Wheeled Mobility Letter of Medical Necessity Form

All sections on this form **must** be completed solely by the **evaluating occupational and/or physical therapist**.
Exception: Technical rationales may be completed by the evaluating ATP designated with an asterisk [*].

*INDIVIDUAL'S NAME:		*ID NUMBER:	

MEMBER INFORMATION AND BACKGROUND							
*1.	Date of Birth (mm/dd/yyyy)						
2.	Date(s) of Evaluation (mm/dd/yyyy)						
*3.	Address Line 1						
	Address Line 2						
	City		State		Zip Code		

*4.	Facility Name (if applicable) Evaluation Location Address L1				
	Evaluation Location Address L2				
	Evaluation City		Evaluation State		Evaluation Zip Code	

*5.	Height		FT		IN	Weight		LBS	

*6.	INDIVIDUALS PRESENT DURING EVALUATION		
	NAME	**CREDENTIALS**	**AGENCY or RELATIONSHIP**
OCCUPATIONAL/PHYSICAL THERAPIST(s)			
DME PROVIDER/ATP			
OTHER(s)			

7.	**a. Primary Reason for Evaluation**	☐ Initial Wheeled Mobility Device	**b. Primary Issues Relating to DME**	☐ Size
		☐ Replacement		☐ Does not address current medical needs
		☐ Modification/Repairs		☐ Does not address current functional needs

	RELEVANT DIAGNOSIS(es)
8.	
8a.	**Explain recent change(s) in medical condition or other relevant information including symptoms, treatments, and medications:**

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9. List all current/previous Durable Medical Equipment (DME) within past five years:

9a. WHEELED MOBILITY DEVICE, including MANUFACTURER AND MODEL	Approximate DATE of PURCHASE	If ineffective, provide reason:
(e.g., Convaid Cruiser stroller)		

9b. WHEELED MOBILITY DEVICE, including MANUFACTURER AND MODEL	Approximate DATE of PURCHASE	If ineffective, provide reason:
(e.g., Convaid Cruiser stroller)		

9c. OTHER DME TYPE, including MANUFACTURER AND MODEL	Approximate DATE of PURCHASE	If ineffective, provide reason:
☐ **Hygiene** (e.g., Anthros Shower/Commode Chair)		
☐ **Stander** (e.g., Altimate EasyStand Evolv)		
☐ **Other Equipment** (e.g., Hospital Bed, Patient Lift, Walker)		
☐ **Other Equipment**		

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10. Functional Skills

ACTIVITY	LEVEL OF INDEPENDENCE						COMMMENTS and EQUIPMENT USED
Bathing	☐	Independent	☐	Min Assistance	☐	Max Assistance	
	☐	Supervision	☐	Mod Assistance	☐	Dependent	
Dressing	☐	Independent	☐	Min Assistance	☐	Max Assistance	
	☐	Supervision	☐	Mod Assistance	☐	Dependent	
Grooming	☐	Independent	☐	Min Assistance	☐	Max Assistance	
	☐	Supervision	☐	Mod Assistance	☐	Dependent	
Eating	☐	Independent	☐	Min Assistance	☐	Max Assistance	
	☐	Supervision	☐	Mod Assistance	☐	Dependent	
Toileting	☐	Independent	☐	Min Assistance	☐	Max Assistance	
	☐	Supervision	☐	Mod Assistance	☐	Dependent	

11. Transfer Skills: ☐ **Independent for all transfers** ☐ **Varied transfer skills (Describe transfer skills and equipment used below.)**
☐ **Dependent for all transfers (Describe transfer method and equipment used below.)**

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12. Ambulation Independence: ☐ **Independent** ☐ **Requires assistance with ambulation** ☐ **Non-ambulatory** ☐ **Varied ambulation skills (Describe below)**

