MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Updated 5/4/10 – Form MSA-1656 has been revised. The updated form can be found at www.michigan.gov/medicaidproviders >> Policy and Forms >> Forms.

Bulletin: MSA 10-16

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

Issued: May 1, 2010

Subject: Prior Authorization and Coverage of Mobility and Custom Fabricated Seating for Beneficiaries in the Community and in Nursing Facilities; Mobility and Seating Evaluation and Justification Form (MSA-1656) for All Beneficiaries; and Revised Special Services Prior Approval-Request/Authorization Form (MSA-1653-B)

Effective: June 1, 2010

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

Medicaid policy for program coverage of mobility and custom fabricated seating systems is being revised to provide clinical practitioners with a new standardized mobility assessment to be used for all beneficiaries. The physician's order for any mobility and custom fabricated seating request must be supported by clinical documentation in the beneficiary's medical record. Standard assessment information will support and expedite the prior authorization process.

Medicaid Managed Care Plans follow their own prior authorization and documentation criteria.

Prior authorization for beneficiaries in the institutional setting is being revised to recognize the facility's overall responsibility for person-centered planning. A written individualized plan of care must be developed in the context of the person-centered planning process in order to specify services and activities, and to accommodate individual needs and preference. The plan of care must comprehensively address each resident's need for health care and other services and ensure that services are delivered in accordance with the individualized plan of care.

The following attached documents delineate the revised policy:

Attachment A - New "Mobility and Seating Evaluation and Justification (MSA-1656) For All Beneficiaries"
Attachment B - Revised "Special Services Prior Approval – Request/Authorization" (MSA-1653-B)
Attachment C - New prior authorization procedure and coverage of Mobility and Custom Fabricated Seating in the Nursing Facility Chapter
Attachment D - New Prior Authorization Procedure and Coverage of Mobility and Custom Fabricated Seating in the Medical Supplier Chapter
Attachment E - MSA-1653-B Special Services Prior Approval – Request/Authorization form
Attachment F - MSA-1656 Mobility and Seating Evaluation and Justification form

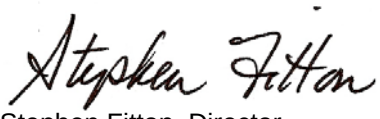
Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

APPROVED



Stephen Fitton, Director
Medical Services Administration

Michigan Department of Community Health (MDCH)
Medical Services Administration (MSA)

Mobility and Seating Evaluation and Justification Form (MSA-1656) for All Beneficiaries

The new **Mobility and Seating Evaluation and Justification (MSA-1656)** provides a standard assessment tool for a licensed/certified medical professional to use when performing wheelchair and seating system assessments and pediatric standing systems. The MSA-1656 must be submitted within 90 days of the date the form is completed for all wheelchairs, Power Operated Vehicles (POV) and seating systems for all ages and covered settings.

The MSA-1656 instructions describe the responsibilities of the treating physician, the physical and occupational therapist, the nursing facility staff (when applicable) and the medical supplier for completing the form.

The MSA-1656 is a clinical assessment that also includes an assessment of current technology options available to meet the beneficiary's medical and functional goals. Once problems and goals are determined, the process includes patient simulation trial using comparable loaner or demonstration technology jointly performed by the clinician and a qualified assistive technology practitioner.

The physician signature in Section 17 of the form is also an attestation of the evaluation and recommendations made on the form as well as the items listed by the medical supplier.

The MSA-1656 assessment will serve as a baseline evaluation for the beneficiary. The MSA-1656 assessment will not have to be completed and submitted again for any requests for additions or revisions to the wheelchair unless there is a change in the beneficiary's functional status.

Form MSA-1656 must be completed by a licensed/certified medical professional. Note: A licensed/certified medical professional is defined as an occupational or physical therapist, or a rehabilitation R.N. 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.

A physical therapy assistant (PTA) or a certified occupational therapy assistant (COTA) may not perform any part of the assessment or evaluation and may not complete or sign the MSA-1656.

The Outpatient Therapy Provider or the Nursing facility may bill for the mobility and seating assessment performed by the licensed/certified medical professional using the Healthcare Common Procedure Coding System (HCPCS) code 97542.

Medical documentation includes:

- A written order for a wheelchair assessment initiated and signed by the treating physician (MD or DO) with the stated medical reason for the referral.

- A properly completed and signed MSA-1656 form including:
  - Section 15 - completed by the medical supplier
  - Section 17 - Physician Attestation and Signature/Date which certifies the treating physician review of the assessment and equipment being requested by the medical supplier.

- An MSA-1653-B form (see Attachment E) completed by a Medicaid-enrolled medical supplier.

For nursing facility residents, the MSA-1656 instructions describe the responsibilities of the treating physician, the nursing facility staff and the medical supplier in preparing the required medical documentation.

Completion of form MSA-1656 without supporting documentation from the medical record is not acceptable. The use of medical supplier created mobility forms or "canned" documentation statements are not acceptable and may not be used as a substitute for information from the medical record or completion of the designated MSA forms. The **medical supplier** must complete the **MSA 1653-B and only Section 15 of the MSA-1656 form**.

Medicaid Provider Forms

Providers may download the MSA-1653-B and MSA-1656 from the MDCH website at www.michigan.gov/medicaidproviders >> Policy and Forms >> Forms.

Submission of Forms and Recordkeeping

- For **beneficiaries in the community setting,** the medical supplier may submit the completed prior authorization request and medical documentation to:

  Michigan Department of Community Health
  Program Review Division
  PO Box 30170
  Lansing, Michigan 48909-7670

  Prior authorization requests with required documentation may be faxed to: 517-335-0075.

- For **beneficiaries in a Nursing Facility**, instructions for the preparation and submission of prior authorization forms by the nursing facility are described in Prior Authorization and Coverage of Mobility and Custom Fabricated Seating Nursing Facility Chapter (Attachment D).

- **Recordkeeping requirements for beneficiaries in all settings** require that a clean and reproducible copy of the physician's order and the MSA-1656 must be retained in the beneficiary's record for seven years.

Michigan Department of Community Health (MDCH)
Medical Services Administration (MSA)

Special Services Prior Approval - Request/Authorization Form MSA-1653-B Requirements Specific to Wheelchairs/Seating Systems

MSA-1653-B must be completed by the medical supplier. For purposes of new or replacement pediatric standing systems and wheelchair/seating systems requests for beneficiaries of all ages and settings, the MSA-1653-B **and** the MSA-1656 must be submitted.

The MSA-1653-B form has been revised. The revised items on the form include:

- Item 18 indicates the reason for the request. When requesting for **repairs** and **parts**, the form requires **full completion**. When requesting a **new** or **replacement wheelchair**, **only items 1 through 18** require completion.
- Item 20 requires the supplier to provide the brand name, model, and catalog or part number for all Durable Medical Equipment (DME), Orthotics and Prosthetics.
- Item 26 remarks and/or documentation of medical necessity now includes "Additional remarks, including other insurance coverage, for services requested."

These items will provide product information to expedite the prior authorization process.

Healthcare Common Procedure Coding System (HCPCS) Codes

Providers must use the valid HCPCS codes for the products requested. Noridian Administrative Services, LLC is the Pricing, Data Analysis and Coding (PDAC) contractor for the Centers for Medicare & Medicaid Services (CMS). One of the services they provide is to guide manufacturers and suppliers on the proper use of HCPCS codes through product reviews and decisions. Providers can access the PDAC website at www.dmepdac.com.

If there is no established Medicaid fee screen for the HCPCS code or a not otherwise classified (NOC) code is appropriate to use, the provider must submit documentation of the acquisition cost via actual invoice dated within 90 days of the date of service. Manufacturer quotes or dealer list prices are not accepted as documentation of cost. If the quote or dealer list is the actual cost, the provider must write on the quote or dealer list, "This amount is the actual acquisition cost", and sign and date the statement. MDCH reserves the right to set a dollar limit on how much MDCH will reimburse for a NOC code or any manually priced procedure code for a specific range of products.

Medicaid Provider Forms

Providers may download the MSA-1653-B from the MDCH website at www.michigan.gov/medicaidproviders >> Policy and Forms >> Forms.

Submission of Forms and Recordkeeping

- For **beneficiaries in the community residential setting,** the medical supplier may submit the completed prior authorization request and medical documentation, mailed or faxed, to:

  Michigan Department of Community Health
  Program Review Division
  PO Box 30170
  Lansing, Michigan 48909-7670
  Fax: (517) 335-0075

- For **beneficiaries in a Nursing Facility (institutional residential setting),** instructions for the preparation and submission of prior authorization forms by the nursing facility are described in Prior Authorization and Coverage of Mobility Device and Custom Fabricated Seating for the Nursing Facility (Attachment D).

- **Recordkeeping requirements for beneficiaries in all settings** require that a clean and reproducible copy of this form, the physician's order and the MSA-1656 must be retained in the beneficiary's record for seven years.

