**This completed form must be attached to all wheelchair and seating prior authorization (PA) requests. All information from the general prior authorization form can be entered when submitting the request via online portal (**[**http://myqualitrac.com**](http://myqualitrac.com)**). If choosing to submit the request via fax: Fax this completed form, a completed general PA form, all required documentation, and documentation of medical necessity to (866) 539-0365.**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PARTICIPANT INFORMATION** | | | | | | | | | | | | |
| Name: | | | | MID: | | | | | | Date of Evaluation: | | |
| Address: | | | | Phone: | | | | | | Physician: | | |
| Age: | | | Sex:  M  F | | | OT: | | |
| Other Insurance: | | | | Height: | | | Weight: | | | PT: | | |
| Referred By: | | | | | | | Date Referred: | | | | | |
| Reason for Referral: | | | | | | | | | | | | |
| Patient Goals: | | | | | | | | | | | | |
| Caregiver Goals: | | | | | | | | | | | | |
| **MEDCIAL HISTORY** | | | | | | | | | | | | |
| Primary Diagnosis: | | | | | | | | | | | | ICD: |
| Secondary Diagnosis: | | | | | | | | | | | | ICD: |
| Other Diagnoses: | | | | | | | | | | | | ICD: |
| Hx/Progression:  (Symptoms) | | | | | | | | | | | | |
| Recent/Planned Surgeries: | | | | | | | | | | | | |
| Cardio-Respiratory:  Intact  Impaired | Comments, other DME currently used (O2, IV, etc.) | | | | | | | | | | | |
| **CURRENT SEATING/MOBILITY (Type – Manufacture – Model)** | | | | | | | | | | | | |
| Chair: | | | | | | | | | | | Age of Chair: | |
| W/C Cushion: | | Age of Cushion: | | | | W/C Back: | | | | | Age of Back: | |
| Reason for  Replacement  Repair  Update:  Why is current equipment not meeting medical needs? | | | | | | | | | | | | |
| Funding Source: | | | | | | | | | | | | |
| **HOME ENVIRONMENT** | | | | | | | | | | | | |
| House  Apartment  Assisted Living Facility  Long Term Care Facility  Alone  w/Family, Caregiver  (list facility or with whom): | | | | | | | | | | | | |
| Entrance:  Level  Ramp  Lift  Stairs | | | | | | | | Entrance Width: | | | | |
| W/C Accessible Rooms?  Yes  No | | | | | Narrowest Doorway Required to Access: | | | | | | | |
| Comments: | | | | | | | | | | | | |
| **TRANSPORTATION** | | | | | | | | | | | | |
| Car  Van  Bus  Adapted W/C Lift  Ramp  Ambulance Other: | | | | | | | | | | | | |
| Driving Requirements: | | | | | | | | | | | | |
| Notes: | | | | | | | | | | | | |
| **COGNITIVE/VISUAL STATUS** | | | | | | | | | | | | |
| Memory Skills | | | Intact  Impaired | | | | | | Comments: | | | |
| Problem Solving | | | Intact  Impaired | | | | | | Comments: | | | |
| Judgement | | | Intact  Impaired | | | | | | Comments: | | | |
| Attention/Concentration | | | Intact  Impaired | | | | | | Comments: | | | |
| Vision | | | Intact  Impaired | | | | | | Comments: | | | |
| Hearing | | | Intact  Impaired | | | | | | Comments: | | | |
| Other | | | Intact  Impaired | | | | | | Comments: | | | |

Idaho Medicaid Seating and Mobility Evaluation (cont.)