13. Coordination, Motor Control, and Balance

ACTIVITY	UNSUPPORTED MOTOR CONTROL						COMMENTS / OTHER
Sitting Balance (Static)	☐	Steady, safe	☐	Leans or slides	☐	Unable	
Upper Extremity Gross Motor Control	☐	Functional	☐	Mild/Moderate Impairment	☐	Dependent	
Upper Extremity Fine Motor Control	☐	Functional	☐	Mild/Moderate Impairment	☐	Dependent	

14. Range of Motion (Attach data as appropriate.)

	RANGE of MOTION	STRENGTH	TONE	COMMENTS	PRESENCE of EDEMA (Y/N)
Head/Neck					
Trunk					
Upper Extremity					
Lower Extremity					

*INDIVIDUAL'S NAME:		*ID NUMBER:	

15. Postural Alignment: <u>Add COMMENT regarding any abnormal finding, including quantitative data</u> (e.g., mixed asymmetry, mixed rotation, severe misalignment between neck and trunk, presence of orthosis(es)/prosthesis(es), if applicable.

	COMMENTS
Head/Neck	
Trunk/Spine	
Pelvis/Hips	
Leg Length	
Ankles/ Feet/ Toes	

16. Pain: ☐ **No Pain** ☐ **Pain** ☐ **Unable to determine if individual is experiencing pain**
(If Pain/Unable to determine pain, describe below.)

17. Skin Integrity and Pressure Management

RISK FACTORS	☐	None	☐	Bony Prominences	☐	Aged Skin	☐	Fecal and/or Urinary Incontinence
	☐	Circulatory Compromise	☐	Impaired Nutritional Status	☐	Immobility	☐	Sensory Deficits
INDICATE HIGH RISK LOCATIONS								
CURRENT SKIN INTEGRITY STATUS	☐	Intact	☐ Impaired, indicate approximate duration:					
			Stage:		Location:		If unstageable, describe:	
HISTORY of SKIN INTEGRITY	☐	Intact	☐ Impaired, indicate approximate duration:					
			Stage:		Location:		If unstageable, describe:	
PRESSURE REDUCING ABILIITES			☐ Functional Self-positioning		☐ Impaired Self-positioning		☐ Non-self-positioning	
PRESSURE REDUCING METHODS USED								

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18. What other least restrictive mobility devices were considered, evaluated, or ruled out?

		Reason:
☐	**Cane**	
☐	**Walker**	
☐	**Standard Manual Wheelchair**	
☐	**Lightweight Wheelchair**	
☐	**Optimally Configured, Ultra Lightweight Wheelchair**	
☐	**Medical Stroller**	
☐	**Power Assist System**	
☐	**Medical Scooter**	
☐	**Other:**	

19. List the primary medical and functional objectives for the recommended wheeled mobility device, including how this will impact the individual's Activities of Daily Living (ADL) independence:

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PERSON'S ABILITY TO UTILIZE REQUESTED WHEELED MOBILITY DEVICE

20. Will this individual be able to participate in mobilizing the recommended wheeled mobility device?

☐ **If YES, complete #20** ☐ **If NO, proceed to #21**

If the individual will be mobilizing the wheeled mobility device, describe the evaluation trials and results, including individual's ability to safely and independently mobilize and utilize the features of the recommended wheeled mobility device system within their customary and relevant environment(s) (i.e., bedroom, bathroom, ramp, varied terrain):

Duration and frequency of evaluation trial(s):
Cognitive/ Safety/ Visual-Motor Skills:
Fine/Gross Motor Skills:
Strength; Endurance:
Ability to control all special features (i.e., power tilt, power recline, power leg rests, seat elevator, power assist, one-arm drive, alternative mobility controls):

21. Does the individual have caretaker support? ☐ **NO** ☐ **YES**

If "YES," is the caretaker trained and able to participate in mobilizing the recommended wheeled mobility device? If the wheeled mobility device will be used in multiple environments, is the caretaker able and willing to transfer the device to and from the individual's home, vehicle, and other environments?