Prior Authorization and Coverage of Mobility and Custom Fabricated Seating Nursing Facility Chapter:

Federal and State health and care standards for nursing facilities require that each facility is responsible to provide sufficient equipment to provide the services required by the regulations. Michigan licensure requires that the necessary equipment for rehabilitative nursing techniques and procedures must be available in adequate supply to meet the needs of all beneficiaries. In addition, nursing services include positioning and body alignment and preventive skin care. The nursing facility is responsible for proper pressure relief and positioning. The use of medical equipment as a substitute for responsible patient care is inappropriate and not covered.

9.8.A. Standard Equipment

Standard durable medical equipment is included in the facility's per diem rate. The durable medical equipment supplier and the nursing facility must make arrangements for purchasing or renting required equipment. Standard durable medical equipment includes, but is not limited to:

- Adaptive Activities of Daily Living (ADL) equipment
- Air mattresses
- Autoclaves
- Bed boards
- Bed cradles
- Bed pans
- Bed rails
- Beds (including hospital beds)
- Bedside safety rails
- Bedside stands
- Blood pressure apparatus
- Canes
- Comfortable cushioned chair
- Commodes
- Crutches
- Emesis basins
- Food pumps
- Footboards
- Footrails
- Footstools
- Freestanding trays for meals
- Geriatric chairs
- Pads, water circulating devices to apply heat or cold therapy (e.g., hot/cold packs, heating pads, etc.)
- Infrared lamps
- Lap and half lap trays
- Lifts
- Oxygen equipment and supplies
- Positioning pillows
- Prefabricated and/or custom fitted positioning components for standard wheelchairs such as laterals, abductors, etc.
- Pressure relief positioning cushions
- Reading lights
- Sitz baths
- Splints
- Suction machines
- Traction equipment
- Trapeze equipment
- Tub lifts
- Urinals
- Walkers
- Wash basins
- Standard manual wheelchairs
- Wheelchairs for transport in or out of the facility

Such equipment must be available for all the residents demonstrating need. Previously acquired equipment should be adapted to meet the beneficiary's needs, if appropriate.

The facility is required to repair/maintain standard equipment, and this expense is included in the per diem rate.

Replacement, repair and maintenance of standard equipment owned or rented by the beneficiary may not be billed separately to Medicaid. It is the nursing facility's responsibility to provide standard equipment via replacement, repair or maintenance.

Nursing Facility Hospice Residents

For hospice beneficiaries residing in the nursing facility, all items and services related to or addressing the terminal illness must be provided by the Hospice. This includes medical devices, durable medical equipment and supplies.

Standard Equipment for Beneficiaries in the Nursing Facility Setting

Medicaid policy has historically established that standard wheelchairs and other specified durable medical equipment are included in the Medicaid facility per diem rate in accordance with State licensure requirements (Michigan Admin. code R325.20708). The following policy describes what is meant by standard wheelchairs relative to current types of wheelchair products that are routinely prescribed and commonly available in the marketplace. This update is not intended to represent any new coverage mandate for wheelchairs in institutional settings but is intended to describe standard wheelchairs routinely prescribed and required for patient use in the long term care environment.

Standard manual wheelchairs are included in the facility's Medicaid per diem rate. A standard manual wheelchair is any wheelchair that is routine or usual for the general population of the nursing facility setting. Standard manual wheelchairs that must be available to meet health and care standards include wheelchairs and accessories that are manufactured stock items including heavy duty, light or ultra light weight and/or strength, hemi chairs, wheelchairs with adjustable or reclining backs, manual tilt in space, removable/adjustable arms, variable seat height, width or depth, anti-thrust seats, laterals, abductors, adductors or other non-custom positioning options. In addition, pressure relief positioning cushions, positioning pillows, trochanter rolls, etc. required for proper beneficiary use of the wheelchair or the provision of nursing services are the responsibility of the facility.

9.8.B. Custom Fabricated Seating and Power Wheelchairs

Manual wheelchairs with custom fabricated seating and/or power wheelchairs for nursing facility residents may be covered when the established standards of coverage are met and the severity and intensity of disease process requires custom fabricated seating, or power operated wheelchair as medically necessary and an integral part of the facility's daily nursing plan of care.

Medical Necessity

A physician's order by itself is not sufficient documentation of medical necessity, even when it is signed by the treating physician. Clinical documentation from the medical record must support the medical necessity for the request and substantiate the physician's order. In addition, Medicaid coverage is not based solely on a physician order, the request must also meet the standards of coverage published by the Program. Refer to Section 1.5 in the Medical Supplier Chapter of the Medicaid Provider Manual for a complete description of policy regarding medical necessity requirements.

The nursing facility's responsibility for each resident's health care needs and other services including patient care, transfers, safety, skin care, equipment, medical supplies, etc., are described in federal regulations and state licensure requirements. The use of medical equipment as a substitute for responsible patient care is inappropriate and not covered.

Refer to the Medical Supplier Chapter, for further information regarding Medicaid definitions and standards of coverage for mobility and custom fabricated seating systems.

Noncovered

Power wheelchairs, custom fabricated seating systems on manual wheelchairs and/or specified add on components are not covered outside the facility per diem rate when:

- There is an appropriate economic alternative.
- The devices are not related to or an integral part of the nursing facility daily plan of care.
- The accessory, add on or component is deemed to be standard under the definition of a standard manual wheelchair.
- The wheelchair is used as a restraint or for the purpose of treating aberrant behaviors.

- The need for the wheelchair is a substitute for appropriate clinical nursing services as defined in federal regulations.
- The wheelchair is inappropriate for the beneficiary's cognitive level or behavioral level.
- The beneficiary is unable to safely operate the wheelchair.
- The wheelchair and/or seating system is not covered outside of the per diem rate when the standard chair can meet functional need or outcome has defined in the plan of care.
- When ordered for nonstandard use (e.g., therapeutic modality or exercise).
- When ordered to increase sitting tolerance that exceeds acceptable medical guidelines for skin care and pressure.

9.8.C. Prior Authorization Procedure

Prior authorization is required for Medicaid coverage of medically necessary power wheelchairs, custom fabricated seating and manual wheelchairs with custom fabricated seating systems outside of the facility per diem rate. The attending physician must initiate the referral for custom seating based on an identified medical need required in the plan of care. Facility clinicians who are responsible for the overall nursing plan of care and treatment for the resident will prepare and submit prior authorization requests and medical documentation directly to the Michigan Department of Community Health (MDCH) Program Review Division within 90 days of the date that the MSA-1656 is completed. The procedure is as follows:

- Attending physician requests a resident assessment for a power wheelchair or custom fabricated seating system with the stated medical reason for the referral.
- Evaluation is completed by an approved licensed/certified medical professional.
- The Nursing Facility Director of Nursing or Nursing Facility Administrator forwards the MSA-1656 assessment to the medical supplier for completion of Section 15.
- The medical supplier completes form MSA-1653-B and **only** Section 15 of the MSA-1656 and returns both forms to the Nursing Facility Director of Nursing or Nursing Facility Administrator.
- Nursing Facility Director of Nursing or Nursing Facility Administrator completes Section 16 of the MSA-1656 and obtains the attending physician signature and attestation Section 17.
- The Nursing Facility Director of Nursing or Nursing Facility Administrator submits the MSA-1656, MSA-1653-B to MDCH and the following facility clinical documentation:
  - The most recent Minimum Data Set (MDS) form with cognitive assessment and cognitive performance scores included.
  - Facility nursing notes summaries or nurses notes for the most recent two months.
  - The current nursing plan of care.
- Other documentation as required by MDCH.

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Submission of Forms and Recordkeeping

The **nursing facility must submit** the prior authorization request (MSA-1653-B and MSA-1656 forms) and the required clinical documentation to:

Michigan Department of Community Health
Program Review Division
PO Box 30170
Lansing, Michigan 48909-7670
Fax: (517) 335-0075

The forms must be submitted to MDCH within 90 days of the date the MSA-1656 is completed. The nursing facility must retain clean reproducible copies of all required documentation for the equipment or wheelchair in the beneficiary file for seven years, including the physician's order, the MSA-1656 and MSA-1653-B.

Michigan Department of Community Health (MDCH)
Medical Services Administration (MSA)

MEDICAL SUPPLIER CHAPTER REVISION

Section 1 Program Overview

Below are common terms used throughout this chapter:
Durable Medical Equipment (DME): DME are those items that are Food and Drug Administration (FDA) approved, can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and can be used in the beneficiary's home. Examples are: hospital beds, wheelchairs, and ventilators. DME is a benefit for beneficiaries when:

- It is medically and functionally necessary to meet the needs of the beneficiary.
- It may prevent frequent hospitalization or institutionalization.
- It is life sustaining.

1.2.A. Healthcare Common Procedure Coding System (HCPCS) codes

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirement as defined by the Code of Federal Regulations (CFR) under 45 CFR 162.10002 for standardized coding systems, established the HCPCS level II codes as the standardized coding system for describing and identifying health care equipment and supplies in health care transactions that are not identified by the HCPCS level I, or Current Procedural Terminology (CPT) codes.

