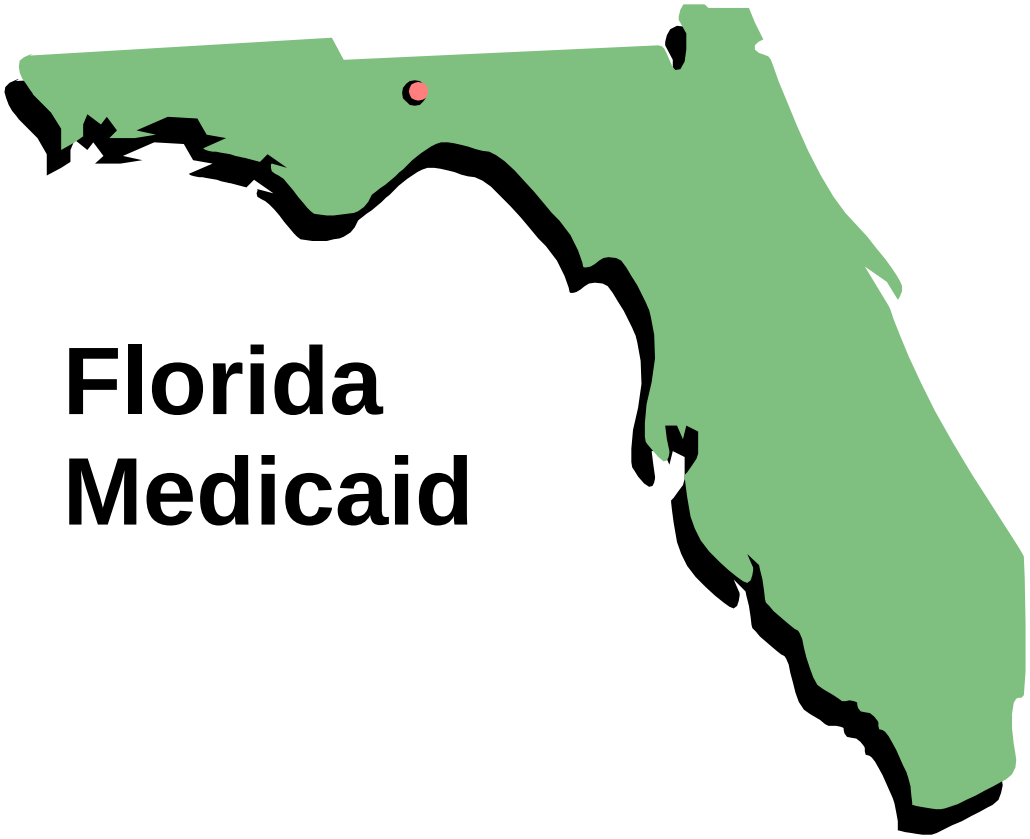


Florida Medicaid

Durable Medical Equipment and Medical Supply Services Coverage Policy: Wheelchairs, Hospital Beds, and Ambulatory Aids

Agency for Health Care Administration
December 2023

Incorporated by reference in
Rule 59G-4.075

Table of Contents

1.0 Introduction

Florida Medicaid wheelchairs, hospital beds, and ambulatory aids durable medical equipment and medical supply (DME) services provide medically necessary equipment or supplies to assist, correct, or improve mobility of eligible recipients.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render wheelchairs, hospital beds, and ambulatory aids DME services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) website at http://ahca.myflorida.com/Medicaid/review/index.shtml.

1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.3 Legal Authority

Florida Medicaid DME services are authorized by the following:

- Title XIX of the Social Security Act (SSA) Section 1902
- Title 42, Code of Federal Regulations (CFR) Part 440
- Section 409.906, Florida Statutes (F.S.)

1.4 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to Florida Medicaid's Definitions Policy.

1.4.1 Certificate of Medical Necessity

Documentation signed by the ordering practitioner to establish a recipient's need for certain durable medical equipment. The CMN states the recipient's diagnosis, prognosis, reason for the equipment, and estimated duration of need.

1.4.2 Claim Reimbursement Policy

A policy document found in Rule Division 59G, F.A.C. that provides instructions on how to bill for services.

1.4.3 Coverage and Limitations Handbook or Coverage Policy

A policy document found in Rule Division 59G, F.A.C. that contains coverage information about a Florida Medicaid service.

1.4.4 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C. containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.4.5 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.4.6 Provider
The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.4.7 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary wheelchairs, hospital beds, and ambulatory aids DME services. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance and Copayments
There is no coinsurance or copayment for this service in accordance with section 409.9081, F.S. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid's Copayments and Coinsurance Policy.

3.0 Eligible Provider

3.1 General Criteria
Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid wheelchairs, hospital beds, and ambulatory aids DME services.

3.2 Who Can Provide
Services must be rendered by one of the following:

- Durable medical equipment and supply services businesses fully licensed in accordance with Chapter 400, F.S.
- Orthopedic physicians' groups primarily owned by physicians and fully licensed in accordance with Chapter 458 or 459, F.S.
- Pharmacies fully licensed in accordance with Chapter 465, F.S.

4.0 Coverage Information

4.1 General Criteria
Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria
Florida Medicaid covers wheelchairs, hospital beds, and ambulatory aids DME in accordance with the American Medical Association's Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS), and the applicable Florida Medicaid fee schedule(s), or as specified in this policy.

Florida Medicaid covers custom and specialized equipment when a less costly alternative is not available to fulfill the recipient's need.

Florida Medicaid-covered DME must include a manufacturer's or one-year warranty, whichever is greater.

Recipients under the age of 21 years residing in a skilled nursing facility may receive customized wheelchairs through this benefit.

4.2.1 Ambulatory Aids

To assist recipients with impaired mobility, including the following:

- Canes, crutches, and walkers
  - Must include tips, pads, and grips
- Pediatric gait trainers
- Wheeled walkers (covered when prescribed in lieu of a wheelchair)
  - Must include a seat and wheel locks to be reimbursable.

4.2.2 Hospital Beds

A standard hospital bed consists of a modified latch spring assembly mattress, bed ends with casters, and two manually operated foot end cranks.

- Bed frame is equipped with IV sockets and accommodates a trapeze bar, side rails, and an overhead frame.

Florida Medicaid covers the following hospital bed types when prescribed:

- Adjustable-height or multi-height hospital beds
- Heavy-duty hospital beds
- Semi-electric or electric hospital beds
  - Recipient must be able to operate the bed controls independently.

4.2.3 Hospital Bed Accessories

Including:

- Hospital bed rails
- Mattress replacements
- Safety enclosure frames and canopies

4.2.4 Patient Lifts

A portable device used to lift and transfer a recipient when the assistance of more than one person is necessary to move the recipient.

- Patient lifts may be hydraulic, mechanical, or electric.
- A patient lift must include the necessary seat, sling, straps, and pad(s).

4.2.5 Traction Equipment

Used to draw or pull sections of the body to improve skeletal alignment.

- Florida Medicaid covers traction equipment when prescribed for an orthopedic impairment requiring traction equipment that prevents ambulation during the period of use.

4.2.6 Trapeze Equipment

A device that is freestanding or attached to a bed that enables the recipient to change position in the bed or to transfer from the bed to a chair or wheelchair.

- Florida Medicaid covers trapeze equipment when a recipient is confined and needs assistance to get in or out of bed, change body position, or sit up for a respiratory condition.
- Florida Medicaid covers trapeze equipment trapeze equipment for exercise to prevent muscular deterioration when prescribed.

4.2.7 Wheelchairs

Florida Medicaid covers a manual or powered wheelchair when the recipient is non-ambulatory or has severe limited mobility. Florida Medicaid covers one wheelchair per recipient, per maximum unit period.

All wheelchair evaluations are valid for up to six months from the date the evaluation is signed and dated by the evaluator.

4.2.7.1 Customized Wheelchairs

Florida Medicaid covers customized manual and power wheelchairs that are specifically constructed for the individual recipient.

4.2.7.2 Wheelchair Rentals

Florida Medicaid covers rental of a temporary wheelchair for up to 10 days. Prior authorization is required to exceed the 10-day limit.

Rent-to-purchase wheelchair information can be found in section 8.5.3.

