OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

SEATING/WHEELED MOBILITY LETTER OF MEDICAL NECESSITY
POWER WHEELCHAIRS AND/OR
ANY CUSTOM WHEELCHAIR (i.e., any wheelchair with a custom seating system)

THIS FORM MUST BE SIGNED BY A PHYSICIAN AND SUBMITTED WITH THE PRIOR AUTHORIZATION REQUEST FOR POWER AND SPECIALLY CONSTRUCTED WHEELCHAIRS AND WHEELCHAIRS WITH CUSTOM SEATING SYSTEMS

Note: This Letter of Medical Necessity should *not* be completed for *manual* wheelchairs without custom seating systems. Medical necessity for manual wheelchairs wthout custom seating systems should be documented using ODHS Form 3414. Attach additional pages or other documentation as needed.

INSTRUCTIONS:

Part A	Complete every item.
Part B1, B2	Complete for all wheelchair request
Part B3	Complete for request of a wheelchair with a custom seating system or adaptive positioning devices for an individual with a moderate/severe impairment
Part B4	Complete for power wheelchair request.
Part C	List all necessary equipment components under the appropriate heading, completion always required.
Part B, C	Must be completed by a licensed physical or occupational therapist, or physiatrist in accordance with rule 5101:3-10-16 of the Ohio Administrative Code (OAC) "Who is fiscally, administratively and contractually independent from the DME provider". (Suppliers are prohibited from completing part B & C this form. In accordance with rule 5101:3-10-16 of OAC.)
Part D	Vendor information on Make/Model Number must be completed for all wheelchair requests.
Part E	Home Assessment for Power Wheelchair, completion necessary only for individual's residing in their personal residence.

A. GENERAL INFORMATION

Name:	Birth Date:		Medicaid Billing #:	
Residence/Facility:		Other Insurance:	Weight:	Height:

B1. CLINICAL ASSESSMENT: Complete for Power wheelchairs and wheelchairs with any type of seating system.

Number of Hours/Day in Wheelchair:	Est. Length of Need (# of Months/Yrs.):	Date of Onset/Injury:
Diagnosis(es) (include written description and ICD-9 codes):		
Presenting Problem:		
Prognosis:		
Three Most Important Facts Reviewer Should Know a. b. c.		
Cardio-Respiratory Status:		
Tone/Movement/Strength:		
Orthopedic Considerations:		
Ambulation/Functional Walking Status:		
Bed Confined: hours per day	Chair Confined: hours per day	
Present Equipment Make:	Model:	Age of Equipment:
Include Beginning and Ending Dates of Any Wheelchair Rental Periods (to include Short Term-Rental billed to the Department): Beginning Date: **N/A** Ending Date: **N/A**		
Equipment Being Requested - X New ☐ Used (Include Make, Model and Serial Number):		
Functional consideration for light weight or heavy duty wheelchairs (other than standard weight):		

B2. CLINICAL ASSESSMENT: Complete for Power wheelchairs and wheelchairs with any type of seating system.

Please describe in detail (e.g., flexible, degrees.)

Sitting Posture/Balance:

Pelvic Tilt/Obliquity/Rotation:

Leg Position:

Scoliosis:

Lordosis/Kyphosis**:**

Head Position:

Shoulder/Scapula Position:

Functional Status
ROM limitations:

Muscle Strength Limitations:

Upper Extremity Function:

Lower Extremity Function:

Does the consumer have a spinal orthotic? ☐ Yes X No
If yes, explain why a spinal orthotic and a seating system are both required:
N/A

Explain why the consumer's need for prolonged sitting tolerance, postural support to permit functional activities, or pressure reduction cannot be met adequately by a planar type seat, lap tray and/or spinal orthotic:

Therapeutic Objectives/Benefits of Prescribed Equipment:

Skin Condition/Integrity

Susceptible to Decubitus Ulcers: ☐ Yes ☐ No
If yes, explain:

Sensation:

Present/history of Ulcers:

Location(s):

Stage:

Ability to Perform Pressure Relief:

Bowel/Bladder Status:

Other Special Considerations:

B 3. CLINICAL ASSESSMENT (Continued)

MODERATE/SEVERE IMPAIRMENT: Complete when ordering a wheelchair with custom seating or adaptive positioning devices for an individual with a moderate or severe impairment

1. Describe custom seating system in Section C of this form.

2. Is the consumer moderately or severely physically impaired? ☐ Yes ☐ No
   If yes, Describe the impairment (s):

3. Indicate the body points of control affected.
   ☐ Head, shoulder & trunk ☐ Shoulders, trunk & hips ☐ Trunk, hips & knees ☐ Hip, knees & feet
   List any other affected body parts:

4. Does the consumer have moderate strength and/or moderate or severe tone (hyper or hypo) that prevents him/her from obtaining or maintaining symmetrical postures? ☐ Yes ☐ No
   If yes, Describe:

5. Does the consumer have moderate or severe skeletal and/or physical deformities/abnormalities which require custom seating or positioning devices for support? ☐ Yes ☐ No
   If yes, Describe deformities or abnormalities:

6. Dislocated hip with a leg length discrepancy of less than two inches? ☐ Yes ☐ No
   If yes, Describe:

7. Fixed contractures of the hips/knees that can not be accommodated by standard components, (i.e.. standard frame, standard footrest)?
   ☐ Yes ☐ No
   If yes, Describe and list degrees:

8. Feet that cannot maintain a plantigrade position? ☐ Yes ☐ No
   If yes, Describe:

9. Describe why the consumers seating needs can not be adequately met by other methods of accommodating the deformity or abnormality.

