UPMC Presbyterian
Center for Assistive Technology

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{add date letter was completed}

To the Medical Insurance Company of ***:

RE: SS# ***

We had the pleasure of seeing @fname@ for a comprehensive Mobility Assistive Equipment (MAE) evaluation. @He@ is a @age@ @male@ with *** {include ICD-9 codes in parentheses}. These conditions result in @him@ having significant limitations in all mobility needs both in the home and community. @He@ currently uses {method of mobility and/or device} that is no longer appropriate in meeting @his@ needs as it *** {describe MRADLs person cannot perform due to current means of mobility but would be more able to participate in with an appropriate MAE}.

Our interdisciplinary team assessment of *** seating and mobility needs determined that the *** is the most reasonable and cost effective alternative in meeting his needs. This equipment was chosen over other alternatives because @fname@ preferred the operation and maneuverability of the device as compared to other devices tried. This equipment is needed for the following reasons:

- @He@ cannot ambulate even with the use of an assistive device due to *** {explain why they cannot functionally ambulate such as weakness, poor endurance, coordination, pain, history of falls etc.}.
- @He@ does not have sufficient upper extremity function to self-propel an optimally configured manual wheelchair due to *** {ex. upper extremity weakness, endurance, coordination, pain, etc.}.

- @He@ is {or is not} a candidate for a scooter/POV as @he@ would {not} be able to {describe safely transfer to and from a POV, operate the tiller system due to ***, or maintain postural stability and position due to ***}. The POV will also {not} adequately maneuver between rooms inside the home per a home assessment performed by {RTS} on {date}.
- The use of a powered mobility device will significantly improve @his@ ability to participate in mobility related activities of daily living and @he@ has not expressed an unwillingness to use one.
- @He@ is not a candidate for a Group 1 power wheelchair as @he@ will use the device continuously throughout the day as well as on surfaces that a Group 1 power wheelchair is not designed for.
- @He@ is further not {or is} a candidate for a Group 1 power wheelchair as {he will continuously use the device throughout the day, or @his@ weight is 300 lbs. or more, or @he@ requires seat functions, specialty controls, or a vent tray}.
- A group 2 {single or multi power option} power wheelchair is needed as @he@ needs {seat functions, and specialty controls, or vent tray.}
- A group 3 {single or multi power option} power wheelchair is recommended as @he@ has a mobility limitation due to *** {neurological condition, myopathy, or congenital skeletal deformity.} and @his@ condition is expected to progress.
- A group 4 power wheelchair is recommended {if all the above criteria is met and if there are added capabilities that are not needed for use in the home (Explain)}.
- Power tilt-in-space and recline are necessary as @he@ {is at high risk for development of pressure ulcer and is unable to perform a functional weight shift; or utilizes intermittent bladder catheritzation and is unable to independently transfer from the wheelchair to bed; or is needed to manage increased tone or spasticity}
- Elevating legrests are necessary as @he@ has {***, cast, or brace which prevents 90 degree flexion at the knee, or has significant edema of the lower extremities, or meets the criteria for and has a reclining back on the wheelchair}.
- A seat elevator is needed as it will allow @him@ to transfer more independently, safely, and efficiently by {raising the seat to stand pivot or use a transfer in a downward direction}. Likewise, it will also allow @him@ to reach and carry out tasks at different surface heights given ***. @His@ need for a seat elevator is also consistent with Rehabilitation Engineering & Assistive Technology Society of North America's (RESNA) Position Paper on Seat Elevating Devices.

Please refer to the attached report for details as needed. Also attached is a copy of the detailed product description from {.rts}, and a prescription for this device.

Without this device *** will have no safe, effective, or independent means of mobility or function either within his home or in the community. @He@ would therefore be at risk for decreased ability to participate in any meaningful mobility related activities of daily living such as getting to the *** for ***, *** for ***, or *** for ***. Also without the use of this device @fname@ will be at significant risk for *** resulting in ***. There are no other treatment alternatives for addressing these seating and mobility needs that we are aware of.

Please give careful consideration in reviewing these recommendations and do not hesitate to contact us should you need clarification of his needs or have any further questions.

