



FROM: Scott Partika, Director

To: Ohio Department of Medicaid Clearance Reviewers

SUBJECT: Amendment of OAC Rule 5160-10-16: DMEPOS Wheelchairs

Rule 5160-10-16 of the Ohio Administrative Code (OAC) sets forth coverage and payment policy for wheelchairs.

As a result of systematic review carried out in accordance with Section 106.03 of the Ohio Revised Code, rule 5160-10-16 will be proposed for amendment. Many of the proposed changes stem from efforts to clarify policy language in response to comments from individual providers, internal staff, DME provider association, or from Medicaid managed care organizations (MCOs).

- Several language clarifying changes will be made to policy provisions of OAC rule 5160-10-16.
 - A clarifying statement regarding CRT will be added in relation to customized wheelchairs.
 - Clarifying statements will be added to the definitions of the seating systems.
 - The explanation of an appropriate environment for powered wheelchairs will be clarified.
 - A statement regarding waiver approval will be added.
 - Will add a clarifying statement to the need verification definition.
 - Will add a statement that novelty PMDs are not considered to be medically necessary.
 - A clarifying statement will describe which evaluators will be able to evaluate an individual's particular needs for wheelchairs that do not incorporate CRT.
 - Will remove redundant statements and the labor formula for wheelchair management.

In addition, several improvements will be made to form ODM 03411, which is referenced in the body of the rule.

Questions pertaining to this clearance should be sent to Rules@Medicaid.Ohio.gov.

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To receive notification when ODM original, revise, refile, or final files a rule package please register for Joint Committee on Agency Rules Review's (JCARR) RuleWatch at www.rulewatchohio.gov where an account can be created to be notified of rule actions by the rule number or department.

The main Ohio Department of Medicaid (ODM) web page includes links to valuable information about its services, programs, and rules; the address is <http://www.medicaid.ohio.gov>.

Rule 5160-10-16 | DMEPOS: wheelchairs

(A) Definitions and explanations.

(1) "Basic equipment package" is the following standard set of parts and accessories that come with a wheelchair at the time of purchase:

- (a) A sling or solid seat with back, a captain's chair, or a stadium-style seat;
- (b) Standard casters or wheels with tires;
- (c) Standard armrests;
- (d) Standard front rigging, such as non-elevating legrests with footrests or a footplate;
- (e) Wheel locks or brakes;
- (f) With a power mobility device, motors;
- (g) With a power mobility device, a non-expandable controller;
- (h) With a power mobility device, a battery charger;
- (i) With a power wheelchair, a standard proportional joystick; and
- (j) With a power-operated vehicle, batteries.

(2) "Complex rehabilitation technology (CRT)" is a categorization of individually configured wheelchairs and wheelchair equipment items for which individual evaluation, fitting, configuration, adjustment, or programming is needed to meet the specific medical and functional needs of the user, as well as services related to those products. CRT includes, for example, customized seating systems, adaptive positioning devices, and alternative drive systems (directional interfaces other than a standard joystick). The use of CRT, in and of itself, does not denote a custom wheelchair.

(3) "Custom wheelchair" is a wheelchair that has a customized seating system. A custom wheelchair, therefore, cannot be easily used or adapted for use by another individual.

(4) "Customized seating system" is a wheelchair seat, wheelchair back, or

combination of wheelchair seat and back that has been tailored specifically and permanently to the particular body shape and positioning needs of an individual user. Customization may be achieved by means of molding, contouring, carving, or other forms of fabrication or by the integration of prefabricated components into the wheelchair frame. Items such as seat cushions and other removable positioning aids do not by themselves constitute a customized seating system.

(4) "DMEPOS Fee Schedule" is a list of payment amounts for durable medical equipment, prostheses, orthoses, and supplies published by the centers for medicare and medicaid services (CMS); it is available at <http://www.cms.gov>. The January 2015 revision is the basis for the medicaid payment amounts described in paragraph (E) of this rule.

(5) "Individualized seating system" is a wheelchair seat, wheelchair back, or combination of wheelchair seat and back that has been tailored to the body shape and positioning needs of an individual user by means of installing and configuring prefabricated cushions or other removable positioning aids.

