State of Louisiana Medicaid
Custom Wheelchair Evaluation Form

***Instructions**:* The therapist and/or provider must complete **ALL** sections of this form and document the form with medical justification for the custom manual or motorized wheelchair and **ALL** non-standard parts. If a section is not relevant to the beneficiary's medical needs, the practitioner should document that section as not applicable. No sections of the form should be left blank or skipped.

1. The Prior Authorization (PA-01) and Custom Wheelchair Evaluation form are required with **ALL** Custom Wheelchair and Wheelchair modification requests.
2. **ALL** documentation must be clear and legible.
3. The individual affirming its contents must complete **ALL** sections of this form. Enter N/A for items/sections that do not apply.
4. Please attach doctor's prescription and the itemized price sheet provided by the manufacturer.
5. Documenting "see attached" in a section is not sufficient.
6. Include for reference the page, section and question numbers when adding comments on pages 14-16.
7. Attachments are available for edema grading and severity of tone.

DO NOT CHANGE OR ALTER THIS FORM.

ONLY THE OFFICIAL LDH VERSION OF THE FORM WILL BE ACCEPTED FOR CUSTOM WHEELCHAIR REQUESTS.

Acronyms

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 – plantar-flexion
PROM – passive range of motion
ROM – range of motion
SPV – supervision
UE – upper extremity
WFL – within functional limits

See page 17 for **Muscle Tone Descriptive System Table**.

See page 18 for **Pitting Edema Scale**.

I. GENERAL INFORMATION (PROVIDER):

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

II. MEDICAL HISTORY (PROVIDER):

Diagnosis: _____
Date of Injury/Onset: _____ Prognosis: _____
Summary of Medical Condition: _____
_____
_____
Relevant past or future surgeries (include dates): _____
Seizure History: □ Yes □ No
If yes, list the number of seizures with anti-seizure medication: _____
Describe severity of seizures:
_____
_____
Describe any recent or expected changes in beneficiary's medical/physical/functional status:
_____
_____
_____
Estimated length of need of wheelchair: _____

III. PRESENT WHEELCHAIR (PROVIDER):

Does the beneficiary currently own any type of wheelchair: □ Yes □ No
If no, what was the beneficiary using before to get around their home and community:
_____
If yes, provide the following information:
Serial #: _____ Date provided: _____
Model: _____ Type: □ Manual □ Power
Size: _____ Price: _____ Funding Source: _____
Wheelchair frame condition: □ Good □ Fair □ Poor
Current seating system: _____ Age: _____ Current condition: □ Good □ Fair □ Poor
Can the wheelchair frame or seating system be modified or repaired? □ Yes □ No
If yes, please explain and include repair cost.
_____
_____
_____
If no, explain why the beneficiary's chair is not meeting his/her beneficiary medical needs:
_____
_____
_____
_____
_____

IV. HOME ENVIRONMENT (PROVIDER/THERAPIST):

□ House □ 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 to the current/recommended wheelchair? □ Yes □ No

If no, will the home be modified? □ Yes □ No

How will wheelchair be stored to avoid damage and/or malfunctioning of parts?

_____

_____

_____

_____

V. TRANSPORTATION (PROVIDER/THERAPIST):

□ Car □ Truck □ Van □ Public transportation □ School Bus □ Other: _____

Must the wheelchair fold for transportation? □ Yes □ No

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

Will the beneficiary sit in the wheelchair during transportation? □ Yes □ No

If yes, will the beneficiary 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: Model _____

□ Non-Communicative

VIII. SENSATION (THERAPIST):

□ Intact □ Impaired □ Absent

If impaired or absent, provide location: _____

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 beneficiary perform pressure reliefs? □ Yes □ No

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

Bowel management: □ Continent □ Incontinent

Bladder management: □ Continent □ Incontinent

Comments: _____

_____

_____

IX. ADL'S (THERAPIST): (assess beneficiary'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
☐ Tube feeding (hours/day): _____ Pump model: _____
Grooming ☐ Independent ☐ Mod I ☐ SPV ☐ Min A ☐ Mod A ☐ Max A ☐ Dependent
Handedness ☐ Right ☐ Left
Comments: _____

