MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 12-53

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

Issued: November 1, 2012

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

Effective: December 1, 2012

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

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

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

Section 1.0 Clarification of Durable Medical Equipment (DME):

Durable Medical Equipment is defined as items that:

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

Section 1.5 Economical Alternative:

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

Section 1.5 New Technology:

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

technology, when the beneficiary's current equipment can meet the beneficiary's basic medical/functional needs. Equipment comprised of features not medical in nature are not covered by Medicaid.

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

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

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

1.7.J. Hospital Discharge Waiver Codes: E0961, E0973, E0990, E1226, K0001, K0002, K0003, K0004, K0195
Standard manual wheelchairs, standard hemi (low-seat), lightweight or high strength/light weight wheelchairs have been removed from the hospital discharge waiver. These items do not require PA if the standards of coverage and documentation requirements are met for specific base codes and accessories. Standard wheelchairs include standard arm and foot rests. Refer to the Medical Supplier database and the Wheelchair/Power Operated Mobility Accessory Reimbursement chart on the MDCH website for items included in the wheelchair base.

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

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

MOBILITY POLICY UPDATES

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

2.46 Walkers Documentation:
Required documentation must be kept in the beneficiary file and be available upon request.

Additions to Documentation requirements:

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

For each walker type, the following must be included:

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

2. Walker with trunk support (E0140):
   Medical/functional reason a standard walker would not meet the beneficiary's ability to perform MRADLs.

3. Enclosed Walker with posterior seat (E0144):
   Medical/Functional reason a standard walker would not meet the beneficiary's ability to perform MRADLs.

4. Heavy Duty Walker (E0147 – E0149):
   Medical/functional reason for a heavy-duty walker (e.g., obesity, severe neurological disorder, or restricted use of hands).

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

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

2.47.B Standards of Coverage:
Additions:

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

2.47.C Prior Authorization for Purchase, Rentals, Repairs, and/or Replacement of Mobility Devices:
PA is required for all power wheelchairs, power-operated vehicles, custom seating, positioning and accessories. Standard wheelchairs with specified accessories/add-ons do not require PA if the standards of coverage and documentation requirements are met. Accessories/attachments for standard wheelchairs (other than standard arm and legs rests), require PA. Refer to the Medical Supplier Database and the Wheelchair/Power Operated Mobility Accessory Reimbursement chart on the MDCH website for items included in the wheelchair base.

Section 1.7.B Clinical Documentation/Evaluation:
The MSA-1656 must be completed for standard wheelchairs that need accessory/attachment add-ons (excluding standard arm and standard legs rests), power wheelchairs, power operated vehicles, custom seating, positioning devices, scooters, tilt-n-space features, gait trainers, strollers, car seats and standers. Standard wheelchairs that do not need accessory/attachment add-ons do not require PA if the standards of coverage and documentation requirements are met.

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

The new MSA-1656, Addendums A & B and MSA-1653-D may be used beginning December 1, 2012. To accommodate for evaluations in-progress MDCH will accept previous versions received on or before February 1, 2013. After February 1, 2013, all previous versions become obsolete.

Addendums A and B:
The evaluator(s) must complete Addendums A and B to clarify the beneficiary's ability to use the requested equipment and list the equipment the beneficiary currently owns/rents and indicate if that equipment is under warranty. The addendums accompany the MSA-1656 for the initial evaluation. The evaluator only completes the specific addendum and section(s) of the addendum that relates to the mobility/seating item requested. For future PA requests, if the beneficiary's medical/functional status has not changed, the evaluator completes only the

applicable addendum for any new or replacement equipment and sends the addendum to the durable medical equipment provider to submit with the PA request (MSA-1653-D).

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

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

The attached documents detail the revised policy:

Attachment A – Revised Evaluation and Medical Justification for Complex Seating and Mobility Devices (MSA - 1656)
Attachment B – Addendum A: Mobility/Seating
Attachment C – Addendum B: Strollers, Gait Trainers, Standers, Car Seats, and Children's Positioning Chairs
Attachment D – Revised Special Services Prior Approval – Request/Authorization Form (MSA-1653-B)
Attachment E – New Complex Seating and Mobility Device Prior Approval – Request/Authorization Form (MSA-1653-D)

The forms above are available on the MDCH website and have electronic fill-in capacity. The fields have unlimited text space. Prior to submitting the MSA-1656, Addendums and the MSA-1653-D, the applicable standards of coverage and documentation requirements listed in the Medicaid Provider Manual must be met.

