



# Wheelchair Initial Evaluation Form

Complete before submitting a prior-authorization request

**Member Information:**

Members Name:

Members Primary Residence:

Medicaid ID#:

Members Date of Birth:

Members Height:

Members Weight:

**Diagnosis:**

**Associated ICD-10 CODE(S):**

**Provider Information:**

Date of face-to-face evaluation:

Date of wheelchair evaluation:

Date of physician's order:

Evaluating therapist name:

Physician's name:

**Evaluation:**

Complete Sections 1-6, 8, and 9 for **manual** wheelchair evaluations

Complete Sections 1-9 for **power** wheelchair evaluations

**1. NEUROLOGICAL FACTORS**

Indicate muscle tone:

WFL (within functional limits)    Hypertonic    Hypotonic    Fluctuating    Absent

Describe active movements affected by muscle tone:

Describe reflexes present:

Member demonstrates quadriplegia, hemiplegia, or uncontrolled arm movement?    YES    NO

Does the member demonstrate spasticity?    YES    NO

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**Vision:**        Normal        Impaired        Blind

**Hearing:**     Normal        Impaired        Deaf

### **2. COGNITIVE ASSESSMENT**

Has the member received a diagnosis related to cognition that would prohibit them from safely and efficiently operating a manual wheelchair or a power wheelchair?        YES        NO

1. If yes, please give detailed description of diagnosis(es):

2. If yes, does the member have a caregiver that is willing and capable of assisting with Mobility Related Activities of Daily Living (MRADL)?        YES        NO

a. If yes, how does the caregiver assist the member?

### **3. POSTURAL CONTROL (stability, orientation, midline, etc.)**

Head Control:

Trunk Control:

Asymmetrical posturing and related diagnosis:

### **4. RANGE OF MOTION (flexion, extension, abduction, adduction, strength, etc.)**

Upper Extremities:

Lower Extremities:

### **5. FUNCTIONAL ASSESSMENT**

Has the member or caregiver expressed a willingness to use a wheelchair?        YES        NO

Is the member currently on hospice care?        YES        NO

If yes, what is the diagnosis for hospice care?

What is the distance the member can safely and effectively ambulate?

Was a gait assessment performed?        YES        NO

If yes, explain findings:

Was an assistive device used as part of the assessment?        YES        NO

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If yes, what device was used:

Does the member currently use a wheelchair?      YES      NO

If yes:

- How long has the member had current wheelchair?
- Why does the wheelchair no longer meet the member's medical needs?
- Can the wheelchair be adapted to meet medical needs of the member?      YES      NO
- How does the member use the wheelchair?      Independently      With assistance      Dependent on caregiver
- Is the member totally dependent upon a wheelchair for MRADL?      YES      NO

If no, explain:

- How many hours per day does or will the member use a wheelchair?
- Can MRADL needs be met with a manual wheelchair?      YES      NO

Can the requested wheelchair be safely and effectively used by the member/caregiver?      YES      NO

How does the member transfer?

Independently      Assistive device      One-person assist      Two-person assist      Lift

### Skin Integrity

Does the member have a risk of or history of decubitus ulcers or skin breakdown?      YES      NO

If yes, please give dates and detailed description (e.g. staging, location, etc.)

Can the member effectively reposition for pressure relief?      YES      NO

If the requested wheelchair is an ultralightweight manual chair, and the member is unable to effectively reposition for pressure relief and has a history of decubitus ulcers or skin breakdown, has there been consideration for a Tilt-in-Space wheelchair?      NO      YES      If yes, explain why an ultralightweight manual wheelchair is more appropriate than a Tilt-in-Space wheelchair.

Does the member have a history of numbness or paresthesia?      YES      NO

If yes, what areas of the body are affected and how?

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Does the member have a fixed hip angle, a trunk cast or brace, excessive extensor tone or a need to change positions two or more times during the day?      YES      NO      If yes, explain:

Is the member's mobility limitation due to arthritis, neurological/neuromuscular condition, myopathy, or a congenital skeletal deformity?      YES      NO      If yes, explain:

### Toileting

Bladder:      Continent      Incontinent

Bowel:      Continent      Incontinent

Does the member utilize intermittent catheterization for bladder management?      YES      NO

### Upper and Lower Extremities:

Does the member experience pain when self-propelling a manual wheelchair?      YES      NO

If yes, describe pain and level of intensity.

Is the pain such that it would prohibit the member from using a manual wheelchair?      YES      NO

Does the member have a diagnosis affecting strength and endurance that would prohibit standard exertion used to self-propel any type of manual wheelchair?      YES      NO

Does the member have a cast, brace, or musculoskeletal condition which prevents 90-degree flexion of the knee?  
YES      NO

Does the member have significant edema of the lower extremities?      YES      NO

### Cardiopulmonary

This section to be completed if the member has a diagnosis related to the cardiopulmonary system.

Check box if there is no related diagnosis.      N/A

With exertion, does the member's blood pressure or heart rate increase to an extent that would be considered detrimental?      YES      NO      If yes, explain:

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Does the member experience hypoxemia when self-propelling a manual wheelchair?      YES      NO

If yes, explain:

Does the member use a ventilator that will be mounted on the wheelchair?      YES      NO

### **6. ENVIRONMENTAL ASSESSMENT**

Does the member reside in a long-term care facility?      YES      NO

If not, does the member reside in an Americans with Disabilities Act (ADA) compliant facility?

YES      NO

Does the member reside in a private residence?      YES      NO

If yes, does the residence allow for wheelchair accessibility?      YES      NO

Indicate the doorway width, ability to turn wheelchair, and type of flooring surface for each of the following:  
(Do not fill out the following table if the member resides in a long-term care or ADA compliant facility.)