(6) "Medical necessity" is defined in rule 5160-1-01 of the Administrative Code. Wheelchairs and wheelchair parts and accessories need to meet additional criteria in order to be considered medically necessary:

(a) Wheelchairs and wheelchair parts and accessories are generally not necessary nor even useful in the absence of illness, injury, impairment, disability, or other condition that limits ambulation. Therefore, a wheelchair needs to provide mobility to an individual for whom ambulation is not possible, requires the assistance of another person, takes inordinate physical effort, or causes considerable physical discomfort.

(b) A wheelchair also needs to be suited to the purposes and daily routines of the individual using it.

(c) A manual wheelchair needs to provide a level of needed functionality that cannot be achieved with an assistive device such as a cane, a crutch or crutches, or a walker.

(d) A power mobility device (PMD) needs to provide a level of needed functionality that cannot be achieved with a manual wheelchair.

~~(e) A PMD needs to be functional in the environment in which it is used. The individual (or someone assisting the individual) needs to have the ability to~~

~~take proper care of the PMD, the individual's place of residence needs to be accessible and have adequate electrical service, transportation of the PMD needs to be available as necessary, and there needs to be sufficient protection for the PMD from the elements. The place of residence is considered to be accessible only if the individual will be able to use the PMD without assistance to enter and leave the residence and to move easily about the main living space (which is used for purposes such as food preparation, eating, sleeping, personal hygiene, and relaxation).~~

(e) A PMD needs to be functional in the environment in which it is used. To verify that the environment is appropriate and accessible by wheelchair, a home visit will be made by a person qualified to make this determination. The home visit will be documented via report on form ODM 03411, "Certificate of Medical Necessity: Wheelchairs". The report will verify that the individual (or someone assisting the individual) has the ability to take proper care of the PMD. The report will verify that the individual's place of residence has sufficient space to both safely operate and store the PMD; This includes having adequate electrical service. The place of residence is considered to be accessible only if the individual will be able to use the PMD without any more assistance than what was determined in the report. The individual will be able to easily enter and leave the residence, and to easily move throughout the living room, kitchen/eating area, a full bathroom, and the individual's bedroom/sleeping area. Transportation of the PMD needs to be available as necessary.

(i) A PMD will not be authorized if any the above conditions are not met, unless verification is provided that access to all the above areas is not necessary or because accommodations have been made to address the individual's activities of daily living.

(ii) If an individual enrolled in a home and community-based services (HCBS) waiver program requires a home modification to qualify for a PMD, but the HCPS waiver program will not make the appropriate modifications until the individual has received their PMD, ODM may approve the PMD based on verification that the HCBS waiver program will make the required home modifications.

(f) A customized seating system needs to enable an individual to sit (or recline, as appropriate) for long periods of time, provide postural support to permit functional activities, or reduce pressure on the body to a degree that cannot be

achieved with items such as a standard wheelchair seat, an individualized seating system (e.g., a prefabricated seat cushion or other removable positioning aid or combination of positioning aids), or a spinal orthotic device.

(7) "Need verification" is a process, similar to prior authorization, by which the department determines whether to make payment for the repair of a wheelchair part or accessory that exceeds the established frequency guideline. The process does not require a prescription from a prescriber, only a completed CMN from the rendering provider describing the repair need. One purpose of need verification is to enable the department to consider whether the purchase of a new piece of equipment might be more cost-effective than continued repair.

(8) "Power mobility device (PMD)" is a collective term for a power wheelchair or a power-operated vehicle (POV, commonly referred to as a "scooter"). Each PMD is classified on the basis of performance into one of eight groups developed under the auspices of CMS:

- (a) Group one power-operated vehicles;
- (b) Group two power-operated vehicles;
- (c) Group one power wheelchairs;
- (d) Group two power wheelchairs;
- (e) Group three power wheelchairs;
- (f) Group four power wheelchairs;
- (g) Group five power wheelchairs; and
- (h) Power mobility devices not otherwise classified.

(9) "Novelty PMDs" such as motorized chairs, travel size, and wheelchair for convenience, are not considered to be medically necessary and will not be considered.

(10) "Routine maintenance" of a wheelchair is any upkeep that is necessary to maintain optimum functioning of the equipment and that does not need a skilled or trained technician to perform.

(11) "Wheelchair" is a collective term for a manual wheelchair or a power mobility device.