References:
The "Wheelchair/Power Operated Mobility Accessory Reimbursement Table," has been updated and is posted on the MDCH website. For clarification purposes, a power point presentation titled "Evaluation and Medical Justification for Complex Seating and Mobility Devices, MSA-1656," is available on the MDCH website. This tool clarifies the roles of the physician, the physical therapist, occupational therapist, Rehab RN and the DME provider in completing the MSA-1656.

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

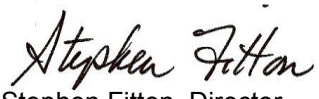
Manual Maintenance

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-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to 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

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

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

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

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

SECTIONS 1 THROUGH SECTION 11 MUST BE COMPLETED BY A LICENSED/CERTIFIED MEDICAL PROFESSIONAL.

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

SECTION	INSTRUCTIONS
1	Indicate the beneficiary name, mihealth number, ordering/referring physician name, specialty and National Provider Identifier (NPI).
2	Medical history is used to gather information in regards to the beneficiary's physical status and progression of disease. Estimate weight if unable to weigh at time of evaluation. The acronym "WFL" means "within functional limits."
3	Home Environment questions reflect the current setting in which the beneficiary lives.
4	Community Activities of Daily Living (ADL) reflects the beneficiary's transportation situation to the community and/or school, if applicable. Indicate if the mobility equipment fits into the vehicle and if the family can lift the mobility equipment into a vehicle.
5	This information reflects the need for pressure relief. If the beneficiary has current decubiti, the evaluator should indicate the stage as defined by the **National Pressure Ulcer Advisory Panel (NPUAP) at www.npuap.org**.
6	**Mandatory for all requests.** Describes the beneficiary's ADL functional ability without mobility devices. The acronym "UE" means "upper extremity." Answer the items regarding visual perception, problem solving and comprehension only if requesting a power mobility item.
7	Evaluation includes measurements of the beneficiary. Relevant measures include adjustments for clothing. Complete the Manual Muscle Test (MMT) for hand only if requesting a power mobility item. This measurement should be of the appropriate hand/digits that will be used to operate specialty controllers.

Manual Muscle Evaluation

0	No increase in muscle tone
1	Slight increase in muscle tone, manifested by a catch and release or by minimal resistance at the end of the range of motion when the attached part is moved in flexion or extension
1+	Slight increase in muscle tone, manifested be a catch, followed by minimal resistance throughout the remainder (less than half) of the ROM
2	More marked increase in muscle tone through most of the ROM, but affected part easily moved
3	Considerable increase in muscle tone, passive movement difficult
4	Affected part rigid in flexion or extension

H = **Hypotonia** O = **Observation**

Modified Ashworth Scale

100%	5	N	Normal	Complete ROM against gravity with full resistance
75%	4	G	Good	Complete ROM against gravity with some resistance
50%	3	F	Fair	Complete ROM against gravity
25%	2	P	Poor	Complete ROM with gravity eliminated
10%	1	T	Trace	Evidence of contractibility but no joint motion
0%	0	O	Zero	No evidence of contractility

C = Complete; IC = Incomplete; ∗ = Pain

<table>
<tr><th>SECTION</th><th colspan="2">INSTRUCTIONS</th></tr>
<tr><td></td><td colspan="2">If evaluator is not able to test beneficiary due to cognition, age, etc., then information for MMT can be based on observation (not on self-report).</td></tr>
<tr><td>8</td><td colspan="2">Check all items that apply for mobility goals. Section is to be used if evaluator has any other comments to establish medical need, functional goals, etc.</td></tr>
<tr><td>9</td><td colspan="2">Evaluator should list all equipment the beneficiary currently owns or uses. Include brand, model, serial number, description and date of purchase/rental.</td></tr>
<tr><td>10</td><td colspan="2">To be completed if beneficiary is in a nursing facility. This section should be completed and signed by the Director of Nursing, Facility Administrator or Ordering/referring Physician. This page must accompany the MSA-1653-D and appropriate Addendum(s) when submitting to the MDCH Program Review Division.</td></tr>
<tr><td>11</td><td colspan="2">To be completed by the evaluator and, if applicable, all team members involved in the evaluation. Enter date of evaluation, evaluator’s name, title, telephone number, place of employment and address. If team evaluation, in Section 11, list all participants and titles (attach additional pages if necessary). The attestation page must accompany the MSA-1653-D and appropriate Addendum(s) when submitting to the Michigan Department of Community Health (MDCH) Program Review Division.</td></tr>
<tr><td rowspan="3">Notes</td><td colspan="2">The applicable addendums must accompany the MSA-1656 & MSA-1653-D when requesting the authorization. Failure to include the appropriate addendum(s) may cause a delay in the authorization process.</td></tr>
<tr><td>Addendum A: To be completed when requesting new or replacement manual wheelchairs with accessories, power mobility devices, and/or seating systems.</td><td>Addendum B: To be completed when requesting new or replacement strollers, standers, gait trainers and children’s positioning chairs.</td></tr>
<tr><td colspan="2">Note:
For beneficiaries residing in a nursing facility, return the completed MSA-1656, addendum(s) and MSA-1653-D to the requesting nursing facility.
For beneficiaries in the community, the MSA-1656, addendum(s) and MSA-1653-D are forwarded to the ordering physician for their review.</td></tr>
</table>

SUBMIT TO:

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

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices

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

SECTION 1: BENEFICIARY INFORMATION

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

SECTION 2: MEDICAL HISTORY

Primary Diagnosis: _____ Onset date:	Secondary Diagnosis: _____ Onset date:

If spinal cord injury or spina bifida indicate the level of injury/impairment:

Relevant past and future surgeries:

Bowel Mgmt: ☐ Continent ☐ Incontinent ☐ Colostomy (Indicate type):

Bladder Mgmt: ☐ Continent ☐ Incontinent ☐ Catheter (Indicate type):

Cardio Status: ☐ WFL ☐ Impaired	Neuro Status: Seizures ☐ YES ☐ NO If YES, Frequency/Duration: /	Respiratory Status: ☐ WFL ☐ Impaired
Balcofen pump present? ☐ YES ☐ NO If YES, date Implanted: _____ Botox? ☐ YES ☐ NO If YES, date of last injection: _____ Other explain:		Sip 'N Puff controller requested? ☐ YES ☐ NO If YES, additional information maybe be required:
Height: _____ Weight: _____	Explain recent changes or trends in weight:	

List medication(s) currently prescribed:

How does the management or severity of the above conditions/impairments affect the need for the equipment requested?

SECTION 3: HOME ENVIRONMENT

Beneficiary resides in: ☐ House ☐ Condo/town home ☐ Apartment ☐ Assisted Living /AFC/Group Home ☐ Nursing Facility

Does beneficiary live alone? ☐ YES ☐ NO If NO, does beneficiary have a caregiver? ☐ YES ☐ NO

If YES, who provides the care? ☐ Family member ☐ RN ☐ LPN ☐ Other (explain)

How many hours per day are provided by the caregiver?

SECTION 4: COMMUNITY ADL (Transportation)

What is the beneficiary's mode of transportation? (Check all that apply.)

☐ Car ☐ Van/SUV ☐ Van w/ Lift ☐ Truck ☐ Taxi Cab ☐ Bus ☐ School Bus ☐ Ambulance ☐ Other

Does the beneficiary attend school or work? ☐ YES ☐ NO

Is the beneficiary transported in the current or requested wheelchair? ☐ YES ☐ NO If NO, explain why the beneficiary cannot be transported in the current or requested chair?

Explain:

SECTION 5: SENSATION AND SKIN ISSUES

Sensation ☐ Intact ☐ Impaired ☐ Absent ☐ Hypersensitive	**Pressure Relief** ☐ Dependent ☐ Independent ☐ Type of assistance needed How does the beneficiary perform pressure relief?	
Does beneficiary have a history of skin decubiti and/or flap surgery? ☐ YES ☐ NO If YES, indicate location:	Does beneficiary have a current decubiti? ☐ YES ☐ NO If YES, describe:	Does beneficiary have other skin issues? ☐ YES ☐ NO If YES, describe:

Beneficiary Name: _____ mihealth Number: _____

SECTION 6: MOBILITY ASSESSMENT *(Mandatory for all requests)*

Functional Ability Without Mobility Device(s)

Sitting:

	Static	Dynamic
WFL	☐	☐
Uses UE for balance	☐	☐
Contact guard assist	☐	☐
Standby assist	☐	☐
Minimum assist	☐	☐
Moderate assist	☐	☐
Maximum assist	☐	☐
Dependent/unable	☐	☐

Standing:

	Static	Dynamic
WFL	☐	☐
Uses UE for balance	☐	☐
Contact guard assist	☐	☐
Standby assist	☐	☐
Minimum assist	☐	☐
Moderate assist	☐	☐
Maximum assist	☐	☐
Dependent/unable	☐	☐

Transfers:

☐ Independent ☐ Type of assistance needed:

How does beneficiary transfer:

☐ Pivot
☐ Sliding
☐ Mechanical Lift
☐ Other: (Explain)

Ambulation within 1 minute:
☐ Independent > or = 150 ft.
☐ Ambulates with assist > or = 150 ft. Explain type of assistance:
☐ Ambulates with device > or = 150 ft.
☐ Ambulates short distance only ____ ft.
☐ Unable to ambulate
☐ Limited due to endurance - Explain:

Explain how this affects equipment ordered?

Complete only if power mobility item is requested (e.g., power wheelchair, scooter, power assisted wheels, etc.)

Visual perception: Has visual acuity and perception that permits safe and independent operation of the equipment requested. ☐ YES ☐ NO

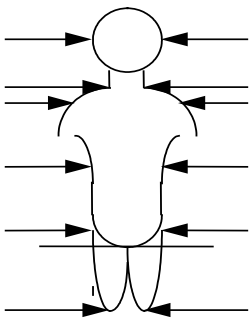
Problem solving: Has problem solving skills appropriate to operate requested power mobility item. ☐ YES ☐ NO
If beneficiary is unable, who will complete? Explain:

Comprehension: Understands and is able to follow directions and conversations that are complex or abstract; understands either spoken or written language. ☐ YES ☐ NO
If NO, explain:

SECTION 7: MODIFIED ASHWORTH SCALE AND MANUAL MUSCLE EVALUATION INFORMATION

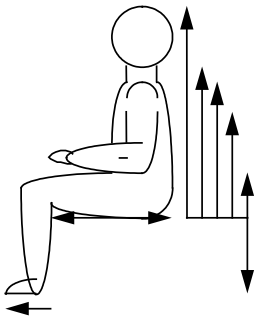
See Form Completion Instructions for Modified Ashworth Scale and Manual Muscle Evaluation.

Width at the:



Head: ____
Neck: ____
Shoulder: ____
Trunk: ____
Hips: ____
Feet: ____

Height:



	L	R
Crown:	____	____
Occiput:	____	____
Shoulder:	____	____
Axilla:	____	____
Elbow:	____	____
Seat Depth:	____	____
Leg Length:	____	____
Foot Length:	____	____

Primitive reflexes present:
☐ Asymmetrical Tonic Neck Reflex
☐ Symmetrical Tonic Neck Reflex
☐ Startle Reflex
☐ Other; Explain:

Explain how this relates to equipment ordered:

Beneficiary Name: _____ mihealth Number: _____

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

SECTION 8: GOALS

Check all that apply.

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

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

Brand	Model	Serial Number	Description	Date of Purchase

SECTION 10: MOBILITY ASSESSMENT - FOR BENEFICIARIES IN A NURSING FACILITY ONLY

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

Nursing Facility Name:		NPI:	Date of Admission:
Mobility History:	☐ Uses nursing facility per diem chair	☐ Uses own personal chair	
Wheelchair Description: *(Currently used or owned)*	Brand:	Model No:	Serial No:
	Components:		

Customized Wheelchair Documentation (Required documentation to accompany this form)

☐ Most Recent MDS ☐ Past Two Months of Nursing Notes ☐ Current Plan of Care that relates to the equipment ordered

Director of Nursing Signature — Date

Click here to enter text.

Print Name

Ordering Physician Signature — Date

Click here to enter text.