22. For residents of skilled nursing facilities:

If this request is for a replacement wheeled mobility device originally purchased under Sec. 17-134d-46 of the Regulations of Connecticut State Agencies (Customized Wheelchairs in Nursing Facilities), attach a copy of the existing 24-hour positioning plan.

What is the estimated length of time per day that the requested wheeled mobility device will be used?

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Based on the clinical assessment, the following wheeled mobility device is suggested to address this individual's medical needs:

23.	* Description of DME component: This list can be pre-populated by the DME provider. Postural components can be combined with hardware (e.g., lateral trunk pads with swing-away mounting hardware; phenolic upper extremity support with channel locks and strap).	**24. Medical Rationale <u>to be completed by evaluating therapist only</u>: Pre-populated, generic, and general rationales and definitions will not be accepted. Information must include:** ▪ The rationale for the requested base or component for this specific individual, as correlated with the documented clinical information. ▪ If appropriate, include reason why a standard component would not address the individual's medical needs. ▪ **Rationales written by the DME provider should be designated with an asterisk** [*]. Include the reason for hardware and electronic components, as compared to less complex alternatives and correlated with necessary functional or technical outcomes.
a.		
b.		
c.		
d.		
e.		

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*INDIVIDUAL'S NAME:		*ID NUMBER:	

f.		
g.		
h.		
i.		
j.		
k.		
l.		
m.		

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*INDIVIDUAL'S NAME:		*ID NUMBER:	

n.		
o.		
p.		
q.		
r.		
s.		
t.		
u.		
v.		

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25a. I certify that I am the Licensed Occupational and/or Physical Therapist identified below. I have included my credentials, affiliated agency, address, and preferred contact information. My signature affirms that I solely wrote each section of this report, except where an asterisk [*] is designated, based upon my own clinical knowledge, training, and evaluation of the individual's medical condition.
Note: All email correspondence utilizes the CHNCT secure email system.

Name:		Credentials:		CT License #:	
Agency:					
Address L1:					
Address L2:					
City:		State:		Zip Code:	
Preferred Phone Number:		Fax Number:		Preferred Email Address:	

ATTENTION: TO FACILITATE A MEDICAL NECESSITY DETERMINATION, PLEASE INDICATE THE PREFERRED METHOD FOR A MEDICAL REVIEWER TO CONTACT YOU, AS NEEDED.

☐ **PHONE** ☐ **EMAIL** ☐ **OTHER**

25b. Electronic Signature Agreement. By clicking "I agree" and electronically signing below, you certify that: (1) you and the agency/facility in which you are employed agree to follow and are in compliance with the Connecticut Department of Social Services *Conditions for DSS Acceptance of Electronic Signatures ("Electronic Signature Policy")* and (2) your electronic signature below complies with the Electronic Signature Policy. **If your agency does not comply with this Agreement, a handwritten signature is required.**

☐	**Therapist's Signature**		**Date of Report (mm/dd/yyyy)**	

***26. Evaluating Assistive Technology Professional (ATP) signature is required when the ATP provides any technical documentation in #24.**

☐	**ATP's Signature and Credentials**		**Date (mm/dd/yyyy)**	

27a. Physician's Contact Information and Signature: By signing below, I have reviewed and concur with the above evaluation:

a.	**Prescribing Physician**		d.	**Physician NPI**	
b.	**Agency**		e.	**Preferred Phone Number**	
c.	**Address**				
	City		**State**	**Zip Code**	
	Preferred Email		**Fax**		

27b. Electronic Signature Agreement. By clicking "I agree" and electronically signing below, you certify that: (1) you and the agency/facility in which you are employed agree to follow and are in compliance with the Connecticut Department of Social Services *Conditions for DSS Acceptance of Electronic Signatures ("Electronic Signature Policy")* and (2) your electronic signature below complies with the Electronic Signature Policy. **If your agency does not comply with this Agreement, a handwritten signature is required.**

☐	**Physician's Signature**		**Date (mm/dd/yyyy)**	