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): If date of onset of injury is on or after 10/01/2015, use ICD-10 codes.
Diagnosis Description: __________________________ Diagnosist 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: __________________________ Price: __________________________ Type: ☐ Manual ☐ Power
Size: __________________________ 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

- Are 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)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Independent</th>
<th>Mod I</th>
<th>SPV</th>
<th>Min A</th>
<th>Mod A</th>
<th>Max A</th>
<th>Dependent</th>
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</thead>
<tbody>
<tr>
<td>Dressing</td>
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<td>Feeding</td>
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<td>Grooming</td>
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<tr>
<td>Handedness</td>
<td>□ Right</td>
<td>□ Left</td>
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</table>

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 where 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
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):

<table>
<thead>
<tr>
<th>LEFT</th>
<th>STRENGTH (MMT)</th>
<th>UPPER EXTREMITY</th>
<th>STRENGTH (MMT)</th>
<th>AROM/PROM</th>
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<td>Lbs.</td>
<td>Grip</td>
<td>Lbs.</td>
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</table>

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 handrim or projections? □ Yes □ No
If so, why? _______________________________________________________

UE Tone: □ Flaccid □ Hypotonia □ Normal □ Hypertonia □ Spasticity □ Rigidity

Comments on the recipient's UE: ______________________________________

______________________________________________________________

Comments: ____________________________________________________

______________________________________________________________

______________________________________________________________
### XIV. LOWER EXTREMITY (THERAPIST):

<table>
<thead>
<tr>
<th>LEFT</th>
<th>AROM/PROM</th>
<th>STRENGTH (MMT)</th>
<th>LOWER EXTREMITY</th>
<th>AROM/PROM</th>
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<td>Ankle EV</td>
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</tbody>
</table>

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: __________________________________________
Justification: ________________________________________________________

Non-standard part on wheelchair: __________________________________________
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Justification: _____________________________________________

Non-standard part on wheelchair: ________________________________
Justification: _____________________________________________
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