4.2.8 Maintenance and Repair

Florida Medicaid covers maintenance and repairs of wheelchairs, hospital beds, and ambulatory aids that meet all of the following:

- Equipment damage is not due to misuse, neglect or wrongful disposition by the recipient, caregiver, or provider
- Equipment's warranty is expired or does not cover the necessary maintenance or repairs
- Florida Medicaid provided the equipment

4.2.9 Used and Refurbished Equipment

Florida Medicaid covers used and refurbished wheelchairs, hospital beds, and ambulatory aids that meet all of the following:

- Equipment records indicate that the item is functional, sanitized, and serviced prior to delivery
- Equipment and replaced parts are the equivalent in quality and condition to the manufacturer's warranty on a new item
- Equipment must be durable enough to meet Florida Medicaid's maximum limit replacement requirements as stated on the DME fee schedule incorporated by reference in Rule 59G-4.002, F.A.C.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- Customized wheelchair rentals
- Wheelchairs, hospital beds, and ambulatory aids DME or medical supplies provided to recipients ages 21 and over residing in institutional settings (e.g., skilled nursing facilities)
- Items listed or identified in a procedure code's description that are billed separately
- Personal comfort, convenience, hygiene, or sanitation items
- Precautionary-type equipment (e.g., power generators)
- Repairs and maintenance of rental equipment, separately
- Replacement parts, repairs, or labor for equipment within the warranty period
- Shipping, handling, labor, measuring, fitting, or adjusting, separately
- Transit tie downs
- Travel time and repair assessment time
- Wheelchair power attendant control, lifts, or ramps

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's Recordkeeping and Documentation Policy.

6.2 Specific Criteria

Providers must maintain the following documentation in the recipient's file, as applicable:

- Equipment and supply delivery, pick-up, and return documentation as specified in section 400.94, F.S.
- Florida Medicaid-covered DME must include manufacturer's or one-year warranty, whichever is greater
- Recipient training documentation
- Rental equipment maintenance and repairs
- Used equipment documentation, including:
  - Signed agreement with recipient, acknowledging receipt of used equipment

Providers must also maintain one of the following in the recipient's file:

- Certificate of Medical Necessity, prepared and signed by the authorizing practitioner, that meets all of the following requirements:
  - Is dated within 21 days after the initiation of service
  - Is less than 12 months old
  - Specifies a diagnosis as the basis for the services prescribed
- Current hospital discharge plan, when applicable, that clearly describes the type of DME item or service ordered
- Written prescription
  - Is less than 12 months old
  - Is dated within 21 days after the initiation of services
  - When applicable, documentation for redetermination of medical necessity or reauthorization of services

The plan of care, when applicable, must be individualized and specify all of the following:

- Frequency of use
- Length of time the recipient requires DME
- Quantity
- Type of DME

6.2.1 Hospital Beds and Accessories

Providers must maintain the following documentation in addition to the criteria specified in section 6.2:

- Hospital beds

- Place of service and address
- Recipient's height and weight
- Severity and frequency of the symptoms that necessitate a hospital bed

- Safety enclosure frames and canopies
  - Statement that the recipient would be institutionalized without the enclosed bed

6.2.2 Wheelchairs

Providers must maintain the following documentation in addition to the criteria specified in section 6.2:

- Customized wheelchairs
  - Custom Wheelchair Evaluation, AHCA Med Serv Form 015, July 2007, incorporated by reference
  - Documentation describing the recipient's physical status, including:
    - Cognitive and physical abilities
    - Mobility, coordination and strength
    - Self-care and activity limitations
  - Itemized invoice
  - List of each customized feature required for unique physical status
- Heavy-duty hospital beds
  - Documentation that recipient weighs in excess of 350 pounds
- Power wheelchairs and motorized scooters
  - Documentation of the recipient's inability to operate a manual wheelchair
  - Documentation of the recipient's ability to independently control the wheelchair or motorized scooter
- Semi-electric and electric hospital beds
  - Documentation that recipient requires frequent changes in body position and is able to operate bed controls independently

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's Authorization Requirements Policy.

