

State of Louisiana Medicaid Power Wheelchair Evaluation

Instructions:

1. The Prior Authorization (PA-01) and the Power Wheelchair Evaluation forms are required with all Power Wheelchair requests.
2. Writing must be legible.
3. All sections must be completed by the professional listed. Enter N/A for items/sections that do not apply.
4. Please attach Physician script and original manufacturer price sheets.
Glossary of terms is on the last page of form

I. GENERAL INFORMATION (PROVIDER):

Date of Evaluation: _____
Recipient Name: _____ DOB: _____
Recipient's Address: _____
Medicaid ID #: _____ Other Insurance: _____
Physician Name: _____ Therapist Name: _____

II. MEDICAL HISTORY (PROVIDER):

Diagnosis: _____ ICD-9 Code: _____
Date of Injury/Onset: _____ Prognosis: _____
Describe any recent or expected changes in recipient's medical/physical/functional status:

Estimated length of need of power wheelchair: _____

III. PRESENT WHEELCHAIR (PROVIDER):

Does the recipient currently own any type of wheelchair: Yes No

If yes, please provide the following information:

Serial #: _____ Age of chair: _____
Model: _____ Type: Manual Power
Size: _____ Price: _____ Funding Source: _____

Can the wheelchair be modified? Yes No

If yes, please explain.

Why is the recipient's chair not meeting the recipient's needs:

IV. HOME ENVIRONMENT (PROVIDER/THERAPIST):

Home Apartment Mobile Home Asst. Living

Alone With family/caregivers

Is the caregiver available 24 hours a day? Yes No

If no, how many hours a day is the caregiver available? _____

Entrance: Level Ramp Stairs/Steps

If the home has stairs/steps are there plans for a ramp? Yes No

Are all the rooms/doors wheelchair accessible? Yes No

If no, will the home be modified? Yes No

Storage of wheelchair: In home Other: _____

Comments: _____

V. TRANSPORTATION (PROVIDER/THERAPIST):

Car Truck Van Public transportation Bus Other: _____

Must the wheelchair fold for transportation? Yes No

Is there a lift or ramp on the vehicle? Yes No

Will the recipient sit in the wheelchair during transportation? Yes No

If yes, will the recipient have tie downs? Yes No

VI. COGNITION (THERAPIST):

Memory Intact Impaired Comments: _____

Problem Solving Intact Impaired Comments: _____

Attn/Concentration Intact Impaired Comments: _____

Vision Intact Impaired Comments: _____

Hearing Intact Impaired Comments: _____

Judgment Intact Impaired Comments: _____

VII. COMMUNICATION (THERAPIST):

Verbal Non Verbal Sign Language Gestures Communication Device

VIII. SENSATION (THERAPIST):

Intact Impaired Absent

History of pressure sores? Yes No

If yes, provide location and stage: _____

Current pressure sores? Yes No

If yes, provide location and stage: _____

Can the recipient perform pressure reliefs? Yes No

If yes, how: _____ If not, why: _____

Bowel management: Continent Incontinent

Bladder management: Continent Incontinent

IX. ADL'S (THERAPIST): (assess recipient's ADL's without a wheelchair)

- Dressing Independent Mod I SPV Min A Mod A Max A Dependent
Bathing Independent Mod I SPV Min A Mod A Max A Dependent
Toileting Independent Mod I SPV Min A Mod A Max A Dependent
Feeding Independent Mod I SPV Min A Mod A Max A Dependent
Grooming Independent Mod I SPV Min A Mod A Max A Dependent
Handedness Right Left

X. PATHOLOGICAL REFLEXES (THERAPIST):

- Asymmetrical tonic neck reflex Symmetrical tonic neck reflex Tonic labyrinthine reflex supine
 Tonic labyrinthine reflex prone Extensor tone Startle Positive Supporting
 Other: _____