X. PATHOLOGICAL REFLEXES (THERAPIST):

☐ Asymmetrical tonic neck reflex ☐ Symmetrical tonic neck reflex ☐ Tonic labyrinthine reflex supine
☐ Tonic labyrinthine reflex prone ☐ Extensor thrust ☐ Startle ☐ Positive Supporting ☐ Muscle spasms
☐ Flexor tone, location and severity: _____
☐ Extensor tone, location and severity: _____
☐ 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

What is the beneficiary's primary mode of mobility:
☐ Ambulatory ☐ Wheelchair ☐ Other: _____

Ambulatory status: ☐ Independent ☐ Mod I ☐ SPV ☐ Min A ☐ Mod A ☐ Max A ☐ Dependent
☐ Non-ambulatory
Distance: ☐ < 25 feet ☐ 25–50 feet ☐ 50–100 feet ☐ 100–200 feet ☐ 200–300 feet ☐ > 500 feet
Device: ☐ Straight Cane ☐ Quad Cane ☐ Crutches ☐ Forearm Crutches ☐ Walker ☐ Gait Trainer
☐ None
If non-ambulatory, indicate the beneficiary's ambulatory potential:
☐ Within 6 months ☐ Expected in 1 year ☐ Not expected
Has the beneficiary tried walking with all ambulatory assistive devices? ☐ Yes ☐ No
Explain why other ambulatory assistive devices are not sufficient for the beneficiary's mobility.
_____
_____
Number of falls per day, week, month: _____
Comments: _____
_____

Manual wheelchair propulsion: ☐ Independent ☐ Mod I ☐ SPV ☐ Min A ☐ Mod A ☐ Max A ☐ Dependent
Method? ☐ UE: left/right ☐ LE: left/right ☐ Both UE and LE: left/right ☐ Other: _____
Distance? ☐ < 25 feet ☐ 25–50 feet ☐ 50–100 feet ☐ 100–200 feet ☐ 200–300 feet ☐ > 500 feet
Has the beneficiary tried using all types of manual wheelchairs? (standard, lightweight, ultra lightweight, one arm drive) ☐ Yes ☐ No

Explain why all types of manual wheelchair are not sufficient for the beneficiary's mobility.
_____
_____

Would the beneficiary be able to propel a manual wheelchair if plastic coated hand rims or projections where added? □ Yes □ No

If no, explain. _____
_____

Hours sitting or expected in manual wheelchair: _____
Can the beneficiary safely propel the recommended wheelchair? □ Yes □ No
Comments: _____
_____

Power wheelchair mobility: □ Independent □ Mod I □ SPV □ Min A □ Mod A □ Max A □ Dependent □ NA

Method? □ Joystick (select one: □ Left □ Right) □ Alternative controls
Hours sitting or expected in power wheelchair: _____
Has the beneficiary demonstrated that he/she can safely and independently operate the recommended power wheelchair? □ Yes □ No
Comments: _____
_____

XII. POSTURE (THERAPIST): (assessment done in sitting without postural correction)

Head Posture: □ WFL □ Flexed □ Extended □ Rotated: left or right □ Laterally flexed: left or right □ Cervical hyperextension
Neck Control: □ Normal □ Good □ Fair □ Poor □ Absent
Neck Tone: □ Normal □ Hypotonia □ Hypertonia □ Spasticity □ Rigidity □ Athetosis □ Ataxia □ Dystonia □ Fluctuating
Severity: □ Mild □ Moderate □ Severe
Trunk Posture: □ WFL
□ Thoracic kyphosis
□ Fixed □ Partially fixed □ Flexible
□ Lumbar lordosis
□ Fixed □ Partially fixed □ Flexible
□ Scoliosis: left or right
Curve: C or S Rib hump: left or right
□ Fixed □ Partially fixed □ Flexible
□ Rotation: left or right
□ Fixed □ Partially fixed □ Flexible
Trunk Tone: □ Hypotonia □ Normal □ Hypertonia □ Spasticity □ Rigidity □ Athetosis □ Ataxia □ Dystonia □ Fluctuating
Severity: □ Mild □ Moderate □ Severe
Pelvis Posture: □ Neutral □ Posterior □ Anterior
□ Fixed □ Partially fixed □ Flexible
□ Obliquity: left higher or right higher
□ Fixed □ Partially fixed □ Flexible
□ Rotation: left or right
□ Fixed □ Partially fixed □ Flexible
Comments: _____
_____

