Connecticut Medical Assistance Program Provider Bulletin 2017-36
Policy Transmittal 2017-11 June 2017

Roderick L. Bremby, Commissioner

Effective Date: May 1, 2017
Contact: Ginny Mahoney @ 860-424-5145

TO: Physicians, Advanced Practice Registered Nurses (APRNs), Physician Assistants (PAs), Medical Equipment, Devices and Supplies (MEDS) Providers, Occupational Therapists, Physical Therapists, Skilled Nursing Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)

RE: Corrected and Updated Policy Regarding Wheeled Mobility Device Policy, Forms and Related Documents

This policy transmittal replaces and supersedes provider bulletin PB 2017-12 "Wheeled Mobility Device Policy, Forms and Related Documents" which was issued by the Department of Social Services (DSS) in April 2017.

Effective on and after May 1, 2017, all evaluations completed by an occupational or physical therapist must be completed on an updated Wheeled Mobility Device Letter of Medical Necessity (LMN) Form. The bulletin has been revised with modest updates to the language in the previous bulletin and also makes two corrections:

1. For wheelchair modifications requested for HUSKY Health members living in the community, the medical progress note can be made by the member's primary care physician, physician assistant, APRN or relevant qualified specialist.

2. For wheelchair modifications requested for HUSKY Health members who reside in nursing facilities and qualify for a custom wheelchair, the medical progress note must be dated **no later** than 60 days prior to the wheelchair modification request date.

This bulletin also reminds providers of the requirements for completing the LMN form and the Accessibility Survey. Both of these forms can be found at the following link: http://www.huskyhealthct.org/providers/forms.html#.
Updates to the Wheeled Mobility Device Guidelines Instructions reflect changes in the requirements for the completion of the Wheeled Mobility Device (LMN) and Accessibility Survey. Based upon extensive dialogue in a collaborative workgroup whose membership included occupational and physical therapists, CMAP durable medical equipment (DME) provider representatives, consumer members, and representatives from DSS and Community Health Network of Connecticut (CHNCT), the LMN form was revised to improve efficiency and terminology.

Wheeled Mobility Device Letter of Medical Necessity Form

The Department will accept an LMN form only if it is completed **solely** by a licensed evaluating therapist who is independent from the DME provider. Please note that the fields in the LMN form that are marked with an asterisk can be completed by the evaluating Assistive Technology Professional (ATP) who is affiliated with the DME provider.

To enable DSS to determine if requested equipment is medically necessary in accordance with section 17b-259b of the Connecticut General Statutes, the following criteria apply when completing the LMN form:

1. Only a licensed evaluating therapist who is independent from the DME provider is permitted to complete the clinical aspect of the form for each individual request. He or she must provide a clinical rationale for the requested components. These fields require an independent clinical assessment, which is why they must be completed by the licensed

evaluating therapist, and not by an individual affiliated with a DME provider.

Only the fields marked with an asterisk (*) may be completed by the evaluating ATP who is affiliated with the DME provider. The ATP is only permitted to provide technical rationales for hardware and electronic components.

All other personnel affiliated with the DME provider are prohibited from completing the LMN form. Information under the signature sections of the LMN form state the requirements for each of the signature fields. The first signature field is for the licensed evaluating therapist who is independent from the DME provider, and certifies by signing where indicated that he or she alone completed the form. The second signature field is for the evaluating ATP who is affiliated with the DME provider, certifying by signing where designated that he or she completed **only** the sections marked with an asterisk (*).

2. Pre-populated forms, generic rationales, and/or incomplete sections of the form are not acceptable. The documentation for wheelchair components must be related to each member's individual medical needs.

DSS will deny prior authorization (PA) requests for lack of information (LOI) when providers do not adhere to the requirements described above, and also in situations in which DSS is unable to obtain needed clinical information.

The evaluating therapist should forward the completed form to the DME provider and to CHNCT by fax, secure email, or by mail, as described in the Wheeled Mobility Device Guidelines Instructions, which are posted at: http://www.huskyhealthct.org/providers/forms.html#.

Accessibility Survey Requirements for In-Home Evaluations

DSS has also become aware that there are inconsistencies in how the Wheeled Mobility Device Accessibility Survey form is being completed. The Accessibility Survey form has, therefore, been updated to ensure correct use of the form, consistent with the Wheeled Mobility Device guidelines.