Sincerely,

{CAT doc}

{CAT clinician}

Cc: @PCP@
{Client}
{.rts}

UPMC Health System
CENTER FOR ASSISTIVE TECHNOLOGY
CLIENT EVALUATION & IN-TAKE FORM

Therapy Evaluation Date: ***
Physician Face to Face Evaluation Date: *
Home Evaluation Date: ***
Specifications Received from Supplier: *
Date Letter Completed: *

1. PRE-ASSESSMENT SCREENING:

NAME: ***
SOCIAL SECURITY NUMBER: ***
ADDRESS: ***
TELEPHONE NUMBER: ***
DATE OF BIRTH: ***
AGE: ***
PRIMARY DIAGNOSES: (include ICD-9 Codes).
SECONDARY DIAGNOSES: ***
INSURANCE #1: ***
INSURANCE #2: ***
REFERRAL SOURCE: ***
PRIMARY CARE PHYSICIAN & ADDRESS: ***

REASON FOR REFERRAL: New Mobility Assistive Equipment (MAE)
TYPE OF CURRENT MAE: *** {describe & make model of wheelchair or scooter or if they are using a cane, crutch or walker}
HOURS PER DAY USING CURRENT MAE: ***
AGE OF MAE: ***
PROBLEMS WITH CURRENT MAE: *** {describe if it is in poor repair or no longer meets needs}
HEIGHT: ***
WEIGHT: *** lbs.
PREFERRED SUPPLIER: ***

TRANSPORTATION RESOURCES: *** {what transportation resources do they have if the MAE is to be transported in a vehicle}
EDUCATION/EMPLOYMENT: *** {describe whether they are working, retired, going to school, etc.}
LIVING SITUATION: *** {describe where they live, with whom, type of dwelling, and support resources}

2. THERAPY FACE TO FACE ASSESSMENT:

ADL STATUS: {describe below how these ADLs are performed specifically with what level of assistance, equipment used including the MAE needed to get to the place where the ADL takes place within the home or community}

- **Bathing:** ***
- **Hygiene: *****
- **Dressing:** ***
- **Self-Feeding:** ***

Instrumental ADL Status: {describe below how these ADLs are performed specifically with what level of assistance, equipment used including the MAE needed to get to the place where the ADL takes place within the home or community}

- **Meal Preparation: *****
- **Housecleaning: *****
- **Managing Finances: *****
- **Shopping: *****
- **Medication Management: *****
- **Laundry: *****
- **Care of Others: *****

Transfer Status: *** {describe the method the person transfers in and out or with the MAE from the perspective of independence, safety, and quality}

Weight Shift: *** {describe whether the person is able to perform an effective weight shift or reposition themselves to address pressure management and comfort needs}

Functional Mobility: *** {Use the following accepted definition of Functional Mobility to describe the person's ability to ambulate from an independence, safety, and quality perspective. The ability to walk consistently, safely and sufficiently to carry out all of the beneficiary's typical daily functions and activities. The inability to functionally ambulate may be caused by one or more medical conditions causing pain or impairing strength, endurance, coordination, balance, speed of execution, sensation or joint range of motion sufficiently to prohibit functional ambulation.}

Community Mobility: * {**describe how the person does or does not get around in their community from an independence, safety, and quality perspective}

Cognition: *** {intact or not intact – describe issues or concerns if any}

Leisure Interests: ***

Home Accessibility: *** {describe any initial reported issues with steps, maneuvering space, doorways, etc. Mention to refer to supplier home assessment}

Functioning Everyday with a Wheelchair (FEW) TOOL

DIRECTIONS TO CLIENT: Please tell me your level of agreement that best matches your ability to function with your current Mobility Assistive Equipment. All examples may not apply to you, and there may be tasks you perform that are not listed. (Go to www.few.pitt.edu for additional instructions if necessary as this is a self-rapport questionnaire)

6= completely agree
5= mostly agree
4= slightly agree
3= slightly disagree
2= mostly disagree
1= completely disagree
0= does not apply

1. The ***stability, durability, and dependability*** features of my wheelchair/scooter contribute to my ability to carry out my daily routines as independently, safely, and efficiently as possible	***
Comments:	
2. The size, fit, postural support and functional features of my wheelchair/scooter match my ***comfort needs***	***
Comments:	
3. The size, fit, postural support and functional features of my wheelchair/scooter match my ***health needs***	***
Comments:	
4. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***operate*** it as independently, safely, and efficiently as possible	***
Comments:	
5. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***reach*** and carry out tasks at different surface heights as independently, safely, and efficiently as possible	***
Comments:	
6. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***transfer*** from one surface to another as independently, safely, and efficiently as possible	***
Comment:	
7. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***carry out personal care tasks*** as independently, safely, and efficiently as possible	***
Comments:	
8. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***get around indoors*** as independently, safely, and efficiently as possible	***
Comments:	
9. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***get around outdoors*** as independently, safely, and efficiently as possible	***
Comments:	
10. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***use personal or public transportation*** as independently, safely, and efficiently as possible	***
Comments:	