XIII. UPPER EXTREMITY (THERAPIST):

LEFT				RIGHT
□ AROM/ □ PROM Please check	STRENGTH (MMT)	UPPER EXTREMITY (Normal ROM)	STRENGTH (MMT)	□ AROM/ □ PROM Please check
	/5	Shoulder Flex 180°	/5	
	/5	Shoulder Ext 45°	/5	
	/5	Shoulder Abd 180°	/5	
	/5	Shoulder Add 40°	/5	
	/5	Elbow Flex 145°	/5	
	/5	Elbow Ext 0-(-5)°	/5	
	/5	Wrist Flex 80°	/5	
	/5	Wrist Ext 70°	/5	
	Lbs.	Grip	Lbs.	

Note: Documentation of percentages are not acceptable for ROM
If unable to test beneficiary strength or ROM please explain why and provide estimate for ROM

_____
_____
_____

Shoulders:

Left	Right
□ WFL	□ WFL
□ Elevated	□ Elevated
□ Depressed	□ Depressed
□ Protracted	□ Protracted
□ Retracted	□ Retracted
□ Subluxed	□ Subluxed

Hands:
□ WFL □ Fisting □ Other: _____

UE Tone: □ Normal □ Flaccid □ Hypotonia □ Hypertonia □ Spasticity □ Rigidity □ Fluctuating □ Dystonia
UE Tone Severity: □ Mild □ Moderate □ Severe

Comments on the beneficiary's UE:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

XIV. LOWER EXTREMITY (THERAPIST):

LEFT				RIGHT	
□ AROM/ □ PROM Please check	STRENGTH (MMT)	LOWER EXTREMITY (Normal ROM)		□ AROM/ □ PROM Please check	STRENGTH (MMT)
	/5	Hip Flex	120°		/5
	/5	Hip Ext.	30°		/5
	/5	Hip Abd	45°		/5
	/5	Hip Add	20°		/5
	/5	Hip IR	45°		/5
	/5	Hip ER	45°		/5
	/5	Knee Flex	135°		/5
	/5	Knee Ext	0°		/5
	/5	Ankle DF	20°		/5
	/5	Ankle PF	50°		/5
	/5	Ankle IV	35°		/5
	/5	Ankle EV	15°		/5

Note: Percentages are not allowed for ROM.
If unable to test the strength or ROM please explain why and provide estimate for ROM.

_____
_____
_____

Hip Posture:

□ Neutral
□ Hip Abduction: left or right
□ Fixed □ Partially fixed □ Flexible
□ Windswept: left or right
□ Fixed □ Partially fixed □ Flexible
□ Subluxed: left or right
□ Hip Adduction: left or right
□ Fixed □ Partially fixed □ Flexible
□ Leg length discrepancy
□ Left shorter □ Right shorter
□ Dislocated: left or right

Does the beneficiary wear AFO's? □ Yes □ No
LE Tone: □ Normal □ Flaccid □ Hypotonia □ Hypertonia □ Spasticity □ Rigidity □ Fluctuating
□ Dystonia
Severity: □ Mild □ Moderate □ Severe
Comments on beneficiary'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, state, severity (using the visual analog scale 0–10), location, and how often (daily, weekly, monthly). _____
_____

Is the beneficiary on pain medication? □ Yes □ No

If yes, list medication. _____

Does pain medication alleviate the beneficiary's pain? _____

Edema: □ Yes □ No

If yes, state severity (grade 0–4): _____

Location: _____

How often (daily, weekly, monthly): _____

Comments: _____
_____
_____
_____

XVII. SEATING MEASUREMENTS (THERAPIST): (sitting)

Height: _____ inches Weight: _____ lbs. Is beneficiary's weight stable: □ Yes □ No

	LEFT	RIGHT	MEASUREMENT
Seat to top of head			
Seat to top shoulder			
Seat to axilla			
Seat to elbow			
Shoulder width			
Chest width			
Hip width			
Seat depth			
Knee to heel			
Foot length			