HCPCS is a system for identifying items and services. It is not a system for making coverage or payment determinations, and the existence of a code does not determine coverage or non-coverage of an item or service. Decisions regarding the addition, deletion, or revision of HCPCS codes are made independent of the process for determination of coverage and payment.

National permanent codes are maintained by the Centers for Medicare and Medicaid Services (CMS) HCPCS Workgroup. The Workgroup is responsible for making decisions about additions, revisions, and deletions to the permanent national alpha-numeric codes. The permanent national codes serve the function of providing a standardized coding system that is managed jointly by private and public insurers.

National codes also include miscellaneous/not otherwise classified (NOC) codes. These codes are used when a supplier is submitting a bill or request for an item or service where there is no existing national code that adequately describes the item or service. Before using a miscellaneous/not otherwise classified code, the supplier should check with the Medicare Pricing, Data Analysis and Coding (PDAC) contractor Noridian Administrative Services, LLC (https://www.dmepdac.com/dmecsapp/do/search) to determine whether there is a specific code that should be used rather than a miscellaneous/not otherwise classified code. CMS has a toll free helpline for this purpose, (877) 735-1326, which is operational during the hours of 9 a.m. to 4 p.m. (EST).

When submitting claims, suppliers are required to use one of these HCPCS codes to identify the items they are billing. The descriptor that is assigned to a code represents the definition of the items and services that can be billed using that code. MDCH reserves the right to determine and apply correct HCPCS codes used for the purpose of reimbursement.

1.3 Place of Service

Amend second paragraph to read as follows:

For residents in a skilled nursing or nursing facility, most medical supplies and DME are considered to be included in the facility's per diem rate. Wheelchair requests for the primary purpose of meeting resident nursing care needs that are the responsibility of the nursing facility are not covered. Wheelchairs for social or recreational purposes are the responsibility of the nursing facility. The Nursing Facility Chapter further describes coverage policy in the nursing facility. The following items are exempt from the per diem rate and may be billed by the medical supplier:

Third bullet replaced with the following:

- Custom fabricated seating systems may be covered outside of the nursing facility per diem rate when a standard item will not meet the medical and functional needs of the user and standards of coverage are met.

1.5 Medical Necessity

Medical devices are covered if they are the most cost effective treatment available that meets the standards of coverage stated in the Coverage Conditions and Requirements Section.

The medical record must contain sufficient documentation of the beneficiary's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement. The information should include the beneficiary's diagnosis, medical condition and other pertinent information, including, but not limited to, duration of the condition, clinical course, prognosis, nature and extent of functional limitations, other therapeutic interventions and results, and past experience with related items. Neither a physician's order nor a certificate of medical necessity by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician. Information in the medical record must support the item's medical necessity and substantiate that the medical device needed is the most appropriate economic alternative that meets MDCH standards of coverage.

A medical device may be determined to be medically necessary when all the following apply:

- It is ordered by the attending physician and clinical documentation from the medical record supports the medical necessity for the request as described above and substantiates the physician order.
- The service meets the standards of coverage published by the Program.
- The service is within applicable federal and state laws, rules, regulations and MDCH promulgated policies.
- It is medically appropriate and necessary to treat a specific medical diagnosis, medical condition or functional need and is an integral part of the nursing facility daily plan of care or is required for the community residential setting.
- It is within accepted medical standards; practice guidelines related to type, frequency, and duration of treatment; and within scope of current medical practice.
- It is inappropriate to use a non-medical item.
- It meets the definition of medical device as defined in Section 1.
- It is the most cost effective treatment available.
- Its use must meet the FDA and manufacturer indications.

1.6 Documentation in Beneficiary File and Recordkeeping Requirements

Amend first paragraph only to read as follows:
The supplier must maintain clean reproducible copies of all required documentation for the specific medical device in the beneficiary file, including the physician's order, the MSA-1656 and MSA-1653-B for seven years.

1.7.A. Prior Authorization (PA) Form

Requests for PA must be submitted on the Special Services Prior Approval-Request/Authorization form (MSA-1653-B). (Refer to the Forms Appendix for a copy of the PA form and completion instructions.) In addition, the medical documentation specific to each type of device requested must accompany the form. The information on the PA request form must be:

- Typed – all information must be clearly typed in the designated boxes on the form.
- Complete – The provider must use the specific HCPCS code and the code description. Medicaid policy indicates when a NOC has been selected for specified use. Otherwise, a NOC code may not be used unless the use of a NOC code for the item has been approved by PDAC. The brand, model, product or part number must be stated on the prior authorization form with the appropriate HCPCS code and description. The prescription and medical documentation must be submitted with the request. (Refer to the standards of coverage and payment rule requirements for additional information).

PA request forms and attached documentation may be mailed or faxed to the MDCH Program Review Division. (Refer to Directory Appendix for website information.)

Instructions for the electronic submission of PA requests and HIPAA 278 transaction code set are available on the MDCH website. (Refer to Directory Appendix for website information.)

1.8 Durable Medical Equipment

1.8.A. Standard Equipment and Custom Fabricated Seating

Standard equipment and custom fabricated seating must be medically necessary and meet the medical need and functional need of the beneficiary.

- Standard equipment and accessories are products ordered from manufacturer stock. Measuring and custom-fitting a medical device to a beneficiary, or custom-assembling a medical device to fit a beneficiary's needs using manufactured stock pieces is not considered to be custom fabricated.
- Custom fabricated seating is made from clinically derived rectified casting, tracings and other images (such as x-rays) of the beneficiary's body part.

  It also includes computer aided design/computer aided manufacturing (CAD/CAM) technology used for the seating system. Computer aided design/manufacturing must be performed by an experienced clinician along with a certified CRTS or ATP who has completed the training course offered by the manufacturer. The outcome should be created jointly by the clinician and the CRTS/ATP. The cost for performing these activities is included in the Medicaid payment rate for the custom fabricated seating system.

MDCH will only consider coverage of custom fabricated seating when a standard item will not meet the medical or functional needs of the user. All custom fabricated equipment requires prior authorization. Once the custom fabricated equipment is purchased, it becomes the property of the beneficiary. To be covered as custom fabricated, the item must meet the MDCH definition of custom fabricated. A manufacturer's use of the term custom fabricated for an item that does not meet the MDCH definition will not be reimbursed as custom fabricated. MDCH reserves the right to determine and apply HCPCS codes used for the purpose of reimbursement.

1.8.C. Repairs and Replacement Parts

Repairs and replacement of component parts for DME owned by the beneficiary are reimbursable if MDCH purchased the item. If MDCH did not purchase the original item, it must be medically necessary, meet the Standards of Coverage detailed in this chapter and include the supporting documentation requirements.

1.10 Non-Covered Items

- Devices used for play, pre-mobility development or exercise are not considered pediatric mobility devices for the purpose of reimbursement and are not covered, e.g., jet mobile, ready racer, creepster crawler.

2.47 Wheelchairs, Pediatric Mobility and Positioning Medical Devices and Seating Systems

Definitions	▪ A **wheelchair** has special construction consisting of a frame and wheels with many different options and includes, but is not limited to, standard, lightweight high strength, powered, etc. ▪ **Pediatric mobility** products are pediatric sized mobility and positioning medical devices [as defined by PDAC] that have a special lightweight construction consisting of a frame and wheels or base with many different options. Pediatric mobility devices include pediatric wheelchairs, transport chairs, hi/low chairs with outdoor/indoor bases, and standing systems specifically designed for children with special needs. These products must meet the definition of a medical device in Section 1 and are not available as commercial product or for which a commercial product can be used as an economic alternative.

	▪ **Licensed/Certified Medical Professional -** Medicaid policy requires that assessments must be performed by a licensed/certified medical professional. A licensed/certified medical professional is defined as an occupational or physical therapist, or a rehabilitation R.N. who has at least 2 years experience in rehabilitation seating and is not an employee of the Medical Supplier. A physical therapy assistant (PTA) or a certified occupational therapy assistant (COTA) may not perform any part of the assessment or evaluation and may not complete or sign the MSA-1656. The Outpatient Therapy Provider or the Nursing facility may bill for the mobility and seating assessment performed by the licensed/certified medical professional using HCPCS Code 97542. ▪ **Pediatric subspecialist** is a physician who is board certified in a pediatric subspecialty such as a physiatrist, neurologist, orthopedist, or neurodevelopmental. A pediatrician is not considered a pediatric subspecialist relative to this policy. **Residential Settings** ▪ An **institutional residential setting** refers to a nursing facility, hospital long term care unit or county medical care facility. ▪ A **community residential setting** is defined as a non-institutional setting in the community, i.e., beneficiary's own home, Adult Foster Care (AFC), Assisted Living or Group Home.

2.47.A. Standards of Coverage

Standards of Coverage for a Manual Wheelchair in Community Residential Settings	For beneficiaries residing in a community residential setting, a manual wheelchair may be covered if the beneficiary demonstrates **all** of the following: ▪ A diagnosis/medical condition that indicates a lack of functional ambulatory status and ambulates less than 150 feet within 1 minute with or without an assistive medical device. ▪ Must be able to regularly use the wheelchair throughout the day. ▪ Must be able to be positioned in the chair safely and without aggravating any medical condition or causing injury. ▪ Purchase of a wheelchair is required for long term use (greater than 10 months). ▪ Must have a method to propel wheelchair, which may include: ➢ Ability to self-propel for at least 60 feet over hard, smooth, and carpeted surfaces. ➢ The beneficiary has a willing and able caregiver to push the chair if needed. In a community residential setting: A **standard hemi-wheelchair** may be covered when a lower seat to the floor is required. A **standard lightweight wheelchair** may be covered when the beneficiary is unable to propel a standard wheelchair due to decreased upper extremity strength or secondary to a medical condition that affects endurance. A **heavy-duty standard wheelchair** may be covered if the beneficiary's weight is more than 250 pounds but does not exceed 300 pounds. An **extra heavy-duty standard wheelchair** is covered if the beneficiary's weight exceeds 300 pounds. A **high strength lightweight or ultra-light standard wheelchair** may be covered when required for a specific functional need.

	Back Up or Secondary standard manual wheelchair may be considered when: ▪ The beneficiary is primarily a power wheelchair user but needs a manual wheelchair to have access to the community or independent living. ▪ The beneficiary's medical condition requires a power wheelchair that cannot accommodate public transportation and, therefore, requires another transport device.
Standards of coverage for Manual Wheelchair in Institutional Residential Settings	Reimbursement and coverage for all standard manual wheelchairs for institutional residential **setting** is included in the per diem rate.
Standards of coverage for Manual Wheelchair with Custom Fabricated Seating System in both Community Residential and Institutional Settings	A **manual wheelchair with a custom fabricated seating system may** be covered if the beneficiary demonstrates **all** of the following: ▪ Medical documentation provides a clinical assessment of the specific functional/clinical need for custom fabricated seating system. Documentation must specifically rule out other standard seating systems. The seating system must also meet standards of coverage. ▪ Has a diagnosis/medical condition that indicates a lack of functional ambulatory status and ambulates less than 150 feet in one minute with or without another assistive medical device. ▪ Ability to self-propel for at least 60 feet over hard, smooth, and carpeted surfaces. ▪ Must be able to regularly use the wheelchair throughout the day. ▪ The wheelchair is required for long term use (greater than 10 months). ▪ The wheelchair must accommodate growth and adjustments for custom fabricating seating systems up to a minimum of 3” in depth and up to 2” in width. The custom fabricated seating system meets MDCH standards of coverage and is an integral part of the care regimen in the community setting or is an integral part of the daily nursing plan of care in an institutional setting.
Standards of Coverage for Power Wheelchairs or Power Operated Vehicles [POV] in both Community Residential and Institutional Settings	**Power Wheelchairs or Power Operated Vehicles (POV)** may be covered if the beneficiary meets **all** of the following: ▪ Lacks ability to propel a manual wheelchair or has a medical condition that would be compromised by propelling a manual wheelchair for at least 60 feet over hard, smooth or carpeted surfaces with or without rest intervals. ▪ Requires the use of a wheelchair for at least four hours throughout the day. ▪ Is able to safely operate, control and maneuver the wheelchair in their environmental setting including through doorways and over thresholds up to one-and-one-half inches as appropriate. ▪ Has a cognitive functional level that permits safe operation of a power mobility medical device with or without training. ▪ Has visual acuity that permits safe operation of a power mobility medical device. ▪ For a three wheeled power mobility medical device has sufficient trunk control and balance.

Standards of Coverage for Pediatric Mobility Devices and Wheelchairs	A **pediatric wheelchair or mobility device** may be covered if the beneficiary meets **all** of the following standards of coverage for each type of device. For CSHCS beneficiaries a medical referral from an appropriate board certified pediatric subspecialist or Office of Medical Affairs (OMA) approved physician is required. MDCH also reserves the right to require an appropriate board certified pediatric subspecialist for Medicaid beneficiaries. **For manual pediatric wheelchairs**: ▪ Has a diagnosis/medical condition that indicates a lack of functional ambulatory status with or without another assistive medical device or has a willing and able caregiver to push the chair **and** the wheelchair is required in a community residential settings. ▪ The wheelchair is required for long term use (greater than 10 months). ▪ The wheelchair must be able to accommodate growth and adjustments for seating systems up to a minimum of 3" in depth and 2" in width. ▪ The wheelchair is designed to be transportable. ▪ It is the most economic alternative available to meet the beneficiary's mobility needs. **For power wheelchairs:** ▪ Lacks ability to propel a manual wheelchair or has a medical condition that would be compromised by propelling a manual wheelchair for at least 60 feet over hard, smooth or carpeted surfaces (this includes the need to rest at intervals). ▪ Is able to safely control the wheelchair through doorways and over thresholds up to one-and-one-half inches. ▪ Has a cognitive, functional level that is adequate for power wheelchair mobility. ▪ Has a visual acuity that permits safe operation of a power mobility medical device. ▪ The wheelchair must be able to accommodate growth and adjustments for seating systems up to a minimum of 3" in depth and 2" in width ▪ For a three wheeled power mobility medical device, beneficiary has sufficient trunk control and balance. **For transport mobility medical devices (e.g., strollers):** ▪ The beneficiary is over the age of three or has a medical condition that cannot be accommodated by commercial products. ▪ It will be the primary mobility medical device for a beneficiary who cannot self propel a manual wheelchair or operate a power wheelchair. ▪ It is required as a transport device when the primary wheelchair cannot be designed to be transportable. ▪ The transport device must be able to accommodate growth and adjustments for seating system up to 3" in depth and 2" in width. ▪ It is the most economic alternative. ▪ It is required for use in the community residential setting.

	<u>For pediatric standing systems with or without wheels</u>: ▪ For CSHCS beneficiaries a medical referral from an appropriate board certified pediatric subspecialist or Office of Medical Affairs (OMA) approved physician is required. MDCH also reserves the right to require an appropriate board certified pediatric subspecialist for Medicaid beneficiaries. ▪ Beneficiary is able to utilize the product without being compromised medically or functionally. ▪ There is a plan of care that documents how the standing system will be used in the community residential setting. ▪ Documentation must address economic alternatives including dynamic vs. non-dynamic factors. ▪ Other economic alternatives have been ineffective. ▪ The standing system must be able to accommodate growth and adjustments for seating system for up to 2 " in depth and 3 " in width. **<u>For Pediatric Hi/Low Chairs</u>** Pediatric hi/low chairs may be covered if all of the following occurs: ▪ This positioning cannot be accommodated by use of other mobility devices or commercial products. ▪ When required for independent transfers. ▪ All mobility products interchangeable bases and seating systems have been ruled out as economic alternatives to separate medical devices. The mobility products bases and/or frames must be able to accommodate growth and adjustments for seating systems up to a minimum of 3" in depth and 2" in width.
Standard Seating System in Community Residential Settings	Seating systems may be covered when required to assure safe mobility and functional positioning when the beneficiary has postural deformities, contractions, tonal abnormalities, functional impairments, muscle weakness, pressure points and seating balance difficulties. Standard seating system is covered if: • There are two or more of the above clinical indications documented in the medical record and in the mobility assessment. • The seating system must be adjustable for growth and weight gain up to a minimum of 3 "in depth and 2" in width. • The reason for the selection when the system cannot be used in more than one mobility device. • It is the most economic alternative. For CSHCS beneficiaries, a written order from an appropriate board certified pediatric sub-specialist or an OMA-approved physician for a pediatric beneficiary is required. MDCH also reserves the right to require an appropriate board certified pediatric subspecialist for Medicaid beneficiaries.

