LETTER OF MEDICAL NECESSITY

Carbonhand® Assistive Powered Glove System

Patient Ful Legal Name: _____ Date of Birth: _____

Patient/Member ID: _____ Date of LMN: _____

Examples: Medicare MBI, Insurance Member ID, or VA ICN.

Privacy Notice: This document may contain protected health information. Transmit and store the completed form using HIPAA- and facility-approved secure methods. Do not include a full Social Security number or send the completed form by unsecured email.

TO WHOM IT MAY CONCERN:

I am writing to recommend the Carbonhand® assistive powered glove system for the above-named patient based on documented functional limitations, objective clinical findings, and demonstrated benefit during clinical trialing.

1. MEDICAL HISTORY AND CURRENT IMPAIRMENT

The patient has a diagnosis of _____, ICD-10 code _____, resulting in persistent upper-extremity weakness, impaired grip strength, reduced grasp endurance, and decreased hand function. As a result, the patient experiences difficulty performing activities requiring sustained grasp, object manipulation, and functional hand use, negatively impacting independence, participation, vocational responsibilities, community engagement, and quality of life.

2. FUNCTIONAL LIMITATIONS AND GOALS

ADL/IADL Areas of Noted Difficulty (check all that apply):

☐ Eating / self-feeding ☐ Meal preparation ☐ Dressing ☐ Grooming / hygiene

☐ Medication management ☐ Household management ☐ Opening containers ☐ Carrying objects

☐ Vocational tasks ☐ Community participation ☐ Recreation / leisure

☐ Other: _____

Patient-Specific Goals:

Goal #1: _____

Goal #2: _____

Goal #3: _____

3. PREVIOUS INTERVENTIONS

☐ Occupational Therapy ☐ Physical Therapy ☐ Home Exercise Program ☐ Orthotic Management

☐ Adaptive Equipment ☐ Other: _____

Despite appropriate rehabilitation and medical management, the patient continues to demonstrate persistent functional hand weakness. Traditional therapy, static orthoses, adaptive equipment, and compensatory strategies do not provide active grip augmentation and do not adequately address ongoing grasp deficits across daily activities.

4. CLINICAL TRIAL DOCUMENTATION

The patient completed a supervised trial of the Carbonhand system. Outcome measures were administered immediately before and after trial use.

Trial Date(s): _____ **Supervising Clinician:** _____

Hand(s) Trialed: ☐ Left ☐ Right ☐ Bilateral **Glove Size(s), if known:** Left: _____ Right: _____

Rating Scale (0–4): **0** = Unable to perform, **1** = Able to perform with difficulty, **2** = Able to perform with moderate difficulty, **3** = Able to perform with minimal difficulty, **4** = Able to perform without difficulty

Task (write in specific activity)	Without Carbonhand (0–4)	With Carbonhand (0–4)
#1:		
#2:		
#3:		

Qualitative Observations:

_____

_____

The patient demonstrated immediate and clinically meaningful improvement in functional hand use during supervised trialing, supporting anticipated benefit during daily activities and community participation.

5. STATEMENT OF MEDICAL NECESSITY

Carbonhand Recommended For: ☐ Left hand ☐ Right hand ☐ Bilateral use

Based on the patient's diagnosis, objective clinical findings, persistent functional limitations, unsuccessful response to previous interventions, and demonstrated functional improvement during supervised Carbonhand trialing, it is my clinical opinion that the Carbonhand assistive powered glove system is **medically necessary**. Clinical consideration is based on documented functional impairment, impact on independence and participation, anticipated benefit, and professional clinical judgment.

The patient demonstrated immediate and clinically meaningful improvements in functional hand use that could not be achieved through traditional therapy, static orthoses, or task-specific adaptive equipment alone. I strongly recommend approval and provision of the Carbonhand system.

Without the Carbonhand system, the patient is expected to continue experiencing reduced independence, activity limitations, and increased reliance on compensatory strategies and/or caregiver assistance.

6. PROVIDER SIGNATURES

Recommending Clinician (OT/PT/MD)

Name: _____

Credentials / Title: _____

NPI #: _____

Facility: _____

Phone / Email: _____

Signature: _____

Date: _____

Co-signing Physician (if required)

Name: _____

Credentials / Title: _____

NPI #: _____

Facility: _____

Phone / Email: _____

Signature: _____

Date: _____