Overall Width (asymmetrical width: windswept/scoliosis): _____

Comments: _____
_____

Does the beneficiary have a brace or orthosis? □ Yes □ No

If yes, please explain. _____
_____
_____
_____

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

1. Provide the itemized price sheet from the manufacturer for all requested items.
2. Describe the medical necessity justification for each requested equipment.
3. Justify seat width and depth requested for the wheelchair frame and seating system.
4. Medically justify each non-standard part on the wheelchair as it relates to beneficiary's specific limitations.
5. Explain why standard or other least costly options for each non-standard part on the wheelchair will not meet the beneficiary's medical needs.
6. Provide examples of other standard or least costly options explored based on beneficiary's specific limitations and why these options would not work.
7. List the wheelchair parts in order of the manufacturer price sheet.
8. Stamp signatures are not accepted.
9. The Provider can assist with all wheelchair/part justifications.

Wheelchair Model: _____
Justification: _____
_____
_____
_____

Seat width: _____ Depth requested: _____
How will this accommodate the beneficiary's current measurements and allow for growth:
_____
_____
_____
_____
_____
_____
_____

NON-STANDARD WHEELCHAIR PARTS: Medical justification **MUST** be documented for each non-standard wheelchair part/item requested. Failure to justify a non-standard part/item may result in denial of that part/item.

NON-STANDARD PARTS	
MEDICAL JUSTIFICATION	
NON-STANDARD PARTS	
MEDICAL JUSTIFICATION	

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NON-STANDARD PARTS	
MEDICAL JUSTIFICATION	

NOTE: Additional comments may be provided on pages 14-16 to support medical necessity for the requested wheelchair and non-standard parts. The additional comment pages are considered a part of the evaluation form. Your signature on page 13 of this form includes affirmation to information included on pages 14-16 as additional comments.

AFFIRMATION OF EVALUATION FORM

Therapist:

I, _____, was present and participated in this evaluation, have personally completed this evaluation, and agree that the above □ **custom manual wheelchair** □ **custom power wheelchair** and all the non-standard parts recommended are medically necessary for the above beneficiary.

_____
Therapist (Print Name)

_____ _____
Therapist's Signature/Credentials Date

Provider:

I, _____, have read this evaluation and agree that the above above □ **custom manual wheelchair** □ **custom power wheelchair** and all the nonstandard parts requested are medically necessary for the above beneficiary.

_____
Provider (Print Name)

_____ _____
Provider's Signature/Credentials Date

ADDITIONAL COMMENTS

Use this area to document any additional information to support medical necessity. If additional comment is related to an item with the form, identify the section you are referencing next to the comment.

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Use this area to document any additional information to support medical necessity. If additional comment is related to an item with the form, identify the section you are referencing next to the comment.

