

Wheelchair and Seating Assessment Guide

(For sections that require justification beyond the available spacing, attach additional pages)

March 2009

Dear Provider:

Many clinicians have requested revisions to the DME Wheeled Mobility Template originally published in July 2007. The following revised form encompasses the suggested improvements from our stakeholders. This form is not a required element of the medical record for a prior approval submission. Although a practitioner completed form is considered part of the medical record, it is not a substitute for the comprehensive medical record that is required in the NYS Medicaid Wheeled Mobility Equipment Guidelines.

If the report of a licensed/certified medical professional's (LCMP) (e.g., physical or occupational therapist) examination is to be considered as part of the medical record, there must be a signed and dated attestation by the supplier that the LCMP has no financial relationship with the supplier. A report without such an attestation will not be considered part of the medical record for prior approval or audit purposes.

Comments and suggestions about this form or other suggested formats are welcome and can be forwarded to:

Division of Provider Relations and Utilization Management
150 Broadway Suite 6E
Albany, NY 12204
(Attn: Wheeled Mobility Evaluation Forms)

Wheelchair and Seating Assessment Guide

(For sections that require justification beyond the available spacing, attach additional pages)

Name: _____ DOB: _____ Date of Evaluation: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone number: _____ Please check one: Male Female
Medicaid ID#: _____ Medicare Other Third Party

Medical History:

A medical summary and history of the patient was received and reviewed. The patient's primary diagnosis is that of:

ICD-9:

Onset: _____ Disease process: Stable Progressive

Additional medical history and recent changes include (attach additional pages as necessary):

Physical Status: affecting the patient's (MRADL) functional ability.

Neuromotor status: Normal Impaired Describe: (i.e.: C5 complete)
Reflexes: Normal Abnormal
Tone: Normal Hypotonicity Hypertonicity Fluctuating
 Combination trunk low, extremities high Ataxia/Athetosis
Degree (mild, mod, severe, etc)
Pain: _____
Height: _____ Weight: _____ lbs. Stable Steady increase (ie: growth) Fluctuation (<10 lbs in 6 mos.)
Seating Measurements:
Hip width: _____ Seat depth: _____ Seat to shoulder: _____ Seat to head: _____
Shoulder width: _____ Chest width: _____ Upper leg length: _____ Lower leg length: _____
Other: _____

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Range of Motion/Posture: related to achieving functional positioning and/or mobility. Limitations Identified.

Head control/posture: WNL WFL Delayed control Fixed Flexible

Describe:

Trunk control: WNL WFL Impaired (if checked, describe in detail)

Trunk posture: WNL WFL Flexible Fixed (if checked, describe in detail)

Upper extremities: WNL WFL Limited (provide specifics i.e.: left elbow -20deg active ext)

Lower extremities: WNL WFL Limited (provide specifics i.e.: right knee -10deg act ext)

Postural asymmetries: (detailed description)

Strength/Coordination/Motor Function:

Upper Extremities: WNL WFL Limited (if checked: provide specifics i.e.: R elbow extensors 3/5)

Lower Extremities: WNL WFL Limited (if checked: provide specifics i.e.: R knee extensors 3/5)

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Fine Motor: Dominance: Right Left Mixed
 Coordination/Control: WNL WFL Impaired

Gross Motor: Rolling: Independent Dependent: Assisted(amount):
 Supine to sit: Independent Dependent: Assisted:
 Sitting:
 Static: Independent Dependent: Assisted:
 Dynamic: Independent Dependent: Assisted:
 Standing:
 Static: Independent Dependent Assisted:
 Dynamic: Independent Dependent: Assisted:
 Walking: Independent Dependent: Assisted:
 Device: Cane Crutch Walker Gait trainer
 AFO Prosthesis Right Left
 0 Ft 10 Ft 50 FT 100+ Ft Therapeutic walking only
 Gross motor processing/planning: Normal Slowed Delayed

Transfers: Type: lift 1 person 2 person slide board squat pivot stand pivot
 Other:
 Weight shifts: Independent Passive Assisted:
 Bed to W/C: Independent Passive Assisted:
 W/C to toilet: Independent Passive Assisted:
 W/C to shower: Independent Passive Assisted:
 W/C to vehicle: Independent Passive Assisted:

Endurance: Normal Good Fair Poor (if fair/good, describe further):

Comments

Sensation:

Intact Impaired Absent (List areas impacted):

Sensory processing:
 Normal Kinesthesia Proprioception Stereognosis Absent

Skin integrity:
 Intact Stage 1 Stage 2 Stage 3 Stage IV
 Specific area/dimension
 History of Pressure Ulcer: Yes No Where/when
 History of skin flap: Yes No Where/when

Plan of Care (related to skin integrity, including for example the positioning schedule, treatments, direct care, etc.):

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Respiratory Status:

Normal SOB Oxygen day night Comments:

Standing duration minutes Recovery time minutes
 Walking duration minutes Recovery time minutes

Visual Status:

Normal Functional Impaired Heminopsia Right Left Comments:

Cognitive Status:

Normal Functional Impaired - Comments:

Language Status:

Expression: Normal Functional Impaired - Comments:
 Reception: Normal Functional Impaired - Comments:
 Augmentative communication system (type/make/model):
 Functional Impaired

Psychosocial/Behavioral Status:

Normal Functional Impaired - Describe:

Mobility- Related Activities of Daily Living (MRADL's):

	Independent	Assisted	Passive	Comments:
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UE dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
LE dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
IADL's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Bowel/Bladder Management:

	Continent	Incontinent	Equipment	Comments:
Bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diaper	
Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Catheter	

Caregiver Support

Home health aide services: hours per week
 Respite services: hours per week
 Family/Caregiver assistance: hours per week
 Other:
 Hours without assistance: hours per week (max 168)

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Home Environment:

Environment: House Apartment Assisted Living Group Home
Entrance: Level Stairs Lift Ramp
Bathroom: Accessible Inaccessible
Living area: Accessible Inaccessible
Door width, smallest
Wheelchair storage, if not in residence describe location and address security:

Transportation:

Driving: Independent Independent from w/c Passive
Vehicle: Car Mini van Full size van Truck Medical transport
 W/C school bus Public transportation
Lift/ramp Yes No Car top carrier Other:
Accessibility of w/c to vehicle: Side door Back door Ramp/lift
Accessibility of w/c to vehicle: Side door Back door Ramp/lift
Safety: Tie downs Other

Vocational/Avocational Status:

Present Equipment:

None
Manufacturer: Purchase date:
Model: Funding Source:
Size: Vendor:
Serial #: Age
Reason(s) for replacement: (provide specifics)

Wheelchair Skills:

Manual propulsion: Dependent Independent Assisted uneven terrain only One arm drive
 Upper extremities Lower extremities Hemi All four extremities
Comments:

Power propulsion:
Scooter with tiller: Independent Unable to use due to physical or environmental restrictions
(If related to home environment provide details from trial and/or description of home environment restrictions):

Power controls:
Standard joystick: Independent Unable to use (describe)

Alternative joystick: Independent Choice of control (describe in detail)

It is projected the patient will spend ___ hours a day in a wheeled mobility device.

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Requested Wheelchair with Justification:

The following requested equipment was felt to be the least costly alternative to meet all necessary needs for this patient.

Manual mobility devices:

Manufacturer:
Type

Model:

Size: (width x depth)

Standard K0001:

- Self propels the wheelchair
- Propels with assistance
- Passive

Comments:

Hemi height K0002:

- For disarticulation of one or both lower extremities
- Requires a lower seat height due to stature
- To enable the patient to place his/her feet on the ground for propulsion

Comments:

Lightweight K0003:

- Patient's medical condition and the weight of the wheelchair affects their ability to self propel
- Patient has marginal propulsion skills

Comments:

High strength lightweight K0004:

- Patient's medical condition and the weight of the wheelchair affects the patient's ability to self propel while engaging in frequent MRADL's that cannot be performed in a standard or lightweight wheelchair
- Patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi height wheelchair

Comments:

Ultra lightweight multi-adjustable K0005:

- The patient's medical condition and the weight of the wheelchair affects the patient's ability to self propel while engaging in frequent MRADL's that can not be performed in a standard, lightweight, or high strength lightweight wheelchair
- The patient's medical condition and the position of the push rim in relation to the patient's arms and hands is integral to the ability to self-propel the wheelchair effectively
- The patient has demonstrated the cognitive and physical ability to independently and functionally self propel the wheelchair
- The patient's medical condition requires multi-adjustable features or dimensions that are not available in a less costly wheelchair (i.e.: pediatric size and growth options)

Comments:

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Heavy Duty K0006:

- The patient weighs more than 250 pounds
- The patient has severe spasticity
- Body measurements cannot be accommodated by standard sized wheelchairs

Comments:

Extra Heavy Duty K0007:

- The patient weighs more than 300 pounds
- Body measurements cannot be accommodated by a heavy duty chair

Comments:

Manual Tilt in Space:

- The patient is dependent for transfers AND
- The patient has a plan of care that addresses the medical need for frequent positioning changes (i.e.: for pressure reduction or poor/absent trunk control) that do not always include a tilt position

Comments:

Backup Manual Wheelchair:

- The patient meets the criteria for a powered mobility device
- The patient meets the criteria for the rented or purchased back up manual wheelchair
- The patient is unable to complete MRADL's without a backup manual wheelchair
- The backup wheelchair accommodates the SPC (seating/positioning components) on the primary wheelchair

Comments:

Pediatric sized folding adjustable wheelchair with seating systems:

- The patient meets the criteria for wheeled mobility
- The wheelchair is an appropriate size for the patient
- The patient meets the criteria for recline and positioning options
- The wheelchair provides growth capability in width AND length

Comments:

Trial of manual mobility device requested: Discuss specific equipment trialed and provide detailed results. Also provide the make/model/components trialed.

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Options:

- Quick release axles: Transport Storage Other:
- Specific seat height required inches Foot propulsion Transfers Leg length
 Other:
- Tires: Decrease maintenance Shock absorbency Decrease pain/spasms
 Pneumatic Solid
 Flat free inserts Other:
- Spoke protector:
 Prevent injury to hands, document risk from trial or past use
 Other:
- Hangers: Type:
 LE support Muscle tightness/orthopedic changes Enable transfers
 Elevate legs Other:
- Foot support: Type:
 Accommodate ankle ROM LE positioning Transfers
 Other:
- Armrest and pads: Type:
 UE Support Adjustable height/angle for postural support Remove for transfers
 Other:
- One arm drive device: Left Right
 Enable propulsion of wheelchair with one arm Unable to propel assisting with feet
 Other:
- Anti-tippers: Prevent tipping Other
- Brake extensions: Independence in applying wheel locks Other
- Other/Comments:

Power mobility base:

- Scooter/POV:** Type/group: _____ Make/model: _____ Size: _____
- Safely transfers **AND** Operates tiller steering system **AND** Maintains posture control/stability without additional aids **AND** Mental capabilities and physical capabilities are sufficient for safe mobility **AND** Adequate home access **AND** Patient's weight is less than or equal to weight capacity of identified scooter/POV **AND** Use of POV will significantly improve the patient's ability to participate in MRADL's.
- The patient has had the trial use of a scooter/POV and has demonstrated safe independent control in confined and open environments, within traffic situations and over smooth and uneven terrain.
- Document specific device(s) trialed (make/model). Describe environment and length of trial)

If selecting a Group 2 POV provide additional justification addressing the medical need:

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Power Wheelchair: Type/group:

Make/model:

Size:

Patient does not qualify for a POV **AND** The patient meets the specific coverage criteria for the selected group wheelchair per guidelines **AND** Patient's has mental and cognitive abilities to safely and independently operate the wheelchair **AND** Patient's weight is less than or equal to weight capacity of identified wheelchair **AND** Home and community environments provide adequate access **AND** Secure storage is available.
 The patient has had the trial use of a power wheelchair and has demonstrated safe independent control in confined and open environments, within traffic situations and over smooth and uneven terrain.

Document specific device(s) trialed (make/model/power systems/components). Describe environment and length of trial)

Tilt: Should include at minimum any trial results, comprehensive plan of care, specific justification for tilt. Please see the Wheeled Mobility Guidelines for published criteria.

