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

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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				
Bathing				
Grooming				
UE dressing				
LE dressing				
Toileting				
IADL's				

Bowel/Bladder Management:

	Continent	Incontinent	Equipment	Comments:
Bowel			Diaper	
Bladder			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:
Model:
Size:
Serial #:
Reason(s) for replacement: (provide specifics)

Purchase date:
Funding Source:
Vendor:
Age

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: Model: Size: (width x depth)
Type

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

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