B 4. CLINICAL ASSESSMENT, (Cont.)
ADDITIONAL QUESTIONS TO SUPPORT MEDICAL NECESSITY FOR A *POWER WHEELCHAIR*

1. Is the consumer totally non-ambulatory and have severe weakness of the upper and lower extremities due to an orthopedic, neurological or muscular condition? ☐ Yes ☐ No
   If yes, Describe:

2. Does the consumer have any physical ability to operate a manual wheelchair? ☐ Yes ☐ No
   If yes, explain why a power wheelchair is needed:

3. Does the consumer have the physical and mental ability to safely operate a power wheelchair?
   If yes, Describe:

4. Document your assessment of the consumer's ability to operate a power wheelchair, addressing:
   Head Control/Head Position:

   Upper Extremity Functioning:

   Joy Stick Control Steering:

   Directionality-Steering Skill:

   Visual/Spatial Perception:

   Safety:

   Mobility Skills in Operation:

   Cognitive Level:

5. Is the consumer dependent upon a power wheelchair for functional activities or is there a significant delay in the acquisition of independence in functional activities that can be positively impacted by a power wheelchair? ☐ Yes ☐ No
   If yes, Describe:

6. Describe functional status and explain how the power wheelchair will allow the consumer to be independent in mobility and allow substantial

   Bathing:
   Grooming:
   Toileting/toilet Hygiene:
   Meal Preparation:
   Laundry:
   Telephone Use:
   Medication Management:
   Finance Management:
   Transfers:
   Use and Care of Equipment:
   Activities for which the power wheelchair facilities independent functioning while in school or work:
   Other Special Considerations:

C: EQUIPMENT PRESCRIPTION

<table>
<tr><td colspan="2">MOBILITY BASE AND ACCESSORIES (List all necessary equipment)
a) g)
b) h)
c) i)
d) j)
e) k)
f) l)</td></tr>
<tr><td colspan="2">DESCRIPTION OF CUSTOM SEATING SYSTEM (Include extent of molding or contouring necessary to customize the seating to meet the individual's needs).
Seat:
Back:</td></tr>
<tr><td colspan="2">ANY OTHER COMPONENTS
1) 4)
2) 5)
3 6)</td></tr>
<tr><td colspan="2">DESCRIBE FEATURES TO ACCOMMODATE GROWTH (CAN THIS WHEELCHAIR BE ENLARGED OR REDUCED IN SIZE?)
Yes</td></tr>
</table>

D. VENDOR INFORMATION

For LTCF residents, I certify that the prescribed wheelchair will be customized to meet the needs of the consumer and is configured or Constructed in such a way that precludes use by any other individual in accordance with Rule 5101:3-10-16 of OAC.

Manufacturer Make and Model #:	
EQUIPMENT SUPPLIER SIGNATURE	**SIGNATURE DATE:**
CONSUMER OR GUARDIAN SIGNATURE (Optional):	**SIGNATURE DATE:**
THERAPIST EVALUATION DATE:	
THERAPIST'S SIGNATURE:	**SIGNATURE DATE:**
THERAPIST'S NAME:	**LICENSE#:**

I have reviewed Parts A, B, C, D, and E of this document and agree that it is an accurate assessment of the client and their needs.

PHYSICIAN'S SIGNATURE:	**SIGNATURE DATE:**
PHYSICIAN'S NAME:	**MEDICAID PROVIDER#:**

The prior authorization request must be submitted within 90 days of the therapist evaluation date in accordance with OAC Rule 5101:3-10-16. If request is not submitted within ninety days, a completely new evaluation is required.
Failure to complete this form in its entirety will result in denial of your request for purchase authorization

C. HOME ASSESSMENT FOR POWER WHEELCHAIR:

Submit a written report of a visit to the home assessing the caregiver's ability to properly provide routine maintenance for the power wheelchair: **Long term care facility**		
Specify how/where batteries will be charged:		
Transportation of the power wheelchair – Explain how the power wheelchair will be transported (e.g., by private vehicle, public transit system) when such transport is required:		
Use this area to document accessibility by the power wheelchair to the home, include such information as doorway dimensions and presence or need for special accommodations such as ramps while addressing:		
Home Entrance (Can consumer enter and exit with PWC or POV?) Living Room: Kitchen/Dining Area: Bedroom: Bathroom: Storage: Where will the power wheelchair be stored? How will it be protected from the elements? Other information about the home which may be useful to the reviewer:		
Name of Vendor/Clinician:		
Signature of Vendor/Clinician:		**Signature Date:**
Company:	**Address:**	**Phone:**