**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 [ ]  NoExplain:  |
| 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 [ ]  NoExplain: |
| If yes, can they be accommodated / compensated for to allow use of a mobility assistive device to participate in MRADL’s? | [ ]  Yes [ ]  NoExplain: |
| Does the user demonstrate the ability or potential ability and willingness to safely use the mobility assistive device? | [ ]  Yes [ ]  NoExplain: |
| Can the mobility deficit be sufficiently resolved with only the use of a cane or walker? | [ ]  Yes [ ]  NoExplain: |
| Does the user’s environment support the use of a[ ]  MANUAL WHEELCHAIR [ ]  POV [ ]  POWER WHEELCHAIR | [ ]  Yes [ ]  NoExplain: |
| If a manual wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment? | [ ]  Yes [ ]  NoExplain: |
| If a POV is recommended, does the user have sufficient stability and upper extremity function to operate it? | [ ]  Yes [ ]  NoExplain: |
| If a power wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment? | [ ]  Yes [ ]  NoExplain: |
| **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: |  |  |
| WFLElev/DropPro/RetractSubluxed | [ ]  L [ ]  R [ ]  L [ ]  R [ ]  L [ ]  R [ ]  L [ ]  R  |
| *ELBOWS:* | ROM:STRENGTH: |  |  |
| ImpairedWFL | [ ]  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*
* *More information is available at idmedicaid.telligen.com*