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 ☐ < 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)*
	☐ 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.

Beneficiary Name: _____ Mihealth Number: _____

Equipment	☐ Requested Beneficiary's ability to use	☐ Current ☐ None
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)*

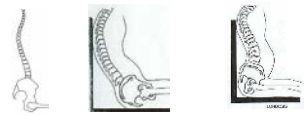
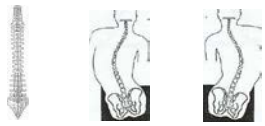
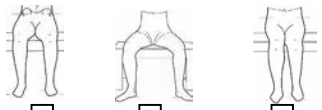
	Device Type *(attach additional page(s) if necessary)*	
All Accessories / Add Ons	☐ Head & Neck	☐ Feet ☐ Footbox
	☐ Arms	☐ Other - Describe
Medical Reason	List and specify Medical Reason for brand(s) and model(s) requested for this beneficiary:	

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 ☐ ↑ 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	☐ 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