Recline: Should include at minimum any trial results, comprehensive plan of care, specific justification for recline. If requested in conjunction with power tilt, address the need for both functions

Other:

Controls: Joystick Other (describe):

Ventilator tray: Stabilize ventilator on wheelchair Other :

Additional Comments:

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SEATING COMPONENT RECOMMENDATIONS and JUSTIFICATION

Components	Justification
<p>Seat Cushion Brand:</p> <p><input type="checkbox"/> basic</p> <p><input type="checkbox"/> positioning</p> <p><input type="checkbox"/> pressure relief</p> <p><input type="checkbox"/> positioning and pressure</p> <p><input type="checkbox"/> custom fabricated</p>	<p>Review seating and positioning component criteria</p> <p><input type="checkbox"/> Current pressure ulcer <input type="checkbox"/> Past history of ulcers</p> <p><input type="checkbox"/> Absent/impaired sensation <input type="checkbox"/> Inability to carry out weight shifts</p> <p><input type="checkbox"/> Continuous confined wheelchair using greater than 4 hours</p> <p><input type="checkbox"/> Well documented history of malnutrition</p> <p><input type="checkbox"/> Postural asymmetries</p> <p><input type="checkbox"/> Other:</p>
<p>Solid seat platform</p> <p><input type="checkbox"/></p>	<p><input type="checkbox"/> Support cushion to prevent hammocking</p> <p><input type="checkbox"/> Base to build custom contoured cushion</p> <p><input type="checkbox"/> Other:</p>
<p>Back Cushion Brand:</p> <p><input type="checkbox"/> general use</p> <p><input type="checkbox"/> positioning back</p> <p><input type="checkbox"/> positioning (post/lateral)</p> <p><input type="checkbox"/> custom fabricated</p>	<p><input type="checkbox"/> Provide posterior trunk support <input type="checkbox"/> Provide lumbar/sacral support</p> <p><input type="checkbox"/> Support trunk in midline <input type="checkbox"/> Provide lateral trunk support</p> <p><input type="checkbox"/> Accommodate deformity <input type="checkbox"/> Accommodate or decrease tone</p> <p><input type="checkbox"/> Facilitate tone</p> <p><input type="checkbox"/> Other:</p>

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Lateral pelvic/thigh support <input type="checkbox"/> non standard hardware (per guidelines)	<input type="checkbox"/> Pelvic in neutral <input type="checkbox"/> Accommodate pelvis <input type="checkbox"/> Position upper legs <input type="checkbox"/> Accommodate tone <input type="checkbox"/> Removable for transfers <input type="checkbox"/> Other:
Medial knee support <input type="checkbox"/> non standard hardware (per guidelines)	<input type="checkbox"/> Decrease adduction <input type="checkbox"/> Accommodate ROM <input type="checkbox"/> Remove for transfers <input type="checkbox"/> Alignment <input type="checkbox"/> Other:
Foot support <input type="checkbox"/> shoe holders <input type="checkbox"/> heel/ankle straps <input type="checkbox"/> ankle hugger <input type="checkbox"/> toe strap	<input type="checkbox"/> Position foot <input type="checkbox"/> Accommodate deformity <input type="checkbox"/> Stability <input type="checkbox"/> Decrease tone <input type="checkbox"/> Control position <input type="checkbox"/> Safety <input type="checkbox"/> Other: * see coverage guidelines when requesting ankle huggers
Lateral trunk supports <input type="checkbox"/> non standard hardware (per guidelines)	<input type="checkbox"/> Decrease lateral trunk leaning <input type="checkbox"/> Accommodate asymmetry <input type="checkbox"/> Contour for increased contact <input type="checkbox"/> Safety <input type="checkbox"/> Control of tone <input type="checkbox"/> Other:
Anterior chest or shoulder supports	<input type="checkbox"/> Trunk/shoulder positioning and posture <input type="checkbox"/> Added abdominal support <input type="checkbox"/> Support during tilt and recline <input type="checkbox"/> Provide anterior head support <input type="checkbox"/> Other:
Headrest	<input type="checkbox"/> Provide posterior head support <input type="checkbox"/> Provide lateral head support <input type="checkbox"/> Support during tilt and recline <input type="checkbox"/> Provide anterior head support <input type="checkbox"/> Other:
Neck support	<input type="checkbox"/> Decrease forward neck flexion <input type="checkbox"/> Decrease neck rotation <input type="checkbox"/> Other:
Upper extremity support	<input type="checkbox"/> Required for positioning when less costly alternatives (see coverage guidelines) are not sufficient <input type="checkbox"/> Other:

Other:

Additional Comments:

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Therapist Name: Address: Phone number:		Therapist's Signature: Date:
Supplier's Name: Address: Phone number:		

I agree with the above findings and recommendations of the therapist and supplier:

Physicians name: Address: Phone number: Medicaid ID: License number:		Physician's Signature: Date:
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