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| **ADL STATUS** | | | | | | | | | |
| ***Activity*** | | ***Indep.*** | ***Assist*** | | ***Unable*** | ***Comments/Other AT Equipment Required*** | | | |
| Dressing | |  |  | |  |  | | | |
| Bathing | |  |  | |  |
| Feeding | |  |  | |  |
| Grooming/Hygiene | |  |  | |  |
| Toileting | |  |  | |  |
| Meal Preparation | |  |  | |  |
| Home Management | |  |  | |  |
| School/Work | |  |  | |  |
| Bowel Management | | Continent  Incontinent | | | |
| Bladder Management | | Continent  Incontinent | | | |
| **MOBILITY SKILLS** | | | | | | | | | |
| ***Skill*** | | ***Indep.*** | ***Assist*** | | ***Unable*** | ***NA*** | ***Comments/History of Past Use*** | | |
| Bed ↔ W/C Transfers | |  |  | |  |  |  | | |
| W/C ↔ Commode Transfers | |  |  | |  |  |  | | |
| Ambulation | |  |  | |  |  | Device: | | |
| Manual W/C Propulsion | |  |  | |  |  |  | | |
| Power W/C, std. Joystick | |  |  | |  |  |  | | |
| Power W/C, alt. Controls | |  |  | |  |  |  | | |
| Weight Shifts | |  |  | |  |  | Type: | | |
| **SENSATION** | | | | | | | | | |
| Intact  Impaired  Absent | | | | HX Pressure Sores:  Yes  No | | | | | Current Pressure Sores:  Yes  No |
| Comments: | | | | | | | | | |
| **CLINICAL CRITERIA/ALGORITHM SUMMARY** | | | | | | | | | |
| Is there a mobility limitation causing an inability to safely participate in one or more Mobility Related Actives of Daily Living in a reasonable time frame? | | | | | | | | Yes  No  Explain: | |
| Are there cognitive or sensory deficits (awareness / judgment / vision / etc.) that limit the user’s ability to safely participate in one or more MRADL’s? | | | | | | | | Yes  No  Explain: | |
| If yes, can they be accommodated / compensated for to allow use of a mobility assistive device to participate in MRADL’s? | | | | | | | | Yes  No  Explain: | |
| Does the user demonstrate the ability or potential ability and willingness to safely use the mobility assistive device? | | | | | | | | Yes  No  Explain: | |
| Can the mobility deficit be sufficiently resolved with only the use of a cane or walker? | | | | | | | | Yes  No  Explain: | |
| Does the user’s environment support the use of a  MANUAL WHEELCHAIR  POV  POWER WHEELCHAIR | | | | | | | | Yes  No  Explain: | |
| If a manual wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment? | | | | | | | | Yes  No  Explain: | |
| If a POV is recommended, does the user have sufficient stability and upper extremity function to operate it? | | | | | | | | Yes  No  Explain: | |
| If a power wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment? | | | | | | | | Yes  No  Explain: | |
| **How many total hours per day does the participant sit or expect to sit in the wheelchair?** | | | | | | | | | |
| **RECOMMENDATION** | **MANUAL WHEELCHAIR  POV  POWER WHEELCHAIR  SEATING  POSITIONING SYSTEM (SPECIFY):** | | | | | | | | |

Idaho Medicaid Seating and Mobility Evaluation (cont.)

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| **MAT EVALUTATION: (NOTE IF ASSESSED SITTING OR SUPINE)** | | | | | |
|  | **POSTURE** | | **FUNCTION** | **COMMENTS** | **SUPPORT** |
| **HEAD & NECK** | Functional  flexed  Extended  Rotated  Laterally Flexed  Cervical Hypertension | | Good Head Control  Adequate Head Control  Limited Head Control  Absent Head Control |  |  |
| **UPPER**  **EXTRE-MITY** | *SHOUILDERS:* | | ROM – Reach to:  Overhead  L  R  Shoulder Ht.  L  R  Wheel Ht.  L  R  STRENGTH: |  |  |
| WFL  Elev/Drop  Pro/Retract  Subluxed | L  R  L  R  L  R  L  R |
| *ELBOWS:* | | ROM:  STRENGTH: |  |  |
| Impaired  WFL | L  R  L  R |
| **WRIST/**  **HAND** | Impaired:  WFL | L  R  L  R | STRENGTH/DEXTERITY: |  |  |
| **TRUNK** | **ANTERIOR/POSTERIOR**  **Diagram  Description automatically generated with low confidence**    WFL Thoracic Lumbar  Kyphosis Lordosis  Flexible  Partly Flexible  Fixed  Other | | **LEFT/RIGHT**      WFL Convex Convex  Left Right  *Views above are posterior*  Flexible  Partly Flexible  Fixed  Other | **ROTATION**  A close-up of a bag  Description automatically generated with medium confidence  Neutral  Left Forward  Right Forward  *Views above are anterior*  Flexible  Partly Flexible  Fixed  Other |  |
| **Pelvis** | **ANTERIOR/POSTERIOR**  **A picture containing linedrawing  Description automatically generated**    WFL Posterior Anterior  Tilt Tilt  Flexible  Partly Flexible  Fixed  Other | | **OBLIQUITY**  **A picture containing text, map  Description automatically generated**    WFL L Lower R Lower  *Views above are posterior*  Flexible  Partly Flexible  Fixed  Other | **ROTATION**  **A close-up of several x-rays  Description automatically generated with low confidence**    WFL Right Left  *Views above are anterior*  Flexible  Partly Flexible  Fixed  Other |  |
| **HIPS** | **POSITION**  A picture containing text, linedrawing  Description automatically generated    Neutral ABduct Adduct  Flexible  Partly Flexible  Fixed  Other | | **WINDSWEPT**  A collage of a person's face  Description automatically generated with low confidence    Neutral Right Left  *Views above are posterior*  Flexible  Partly Flexible  Fixed  Other | **RANGE OF MOTION**  ***L:*** Flex \_\_\_\_\_\_\_˚  Ext\_\_\_\_\_\_\_\_˚  Int R\_\_\_\_\_\_\_˚  Ext R\_\_\_\_\_\_\_˚  *R:* Flex \_\_\_\_\_\_\_˚  Ext\_\_\_\_\_\_­\_\_˚  Int R\_\_\_\_\_\_\_˚  Ext R\_\_\_\_\_\_\_˚ | **Lower Extremity**  **Able to:**  Bear Weight  Sit to Stand  Floor Sit to  Stand |