Comments: _____

XI. MOBILITY (THERAPIST):

Bed to Wheelchair Transfers: Independent Mod I SPV Min A Mod A Max A Dependent
Method? Stand Pivot Squat Pivot Scoot Pivot Sliding Board Lift

Ambulatory status: Independent Mod I SPV Min A Mod A Max A Dependent
 Non-ambulatory

Distance: < 25 feet 25 - 50 feet 50- 100 feet 100-150 feet >150 feet

Device: Straight Cane Quad Cane Crutches Forearm Crutches Walker None

Other: _____

If non-ambulatory, indicate the recipient's ambulatory potential:

Within 6 months Expected in 1 year Not expected

Has the recipient tried walking with all ambulatory assistive devices? Yes No

Please explain why all the ambulatory assistive devices are not sufficient for the recipient's mobility. _____

Manual wheelchair propulsion: Independent Mod I SPV Min A Mod A Max A Dependent
Method? UE LE Both Other: _____

Distance? < 25 feet 25 - 50 feet 50- 100 feet 100-150 feet >150 feet

Has the recipient tried using all types of manual wheelchairs? (standard, lightweight, ultra lightweight, one arm drive) Yes No

Please explain why all manual wheelchairs are not sufficient for the recipient's mobility. _____

Would the recipient be able to propel a manual wheelchair if plastic coated handrims or projections were added? Yes No

If no, please explain. _____

Power wheelchair mobility: Independent Mod I SPV Min A Mod A Max A Dependent
Method? Joystick Alternative controls

Hours sitting in wheelchair: _____

Has the recipient demonstrated that he/she can safely and independently operate the recommended power wheelchair? Yes No

Comments: _____

XII. POSTURE (THERAPIST): (note if assessment done in sitting or supine)

- Head Posture: WFL Flexed Extended Rotated Laterally flexed Cervical hyperextension
 Head Control: Normal Good Fair Poor Absent
 Trunk Posture: WFL Thoracic kyphosis Lumbar lordosis Scoliosis: left or right C or S curve
 Rotation: left or right
 Trunk Tone: Hypotonia Normal Hypertonia Spasticity Rigidity Athetosis Ataxia
 Tremors
 Severity: Mild Moderate Severe
 Pelvis: Neutral Posterior Anterior Obliquity: left or right Rotation: left or right
 Windswept: left or right Subluxation Dislocation Fracture

XIII. UPPER EXTREMITY (THERAPIST):

LEFT		RIGHT		
AROM/PROM	STRENGTH (MMT)	UPPER EXTREMITY	STRENGTH (MMT)	AROM/PROM
	/5	Shoulder Flex	/5	
	/5	Shoulder Ext	/5	
	/5	Shoulder Abd	/5	
	/5	Shoulder Add	/5	
	/5	Elbow Flex	/5	
	/5	Elbow Ext	/5	
	/5	Wrist Flex	/5	
	/5	Wrist Ext	/5	
	Lbs.	Grip	Lbs.	

If unable to test the recipient's strength or ROM please explain why. _____

Shoulders:

- WFL
 Elevated/Depressed Fixed Partially flexible Flexible
 Protracted/Retracted Fixed Partially flexible Flexible
 Subluxed

Hands:

- WFL Fisting Other: _____
 Does the recipient require plastic coated handrims or projections? Yes No
 If so, why? _____

UE Tone: Flaccid Hypotonia Normal Hypertonia Spasticity Rigidity

Comments on the recipient's UE: _____

XIV. LOWER EXTREMITY (THERAPIST):

LEFT			RIGHT	
AROM/PROM	STRENGTH (MMT)	LOWER EXTREMITY	AROM/PROM	STRENGTH (MMT)
	/5	Hip Flex		/5
	/5	Hip Ext.		/5
	/5	Hip Abd		/5
	/5	Hip Add		/5
	/5	Hip IR		/5
	/5	Hip ER		/5
	/5	Knee Flex		/5
	/5	Knee Ext		/5
	/5	Ankle DF		/5
	/5	Ankle PF		/5
	/5	Ankle IV		/5
	/5	Ankle EV		/5