Custom Fabricated Seating Systems	Special seating systems may be covered when required to assure safe mobility and functional positioning when the beneficiary has postural deformities, contractions, tonal abnormalities, functional impairments, muscle weakness, pressure points, and seating balance difficulties. custom fitted or modified may be covered if: ▪ There are two or more of the above clinical indications documented in the medical record and in the mobility assessment. The severity of the clinical indications cannot be accommodated by a standard seating system. ▪ The seating system must be adjustable for growth and weight gain up to a minimum of 3" in depth and 2" in width. ▪ The reason for the selection when the seating system cannot be used in more than one mobility device. ▪ It is the most economic alternative. ▪ A written order from an appropriate board certified pediatric subspecialist or an OMA-approved physician for a pediatric beneficiary. MDCH also reserves the right to require an appropriate board certified pediatric subspecialist for Medicaid beneficiaries.
Manual or Power Recline Feature	**Manual or Power Recline** may be covered when needed for relief of pressure on the seat and/or back and one of the following applies: ▪ History of skin breakdown or current indication of imminent skin breakdown that cannot be controlled (or has not in the past) by less costly modalities such as pressure relief cushions or manual pressure relief techniques. ▪ Has ability to tolerate a 90 – 135 degree of range of motion at the hip needed for reclining without triggering excessive abnormal tone. ▪ Is unable to tolerate an upright position in a wheelchair for long periods of time due to fatigue, shortness of breath, increased tone, or discomfort related to pressure that cannot be manually relieved. ▪ A low shear recline back is covered when the beneficiary does not have the ability to reposition themselves in the chair following reclining and the shearing would result in skin breakdown.
Manual Tilt-In-Space or Recline Function in Community Residential Settings	**Manual tilt-in-space** function allows the seat and back of the wheelchair to move as a unit such that the angle of the back to the floor changes from approximately 90 degrees to 45 degrees or less. This change in position does not affect the hip-to-knee angle. The seat may be tilted manually. The tilt-in-space function to a wheelchair may be covered if one or more of the following apply: ▪ History of skin breakdown or current indication of skin breakdown that cannot be controlled (or has not in the past) by less costly modalities such as pressure relief cushions or manual pressure relief techniques. ▪ Excessive extensor or flexor muscle tone that is exacerbated by change in hip angle and makes positioning in any upright chair ineffective and a reason why changing angles of position is medically necessary. ▪ Very low muscle tone that cannot maintain upright positioning against gravity, causing spinal anomalies. ▪ Beneficiary has knee contractures and has a custom molded seating system. Coverage of both a **manual tilt-in-space and recline function** for a wheelchair requires medical need such as high probability of the development of hip contractures if only a tilt-in-space without recline is used. Also, there is a medical contraindication to using recline only without the tilt-in-space function.

Power Tilt-in-Space or Recline Function in both Community and Institutional Residential Settings	**Power recline or tilt-in-space** function may be covered if **all** of the following exists: ▪ An existing medical condition results in the inability to reposition self without the use of a power tilt or recline mechanism. ▪ The frequency of repositioning is clinically indicated and is an integral part of the nursing facility plan of care. ▪ Beneficiary requires assistance to use a manual tilt-in-space or recline system and there are regular periods of time that the beneficiary is without assistance. MDCH also reserves the right to require an appropriate board certified pediatric subspecialist for Medicaid beneficiaries. ▪ Beneficiary requires assistance to use a manual tilt-in-space or recline system and is able to independently care for himself when provided a power recline or tilt-in-space modification.
Wheelchair Accessories	Reimbursement may be made for separate wheelchair accessories that have designated HCPCS codes. Separate reimbursement may be considered for specific **wheelchair accessory codes** when provided in conjunction with the purchase of a manual wheelchair, power wheelchair or as additions to an existing wheelchair if: ▪ Required to provide safety ▪ Required for appropriate positioning ▪ It is the most economic alternative For additions to an existing wheelchair, the physician, occupational or physical therapist must address the status/condition of the current chair and include the brand, model, serial number and age of current chair**. If MDCH did not purchase the chair being modified, all documentation requirements must be provided as if the request is for a new or initial chair. For accessories that are not covered, please refer to Section 1.10 Noncovered Items.**

2.47.B. Prior Authorization for Mobility devices, Repairs, Replacement

Prior Authorization	The Medicaid Utilization Analyst (Program Review Division) is the authorized Medicaid representative who determines if the service requested falls within the standards of coverage. A prior authorization request may be returned or denied if the documentation is incomplete and not specific to the beneficiary and device requested. ▪ MDCH has the right to request additional documentation to determine medical necessity. For CSHCS beneficiaries a medical referral from an appropriate board certified pediatric subspecialist or Office of Medical Affairs (OMA) approved physician is required. MDCH also reserves the right to require an appropriate board certified pediatric subspecialist for Medicaid beneficiaries. For beneficiaries in the community, the decision notice is sent to the medical supplier with a copy to the beneficiary. For beneficiaries in the institutional residential setting, the decision notice is sent to the institutional residence with a copy to the beneficiary. **Prior authorization is required for**: ▪ All adult wheelchairs, power operated vehicles, seating and accessories. ▪ Rental of a standard wheelchair beyond three months for hospital discharge waiver. ▪ New and replacement custom fabricated seating systems, the addition of functions for tilt-in-space and/or recline (power or manual). ▪ Diagnosis/medical conditions that are not listed as approved to bypass prior authorization for pediatric mobility items.

Clinical Documentation **MSA-1656**	▪ The evaluation and clinical documentation (MSA-1656) must be submitted within 90 days of the date the form is completed. For CSHCS beneficiaries a medical referral from an appropriate board certified pediatric subspecialist or Office of Medical Affairs (OMA) approved physician is required. MDCH also reserves the right to require an appropriate board certified pediatric subspecialist for Medicaid beneficiaries.
Prior Authorization Exceptions	Prior authorization is **not** required for the following if Standards of Coverage are met: ▪ The rental of specific wheelchairs up to the first three months after hospital discharge. ▪ The rental of standard wheelchairs for up to three months following outpatient surgery or discharge from a rehabilitation/nursing facility if standards of coverage are met. ▪ Specific accessory codes and/or repair codes. ▪ Specific pediatric mobility devices (that do not include any accessories) if the related diagnosis/condition is one of the following: ➢ Spinal Muscular Atrophy ➢ Motor Neuron Disease ➢ Other Anterior Horn Cell Disease ➢ Anterior Horn Cell Disease, Unspecified ➢ Hemiplegia and Hemiparesis ➢ Infantile Cerebral Palsy ➢ Other Specified Myoneural Disorders ➢ Myoneural Disorders, Unspecified ➢ Spina Bifida With Hydrocephalus ➢ Spina Bifida Without Mention of Hydrocephalus ➢ Spina Bifida (Other Congenital Anomalies of Nervous System) ➢ Microcephalus ➢ Reduction Deformities of Brain ➢ Congenital Hydrocephalus ➢ Muscular Dystrophies and Other Myopathies NOTE: IF prior authorization is required for any component of the mobility device (including accessories) then PA is required for the device as well For example, if a custom fabricated seating system is required, then prior authorization for the pediatric mobility device is also required.
Prior Authorization for Beneficiaries in the Community Setting	The prior authorization process for beneficiaries in the community is initiated by the attending physician's written order for a seating/mobility evaluation that includes the reason for the referral. The evaluation must be completed by a licensed/certified medical professional using the Mobility and Seating Evaluation and Justification Form MSA-1656. The completed MSA-1656 is forwarded to a Medicaid enrolled Medical Supplier selected by the beneficiary. The medical supplier completes the MSA-1653-B form and Section 15 of the MSA-1656 and forwards both forms to the attending physician for his/her attestation and signature in Section 17. The attending physician returns the signed MSA-1656 and the MSA-1653-B to the Medical Supplier who submits both forms and any other necessary clinical documentation to MDCH-MSA, Program Review Division. Once the authorization is processed, the MSA-1653-B is returned to the Medical Supplier. A notice of the decision is also sent to the beneficiary.

Payment Rules	A wheelchair can be considered a **capped rental** or **purchase** item. **Repairs** for beneficiary owned wheelchairs are covered only after manufacturer warranty has been exhausted. It is the responsibility of the provider to supply loaner equipment while the original item is being serviced. If repair of a wheelchair not purchased by MDCH is requested, the item must be medically necessary and meet the basic Standards of Coverage. The repair of a second (older) manual or power wheelchair used as a backup chair is not covered. Repair of a wheelchair involving the replacement of a component part includes the cost of the part and the labor associated with its removal, replacement and finishing. **Replacement** of a wheelchair is subject to manufacturer warranty and/or cost of repairs. The replacement may also be considered when a significant change in the patient's condition has occurred or the item cannot be restored to a serviceable condition. Replacement of wheelchairs for youth will be evaluated on an individual basis due to the expected growth pattern. Based on these conditions, a wheelchair may be considered for replacement every five years for adults and every two years for children.

2.47.C. Wheelchairs and Power Operated Vehicles for Residents in the Community Residential Setting

Wheelchair Coverage in a Nursing Facility	For all wheelchairs, accessories, and custom fabricated seating covered outside of the nursing facility per diem rate, the nursing facility is responsible for completing and submitting the prior authorization request to MDCH. The Medical Supplier is responsible for completing: ▪ MSA-1653-B ▪ Only Section 15 of MSA-1656 form These completed items are forwarded to the nursing facility responsible for submitting the prior authorization request.
Prior Authorization Procedures for Power Operated Vehicles and Custom Fabricated Seating in a Nursing Facility	Prior authorization is required for Medicaid coverage and separate reimbursement for medically necessary power operated vehicles and power or manual wheelchairs with custom fabricated seating systems. The request for a resident assessment must be initiated by the attending physician with the stated medical reason for the referral. Facility clinicians who are responsible for the overall nursing plan of care and treatment for the resident will prepare and submit prior authorization requests and medical documentation directly to the MDCH Program Review Division. ▪ The Nursing Facility Director of Nursing or Nursing Facility Administrator must forward the MSA-1656 assessment to the medical supplier for completion of Section 15. ▪ The medical supplier completes form MSA-1653-B and only Section 15 of the MSA-1656 and returns both forms to the Nursing Facility Director of Nursing or Nursing Facility Administrator. ▪ The prior authorization decision notice is sent to the facility and the beneficiary. The facility will forward a copy to the medical supplier. Refer to the Nursing Facility Chapter for further information regarding prior authorization of wheelchairs and custom fabricated seating systems for beneficiaries in community residential settings.