7.2 Specific Criteria

Providers must obtain authorization from the quality improvement organization (QIO) as follows:

- For miscellaneous procedure codes
- When indicated on the applicable Florida Medicaid fee schedule(s)

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Claim Type

Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, incorporated by reference in Rule 59G-4.002, F.A.C.

8.3.1 Customized Equipment
Providers must include a non-classified procedure code for customized equipment on the claim form.

8.3.2 Pediatric Gait Trainers
Providers must use miscellaneous code E1399 on the claim form for pediatric gait trainers.

8.3.3 Hospital Bed Accessories
Providers must use a hospital bed procedure code on the claim form for safety enclosure frames and canopies.

8.4 Diagnosis Code
Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate
For a schedule of rates, incorporated by reference in Rule 59G-4.002, F.A.C., visit AHCA's website at http://ahca.myflorida.com/Medicaid/review/index.shtml.

8.5.1 By-Report Claims
By-report claims involve non-classified procedure codes as indicated by the DME fee schedule and require medical reviews by the QIO to approve and price the DME service.

Providers must submit all of the following to the Florida Medicaid QIO:
- Description of the items or services provided, including manufacturer's information
- Documentation of medical necessity
- Documentation of the provider's costs incurred, including invoices
- Documentation of the warranty and before and after descriptions of the item for repairs

8.5.2 Maintenance and Repair
Florida Medicaid reimburses for repair costs up to 75% of the equipment's original cost.

8.5.3 Rental Equipment
Florida Medicaid reimburses for rental equipment at the prorated daily amount of the monthly rate, per day, when the item is returned to the provider before the end of a 30-day period.

Florida Medicaid reimburses for up to the total of ten monthly claims for rent-to-purchase items; the item(s) then becomes the personal property of the recipient at the end of the lease.

Florida Medicaid reimburses for non-standard wheelchair components by calculating the difference in rates between the standard component and the non-standard component.

8.5.3.1 Wheelchair Rentals
Florida Medicaid's rental amount for wheelchairs includes all of the following components:
- Armrests and backs
- Battery chargers
- Leg and footrests
- Wheels and tires

8.5.4 Used and Refurbished Equipment
Florida Medicaid reimburses for used equipment at the lesser of 66% of:
- The provider's usual and customary fee for new equipment

- The maximum rate on the applicable fee schedule

Florida Medicaid reimburses for refurbished equipment at 100% of the maximum rental fee on the applicable fee schedule.

9.0 Appendix

9.1 Custom Wheelchair Evaluation Form

9.1 Custom Wheelchair Evaluation

The intent of this form is to secure sufficient information to determine the medical necessity for a custom wheelchair request submitted for prior approval to Florida Medicaid.
This form must be completed by the licensed therapist or the certified physiatrist performing the evaluation.
The evaluator may choose to include additional information that substantiates medical necessity for the equipment requested.

Recipient Name:		Date Referred:		Date of Evaluation:	
Address:		Phone:		Physician:	
		Age:	Sex:	OT:	
Funding:		Date of Birth:		PT:	
Referred By:		Height:			
		Weight:			
Medicaid ID #					

Reason for Referral:

Patient Goals:

Caregiver Goals:

MEDICAL HISTORY:

Dx: ICD:_____ ICD:_____ ICD:_____ ICD:_____

Date of injury or onset:

Prognosis/ Hx:

Recent / Planned Surgeries:

Cardio-Respiratory Status: ❒Intact ❒Impaired

Comments:

CURRENT SEATING / MOBILITY: (Type – Manufacturer – Model)

Chair:			Age:
Serial #			
W/C Cushion:	Age:	**W/C Back**:	Age:

Other Positioning Components:

Reason for ❒Replacement / ❒Repair / ❒Update:

Funding Source:

AHCA Med Serv Form 015, July 2007 (incorporated by reference in Rule 59G-4.075, F.A.C.)