	Entryway or Doorway Width	Ability to Turn Chair within the Room	Flooring Surface
<b>Kitchen</b>			
<b>Bathroom</b>			
<b>Bedroom</b>			
<b>Hallways</b>			
<b>Living room</b>			

### **7. POWER WHEELCHAIR**

Is the member or caregiver physically and mentally capable of operating power wheelchair safely with respect to self and others?      YES      NO

Will a power wheelchair significantly improve the member's ability to participate in MRADLs?      YES      NO

Has the member or caregiver expressed a willingness to utilize a power wheelchair?      YES      NO

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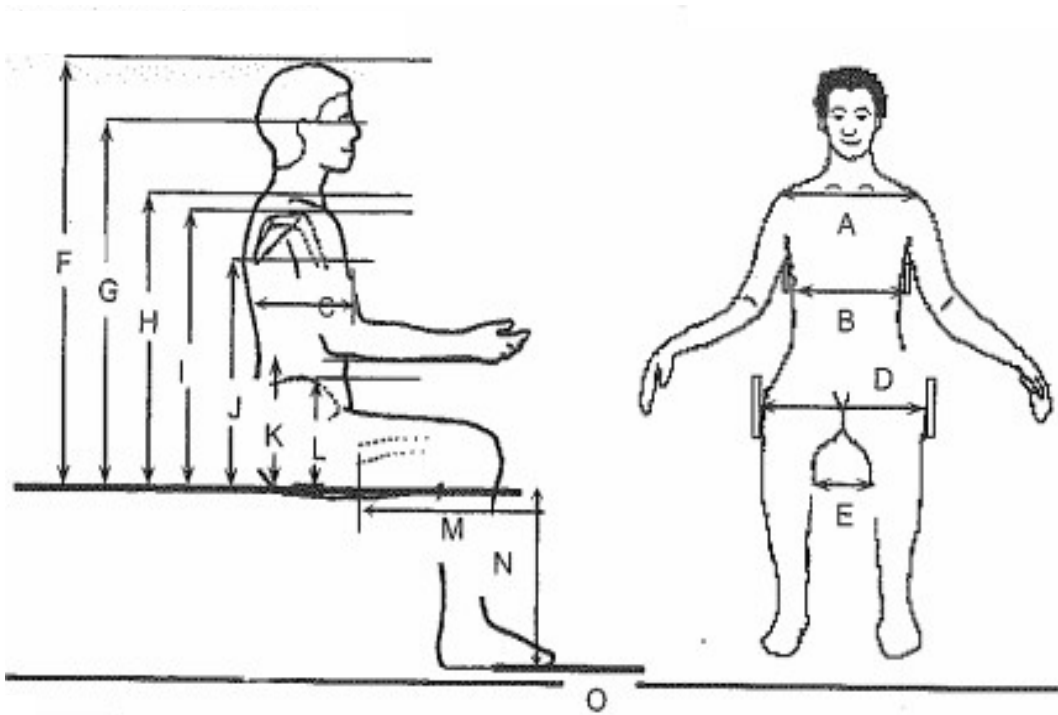
Is the mobility limitation secondary to severe neurological condition, myopathy, or congenital skeletal deformity?

YES      NO      If yes, explain:

*Reminder to Providers: When requesting authorization for a power wheelchair, a "Wheelchair Training Checklist Form" must be completed.*

### **8. MEASUREMENTS**

The following measurements can be taken by the evaluating therapist or a RESNA-certified Assistive Technology Professional (ATP).



Indicate all measurements outlined above.

Body Structure	Measurements	Body Structure	Measurement Left	Measurement Right
A. Shoulder Width		H. Seat to Top of Shoulder		
B. Chest Width		I. Acromium Process (tip of shoulder)		
C. Chest Depth (front-back)		J. Inferior Angle of Scapula		
D. Hip Width		K. Seat to Elbow		

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Body Structure	Measurements	Body Structure	Measurement Left	Measurement Right
E. Between Knees		L. Seat to Iliac Crest		
F. Top of Head		M. Upper Length of Leg		
G. Occiput		N. Lower Length of Leg		
		O. Foot Length		

### **9. MEDICAL NECESSITY**

Wheelchair requests require the evaluating therapist justify medical necessity for not only the wheelchair, but the accompanying accessories, attachments, components, and options. The process of identifying medically necessary equipment and the justification of those items can be a collaborative effort of all licensed/certified professionals involved with direct member care.

Use the following narrative box to identify each requested item with its associated HCPCS code and why it is medically necessary. The evaluating therapist may choose to complete a letter of medical necessity (LMN) separately from this form and attach it as part of the submission request.

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The LMN must be member specific. In accordance with Utah Administrative Code R414-1-2(18), using prepopulated generic statements or copy/paste statements used for other wheelchair requests are not considered appropriate for an LMN and will be returned as inadequate.

As the evaluating therapist, I hereby attest I have personally completed this evaluation and I am not an employee of, or working under contract, to the manufacturer(s) or the provider(s) of the equipment recommended in my evaluation. I further attest I have not and will not receive remuneration of any kind from the manufacturer(s) or the provider(s) for the equipment I have recommended in this evaluation.

Therapist Name (print):

Therapist's Signature: \_\_\_\_\_

Title:

Therapist Signature Date:

I have reviewed and agree with the findings in this evaluation.

ATP Name (print):

ATP Signature: \_\_\_\_\_

Phone:

ATP Signature Date:

I have reviewed and agree with the findings in this evaluation.

Physician's Name (print):

Physician's Signature: \_\_\_\_\_

Physician's Signature Date: