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 date the evaluation was completed.

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. **Modified Ashworth Scale** 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** **Manual Muscle Evaluation** 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 MDHHS 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 Health and Human Services (MDHHS) 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 Health and Human Services
Program Review Division
PO Box 30170
Lansing, Michigan 48909 **Fax: (517) 335-0075**

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

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
Baclofen 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

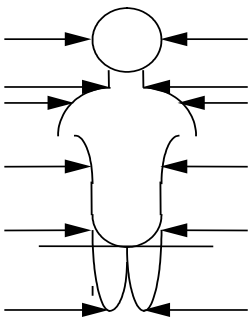
Problem solving: Has problem solving skills appropriate to operate requested power mobility item. ☐ YES ☐ NO
If beneficiary is unable, who will complete? Explain:

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

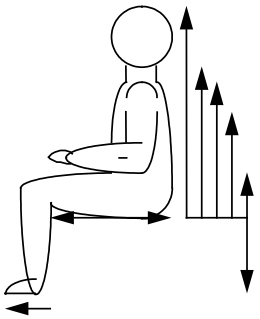
See Form Completion Instructions for Modified Ashworth Scale and Manual Muscle Evaluation.

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	**MMT/O** (Manual Muscle) ☐ Test ☐ Observation	**TONE**	Explain how this affects equipment ordered:
	Left / **Right**	**Left** / **Right**		
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

Beneficiary Name: _____ mihealth Number: _____

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

Print Name

Ordering Physician Signature Date

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.

Enter Date Here
Evaluation Date

Enter Text Here
Evaluator Name/Title (Print)

Enter Text Here
Place of Employment and Address

NPI Phone Number

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 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.