(B) Providers.

(1) Prescribing providers. Eligible medicaid providers of the following types, acting within their scope of practice, may certify the medical necessity of a wheelchair:

- (a) A physician;
- (b) An advanced practice registered nurse with a relevant specialty;
- (c) A physician assistant; or
- (d) A podiatrist.

(2) Evaluators. The following professionals may evaluate an individual's particular needs:

- (a) For wheelchairs incorporating CRT, a physiatrist, orthopedic surgeon, neurologist, physical therapist, or occupational therapist; or
- (b) For wheelchairs not incorporating CRT, a physiatrist, orthopedic surgeon, neurologist, a physician, physical therapist, or occupational therapist.

(3) Rendering providers. The following eligible providers may furnish a wheelchair, part, or accessory or may render a related service:

- (a) For manual wheelchairs without CRT, a provider enrolled as a basic durable medical equipment (DME) supplier; or
- (b) For PMDs and CRT, a provider enrolled as a specialized DME supplier.

(4) Billing providers. The following eligible providers may receive medicaid payment for submitting a claim for a wheelchair, part, accessory, or related service:

- (a) For manual wheelchairs without CRT, a provider enrolled as a basic DME supplier; or
- (b) For PMDs and CRT, a provider enrolled as a specialized DME supplier.

(C) Coverage.

(1) Principles.

(a) The medical necessity of a wheelchair needs to be determined before the department will make payment. For a wheelchair purchased by the department, this necessity is documented on form ODM 03411, "Certificate of Medical Necessity: Wheelchairs" (~~rev. 7/2021~~). The medical necessity of a wheelchair that has not been purchased by the department is documented either on this certificate of medical necessity (CMN) or on an equivalent form.

(b) If more than one type of wheelchair will meet an individual's needs and satisfy the criteria of medical necessity, then the maximum payment amount is the lowest of the respective costs, regardless of which wheelchair is supplied.

(c) The provision of or payment for the purchase, repair, or rental of a medically necessary non-custom wheelchair for a resident of a long-term care facility (LTCF) is the responsibility of the LTCF. This responsibility holds even if the wheelchair incorporates CRT other than a customized seating system. In turn, the LTCF receives medicaid payment in accordance with Chapter 5160-3 of the Administrative Code. Therefore, claims submitted to the department by wheelchair suppliers for the purchase, repair, or rental of non-custom wheelchairs furnished to LTCF residents will be denied.

(d) A custom PMD, including power functions, is not precluded from being provided to an individual in a LTCF solely for being a resident of a LTCF. The availability of LTCF staff should not be considered when determining the necessity of a PMD. The same criteria that are applied to an individual not residing in a LTCF should be applied to an individual residing in a LTCF. If an individual residing in a LTCF has met the policy criteria for a power wheelchair, it should be provided.

(2) Purchase.

(a) Custom wheelchairs for individuals living in a LTCF and wheelchairs for individuals not living in a LTCF. Prior authorization (PA) is needed, and a face-to-face evaluation of need has to be performed by a prescribing provider ~~not earlier than~~ within one hundred eighty days ~~before the submission of~~ submitting the PA request.

(b) Constraints and limitations.

(i) The purchase of a wheelchair includes the basic equipment package, delivery, setup, instruction and training in use, and adjustments or minor modifications. No separate payment is made for these items. Payment for other parts or accessories, either parts or accessories that are substituted for individual items in the basic equipment package or parts or accessories outside the basic equipment package that are added after a wheelchair is purchased, is subject to PA.

(ii) Authorization will not be given for the purchase of more than one wheelchair for concurrent use by an individual. An exception to this restriction may be made if it can be satisfactorily demonstrated that having a second wheelchair, such as a manual wheelchair in addition to a PMD, significantly improves an individual's mobility and is cost-effective.

(3) Repair, including replacement of existing parts or accessories.

(a) Custom wheelchairs for individuals living in a LTCF and wheelchairs for individuals not living in a LTCF. The repair of a component such as a frame, seating system, motor, drive system, or battery is subject to need verification. No verification is needed for the repair of a wear item, such as a caster bearing, tire, arm pad).

(b) Constraints and limitations.