If unable to test the recipient's strength or ROM please explain why. _____

Hip position:

- Neutral Hip Abduction Hip Adduction Subluxed Dislocated Leg length discrepancy
 Fixed Partially fixed Flexible

Windswept:

- Neutral Right Left
 Fixed Partially fixed Flexible

Does the recipient wear AFO's? Yes No

LE Tone: Flaccid Hypotonia Normal Hypertonia Spasticity Rigidity

Comments on recipient's LE: _____

XV. BALANCE (THERAPIST):

Sitting Balance:

- Static: Normal Good Fair Poor Absent
 Dynamic: Normal Good Fair Poor Absent

Standing Balance:

- Static: Normal Good Fair Poor Absent
 Dynamic: Normal Good Fair Poor Absent

Comments: _____

XVI. PAIN AND EDEMA (THERAPIST):

Pain: Yes No

If yes, please state severity (using the visual analog scale 0-10), location, and how often (daily, weekly, monthly). _____

Is the recipient on pain medication? Yes No

If yes, please list medication. _____

Does pain medication alleviate the recipient's pain? _____

Edema: Yes No

If yes, please state severity, location, and how often (daily, weekly, monthly). _____

Comments: _____

XVII. SEATING MEASUREMENTS (THERAPIST): (supine/sitting)

Height: _____	Weight: _____
Hip width: _____	Shoulder width _____
Seat depth: _____	Top of shoulder _____
Iliac crest : _____	Inferior angle of scapula: _____
Knee to heel: _____	Acromium process _____
Foot length: _____	Elbow: _____
Chest width: _____	Chest depth: _____
Top of head: _____	Occiput: _____

Does the recipient have a brace or orthosis? Yes No

If yes, please explain. _____

XVIII. RECOMMENDED WHEELCHAIR AND NON-STANDARD PARTS (THERAPIST/PROVIDER):

1. Please provide the original manufacturer price sheet.
2. Please describe the medical necessity for the requested equipment.
3. Please justify seat width and depth requested.
4. Medically justify each non-standard part on the wheelchair.
5. List the wheelchair parts in order of the manufacturer price sheet.
6. Stamp signatures are not accepted.
7. The provider can assist with all wheelchair/part justifications.

Wheelchair Model: _____

Justification: _____

Seat width and depth requested, how will this accommodate the recipient's current measurements: _____

Justification: _____

Non-standard part on wheelchair: _____
Justification: _____

Non-standard part on wheelchair: _____
Justification: _____

Non-standard part on wheelchair: _____
Justification: _____

Non-standard part on wheelchair: _____
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Non-standard part on wheelchair: _____
Justification: _____

Non-standard part on wheelchair: _____
Justification: _____

Therapist:
I, _____ was present and participated in this evaluation, have personally completed this evaluation, and agree that the above power wheelchair and all the non-standard parts recommended are medically necessary for the above patient.

Physician:
I, _____, have read this evaluation and agree that the above power wheelchair and all the non-standard parts recommended are medically necessary for the above patient.

Therapist (Print Name)

Therapist's Signature/Credentials

Date

Physician (Print Name)

Physician's Signature/Credentials

Date

Provider (Print Name)

Provider's Signature/Credentials

Date

Glossary of Terminology

Abd – abduction
Add – adduction
AFO – ankle foot orthosis
AROM – active range of motion
Asst – assistive
Attn – attention
DF – dorsi-flexion
DOB – date of birth
ER – external rotation
EV – eversion
Ext – extension
Flex – flexion
IR – internal rotation
IV – inversion
Lbs – pounds
LE – lower extremity
Max A – maximal assistance
Min A – minimal assistance
MMT – manual muscle testing
Mod A – moderate assistance
Mod I – modified independent
N/A – not applicable
PF – planter-flexion
PROM – passive range of motion
ROM – range of motion
SPV – supervision
UE - upper extremity
WFL – within functional limits