3.THERAPY PHYSICAL MOTOR ASSESSMENT:

UPPER EXTREMITY FUNCTION: ***

LOWER EXTREMITY FUNCTION: ***

POSTURE (SITTING & SUPINE): ***

4. GOALS FOR A NEW SEATING & MOBILITY DEVICE: {have client state what they ae looking for in a new MAE device such as what they want it to do to address their problems or allow them to participate in MRADLs}

1. ***
2. ***
3. ***
4. ***
5. ***

5. PHYSICIAN FACE TO FACE ASSESSMENT:

{paste physician note here. VERIFY INFORMATION IS CONSISTENT WITH THERAPIST INFORMATION ESP. MANUAL MUSCLE TERSTING}

6. EVALUATION PROCEDURES:

CLINICAL TRIALS/SIMULATION:

Pressure Mapping: Pressure mapping using the Force Sensing Array (FSA) system revealed *** {if pressure mapping or other objective measurement tools were performed, describe the results here}

SmartWheel: Data gathered from the SmartWheel revealed that ***

Devices Tried: *** was provided with an opportunity to try ***. He was able to drive the system in a safe and effective manner within the clinic, corridors as well as maneuver in tight spaces such as the bathroom and elevator.

Client Impressions: ***reported that he was satisfied with the performance of the *** and wishes to pursue it as a reasonable alternative for safe and effective mobility within the home and community.

Home Assessment: A visit to the home was conducted by *** on ***. Reports from the visit include: ***

7. RECOMMENDATIONS:

Mobility Assistive Equipment: *** {describe make and model as well as CMS Group number}
Supplier: ***
Estimated Length of Need: Indefinitely due to nature of diagnosis

INTERVENTION & SPECIFICATION	JUSTIFICATION
Seat- *** {skin protection cushion, positioning cushion, or combination skin protection and positioning cushion}	Provide appropriate base support and pelvic positioning. Provide appropriate pressure distribution over weight bearing surface of the buttocks to reduce the potential for skin breakdown.
Seat Frame – Tilt-in-space and/or reclining backrest seating system	Provide for gravitational postural realignment to reduce further development of collapsing spinal deformities. Allow for weight shifts to reduce the potential for pressure sores.
Seat Frame - Power seat elevator	Necessary to allow *** to be able to transfer more safely and independently. {add more specific detail}
Lap Belt- push-button pelvic belt	Provide safety and stability when operating wheelchair. Provide additional pelvic positioning in conjunction with seat cushion.
Thigh Guides /Abductor Wedge- ***	Provide appropriate thigh alignment to prevent problems with hip dislocation as well as the development of a windswept deformity

Leg /Foot Support- ***	Provide appropriate foot support (If elevating legrests recommended, explain)
Back Support- ***	Provide appropriate back support and trunk stability. Reduce the potential for development of spinal deformities.
Head Support- *** headrest and *** mounting hardware	Provide head support when tilted back.
Arm Support- desk-length height adjustable armrests and armpads	Provide appropriate arm support and additional trunk stability through weight bearing in the upper extremities.
Tires /Casters- standard tires and casters with flat free inserts	Standard options. Flat free inserts are necessary as *** does not have the physical capability or resources to repair a flat tire and could become stranded.
Wheel-Locks /Anti-tippers- rear anti-tippers	Provide safety and stability of the device.
Tie Downs- ***	Provide safety and securement of the device when being transported in a vehicle.
Controller- programmable proportional joystick mounted on the *** with *** mounting hardware	Necessary to operate device. Programmable to configure the driving parameters specific to *** needs due to ***
Batteries- Group *** gel cell batteries and charger	Necessary to power device.
Miscellaneous- ***	***

Miscellaneous- ***	***
Miscellaneous- ***	***

IMPLEMENTATION PLAN: The specifications of this prescription will be submitted to *** primary care physician and insurance carrier for authorization. Upon approval the specifications will be provided by *** {RTS} and delivered to the Center for Assistive Technology for fitting and delivery. Upon delivery, @.fname@ will be trained in the use of the mobility device and will demonstrate safe and effective use. In addition, he will be given information about its maintenance. Follow-up appointments will be scheduled as needed to modify the equipment as well as to verify that it continues to meet his needs.

This concludes our face to face assessment and we are all in agreement.

_____Date:_____
{signature physician}

_____Date:_____
{signature therapist}

Cc: CAT Medical Records
{PCP}
{Client}
{RTS}