(i) For a wheelchair not purchased by the department, submission of documentation of the medical necessity of the wheelchair itself is needed for the initial repair but not for subsequent repairs. The determination that a wheelchair not purchased by the department is medically necessary does not indicate that the wheelchair itself would be authorized for purchase.

(ii) Payment is not permitted for temporary replacement equipment (a "loaner wheelchair") provided while an individual's wheelchair is being repaired.

(iii) No payment is made for routine maintenance.

(4) Rental.

(a) Custom manual wheelchairs. PA is needed.

(b) Non-custom manual wheelchairs for individuals not living in a LTCF. No PA is needed for the first three months. PA is needed for rental periods after the first three months.

(c) PMDs. PA is needed.

(d) Constraints and limitations.

(i) Payment will not be made for the rental of more than one wheelchair per month for an individual.

(ii) Payment for rental is all-inclusive; no separate payment is made for any other wheelchair-related items.

(iii) During a rental period and for ninety days afterward, all rental amounts paid are applied toward purchase.

(iv) The total of the rental amounts cannot exceed the purchase amount.

(5) Evaluation and management.

(a) An evaluator may receive payment for determining an individual's needs for a wheelchair. Not more than one payment will be made per wheelchair per individual.

(b) Payment includes all services rendered by the evaluator, including evaluation, product selection, confirmation at delivery, and follow-up.

(D) Additional constraints and limitations.

(1) After delivery, the supplier needs to maintain documentary evidence that the following statements are true concerning a wheelchair and any related accessories:

(a) They were delivered to the individual for whom they were prescribed;

(b) They are consistent with the items described in the CMN; and

(c) They correspond exactly to the items listed on the submitted claim.

(2) Claim payments for which there is insufficient documentation are subject to recovery.

(3) A PA request needs to specify all relevant information (e.g., HCPCS code, manufacturer, model). A PA request for repair needs to include the serial number of the equipment and a complete itemization of parts and estimated labor needed.

(4) When an authorization specifies a manufacturer, model, part number, or other information identifying a particular item, then a supplier may provide and subsequently submit claims only for the specified item.

(5) Payment will not be authorized for a wheelchair to be used by an individual younger than one year. For a child one year of age or older whose needs are not met by an adult-sized wheelchair, consideration for authorization will be given only to wheelchairs that accommodate growth, unless there is a more appropriate, cost-effective, medically necessary alternative available. Payment may be made for additional parts needed to "grow" a wheelchair if the combined cost of the parts and related labor is less than the cost of a new wheelchair.

(6) Payment will not be authorized for wheelchairs, parts, accessories, or modifications whose primary application is leisure or recreational activities.

(7) Payment will not be authorized for a PMD intended exclusively for outdoor use.

(8) A wheelchair purchased by medicaid is the property of the individual for whom it was prescribed.

(E) Claim payment.

(1) As of the effective date of this rule, the payment amount is established as the lesser of the submitted charge or the applicable medicaid maximum from the following list:

(a) For purchase of a covered new wheelchair, part, or accessory, ninety per cent of the allowed amount listed for Ohio on the "DMEPOS Fee Schedule";

(b) For purchase of a covered group four power wheelchair for which there is no medicare allowed amount, one hundred ten per cent of the medicaid maximum payment amount allowed for purchase of the most closely corresponding covered group three power wheelchair;

(c) For purchase of any other covered wheelchair, new part, or new accessory for which there is no medicare allowed amount, payment will be determined by report prior authorization pricing;

(d) For purchase of a covered wheelchair, part, or accessory that has been previously used but remains in good working order, fifty per cent of the medicaid maximum payment amount allowed for purchase of a comparable new wheelchair, part, or accessory;

(e) For monthly rental of a covered wheelchair to which rental applies, ten per cent of the medicaid maximum payment amount allowed for purchase;

(f) For performance of ~~an evaluation and~~ wheelchair management related services, eighty per cent of the amount established by the medicare physician fee schedule.~~;~~~~or~~

(g) For labor provided for a covered repair or covered maintenance, the result L obtained by the formula $L = ([W + B] P + M) A 0.25$.