Michigan Department of Community Health

Special Services Prior Approval - Request/Authorization Completion Instructions

The MSA-1653-B must be used by Medicaid enrolled Medical Suppliers, DME Providers, Orthotists, Prosthetists, Hearing Aid Dealers, Audiologists and Cochlear Manufacturers. Note: Requests for new or replacement wheelchairs require completion of only boxes 2-18 and 28 submitted with a completed "Mobility and Seating Evaluation and Justification" form (MSA-1656).

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 18	Complete this box ONLY for wheelchair requests. • For repairs or parts, complete MSA-1653-B. (Do not include MSA-1656.) • For new or replacement 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 25	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 26	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 28	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.

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

1. PRIOR AUTHORIZATION NUMBER (MDCH USE ONLY)

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 ☐ M ☐ 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? ☐ **YES** ☐ **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. WHEELCHAIR REQUESTS ONLY (CHECK APPROPRIATE BOXES)

A. IF THIS FORM IS FOR ☐ REPAIR, ☐ PARTS, ☐ ADDITIONS OR ☐ REVISIONS COMPLETE ENTIRE FORM.
B. ARE REPAIR OR PARTS TO THE WHEELCHAIR ASSOCIATED WITH THE BENEFICIARY'S FUNCTIONAL STATUS: ☐ YES ☐ NO
C. IF THIS FORM IS FOR
☐ NEW WHEELCHAIR OR
☐ REPLACEMENT WHEELCHAIR, **PROCEED TO SECTION 28, SIGN, AND SUBMIT WITH A COMPLETED FORM MSA-1656**.

19. LINE NO.	20. DESCRIPTION OF SERVICE (MUST INCLUDE BRAND NAME, MODEL, CATALOG OR PART NUMBER)	21. PROCEDURE CODE	22. MODIFIER	23. QUANTITY	24. CHARGE
01					
02					
03					
04					
05					
06					
07					

25. ICD-9-CM DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.	26. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE, FOR SERVICES REQUESTED.

27. INDICATE ANY OTHER SERVICES PROVIDED TO THIS BENEFICIARY DURING THE PAST YEAR.

28. 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 ☐ INSUFFICIENT DATA ☐
DENIED ☐ NO ACTION ☐
APPROVED AS AMENDED ☐

30. CONSULTANT REMARKS

CONSULTANT SIGNATURE DATE

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Mobility and Seating Evaluation and Justification
Completion Instructions

This form should be completed for NEW or REPLACEMENT mobility device and seating systems. It must be submitted with the Special Services Prior Approval -Request/Authorization (MSA-1653-B). The evaluation and justification must be submitted within 90 days of the date the form is completed.

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

SECTION 1 THROUGH SECTION 14 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 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, COTA, OTA may not evaluate for, complete or sign this document.)

SECTION	INSTRUCTIONS
1	Indicate the beneficiary resides in a nursing facility, permanent legal address, telephone number, designated contact person for the beneficiary, designated person's (i.e., parent, guardian, legal representative or beneficiary) telephone number, date and time seen, evaluator name and title, date, evaluator phone number and evaluator's place of employment. If team evaluation lists 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.
3	Home Environment questions reflect the current setting in which the beneficiary lives.
4	Community ADL reflects the beneficiary's transportation situation to the community and/or school if applicable.
5	This information reflects the need for pressure relief for a beneficiary.
6	ADL Status reflecting the beneficiary's current functioning.
7	The communication section indicates if a speech generating device is utilized by the beneficiary and needs hardware attached to the wheelchair.
8	Wheelchair skills indicate how the beneficiary could operate various types of wheelchairs.
9	Mobility/Balance reflects the current ambulation, sitting and standing status of the beneficiary.
10	Power mobility safety relates to the beneficiary's abilities to safely operate a power mobility device. Definitions : Good-(FIM level7/6), completes tasks by self; Fair-(FIM level 5), requires verbal cues; Poor-(FIM level 4 and below), requires physical intervention/assistance to complete task.
11	Current mobility/seating supplies information regarding the current wheelchair seating system the beneficiary uses.
12	Mat Evaluation includes measurements of the beneficiary. Relevant measures include adjustments for clothing.
13	This section is to address the beneficiary goals for the wheelchair mobility and seating system. This also includes other equipment trials of which three other types have been given a trial with the reasons those were not adequate.
14	**To be completed by the licensed/certified medical professional** who completed the evaluation. The signature certifies the information is applicable to the named beneficiary.
15	**To be completed by the supplier.** Supplier gives a narrative description of the items, accessories and options ordered along with the appropriate HCPCS code, modifier and quantity. The supplier also lists the charge for each item, accessory or option. The person from the Medical Supplier Company lists their name along with the name, telephone number and address of the supplier. There are two sections to accommodate entries by two separate providers for the requested equipment. **Note:** For beneficiaries residing in a nursing facility return the completed MSA-1656 and MSA-1653-B, to the requesting nursing facility. For beneficiaries in the community the MSA-1656 and MSA-1653-B is forwarded to the treating physician for their review and attestation.

SECTION	INSTRUCTIONS
16	**To be completed by the nursing facility director of nursing, administrator or treating physician.** ➢ Forward to the treating physician for their review and attestation. ➢ After section 17 is completed and returned. Send along with the most recent MDS, past two months of nursing notes, and current care plan to for their completion of the order.
17	**To be completed by the treating physician.** The treating physician reviews the evaluation and the ordered equipment and costs and certifies the equipment is appropriate and most cost effective alternative for the beneficiary.

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 program is sought.

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

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Mobility and Seating Evaluation and Justification

Sections 1-14 must be completed by a licensed/certified medical professional.*
Section 15 is to be completed by the DME Provider.
Section 16 must be completed by the Nursing Facility DON, Administrator, or treating physician.
Section 17 must be completed by the treating physician.

Beneficiary Information

Beneficiary Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F

mihealth #: _____

Treating Physician: _____

Physician Specialty: _____

Other Insurance: _____

_____

SECTION 1: BENEFICIARY ADDITIONAL INFORMATION

Beneficiary resides in Nursing Facility? ☐ YES ☐ NO

Beneficiary address: _____

_____

Beneficiary phone: _____

Designated contact person: *(i.e., parent, legal guardian, legal representative or beneficiary)*

_____

Contact person phone: _____

Evaluation date: _____ Time: _____

Evaluator name: _____

Title: _____

Date: _____ Phone: _____

Place of Employment:

_____

If team evaluation, list all participants:

_____

_____

SECTION 2: MEDICAL HISTORY

Primary Diagnosis: _____

Onset date: _____

ICD-9-CM Code: _____

Secondary Diagnosis: _____

Onset date: _____

ICD-9-CM Code: _____

Progressive Disease: ☐ YES ☐ NO

Other Service - Hospice: ☐ YES ☐ NO

Height: _____ Weight: _____

Relevant past and future surgeries: _____

_____

Explain recent changes or trends in weight: _____

Cardio Status: (Check)
☐ Intact ☐ Impaired ☐ N/A

Functional Limitations:

Respiratory Status: (Check)
☐ Intact ☐ Impaired ☐ N/A

Functional Limitations:

Orthotics (describe):

SECTION 3: HOME ENVIRONMENT

Does beneficiary reside in: ☐ House ☐ Condo/town home ☐ Apartment ☐ Assisted Living ☐ Nursing Facility ☐ Adult Foster Care (AFC) ☐ Group Home

Does beneficiary live alone? ☐ YES ☐ NO

Does beneficiary have a caregiver? ☐ YES ☐ NO If YES, how many hours with caregiver? _____

Is the home wheelchair accessible for the beneficiary? ☐ YES ☐ NO

Storage of Wheelchair: ☐ In home ☐ School ☐ Other

Comments: _____

*A licensed/certified medical professional means an occupational or physical therapist or rehabilitation R.N. who has at least two (2) years experience in rehabilitation seating and is not an employee of the Medical Supplier. (PTA, COTA, OTA may not evaluate for or complete or sign this document.)

Beneficiary Name: _____ **mihealth** Number: _____

SECTION 4: COMMUNITY ADL

Transportation:
What is beneficiary's **mode** of transportation? (Check all that apply.)
☐ Car ☐ Van ☐ Cab ☐ Bus ☐ School Bus ☐ Ambulance ☐ Other: _____
Are tiedowns needed for transport? ☐ YES ☐ NO
Where is wheelchair stored during transport? _____

Is beneficiary a self driver? ☐ YES ☐ NO If YES, do they drive while in wheelchair? ☐ YES ☐ NO
Does beneficiary attend school? ☐ YES ☐ NO
If YES, provide name of school: _____
List school mobility requirements: _____
Other:

SECTION 5: SENSATION AND SKIN ISSUES

Sensation ☐ Intact ☐ Impaired ☐ Absent ☐ Hypersensitive	**Pressure Relief** ☐ Dependent ☐ Independent ☐ Assist Method:	
Skin Issues/Skin Integrity Current skin issues? ☐ YES ☐ NO ☐ Intact ☐ Red area ☐ Open Area ☐ Scar Tissue ☐ At risk from prolonged sitting Where:	Does beneficiary have a history of skin issues (e.g. allergies)? ☐ YES ☐ NO Describe: _____	Does beneficiary have a history of skin flap surgeries? ☐ YES ☐ NO Where: _____ When: _____
Complaint of Pain: (Describe)		

SECTION 6: ADL STATUS (in reference to wheelchair use)

	Indep	Assist	Unable	Indep with Equip	Not assessed	Comments
Dressing						
Eating						
Grooming/Hygiene						
Bowel Mgmt: ☐ Continent ☐ Incontinent ☐ Accidents						Comments:
Bladder Mgmt: ☐ Continent ☐ Incontinent ☐ Accidents						Comments:

SECTION 7: COMMUNICATION

Does beneficiary use a speech generating device? ☐ YES ☐ NO If YES, provide Manufacturer/Model :

SGD mount needed? ☐ YES ☐ NO If YES, describe:

SECTION 8: WHEELCHAIR (W/C) SKILLS

	Indep	Assist	Dependent/ unable	N/A	Comments (specify)
Bed ↔ Wheelchair Transfers	☐	☐	☐	☐	
W/C ↔ Commode Transfers	☐	☐	☐	☐	
Operate Power W/C: Std. Joystick	☐	☐	☐	☐	☐ Safe ☐ Functional Distance:
Operate Power W/C: w/ Alternative Controls	☐	☐	☐	☐	☐ Safe ☐ Functional Distance:
☐ Manual W/C Propulsion ☐ Power Assist Manual W/C	☐ UE or LE strength and endurance sufficient to propel 60 ft.				Arm: ☐ left ☐ right ☐ both Foot: ☐ left ☐ right ☐ both
	Comments:				
Operate Scooter	☐ Strength, hand grip, balance, transfer appropriate for use ☐ Living environment appropriate for scooter use				
Total hours in wheelchair per day:					

Beneficiary Name: _____ **mihealth** Number: _____

SECTION 9: MOBILITY/BALANCE

Balance		Ambulation
Sitting Balance	Standing Balance	
☐ WFL ☐ Uses UE for balance in sitting ☐ Min Assist ☐ Mod Assist ☐ Max Assist ☐ Unable	☐ WFL ☐ Min Assist ☐ Mod Assist ☐ Max Assist ☐ Unable ☐ Uses Assistive Device	☐ Independent > or = 60 ft. ☐ Ambulates with Assist > or = 60 ft. ☐ Ambulates with Device > or = 60 ft. ☐ Indep. Short Distance Only < 60 ft. ☐ Unable to Ambulate ☐ Endurance Explain:

SECTION 10: POWER MOBILITY SAFETY

Handedness: ☐ Right ☐ Left Comments:

Functional Processing Skills for Wheeled Mobility

Are beneficiary's processing skills adequate for safe wheelchair operation? ☐ YES ☐ NO

Age appropriate? ☐ YES ☐ NO Explain: _____

Does the beneficiary demonstrate ability to operate wheelchair safely? ☐ YES ☐ NO

Is beneficiary able to navigate within room/home? ☐ YES ☐ NO

Is beneficiary able to navigate within facility or school? ☐ YES ☐ NO ☐ N/A

Skills for operating a power wheelchair: (Document your assessment of the beneficiary's ability to operate a power wheelchair addressing the items below.)

	GOOD	FAIR	POOR
Head Control/Head Position	☐	☐	☐
Upper Extremity Functioning-Right	☐	☐	☐
Upper Extremity Functioning-Left	☐	☐	☐
Joystick Control Steering	☐	☐	☐
Directionality-Steering Skill	☐	☐	☐

	GOOD	FAIR	POOR
Visual/Spatial Perception	☐	☐	☐
Safety	☐	☐	☐
Mobility Skills in Operation	☐	☐	☐
Cognitive Level	☐	☐	☐

SECTION 11: CURRENT MOBILITY/SEATING

Current Mobility Base: ☐ None ☐ Dependent ☐ Without Tilt ☐ With Tilt ☐ Manual ☐ Scooter ☐ Outdoor base

☐ Power - Type of Control: _____

Manufacturer: _____ Model: _____ Serial #: _____

Size: _____ Base Age: _____

Current Condition of Mobility Base:

Current Seating System: _____ Age of Seating System: _____

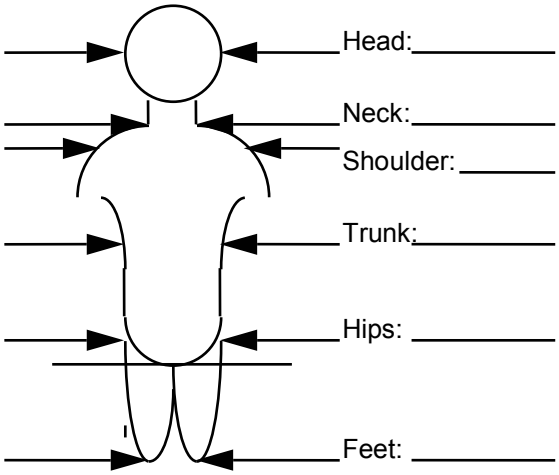
COMPONENT	MANUFACTURER/CONDITION		
	Under Warranty	Reusable	Describe Reason Needed
Seat (specify)	☐ YES ☐ NO	☐ YES ☐ NO	
Cushion (specify)	☐ YES ☐ NO	☐ YES ☐ NO	
Back (specify)	☐ YES ☐ NO	☐ YES ☐ NO	
Lateral trunk supports	☐ YES ☐ NO	☐ YES ☐ NO	
Thigh support	☐ YES ☐ NO	☐ YES ☐ NO	
Knee support	☐ YES ☐ NO	☐ YES ☐ NO	
Foot support	☐ YES ☐ NO	☐ YES ☐ NO	
Foot strap	☐ YES ☐ NO	☐ YES ☐ NO	
Head support	☐ YES ☐ NO	☐ YES ☐ NO	
Pelvic stabilization	☐ YES ☐ NO	☐ YES ☐ NO	
Anterior Chest/Shoulder Support	☐ YES ☐ NO	☐ YES ☐ NO	
UE Support	☐ YES ☐ NO	☐ YES ☐ NO	
Other: (describe)	☐ YES ☐ NO	☐ YES ☐ NO	

Beneficiary Name: _____ **mihealth** Number: _____

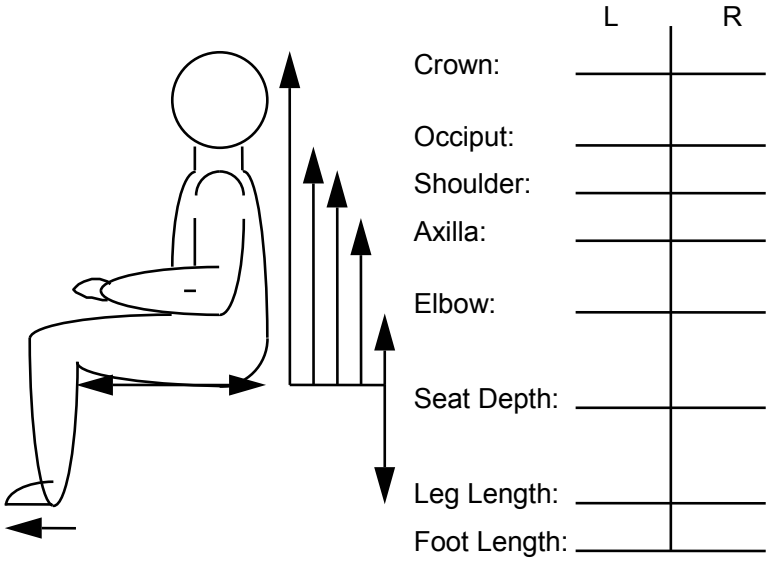
Overall seat height: _____ (includes seat and cushion)	Overall W/C length: _____ (includes footrest)	Overall W/C width: _____
Growth adaptability for pediatrics: Seat width: _____ Seating system height: _____		Seat depth: _____ Frame growth adaptability: _____
Describe posture in present seating system:		
List other mobility devices (i.e., stroller, manual, power, etc.):		

SECTION 12: MAT EVALUATION

Width at the:

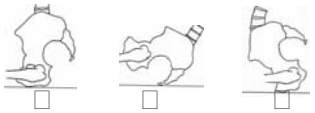
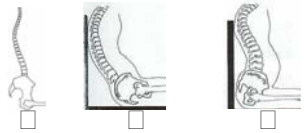
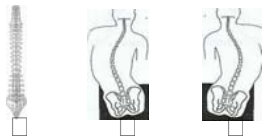
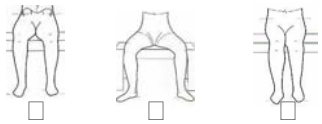


Height:



Describe reflexes/tonal influence on body:

Beneficiary Name: _____ **mihealth** Number: _____

POSTURE:				COMMENTS:
	Lateral View	**AP View**	**Superior View**	
PELVIS	**Anterior / Posterior**  ☐ Neutral ☐ Posterior ☐ Anterior ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	**Obliquity**  ☐ WFL ☐ R elev ☐ L elev ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	**Rotation-Pelvis**  ☐ WFL ☐ Right Anterior ☐ Left Anterior ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	
TRUNK	**Anterior / Posterior**  ☐ WFL ☐ ↑ Thoracic Kyphosis ☐ ↑ Lumbar Lordosis ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	**Left Right**  ☐ WFL ☐ Convex Left ☐ Convex Right ☐ c-curve ☐ s-curve ☐ multiple ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	**Rotation-shoulders and upper trunk**  ☐ Neutral ☐ Left anterior ☐ Right anterior ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	
	Describe LE Neurological Influence/Tone:			
	Anterior View	**Superior View**		**COMMENTS:**
HIPS	**Position**  ☐ Neutral ☐ ABduct ☐ Adduct ☐ Fixed ☐ Subluxed ☐ Partly Flexible ☐ Dislocated ☐ Flexible	**Windswept**  ☐ Neutral ☐ Right ☐ Left ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	**Hip Flexion/Extension Limitations: (PROM in Degrees)** **Hip Internal/External Range of Motion Limitations:**	

KNEES & FEET

Knee

PROM Degrees

	Left	Right
Flexion		
Extension		

Strength

	Left	Right
Flexion		
Extension		

Foot Positioning

PROM Degrees

	Left	Right
Dorsi-Flexed		
Plantar Flexed		
Inversion		
Eversion		

Beneficiary Name: _____ **mihealth** Number: _____

POSTURE:				**COMMENTS**
HEAD & NECK	☐ Functional ☐ Flexed ☐ Extended ☐ Rotated L ☐ Lat Flexed L ☐ Rotated R ☐ Lat Flexed R ☐ Cervical Hyperextension	☐ Good Head Control ☐ Adequate Head Control ☐ Limited Head Control ☐ Absent Head Control	**Describe Tone/Movement of Head and Neck:**	
Upper Extremity	**SHOULDERS** **Left** ☐ Functional ≥ 90° ☐ Flexion ☐ Abduction **Right** ☐ Functional ≥ 90° ☐ Flexion ☐ Abduction	**UE Strength Concerns:** ☐ N/A ☐ None ☐ Concerns:	**Describe Tone/Movement of UE:**	
	ELBOWS **AROM** Left / Right Flexion ☐ ☐ Extension ☐ ☐	**Strength Concerns:**		
WRIST & HAND	**Grasp** Left / Right Partial ☐ ☐ Full ☐ ☐	**Strength / Dexterity:**		

SECTION 13: GOALS AND EQUIPMENT TRIALS

Goals for Wheelchair Mobility (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)
- ☐ Provide dependent mobility
- ☐ Provide recline
- ☐ Provide tilt
- ☐ Assisted mobility
- ☐ Other: Explain: _____

Growth adaptability:

Seat width: _____ Seat depth: _____

Seating system height: _____ Frame growth adaptability: _____

☐ **Goals for Seating System** (Check all that apply.)

- ☐ Optimize pressure relief
- ☐ Provide support needed to facilitate function or safety
- ☐ Provide corrective forces to assist with maintaining or improving posture
- ☐ Accommodate client's posture: (current seated postures and positions are not flexible or will not tolerate corrective forces)
- ☐ Client to be independent with relieving pressure in the wheelchair
- ☐ Enhance physiological function, such as breathing, swallowing, digestion
- ☐ Change in structure
- ☐ Other: Explain _____

Growth adaptability (Please describe) _____

Beneficiary Name: _____ **mihealth** Number:_____

Simulation ideas:

State the specific economic alternatives considered and provide model and brand:

Trial model and brand:

State why other equipment was unsuccessful:

Describe trial in prescribed wheelchair:

Does the beneficiary require the mobility item for at least ten (10) months? ☐ YES ☐ NO

SECTION 14: LICENSED/CERTIFIED MEDICAL PROFESSIONAL ATTESTATION AND SIGNATURE/DATE

I certify that I conducted the evaluation and have completed the information presented in Sections 1 - 13 and that I am not employed or have any other financial arrangement with the selected durable medical equipment provider. I certify that the information contained in this form is true, accurate, and complete to the best of my knowlege, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Licensed/Certified Medical Professional Signature:

_____ Date: _____

SECTION 15: NARRATIVE DESCRIPTION OF EQUIPMENT AND COST

This section is to be completed by the DME Provider (designed to accommodate equipment from two separate providers, i.e. Provider A and Provider B) and then signed by the treating physician as directed below:

Provider A:

Provide the following information: HCPCS code and modifier; quantity; brand; model, catalog or part number; narrative description of all items, accessories and options suggested ordered; and Supplier's charge. (Attach additional sheets if needed.)

LINE NO.	DESCRIPTION OF SERVICE (MUST INCLUDE BRAND NAME, MODEL, CATALOG OR PART NUMBER)	PROCEDURE CODE	MODIFIER	QUANTITY	CHARGE
01					
02					
03					
04					
05					
06					
07					

Beneficiary Name: _____ **mihealth** Number:_____

I certify that the services and items being supplied under this request are consistent with the MSA-1656 assessment for this beneficiary and that the requested items are appropriate and can safely be used in the beneficiary's environment when used as described in the MSA-1656 assessment.

I understand that, as the Supplier, I will be reimbursed in accordance with pricing guidelines of the state Medicaid program for Durable Medical Equipment and that I will not be paid more than the amount authorized.

I will not seek any additional payment above the amount Medicaid authorized from the nursing facility, beneficiary or beneficiary's responsible party, or other party for any equipment authorized. I also agree that modifications and adjustments (for equipment authorized as a result of this assessment) required within the first six months of delivery are covered within the authorized amount.

I understand that services and items 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.

Name of person completing information: _____ Date: _____

Name of DME Company: _____ Phone: _____

Address: _____

Provider B:

Provide the following information: HCPCS code and modifier; quantity; brand; model, catalog or part number; narrative description of all items, accessories and options suggested ordered; and Supplier's charge. (Attach additional sheets if needed.)

LINE NO.	DESCRIPTION OF SERVICE (MUST INCLUDE BRAND NAME, MODEL, CATALOG OR PART NUMBER)	PROCEDURE CODE	MODIFIER	QUANTITY	CHARGE
01					
02					
03					
04					
05					
06					
07					

I certify that the services and items being supplied under this request are consistent with the MSA-1656 assessment for this beneficiary and that the requested items are appropriate and can safely be used in the beneficiary's environment when used as described in the MSA-1656 assessment.

I understand that, as the Supplier, I will be reimbursed in accordance with pricing guidelines of the state Medicaid program for Durable Medical Equipment and that I will not be paid more than the amount authorized.

I will not seek any additional payment above the amount Medicaid authorized from the nursing facility, beneficiary or beneficiary's responsible party, or other party for any equipment authorized. I also agree that modifications and adjustments (for equipment authorized as a result of this assessment) required within the first six months of delivery are covered within the authorized amount.

I understand that services and items 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.

Beneficiary Name: _____ **mihealth** Number: _____

Name of person completing information: _____ Date: _____

Name of DME Company: _____ Phone: _____

Address: _____

SECTION 16: MOBILITY ASSESSMENT - NURSING FACILITY

This section is to be completed by the Nursing Facility Director of Nursing, Nursing Facility Administrator or treating physician.

Date of Admission to Nursing Facility: _____

Mobility History:

☐ Uses Nursing Facility Per Diem Chair ☐ Uses own personal chair

Wheelchair Description:

Brand: _____ Model Number: _____

Serial number: _____

Components: _____

Customized Wheelchair Documentation (Required documentation to accompany this form)

☐ Most Recent MDS ☐ Past Two Months of Nursing Notes

☐ Current Plan of Care

R.N./Director of Nursing Signature: _____ Date: _____

Print Name: _____

Nursing Facility Administrator Signature: _____ Date: _____

Print Name: _____

Treating Physician Signature: _____ Date _____

Print Name: _____

SECTION 17: TREATING PHYSICIAN ATTESTATION AND SIGNATURE/DATE

I certify that I am the treating physician identified in the beneficiary section of this form. I have reviewed Sections 1-13 of the assessment. I have reviewed the costs and equipment recommended for this beneficiary in Sections 15. Any statement on my letterhead attached hereto and prescription have been reviewed and signed by me. I certify 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.

Treating Physician Signature: _____ Date: _____

Address: _____ Phone number: _____

_____