The ATP, or designee from the DME provider, who submits the PA is responsible for completing an in-home assessment and an on-site survey in order to determine the size and type of wheelchair that will fit in the home. This assessment and survey must determine that the wheelchair is capable of fitting through bathrooms, doorways, hallways, etc. and that it will meet the needs of the member for whom the PA request is being submitted.

The in-home assessment must be completed by the ATP or DME provider designee and must take place in the HUSKY Health member's home. If the member is being evaluated in a clinic setting, the Accessibility Survey must be completed **after** an assessment is completed in the member's home. The Accessibility Survey Form must be signed by the DME provider and the member or his or her designated representative. By signing the form, the DME provider certifies that he or she performed an in-home assessment, with the requested wheelchair or similar wheelchair with projected measurements, and that it fits in all areas of the home **and** meets the individual's mobility-related Activities of Daily Living needs. Incomplete forms are not acceptable.

Both of these requirements are effective for any evaluations completed on and after May 1, 2017.

Repairs/Modifications

Please refer to Provider Bulletin 2016-74 for Durable Medical Equipment (DME) Fee Schedule Changes to Repairs and Modifications to Customized Wheelchairs.

The DME provider must verify the codes on the DSS Fee Schedule to determine which components require prior authorization for repairs (NU RB) or modifications (NU KA).

All of the following documentation is required for custom wheelchair **repairs** requiring PA:

1. Completed PA request form or online portal submission;
2. Prescription from the ordering physician, PA or APRN, which is valid for two (2) years from the original purchase of the wheeled mobility device;
3. Technician report indicating which item(s) require(s) repair and the reason for the part repair/replacement;
4. DME provider quotation, including codes, manufacturer's suggested retail price (MSRP) pricing and allowable pricing; and
5. Manufacturer quotations as outlined in the DSS MEDS Pricing Policy.

All of the following documentation is required for custom wheelchairs **modifications** for components requiring PA:

1. Completed PA request form or online portal submission;
2. Prescription from the ordering physician, PA or APRN as outlined in the Wheeled Mobility Policy on the HUSKY Health Web site;
3. Updated clinical notes from the member's primary care provider;
4. DME provider quotation, including codes, MSRP pricing and allowable pricing;
5. Manufacturer quotations as outlined in the DSS MEDS Pricing Policy; and
6. Clinical documentation from the evaluating physical/occupational therapist as outlined below.

Clinical Documentation Requirements for Custom Wheelchair Modifications

All modifications require a new prescription from the physician, APRN or PA. Modifications cannot be billed as repairs.

The following documentation is required for wheelchair modifications requested for HUSKY Health members living in the community:

- A medical progress note from the member's primary care physician, physician assistant or APRN or relevant qualified specialist completed, not more than 6 months prior to the wheelchair modification request date; and
  - For modifications requested **less than 6 months** after the date of custom wheelchair delivery: an addendum to the initial wheelchair PA request, written by the licensed evaluating therapist, that documents changes in the member's medical condition, changes in functional needs and capabilities and clinical justification for each component outlined in the request; and
  - For modifications requested **more than 6 months** after the date of custom wheelchair delivery: a fully completed Wheeled Letter of Medical Necessity Form.

The following documentation is required for wheelchair modifications requested for HUSKY Health members who previously qualified for a custom wheelchair under Sec. *17-134d-46* of the Regulations of Connecticut State Agencies, Customized Wheelchairs in Nursing Facilities:

- A medical progress note with a date no greater than 60 days before the wheelchair modification request date; and
  - For modifications requested **less than 6 months** after the date of custom wheelchair delivery: a documentation addendum, written by the licensed evaluating therapist, that documents changes in the member's medical condition, changes in functional needs/capabilities and clinical justification for each component outlined in the request; and
  - For modifications requested **more than 6 months** after the date of custom wheelchair delivery: A fully completed Wheeled Letter of Medical Necessity Form.

Physiatrist evaluations are not required for wheelchair modifications that cost less than $1,000.00. As outlined in PB 2009-55, any modification priced at $1,000.00 or more requires the signature of the involved physiatrist or orthopedist, in addition to a therapist, attending physician and nurse, on the W-628 Form.

For questions regarding the PA process, please contact CHNCT at 1-800-440-5071, between the hours of 8:00 a.m. to 6:00 p.m.

Distribution: This policy transmittal is being distributed to providers of the Connecticut Medical Assistance Program by DXC Technology.

Responsible Unit: DSS, Division of Health Services, Medical Policy and Regulations, Ginny Mahoney, Policy Consultant (860) 424-5145

Date Issued: June 2017