(i) ~~L is the medicaid maximum payment amount for labor, reported in fifteen-minute units.~~

(ii) ~~W is the hourly median wage for medical equipment repairers in Ohio reported by the United States bureau of labor statistics (available at <http://www.bls.gov/oes/>). (The initial wage figure used was from May 2014.)~~

(iii) ~~B is hourly employee-related expenses such as benefits, calculated as thirty-five per cent of wages.~~

(iv) ~~P is a productivity adjustment factor, defined as the ratio of the number of total work hours per day (specified as eight) to the number of available productive work hours per day (specified as six and a half).~~

(v) ~~M is an hourly mileage allowance, defined as the ratio of the daily mileage allowance to the number of available productive work hours per day. The daily mileage allowance is the product of the average travel speed (specified as thirty-five miles per hour), the average total travel time (specified as one hour and fifteen minutes), and the federal standard mileage rate for business (available at <http://www.irs.gov>). (The initial standard mileage rate used was for 2015.)~~

(vi) ~~A is an administrative cost factor, specified as one hundred ten per cent.~~

(2) After the effective date of this rule, if the medicare amount for an item or service becomes less than the current medicaid maximum payment amount, then the medicaid maximum payment amounts related to that item or service are reestablished on the basis of the new medicare amount.

(3) After the effective date of this rule, if updates to the medicare wheelchair management ~~median hourly wage or the federal standard mileage rate~~ would cause a variance of at least five per cent in the maximum payment amount for labor, then the maximum payment amount is reestablished on the basis of the updated figures.

(4) The payment provisions of this rule supersede entries in appendix DD to rule 5160-1-60 of the Administrative Code that pertain to wheelchairs, parts, accessories, or related services.

Ohio Department of Medicaid
CERTIFICATE OF MEDICAL NECESSITY: WHEELCHAIRS

Only applicable sections of this form need to be completed and submitted.

	Section					Repair
	A	B	C	D	E	
Purchase/rental authorization of a manual wheelchair	X	X				
Purchase/rental authorization of a power mobility device	X		X			
Purchase authorization of additional parts or accessories not included in the basic equipment package	X			X		
Purchase authorization of custom seating	X				X	
Need verification of a repair						X

EXAMPLE:

<i>Purchase of a power wheelchair with an expandable controller, a head array, and custom seating</i>	X		X	X	X	
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The prescribing provider or qualified evaluator must furnish all clinical information (e.g., diagnosis, functional assessment, recommendation); the provider may transcribe this information. The provider may furnish technical specifications (e.g., personal identifying information, HCPCS code, serial number, warranty period). Signatures and signature information must be completed by the appropriate authority.

Section A – Identifying Information

Customer	Evaluator	Provider
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI, if applicable, or license number	NPI
Height (in.) Weight (lbs.)	Telephone number	
Address* ☐ Long-term care facility	*Note: Provision of or payment for a non-custom wheelchair used by a resident of a long-term care facility (LTCF) is the responsibility of the LTCF.	

Clinical Indicators

Diagnosis code(s)	Prognosis
Number of hours per day of wheelchair use, current or estimated	Estimated length of need
Most important clinical or functional factors to consider 1. 2. 3.	

False certification constitutes Medicaid fraud.

Name of individual _____ Medicaid ID number _____

Section B – Recommendation for a Manual Wheelchair

☐ Purchase ☐ Rental for Months ☐ Modification ☐ Custom Wheelchair

Requested dates of rental From ____/____/____ to ____/____/____		Prior dates of rental From ____/____/____ to ____/____/____
Description of capacity limitations (e.g., of cardiopulmonary function, neuromuscular function, muscle tone, range of motion, strength, stamina, balance, coordination) necessitating a manual wheelchair		
☐ This information is attached in another format.		
Current wheelchair — Manufacturer, make, model, age		
Explanation of features needed to address specific functional needs (e.g., low seat, heavy duty frame, lightweight frame, capacity to "grow" with a child)		
☐ This information is attached in another format.		
Specific item recommended [Parts and accessories not included in the basic equipment package should be listed in Section D.] Suggested format: <i>Quantity; HCPCS code; manufacturer; model; description; condition (new, used)</i>		
Warranty period		
☐ This information is attached in another format.		
I certify that a manual wheelchair will provide a level of functionality for this individual that cannot be achieved with an assistive device such as a cane, a crutch or crutches, or a walker.		
Signature of evaluator/prescriber	Date of evaluation	Date of signature (if different)

Attestation of Medical Necessity

<i>I hereby attest that the certification information above and the following statements are all true, correct, and complete.</i> <i>Ambulation is not possible, takes inordinate physical effort, or causes considerable physical discomfort.</i> <i>The recommended wheelchair, part, or accessory is suited to the purposes and daily routines of the individual.</i>		
Signature of prescriber	NPI	Date of signature

False certification constitutes Medicaid fraud.