HOME ENVIRONMENT:

❒House	❒Apt	❒Asst Living	❒LTCF	❒Alone	❒w/ Family-Caregivers:	
Length of time at residence:						
Entrance:	❒Level	❒Ramp	❒Lift	❒Stairs		Entrance Width:
W/C Accessible Rooms:	❒Yes	❒No	Narrowest Doorway Required to Access:			
Is a caregiver available 24 hours a day:	❒Yes	❒No	If no, how many hours a day is a caregiver available?			
Comments:						
TRANSPORTATION:	❒Car	❒Van	❒Bus	❒Adapted W/C Lift	❒Ramp	❒ Ambulance ❒Other:

COGNITIVE / VISUAL STATUS:

Memory Skills	❒Intact:	❒Impaired:	Comments:
Problem Solving	❒Intact:	❒Impaired:	Comments:
Judgment	❒Intact:	❒Impaired:	Comments:
Attn / Concentration	❒Intact:	❒Impaired:	Comments:
Vision	❒Intact:	❒Impaired:	Comments:
Hearing	❒Intact:	❒Impaired:	Comments:
Other	❒Intact:	❒Impaired:	Comments:

ADL STATUS:	Indep	Assist	Unable	Comments / Other AT Equipment Required
Dressing	❒	❒	❒	
Bathing	❒	❒	❒	
Feeding	❒	❒	❒	
Grooming/Hygiene	❒	❒	❒	
Toileting	❒	❒	❒	
Meal Prep	❒	❒	❒	
Home Management	❒	❒	❒	
Bowel Management:	❒Continent	❒Incontinent		
Bladder Management:	❒Continent	❒Incontinent		

MOBILITY SKILLS:	Indep	Assist	Unable	N/A	Comments
Bed ↔ W/C Transfers	❒	❒	❒	❒	
W/C ↔ Commode Transfers	❒	❒	❒	❒	
Ambulation:	❒	❒	❒	❒	Device:
Manual W/C Propulsion:	❒	❒	❒	❒	
Operate Power W/C w/ Std. Joystick	❒	❒	❒	❒	
Operate Power W/C w/ Alternative Controls	❒	❒	❒	❒	
Ability to Stand	❒	❒	❒	❒	
Able to Perform Weight Shifts	❒	❒	❒	❒	Type:
Hours Spent Sitting in W/C Each Day:			Comments:		

SENSATION:

❒Intact ❒Impaired ❒Absent	Hx of Pressure Sores ❒Yes ❒No
Current Pressure Sores ❒Yes ❒No Location/Stage	
Comments:	

CLINICAL CRITERIA / ALGORITHM SUMMARY

Is there a mobility limitation causing an inability to safely participate in one or more Mobility Related Activities of Daily Living (MRADL) in a reasonable time frame? ❒Yes ❒No

Explain:

Are there cognitive or sensory deficits (awareness, judgment, vision, etc..) that limit the user's ability to safely participate in one or more MRADL's or ADL's? ❒Yes ❒No

If yes, can they be accommodated or compensated for to allow use of a mobility assistive device to participate in MRADL's? ❒Yes ❒No

Explain:

Does the user demonstrate the ability or potential ability and willingness to safely use the mobility assistive device? ❒Yes ❒No

Explain:

Can the mobility deficit be sufficiently resolved with only the use of a cane or walker? ❒Yes ❒No

Explain:

Does the user's environment support the use of a ❒ MANUAL WHEELCHAIR ❒ POV ❒POWER W**HEELCHAIR:** ❒Yes ❒No

Explain:

If a manual wheelchair is recommended, does the user have sufficient function or abilities to use the recommended equipment? ❒Yes ❒No ❒N/A

Explain:

If a POV is recommended, does the user have sufficient stability and upper extremity function to operate it? ❒Yes ❒No ❒N/A

Explain:

If a power wheelchair is recommended, does the user have sufficient function or abilities to use the recommended equipment? ❒Yes ❒No ❒N/A

Explain:

RECOMMENDATION / GOALS:

❒ **MANUAL** WHEELCHAIR ❒ **POV** ❒**POWER** W**HEELCHAIR:** ❒**POSITIONING SYSTEM**(TILT/RECLINE) ❒**SEATING**

MAT EVALUATION: (NOTE IF ASSESSED SITTING OR SUPINE)

