Connecticut Medical Assistance Program Provider Bulletin 2017-12
Policy Transmittal 2017-07 April 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: Wheeled Mobility Device Policy, Forms and Related Documents

The purpose of this policy transmittal is to notify enrolled Connecticut Medical Assistance Program (CMAP) medical (physicians, APRNs, PAs, occupational therapists and physical therapists) and MEDS providers with revisions to the Wheeled Mobility Device Policy Guidelines and related forms. Effective on or after May 1, 2017, all evaluations completed by an occupational or physical therapist will need to be completed on the updated Wheeled Mobility Device Letter of Medical Necessity Form (LMN form).

This bulletin also reminds providers of the requirements for completing the LMN form and the Accessibility Survey, which both can be found at the following link: http://www.huskyhealthct.org/providers/provider_manual.html#

Updates in the Wheeled Mobility Device Guidelines Instructions reflect changes in the requirements for the completion of the LMN form and Accessibility Survey.

Based upon extensive dialogue in a collaborative workgroup that included participation of occupational and physical therapists, CMAP durable medical equipment (DME) provider representatives, consumer members, and representatives from the Department of Social Services (DSS) and Community Health Network of Connecticut (CHNCT), the content of the LMN form was revised to improve efficiency and terminology.

Wheeled Mobility Device Letter of Medical Necessity Form

The Department will only accept a LMN form that is completed **solely** by a licensed evaluating therapist, with the exception that the fields marked with an asterisk may be completed by the evaluating Assistive Technology Professional (ATP).

To enable the Department to determine if requested equipment is medically necessary in accordance with section 17b-259b of the Connecticut General Statutes, the following criteria must be applied when completing this form:

1. Only the licensed evaluating therapist is permitted to complete the clinical aspect of the form for each individual request and 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. 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 is for the licensed evaluating therapist, which certifies that he or she alone completed the form by signing where indicated. The second signature is for

the evaluating ATP, which certifies that he or she completed **only** the sections marked with an asterisks (*) by signing where designated.

2. A form not exclusively completed by the evaluating licensed therapist with the exception of the fields marked with an asterisk (*), will not conform with these policy requirements.

3. 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.

The Department will deny prior authorization (PA) requests for lack of information (LOI) when providers do not adhere to the requirements above, and also in situations in which the Department 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/provider_manual.html#

Accessibility Survey Requirements for In-Home Evaluations

The Department has also become aware that there are inconsistencies with the completion of the Wheeled Mobility Device Accessibility Survey form. The Accessibility Survey form has therefore been updated to ensure the correct use of the form, consistent with the requirements of the Wheeled Mobility Device guidelines.

The ATP, or designee from the DME provider, who submit 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. The assessment and survey must determine whether the wheelchair is capable of fitting through bathrooms, doorways, hallways, etc. and 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 must be signed by the DME provider and the member or his or her designated representative. In 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 the requested wheelchair fits or will fit 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 will be effective for any evaluations completed on or 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 DME 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, 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 Website;
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 a HUSKY Health member living in the community:

- A medical progress note from the member's primary care physician completed, within 6 months from 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 wheel-chair 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.
    - For modifications requested **more than 6 months** after the date of custom wheelchair delivery: A fully completed LMN 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 later than 30 days from the wheelchair modification request date.
- 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.
- For modifications requested **more than 6 months** after the date of custom wheelchair delivery: A fully completed LMN form.
- Physiatrist evaluations will not be required for wheelchair modifications under $1,000.00.

As outlined in PB 2009-55, any modification priced $1,000.00 or more will also require 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 prior authorization 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 Hewlett Packard Enterprise.

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

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