Name of individual _____ Medicaid ID number _____

Section C – Recommendation for a Power Mobility Device

☐ Purchase ☐ Rental for ____ Months ☐ Modification ☐ Custom Wheelchair

Requested dates of rental From ____/____/____ to ____/____/____	Prior dates of rental From ____/____/____ to ____/____/____														
"Power mobility device (PMD)" is a collective term for a power wheelchair or a power-operated vehicle (POV, commonly referred to as a "scooter"). Description of capacity limitations (e.g., of cardiopulmonary function, neuromuscular function, muscle tone, range of motion, strength, stamina, balance, coordination) necessitating a PMD ☐ This information is attached in another format.															
Current mobility device — Manufacturer, make, model, age															
Functional description of the individual MARK ALL STATEMENTS ABOUT THE INDIVIDUAL THAT APPLY. <table border="0"><tr><td>☐ Has demonstrated the ability to transfer safely to and from a POV.</td><td>☐ Currently weighs less than 125 pounds and is expected to grow.</td></tr><tr><td>☐ Has demonstrated the ability to operate a POV tiller steering system safely.</td><td>☐ May need adjustment or minimal configuration of a standard seat (e.g., size, back angle).</td></tr><tr><td>☐ Has demonstrated the ability to maintain postural stability and position on a POV.</td><td>☐ Needs a standard seat that will accommodate the following type of cushion: _____.</td></tr><tr><td>☐ Will use the PMD intermittently only in level, smooth, unobstructed environments.</td><td>☐ Needs a powered tilting or reclining seat for the following therapeutic or functional reasons: _____.</td></tr><tr><td>☐ Travels not only on smooth, level surfaces (tile, low-pile carpet, pavement) but also over thick carpet, gravel, grass, uneven terrain, high thresholds or surface transitions, steep ramps, hills, curbs, or other obstacles.</td><td>☐ Needs the following drive control interface (other than a standard joystick): _____.</td></tr><tr><td>☐ Travels over longer distances (e.g., across school campus, to and from bus stops) or over extended periods of time without recharging the battery.</td><td>☐ Will use two or more power accessories (e.g., power elevating legrests, power seat elevation, peripheral devices, ventilator).</td></tr><tr><td>☐ Engages in activities (e.g., running errands, crossing intersections) that may call for increased speed for safe and efficient travel.</td><td>☐ Will have additional needs in the near future that can be accommodated by the recommended PMD.</td></tr></table> ☐ This information is attached in another format.		☐ Has demonstrated the ability to transfer safely to and from a POV.	☐ Currently weighs less than 125 pounds and is expected to grow.	☐ Has demonstrated the ability to operate a POV tiller steering system safely.	☐ May need adjustment or minimal configuration of a standard seat (e.g., size, back angle).	☐ Has demonstrated the ability to maintain postural stability and position on a POV.	☐ Needs a standard seat that will accommodate the following type of cushion: _____.	☐ Will use the PMD intermittently only in level, smooth, unobstructed environments.	☐ Needs a powered tilting or reclining seat for the following therapeutic or functional reasons: _____.	☐ Travels not only on smooth, level surfaces (tile, low-pile carpet, pavement) but also over thick carpet, gravel, grass, uneven terrain, high thresholds or surface transitions, steep ramps, hills, curbs, or other obstacles.	☐ Needs the following drive control interface (other than a standard joystick): _____.	☐ Travels over longer distances (e.g., across school campus, to and from bus stops) or over extended periods of time without recharging the battery.	☐ Will use two or more power accessories (e.g., power elevating legrests, power seat elevation, peripheral devices, ventilator).	☐ Engages in activities (e.g., running errands, crossing intersections) that may call for increased speed for safe and efficient travel.	☐ Will have additional needs in the near future that can be accommodated by the recommended PMD.
☐ Has demonstrated the ability to transfer safely to and from a POV.	☐ Currently weighs less than 125 pounds and is expected to grow.														
☐ Has demonstrated the ability to operate a POV tiller steering system safely.	☐ May need adjustment or minimal configuration of a standard seat (e.g., size, back angle).														
☐ Has demonstrated the ability to maintain postural stability and position on a POV.	☐ Needs a standard seat that will accommodate the following type of cushion: _____.														
☐ Will use the PMD intermittently only in level, smooth, unobstructed environments.	☐ Needs a powered tilting or reclining seat for the following therapeutic or functional reasons: _____.														
☐ Travels not only on smooth, level surfaces (tile, low-pile carpet, pavement) but also over thick carpet, gravel, grass, uneven terrain, high thresholds or surface transitions, steep ramps, hills, curbs, or other obstacles.	☐ Needs the following drive control interface (other than a standard joystick): _____.														
☐ Travels over longer distances (e.g., across school campus, to and from bus stops) or over extended periods of time without recharging the battery.	☐ Will use two or more power accessories (e.g., power elevating legrests, power seat elevation, peripheral devices, ventilator).														
☐ Engages in activities (e.g., running errands, crossing intersections) that may call for increased speed for safe and efficient travel.	☐ Will have additional needs in the near future that can be accommodated by the recommended PMD.														

False certification constitutes Medicaid fraud.

Name of individual _____ Medicaid ID number _____

Continued on the next page

Section C – Recommendation for a Power Mobility Device, continued

Specific item recommended [Parts and accessories not included in the basic equipment package should be listed in Section D.] Suggested format: <i>Quantity; HCPCS code; manufacturer; model; description; condition (new, used)</i>		
Warranty period ☐ This information is attached in another format.		
Explanation, if appropriate, of why a PMD with a different group classification (e.g., group 2 power wheelchair instead of group 3 power wheelchair) would not be sufficient to meet the individual's needs		
Other comments		
Signature of evaluator/prescriber	Date of evaluation	Date of signature (if different)

Attestation of Medical Necessity

<i>I hereby attest that the certification information above and the following statements are all true, correct, and complete.</i> <i>Ambulation is not possible, takes inordinate physical effort, or causes considerable physical discomfort.</i> <i>The recommended wheelchair, part, or accessory is suited to the purposes and daily routines of the individual.</i>		
Signature of prescriber	NPI	Date of signature

False certification constitutes Medicaid fraud.

Name of individual _____ Medicaid ID number _____

Section C– Recommendation for a Power Mobility Device, continued

Home assessment

This section verifies that a home visit was completed to determine if the residence is appropriate for a PMD.

A PMD needs to be functional in the environment in which it is used.

A residence will be considered accessible only if the consumer can enter, leave, and move around the residence by PMD without assistance.

- ☐ The individual can enter/exit the residence ☐ The individual cannot enter/exit the residence
- ☐ Ramp is not required ☐ Appropriate ramp exists ☐ Ramp is required but doesn't exist
- ☐ Indoor stairs are not required to reach residence ☐ Elevator can take wheelchair to the individual's floor
- ☐ Internal stairs prevent wheelchair from accessing residence
- ☐ Door width is appropriate for access Door width: _____ inches Wheelchair width: _____ inches
- ☐ Access will be available after home modification is complete through waiver services

Comments _____

- ☐ All areas of the main living space are available ☐ All areas of the main living space are not available
- ☐ Living room is accessible ☐ Door width: _____ inches ☐ No door; archway, cased opening
- ☐ Kitchen/dining area is accessible ☐ Door width: _____ inches ☐ No door; archway, cased opening
- ☐ Bedroom is accessible ☐ Door width: _____ inches ☐ No door; archway, cased opening
- ☐ Bathroom is accessible ☐ Door width: _____ inches

Comments _____

Specify how/where the batteries will be charged: _____

How will the PMD be transported when required (e.g., public, private vehicle): _____

Where will the PMD be stored? How will it be protected from the elements? _____

Other information that may be useful in completing the review:

☐ This information is attached in another format.

Attestation [This section must be signed by the home visit evaluator.]

I hereby attest that the certification information home visit information is true, correct, and complete.

Printed name and title of evaluator

Signature of evaluator

Signature date

Telephone number

Attestation [This section must be signed by the prescriber.]

I hereby attest that the certification information home visit information is true, correct, and complete.

Signature of prescriber

Date of signature

False certification constitutes Medicaid fraud.

Name of individual _____ Medicaid ID number _____

Section D – Parts and Accessories Not Included in the Basic Equipment Package

Specific item recommended <i>Suggested format: Quantity; HCPCS code; manufacturer; model; description; condition (new, used); interrelationship (if any) with other parts and accessories; explanation of why the item is necessary for this particular individual or why the frequency limit is exceeded</i>	
Warranty period ☐ This information is attached in another format.	
Usual and customary charge for each "miscellaneous" or "not otherwise specified" item	
Other comments	
Signature of evaluator/prescriber	Date of signature

Attestation of Medical Necessity

<i>I hereby attest that the certification information above and the following statements are all true, correct, and complete.</i> <i>Ambulation is not possible, takes inordinate physical effort, or causes considerable physical discomfort.</i> <i>The recommended wheelchair, part, or accessory is suited to the purposes and daily routines of the individual.</i>		
Signature of prescriber	NPI	Date of signature

False certification constitutes Medicaid fraud.

Name of individual _____ Medicaid ID number _____

Section E – Custom Seating

Problems necessitating a custom seating system

MARK ALL AREAS THAT APPLY.

- | | |
|---|--|
| ☐ 1. Sitting posture/balance | ☐ 9. Range of motion |
| ☐ 2. Head position | ☐ 10. Upper extremity function |
| ☐ 3. Shoulder/scapula position | ☐ 11. Lower extremity function |
| ☐ 4. Spinal curvature
☐ Scoliosis ☐ Lordosis ☐ Kyphosis | ☐ 12. Skin condition/integrity (e.g., susceptibility to decubitus ulcers) |
| ☐ 5. Pelvic displacement
☐ Sagittal tilt ☐ Lateral tilt ☐ Rotation | ☐ 13. Sensation |
| ☐ 6. Leg/hip/knee/foot position (e.g., dislocation, contracture) | ☐ 14. Ability to shift body weight |
| ☐ 7. Other skeletal structure _____ | ☐ 15. Bowel or bladder function |
| ☐ 8. Muscle tone
Score (e.g., on the Modified Ashworth Scale): _____ | ☐ 16. Other consideration _____ |

Explanation of the problem, how a custom seating system will address it, and why the individual's needs (e.g., for prolonged sitting, postural support, or pressure reduction) cannot be met adequately with a standard seat, prefabricated seat cushion, removable positioning accessory or combination of accessories, spinal orthosis, or other device

☐ This information is attached in another format.

If the individual currently has a spinal orthosis, explanation of why both a spinal orthosis and a seating system are required

Full description of the recommended custom seating system, including fabrication or construction method

☐ This information is attached in another format.

Signature of evaluator/prescriber

Date of evaluation

Date of signature (if different)

Technical specification of the recommended custom seating system, including relevant HCPCS codes and estimated cost

☐ This information is attached in another format.

Name of provider representative

Signature

Date of signature

Attestation of Medical Necessity

I hereby attest that the certification information above and the following statements are all true, correct, and complete.

Ambulation is not possible, takes inordinate physical effort, or causes considerable physical discomfort.

The recommended wheelchair, part, or accessory is suited to the purposes and daily routines of the individual.

Signature of prescriber

NPI

Date of signature

False certification constitutes Medicaid fraud.

CERTIFICATE OF MEDICAL NECESSITY: WHEELCHAIRS

This page is to be completed by the provider.

Repair

Customer name	Medicaid ID number
Provider name	Medicaid provider number
Wheelchair — manufacturer, model, serial number	
Date on which the equipment/part/accessory to be repaired was originally delivered or installed	
Reason for repair, including a description of the wear, damage, or malfunction	
Description, including dates, of previous repairs made to this same equipment/part/accessory	
Parts needed to complete repair Suggested format: <i>Quantity; HCPCS code; manufacturer; model; part number; serial number; condition (new, used); warranty period</i>	
Estimated labor time needed	
Other comments	
☐ This information is attached in another format.	

Attestation

<i>I hereby attest that the parts and labor described above are necessary and represent the most cost-effective means of completing the repair.</i>		
Name of provider representative	Signature	Date of signature

False certification constitutes Medicaid fraud.