Idaho Medicaid Seating and Mobility Evaluation (cont.)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MAT EVALUTATION, CONTINUED: (NOTE IF ASSESSED SITTING OR SUPINE)** | | | | | | | | | | |
| **KNEE**  **&**  **FEET** | **KNEE RANGE OF MOTION**  ***L:***  WFL  Flex\_\_\_\_\_\_\_\_**˚**  Ext\_\_\_\_\_\_\_\_\_**˚**  ***R:***  WFL  Flex\_\_\_\_\_\_\_\_**˚**  Ext\_\_\_\_\_\_\_\_\_**˚** | | **Strength:**  Knee extension ROM  @\_\_\_\_\_**˚** of hip flex  L:\_\_\_\_\_ R:\_\_\_\_\_ | | | | **FOOT POSITIONING**  WFL  L  R  Dorsi-  L  R  flexed  Plantar  L  R  Flexed  Inversion  L  R  Eversion  L  R | | Foot Positioning Needs: | |
| **MOBIL-ITY** | **BALANCE**  *Sit: Stand:*  WFL  Min Support  Mod Support  Unable | | **TRANSFERS**  Independent  Minimal Assistance  Maximal Assistance  Sliding Board  Lift/Sling Required  Floor to Chair | | | | **AMBULATION**  Unable  With Assistance  With Device  Indep. w/o Device  Indep. Short Dist. Only | | Notes: | |
| A picture containing linedrawing, map  Description automatically generated | | | | | | | **NEUROMUSCULAR STATUS:**  Tone:  Reflexive Responses:  Effect on Function: | | | |
| **MEASUREMENTS – SITTING** | | | | | | | | | **LEFT** | **RIGHT** |
| **A:** Shoulder Width | | | |  | | Degree of Hip Flexion | | |  |  |
| **B:** Chest Width | | | |  | | **H:** Top of Shoulder | | |  |  |
| **C:** Chest Depth (Front – Back) | | | |  | | **I:** Acromium Process (Tip of Shoulder) | | |  |  |
| **D:** Hip Width – *for asymmetrical width (scoliotic or windswept) measure widest pt. to widest pt.* | | | |  | | **J:** Inferior Angle of Scapula | | |  |  |
| **K:** Iliac Crest | | |  |  |
| **E:** Between Knees | | | |  | | **M:** Sacrum to Popliteal Fossa | | |  |  |
| **F:** Top of Head | | | |  | | **N:** Knee to Heel | | |  |  |
| **G:** Occiput | | | |  | | **O:** Foot Length | | |  |  |
| **Summary of**  **Postural Asymmetries:**  **Additional Comments:** | | | | | | | | | | |
| Physical/Occupational Therapist: | | Signed: | | | Date: | | | Phone: | | |
| Physician: | | Signed: | | | Date: | | | Phone: | | |

* *The status of a prior authorization request may be checked via portal or by calling (866) 538-9510.*
* *Any questions regarding this process may be sent to* [*IDMedicaidsupport@telligen.com*](mailto:IDMedicaidsupport@telligen.com)
* *More information is available at idmedicaid.telligen.com*