MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Evaluation and Medical Justification for Complex Seating Systems 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.
NOTE: Only complete sections that apply to the requested equipment/accessories.

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

Beneficiary Name: _____ Mihealth Number: _____

SECTION(s)	☐ Requested	☐ Current ☐ None
Manual wheelchair with accessory add-ons.	☐ 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 ☐ Cannot propel manual wheelchair without caregiver assist. ☐ Cannot propel manual wheelchair, used for transport only. ☐ Medical reason for power assisted wheels: Chair width _____inches. Chair depth _____inches. ☐ Tilt ☐ Tilt & Recline Medical reasons for function indicated: Hours of continuous wheelchair use per day: ☐ > 4 hours	Specify brand, model and serial numbers, age of current base: Chair width _____inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? *(i.e., home, school, community)* ☐ < 4hours; if < 4 hours, how many? _____
	☐ **Requested**	☐ **Current** ☐ **None**
Power wheelchair with standard joystick	☐ Able to propel manual wheelchair _____ feet. ☐ YES ☐ 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, explain: Chair width _____inches. Chair depth _____inches. **Power** functions requested: *(Check all that apply.)* ☐ Recline ☐ Elevating seat ☐ Center mount elevating leg rests ☐ Tilt ☐ Tilt & Recline ☐ Elevating leg rests ☐ YES ☐ NO Able to perform, manipulate or work all seat functions without assistance? ☐ YES ☐ NO Requires verbal and/or physical assistance to manipulate seat functions? ☐ YES ☐ NO Has pressure relief plan of care with equipment? If YES, (explain) _____ Hours of continuous wheelchair use per day: ☐ > 4 hours ☐ < 4hours; if < 4 hours, how many? _____	Specify brand, model and serial numbers, age of current base: Chair width _____inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? *(i.e., home, school, community)* **Manual** functions requested: ☐ Tilt ☐ Tilt & Recline

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

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

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

Beneficiary Name: _____ Mihealth Number: _____

	☐ Requested	☐ Current ☐ None
Equipment	**Beneficiary's ability to use**	
Power wheelchair with alternate controls	☐ Able to propel manual wheelchair _____ feet. ☐ YES ☐ 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: Chair width _____inches. Chair depth _____inches.	Specify brand, model and serial numbers, age of current base: Chair width _____inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? *(i.e., home, school, community)*

Power functions requested: *(Check all that apply.)*

☐ Recline ☐ Elevating seat ☐ Center mount elevating leg rests
☐ Tilt ☐ Tilt & Recline ☐ Elevating leg rests

Manual functions requested:
☐ Tilt ☐ Tilt & Recline

☐ YES ☐ NO Able to perform, manipulate or work all seat functions without assistance?
☐ YES ☐ NO Requires verbal and/or physical assistance to manipulate seat functions?
☐ YES ☐ NO Has pressure relief plan of care with equipment?

Explain:

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: ☐ > 4 hours ☐ < 4hours; if < 4 hours, how many? _____

	☐ Requested	☐ Current ☐ None
Power wheelchair standing feature	☐ Beneficiary has a history of pressure ulcers on pelvis, buttocks, hips or back ☐ Will be used for pressure relief in lieu of tilt, recline, tilt/recline, and custom seating ☐ Pressure relief is done by the beneficiary without assistance If assistance with pressure relief is required, indicate amount and frequency needed: _____	Specify brand, model and serial numbers, age of current base: Chair width _____inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? *(i.e., home, school, community)*

Chair width _____inches. Chair depth _____inches.

Indicate current pressure relief plan of care (including frequency and duration):

Is beneficiary/caregiver compliant with current pressure relief plan of care? ☐ YES ☐ NO

If NO, explain:

Beneficiary Name: _____ Mihealth Number _____

Equipment	☐ Requested	☐ Current ☐ None
Scooter	☐ Able to propel manual wheelchair _____ feet. ☐ Independent trunk balance, ☐ Adequate bilateral hand functions to work tiller. Chair width _____inches. Chair depth _____inches.	Specify brand, model and serial numbers, age of current base: Chair width _____inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? *(i.e., home, school, community)*

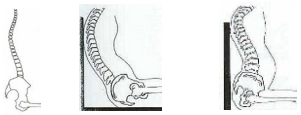
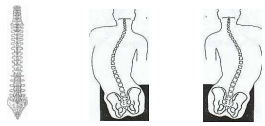
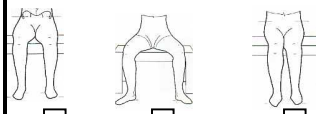
	Device Type *(attach additional page(s) if necessary)*	
All Accessories / Add Ons	☐ Head & Neck	☐ Feet ☐ Footbox
	☐ Arms	☐ Other - Describe
Medical Reason	List and specify Medical Reason for brand(s) and model(s) requested for this beneficiary:	

Growth adaptability of device	**Requested**	**Current**
REQUIRED	Seat width: (inches) _____	Seat width: (inches) _____
	Back height: (inches) _____	Back height: (inches) _____
	Seat depth: (inches) _____	Seat depth: (inches) _____
	Maximum frame growth: (inches)	Maximum frame growth: (inches)

Beneficiary Name: _____ Mihealth Number _____

SEATING SYSTEM

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

POSTURE:				**COMMENTS:**
	Lateral View	AP View	Superior View	
TRUNK	Anterior / Posterior  ☐ WFL Kyphosis ☐ ↑ Thoracic Lordosis ☐ ↑ 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	☐ Hypertonia ☐ Hypotonia
	Anterior View	Superior View	ROM	MMT/O
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:	
	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	If spinal curvature present, indicate degree.

Beneficiary Name: _____ Mihealth Number _____

Requested Seating System		Current Seating System ☐ None	
Length of warranty? _____ Mobility device to be used with:		Length of warranty: _____ Warranty begin date: _____ Mobility device is used with:	
☐ Planar/Non-custom contour	☐ Custom *	☐ Planar/Non-custom contour	☐ Custom *
Manufacturer:	Type:	Manufacturer:	Type:
Components include: ☐ Seat only ☐ Back only ☐ Back and Seat	Components include: ☐ Seat only ☐ Back only ☐ Back and Seat	Date provided: Components include: ☐ Seat only ☐ Back only ☐ Back and Seat	Date provided: Components include: ☐ Seat only ☐ Back only ☐ Back and Seat
Lateral Components Include:	Lateral Components Include:	Lateral Components Include:	Lateral Components Include:
☐ Trunk ☐ Hip ☐ Thigh ☐ Knee ☐ Abductor ☐ Anti-thrust	☐ Trunk ☐ Hip ☐ Thigh ☐ Knee ☐ Abductor ☐ Anti-thrust	☐ Trunk ☐ Hip ☐ Thigh ☐ Knee ☐ Abductor ☐ Anti-thrust	☐ Trunk ☐ Hip ☐ Thigh ☐ Knee ☐ Abductor ☐ Anti-thrust
Other Components - List:	Other Components - List:	Additional Components: ☐ Yes ☐ No If Yes, describe:	Additional Components: ☐ Yes ☐ No If Yes, describe:
If requesting custom seating, specify why planar/non-custom contour does not meet beneficiary's medical needs.			

* For definition of custom refer to MDHHS Medicaid Provider Manual, Medical Supplier Chapter, sections Standard Equipment and Custom-Fabricated Seating, and section Standards of Coverage

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.

_____
Evaluation Date

Evaluator Name/Title (Print)

Place of Employment and Address

NPI Phone Number

Evaluator Signature Date