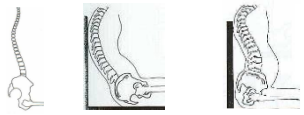
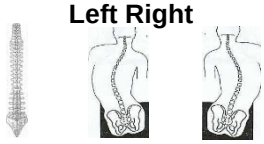
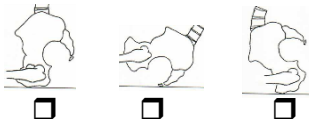
	POSTURE:	FUNCTION:	COMMENTS:	SUPPORT NEEDED
HEAD & NECK	❒ Functional ❒ Flexed ❒ Extended ❒ Rotated ❒ Laterally Flexed ❒ Cervical Hyperextension	❒ Good Head Control ❒ Adequate Head Control ❒ Limited Head Control ❒ Absent Head Control ❒ Tone/ Reflex		

<table>
<tr><td rowspan="2">UPPER EXTREMITY</td><td>SHOULDERS
Left Right
❒WFL ❒WFL
❒Elev / dep ❒Elev / dep
❒Pro / retract ❒Pro / retract
❒Subluxed ❒Subluxed</td><td>R.O.M.

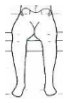
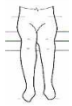
Strength:

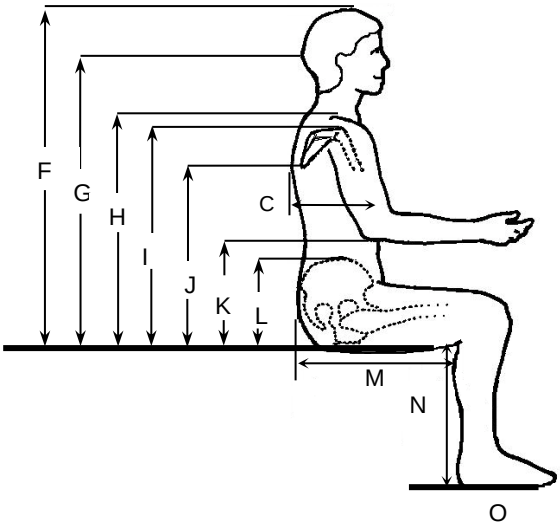
Tone/Reflex:</td><td></td><td></td></tr>
<tr><td>ELBOWS
Left Right
❒Impaired ❒ Impaired
❒WFL ❒ WFL</td><td>R.O.M.

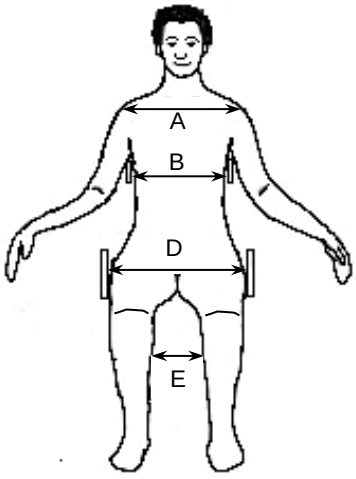
Strength:

Tone/Reflex:</td><td></td><td></td></tr>
<tr><td>WRIST & HAND</td><td>Left Right
❒Impaired ❒Impaired
❒WFL ❒WFL</td><td>Strength / Dexterity:</td><td></td><td></td></tr>
<tr><td>TRUNK</td><td>Anterior / Posterior
 
❒ WFL ❒ ↑ Thoracic Kyphosis ❒ ↑ Lumbar Lordosis
❒ Fixed ❒ Flexible
❒ Partly Flexible ❒ Other</td><td>Left Right
 
❒ WFL ❒ Convex Left ❒ Convex Right
❒ Fixed ❒ Flexible
❒ Partly Flexible ❒ Other</td><td>Rotation
 
❒ Neutral
❒ Left Forward
❒ Right Forward
❒ Fixed ❒ Flexible
❒ Partly Flexible ❒Other</td><td></td></tr>
<tr><td>PELVIS</td><td>Anterior / Posterior
 
❒ Neutral ❒ Posterior ❒ Anterior
❒ Fixed ❒ Other
❒ Partly Flexible
❒ Flexible</td><td>Obliquity
 
❒ WFL ❒ Left Lower ❒ Rt. Lower
❒ Fixed ❒ Other
❒ Partly Flexible
❒ Flexible</td><td>Rotation
 
❒ WFL ❒ Right ❒ Left
❒ Fixed ❒ Other
❒ Partly Flexible
❒ Flexible</td><td></td></tr>
</table>

AHCA Med Serv Form 015, July 2007 (incorporated by reference in Rule 59G-4.075, F.A.C.)

HIPS	**Position**    ❒ Neutral ❒ ABduct ❒ ADduct ❒ Fixed ❒ Subluxed ❒ Partly Flexible ❒ Dislocated ❒ Flexible	**Windswept**    ❒ Neutral ❒ Right ❒ Left ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	**Range of Motion**  **Left** **Right** Flex: _____° _____° Ext: _____° _____° Int R: _____° _____° Ext R: _____° _____°	
KNEES & FEET	**Knee R.O.M.** Left Right ❒ WFL ❒ WFL ❒ Flex_____° ❒ Flex_____° ❒ Ext _____° ❒ Ext _____°	Strength: Hamstring ROM Limitations: (Measured at ___° Hip Flex) Left_____ Right_____ Orthosis? Prosthetic?	**Foot Positioning** ❒ WFL ❒L ❒R ❒ Dorsi-Flexed ❒L ❒R ❒ Plantar Flexed ❒L ❒R ❒ Inversion ❒L ❒R ❒ Eversion ❒L ❒R	Foot Positioning Needs:
MOBILITY	**Balance** Sitting Balance: / Standing Balance ❒ WFL / ❒ WFL ❒ Min Support / ❒ Min Support ❒ Mod Support / ❒ Mod Support ❒ Unable / ❒ Unable	**Transfers** ❒ Independent ❒ Min Assist ❒ Max Assist ❒ Sliding Board ❒ Lift or Sling Required	**Ambulation** ❒ Unable to Ambulate ❒ Ambulates with Assistance ❒ Ambulates with Device ❒ Independent without Device ❒ Indep. Short Distance Only	





Neuro-Muscular Status:

Tone:

Reflexive Responses:

Effect on Function:

	Measurements in Sitting:	Left	Right		
	A: Shoulder Width				
	B: Chest Width			**H:**	Top of Shoulder
	C: Chest Depth (Front – Back)			**I:**	Acromium Process (Tip of Shoulder)
	D: Hip Width			**J:**	Inferior Angle of Scapula
	** Asymmetrical Width			**K:**	Elbow
	E: Between Knees			**L:**	Iliac Crest
	F: Top of Head			**M:**	Sacrum to Popliteal Fossa
	G: Occiput			**N:**	Knee to Heel
				O:	Foot Length

Additional Comments and please add Trunk and Pelvic width with brace/ Orthosis, when applicable.
** Asymmetrical Width: i.e., windswept or scoliotic posture; measure widest point to widest point

REQUESTED EQUIPMENT:

Requested Frame (make and model):
Dimensions:
Amount of growth available:

SIGNATURE:

As the evaluating therapist, I hereby attest that I have personally completed this five page evaluation form and that I am not an employee of, or working under contract to, the manufacturer(s) or the provider(s) of the durable medical equipment recommended in my evaluation. I further attest that I have not and will not receive remunerations of any kind from the manufacturer(s) or the Medicaid Durable Medical Equipment provider(s) for the equipment I have recommended with this evaluation. I accept the responsibility of performing a follow-up evaluation at the time of the initial fitting and delivery of the recommended equipment and will be available for a follow-up evaluation six months after the equipment was delivered to recommend any additional adjustments, if a six-month follow up evaluation is needed.

I am currently enrolled as a Medicaid provider and my provider number is: _____

or, I am not currently enrolled as a Medicaid Provider and have attached a copy of my current license, as follows: (double click on appropriate box and select: Checked):

	License #
☐ Physical Therapy license	
☐ Occupational Therapy license	
☐ Physiatrist board certification	

_____ _____ _____

Signature, as it appears on license or certification ***Date*** ***Daytime contact number(s)***

_____ _____ _____

Fax Number ***Email Address*** ***Cell phone number (optional)***

Optional:

Physician: I have read & concur with the above assessment _____ **Date:** _____ **Phone:** _____

AHCA Med Serv Form 015, July 2007, (incorporated by reference in Rule 59G-4.075, F.A.C.)