptability: _____	
Equipment	Device Type (attach additional page(s) if necessary)	Medical Reason	
All Accessories / Add Ons	<input type="checkbox"/> Head & Neck Type: _____		
	<input type="checkbox"/> Arms Type: _____		
	<input type="checkbox"/> Feet Type: _____		
	<input type="checkbox"/> Other - Describe _____		
Medical Reason	Specify Medical Reason for brand(s) and model(s) requested for this beneficiary:		

Beneficiary Name: _____ Mihealth Number: _____

EVALUATOR (PT, OT, PHYSIATRIST OR REHAB RN) ATTESTATION AND SIGNATURE/DATE

I certify that I conducted the evaluation and have completed the information in the appropriate Sections of the MSA-1656-Addendum B and that there is no financial arrangement with the selected durable medical equipment provider and/or the evaluating clinician. I certify that the equipment requested is the most economical alternative that meets the beneficiary's basic medical and functional needs. I certify that the information contained in this form is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

[Click here to enter text.](#)

Evaluation Date

[Click here to enter text.](#)

Evaluator Name/Title (Print)

[Click here to enter text.](#)

Place of Employment and Address

[Click here to enter text.](#)

NPI

[Click here to enter text.](#)

Phone Number

Evaluator Signature

[Click here to enter text.](#)

Date

Special Services Prior Approval - Request/Authorization Completion Instructions

The MSA-1653-B must be used by Medicaid enrolled DME, Medical Suppliers, Orthotists, Prosthetists, Hearing Aid Dealers, Audiologists and Cochlear Manufacturers.

MDCH requests that the MSA-1653-B be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDCH website www.michigan.gov/medicaidproviders >> Policy and Forms >> Forms. The form is generally self-explanatory. For complete information on required modifiers, documentation, and appropriate quantity amounts, refer to the following documents:

- Standards of Coverage portion of the provider-specific chapters of the Medicaid Provider Manual.
- Billing & Reimbursement for Professionals Chapter of the Medicaid Provider Manual.
- Provider-specific databases on the MDCH website. www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Completion of this form is as follows:

Box 1	MDCH Use Only
Box 12	Check Yes if beneficiary is in a Nursing Facility or No if the beneficiary is not in a Nursing Care Facility. If Yes, include the Nursing Facility name, address and phone number.
Box 19	Enter a complete description of the item requested, including manufacturer, model, style, etc. DME, orthotics and prosthetics, must provide the brand name, model, and catalog or part number.
Box 20	Enter the HCPCS Procedure Code.
Box 21	Enter the applicable HCPCS Modifier.
Box 24	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description). DME/POS providers must submit the prescription/CMN with this form.
Box 25	Any additional remarks regarding the request should be listed in this box such as verbal authorization date, retroactive date of service if being requested. Provide other insurance coverage for services requested.
Box 27	Must be completed for all requests.

Form Submission

PA request forms and required documentation for all eligible Medicaid beneficiaries must be mailed or faxed to:

**MDCH - Medical Services Administration
Program Review Division
P.O. Box 30170
Lansing, Michigan 48909**

Fax Number: (517) 335-0075

To check the status of a PA request, contact the MDCH - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276**.

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

Michigan Department of Community Health
SPECIAL SERVICES
PRIOR APPROVAL – REQUEST/AUTHORIZATION

1. PRIOR AUTHORIZATION NUMBER (MDCH USE ONLY)
Proof #3

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

2. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIAL)		3. NPI NUMBER		4. PHONE NUMBER	
5. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)				6. FAX NUMBER	
7. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)		8. SEX <input type="checkbox"/> M <input type="checkbox"/> F	9. BIRTH DATE		10. MIHEALTH CARD NUMBER
11. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP)					
12. DOES BENEFICIARY RESIDE IN A NURSING FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PROVIDE FACILITY NAME, ADDRESS, PHONE NUMBER.					
13. REFERRING/ORDERING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL)			14. NPI NUMBER		15. PHONE NUMBER
16. REFERRING/ORDERING PHYSICIAN'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)				17. FAX NUMBER	
18. LINE NO.	19. DESCRIPTION OF SERVICE (MUST INCLUDE BRAND NAME, MODEL, CATALOG OR PART NUMBER)	20. PROCEDURE CODE	21. MODIFIER	22. QUANTITY	23. CHARGE
01					
02					
03					
04					
05					
06					
07					
24. ICD-9-CM DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.			25. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE, FOR SERVICES REQUESTED.		
26. INDICATE ANY OTHER SERVICES PROVIDED TO THIS BENEFICIARY DURING THE PAST YEAR.					
27. PROVIDER CERTIFICATION: THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR APPROVAL FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR APPROVAL AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF APPROVED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.					
PROVIDER'S SIGNATURE				DATE	
MDCH USE ONLY					
29. REVIEW ACTION: APPROVED <input type="checkbox"/> INSUFFICIENT DATA <input type="checkbox"/> DENIED <input type="checkbox"/> NO ACTION <input type="checkbox"/> APPROVED AS AMENDED <input type="checkbox"/>			30. CONSULTANT REMARKS		
CONSULTANT SIGNATURE				DATE	

Complex Seating and Mobility Device Prior Approval - Request/Authorization Completion Instructions

The MSA-1653-D must be used by Medicaid enrolled DME Providers. Note: Requests for new or replacement wheelchairs require completion of only boxes 2-18, 28 and 30 submitted with a completed "Evaluation and Medical Justification for Complex Seating and Mobility Devices" form (MSA-1656).

MDCH requests that the MSA-1653-D be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDCH website www.michigan.gov/medicaidproviders >> Policy and Forms >> Forms. The form is generally self-explanatory. For complete information on required modifiers, documentation, and appropriate quantity amounts, refer to the following documents:

- Standards of Coverage portion of the provider-specific chapters of the Medicaid Provider Manual.
- Billing & Reimbursement for Professionals Chapter of the Medicaid Provider Manual.
- Provider-specific databases on the MDCH website. www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Completion of this form is as follows:

Box 1	MDCH Use Only
Box 11	Beneficiary address. If beneficiary resides in Nursing Facility include the Nursing Facility name, address and phone number.
Box 17	Complete this box ONLY for wheelchair requests. <ul style="list-style-type: none"> • For repairs or parts, complete MSA-1653-B. (Do not include MSA-1656.) • For new or replacement (due to a change in beneficiary basic medical functional status requests), stop at this point and complete MSA-1656. Both forms must be submitted for Prior Authorization consideration.
Box 20	Enter a complete description of the item requested, including manufacturer, model, style, etc. DME, orthotics and prosthetics, must provide the brand name, model, and catalog or part number.
Box 21	Enter the HCPCS Procedure Code.
Box 22	Enter the applicable HCPCS Modifier.
Box 27	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description). DME/POS providers must submit the prescription/CMN with this form.
Box 28	Any additional remarks regarding the request should be listed in this box such as verbal authorization date, retroactive date of service if being requested. Provide other insurance coverage for services requested.
Box 29	Must be completed for all requests.

Form Submission

PA request forms and required documentation for all eligible Medicaid beneficiaries must be mailed or faxed to:

**MDCH - Medical Services Administration
Program Review Division
P.O. Box 30170
Lansing, Michigan 48909**

Fax Number: (517) 335-0075

To check the status of a PA request, contact the MDCH - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276**.

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

Michigan Department of Community Health
**Complex Seating and Mobility Device
 Prior Approval - Request/Authorization**

1. PRIOR AUTHORIZATION NUMBER (DO NOT USE ONLY)
ATTACHMENT E
Proof #3

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

2. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIAL)		3. NPI NUMBER		4. PHONE NUMBER	
5. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)				6. FAX NUMBER	
7. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)		8. SEX <input type="checkbox"/> M <input type="checkbox"/> F	9. BIRTH DATE	10. MIHEALTH CARD NUMBER	
11. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP). IF RESIDES IN NURSING FACILITY INDICATE NAME OF FACILITY, ADDRESS AND PHONE NUMBER.					
12. NAME OF DESIGNATED CONTACT PERSON (E.G., BENEFICIARY, PARENT, GUARDIAN, ETC.)				13. PHONE NUMBER	
14. OTHER INSURANCE NAME		15. POLICY NUMBER		16. FAX NUMBER	
17. AUTHORIZATION TYPE: <input type="checkbox"/> NEW WHEELCHAIR <input type="checkbox"/> RENTAL ONLY <input type="checkbox"/> REPAIR <input type="checkbox"/> REPLACEMENT				18. MSA-1656 SUBMITTED ON	

19. LINE	DESCRIPTION OF SERVICE	20. PROCEDURE CODE	22. MODIFIER	23. QUANTITY	24. CHARGE	25. COVERED BY OTHER INSURANCE?		26. DATE LAST REPLACED (MM/DD/YYYY)
						YES	NO	
01						<input type="checkbox"/>	<input type="checkbox"/>	
02						<input type="checkbox"/>	<input type="checkbox"/>	
03						<input type="checkbox"/>	<input type="checkbox"/>	
04						<input type="checkbox"/>	<input type="checkbox"/>	
06						<input type="checkbox"/>	<input type="checkbox"/>	

FOR ADDITIONAL ITEMS ADD PAGE WITH DESCRIPTION, PROCEDURE CODE(S), MODIFIER(S), QUANTITY, CHARGE, IF COVERED BY OTHER INSURANCE, AND IF APPLICABLE DATE OF LAST REPLACED.

27. ICD-9-CM DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.	28. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE, FOR SERVICES REQUESTED.
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29. INDICATE ANY OTHER SERVICES PROVIDED TO THIS BENEFICIARY DURING THE PAST YEAR.

30. DME PROVIDER CERTIFICATION: THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR APPROVAL FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR APPROVAL AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF APPROVED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

DME'S SIGNATURE _____	DATE _____
ADDITIONAL DME'S SIGNATURE _____	DATE _____

MDCH USE ONLY

29. REVIEW ACTION: APPROVED <input type="checkbox"/> INSUFFICIENT DATA <input type="checkbox"/> DENIED <input type="checkbox"/> NO ACTION <input type="checkbox"/> APPROVED AS AMENDED <input type="checkbox"/>	30. CONSULTANT REMARKS
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CONSULTANT SIGNATURE _____	DATE _____
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