Print Name

SECTION 11: EVALUATOR (PT, OT, PHYSIATRIST OR REHAB RN) ATTESTATION AND SIGNATURE/DATE

I certify that I conducted the evaluation and have completed the information presented in Sections 1 - 9, and that there is no financial arrangement with the selected durable medical equipment provider and/or the evaluating clinician. I certify that the equipment requested is the most economical alternative that meets the beneficiary's basic medical and functional needs. I certify that the information contained in this form is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Click here to enter text.

Evaluation Date

Click here to enter text.

Evaluator Name/Title (Print)

Click here to enter text.

Place of Employment and Address

Click here to enter text. — Click here to enter text.

NPI — Phone Number

Click here to enter text.

Evaluator Signature — Date

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

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

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

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

Beneficiary Name: _____ Mihealth Number: _____ Attachment B

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)*

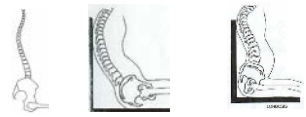
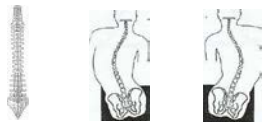
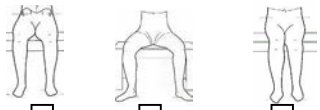
	Device Type *(attach additional page(s) if necessary)*	
All Accessories / Add Ons	☐ Head & Neck	☐ Feet ☐ Footbox
	☐ Arms	☐ Other - Describe
Medical Reason	List and specify Medical Reason for brand(s) and model(s) requested for this beneficiary:	

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 Kyphosis ☐ ↑ Thoracic Lordosis ☐ ↑ Lumbar ☐ 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 MDCH 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.

Click here to enter text.
Evaluation Date

Click here to enter text.
Evaluator Name/Title (Print)

Click here to enter text.
Place of Employment and Address

Click here to enter text. Click here to enter text.
NPI Phone Number

Click here to enter text.
Evaluator Signature Date

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Attachment C

Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Addendum B: Strollers, Gait Trainers, Standers, Car Seats, and Children's Positioning Chairs

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

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

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

Beneficiary Name: _____ Mihealth Number: _____

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

Beneficiary Name: _____ Mihealth Number: Attachment C

	☐ Requested	☐ Current ☐ None
Equipment	**Beneficiary's ability to use**	**Where device is used**
Car seat	Indicate medical special needs for use and adaptions needed:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? *(i.e., home, school, community)*

	☐ Requested	☐ Current ☐ None
Stander *(If less than age 21)*	☐ Is dependent with standing ☐ Walks with assistive device ☐ Walks with gait trainer ☐ Required for post-op care Specify treatment plan and state any surgical or other interventions that affect standing:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? *(i.e., home, school, community)*
	Indicate current standing plan of care (including how many times per day and how long):	
	Is the beneficiary/caregiver compliant with standing plan of care? ☐ YES ☐ NO If NO, explain:	

	☐ Requested	☐ Current ☐ None
Growth adaptability of device	Seat width: _____ Seating system height: _____ Seat depth: _____ Frame adaptablility:	Seat width: _____ Seating system height: _____ Seat depth: _____ Frame adaptablility:

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

Beneficiary Name: _____ Mihealth Number: _____

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

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

Click here to enter text.
Evaluation Date

Click here to enter text.
Evaluator Name/Title (Print)

Click here to enter text.
Place of Employment and Address

Click here to enter text. Click here to enter text.
NPI Phone Number

Click here to enter text.
Evaluator Signature Date

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

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

Special Services Prior Approval - Request/Authorization Completion Instructions

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

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

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

Completion of this form is as follows:

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

Form Submission

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

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

Fax Number: (517) 335-0075

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

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

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

Michigan Department of Community Health

SPECIAL SERVICES
PRIOR APPROVAL – REQUEST/AUTHORIZATION

1. PRIOR AUTHORIZATION NUMBER (MDCH USE ONLY)

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

24. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.	25. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE, FOR SERVICES REQUESTED.

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

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

PROVIDER'S SIGNATURE DATE

MDCH USE ONLY

28. REVIEW ACTION:	29. CONSULTANT REMARKS
APPROVED ☐ INSUFFICIENT DATA ☐ DENIED ☐ NO ACTION ☐ APPROVED AS AMENDED ☐	

CONSULTANT SIGNATURE DATE

Michigan Department of Community Health

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

The MSA-1653-D must be used by Medicaid enrolled DME Providers. Note: Requests for new complex seating or mobility devices submit with a completed Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices" form (MSA-1656).

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

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

Completion of this form is as follows:

Box 1	MDCH Use Only
Box 11	Beneficiary address. If beneficiary resides in Nursing Facility include the Nursing Facility name, address and phone number.
Box 17	Complete this box ONLY for wheelchair requests. • For repairs or parts, complete MSA-1653-D. (Do not include MSA-1656.) • For new or replacement (due to a change in beneficiary basic medical functional status requests), stop at this point and complete MSA-1656. Both forms must be submitted for Prior Authorization consideration.
Box 20	Enter a complete description of the item requested, including manufacturer, model, style, etc. DME, orthotics and prosthetics, must provide the brand name, model, and catalog or part number.
Box 21	Enter the HCPCS Procedure Code.
Box 22	Enter the applicable HCPCS Modifier.
Box 27	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description). DME/POS providers must submit the prescription/CMN with this form.
Box 28	Any additional remarks regarding the request should be listed in this box such as verbal authorization date, retroactive date of service if being requested. Provide other insurance coverage for services requested.
Box 30	Must be completed for all requests.

Form Submission

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

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

Fax Number: (517) 335-0075

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

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

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

Michigan Department of Community Health

Complex Seating and Mobility Device Prior Approval - Request/Authorization

1. PRIOR AUTHORIZATION NUMBER (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). IF RESIDES IN NURSING FACILITY INDICATE NAME OF FACILITY, ADDRESS AND PHONE NUMBER.			
12. NAME OF DESIGNATED CONTACT PERSON (E.G., BENEFICIARY, PARENT, GUARDIAN, ETC.)			13. PHONE NUMBER
14. OTHER INSURANCE NAME	15. POLICY NUMBER		16. FAX NUMBER
17. AUTHORIZATION TYPE: ☐ **NEW WHEELCHAIR/REPLACEMENT** ☐ **REPAIR** ☐ **RENTAL ONLY**			18 **MSA-1656 SUBMITTED ON**

19. LINE	DESCRIPTION OF SERVICE, BRAND, MODEL, CATALOG, AND PARTS	20. PROCEDURE CODE	22. MODIFIER	23. QUANTITY	24. CHARGE	25. COVERED BY OTHER INSURANCE? YES	25. COVERED BY OTHER INSURANCE? NO	26. DATE LAST REPLACED (MM/DD/YYYY)
01						☐	☐	
02						☐	☐	
03						☐	☐	
04						☐	☐	
05						☐	☐	
06						☐	☐	
07						☐	☐	
08						☐	☐	
09						☐	☐	

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

27. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.	28. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE, FOR SERVICES REQUESTED.

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

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

DME'S SIGNATURE DATE

ADDITIONAL DME'S SIGNATURE DATE

MDCH USE ONLY

31. REVIEW ACTION: ☐ APPROVED ☐ DENIED ☐ INSUFFICIENT DATA ☐ NO ACTION ☐ APPROVED AS AMENDED

32. CONSULTANT REMARKS

CONSULTANT SIGNATURE AND DATE

Michigan Department of Community Health

Complex Seating and Mobility Device
Prior Approval - Request/Authorization

Additional Page (Use only if requesting additional mobility items)

Beneficiary Name: _____ Mihealth Number: _____

19. LINE	DESCRIPTION OF SERVICE, BRAND, MODEL, CATALOG, AND PARTS	20. PROCEDURE CODE	22. MODIFIER	23. QUANTITY	24. CHARGE	25. COVERED BY OTHER INSURANCE?		26. DATE LAST REPLACED
						YES	NO	(MM/DD/YYYY)
10						☐	☐	
11						☐	☐	
12						☐	☐	
13						☐	☐	
14						☐	☐	
15						☐	☐	
16						☐	☐	
17						☐	☐	
18						☐	☐	
19						☐	☐	
20						☐	☐	
21						☐	☐	
22						☐	☐	
23						☐	☐	
24						☐	☐	
25						☐	☐	
26						☐	☐	
27						☐	☐	
28						☐	☐	
29						☐	☐	
30						☐	☐	
31						☐	☐	
32						☐	☐	
33						☐	☐	
34						☐	☐	

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