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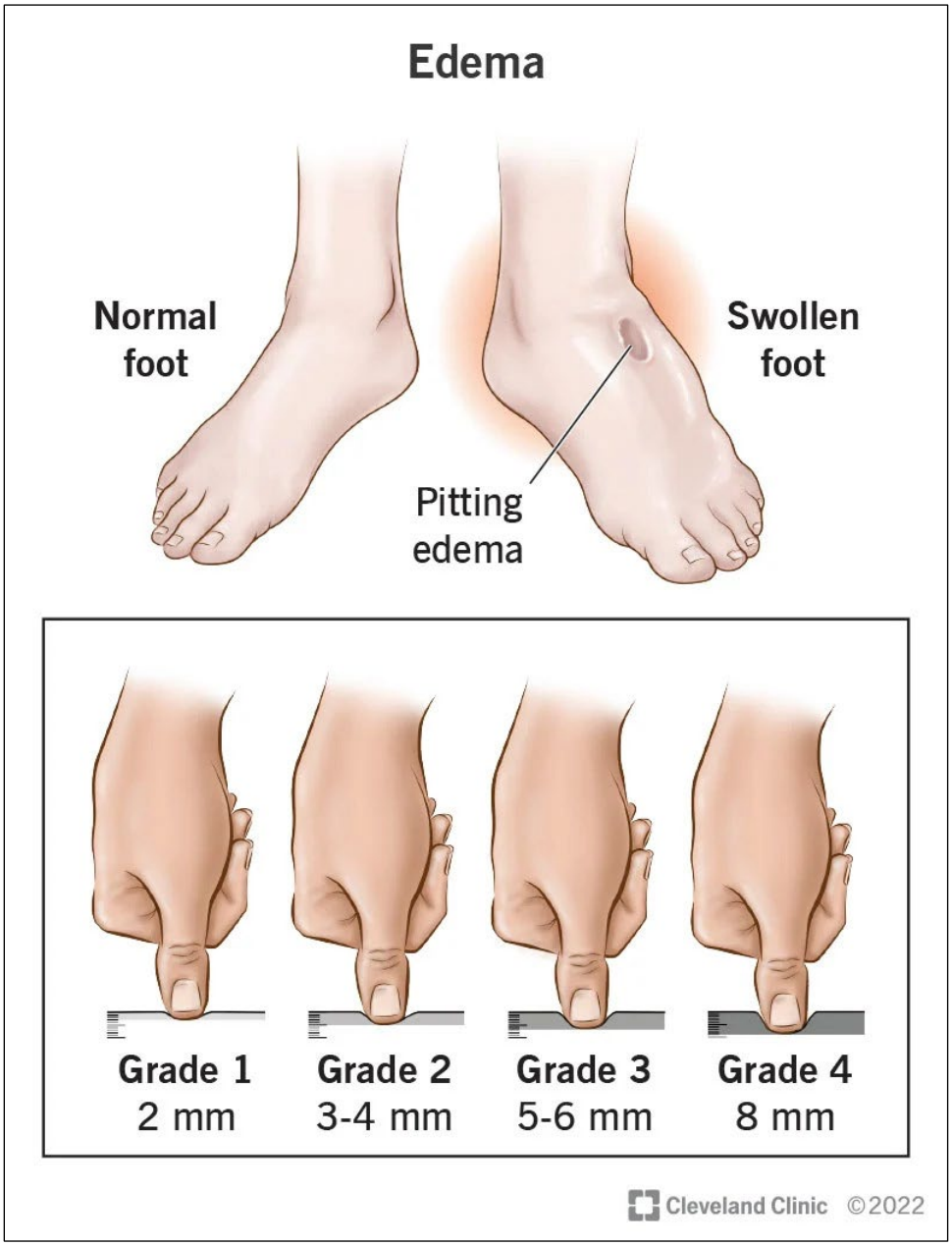
MUSCLE TONE: DESCRIPTIVE SYSTEM

HYPOTONIA			NORMAL	HYPERTONIA			INTERMITTENT TONE
Severe	**Moderate**	**Mild**		**Severe**	**Moderate**	**Mild**	
ACTIVE							
Inability to resist gravity; lack of contraction at proximal joints; limited voluntary movement	Decreased tone primarily in axial muscles and proximal muscles of the extremities; interferes with length of time a posture can be sustained	Decreased tone interferes with axial muscle contractions; delays initiation of movement.	Quick and immediate postural adjustment during movement; ability to use muscles in synergic and reciprocal patterns for stability and mobility depending on tasks	Delay in postural adjustments; poor coordination; slowness of movement	Limitation in speed, coordination, variety of movement patterns and active ROM	Stiffness of muscles in stereotypic patterns; limits active ROM; little or no ability to move against gravity; very limited patterns of movement	Occasional and unpredictable resistance to postural changes alternating with normal adjustment; may have difficulty initiating active movement or sustaining posture
PASSIVE							
Joint hyper extensibility; no resistance to movement imposed by examiner; full or excessive passive ROM	Mild resistance to movement in distal extremities only; elbow and knee joint hyper extensibility	Mild resistance in proximal and distal segments; full ROM	Body parts resist displacement; momentarily maintain new posture when placed	Resistance to change of posture in part or throughout ROM; poor ability to accommodate to passive movements	Resistance to change of posture throughout the range; limited passive ROM at some joints	ROM limited; examiner unable to overcome resistance of muscle to complete full range	Unpredictable resistance to imposed movements alternating with complete absence of resistance

Data in table obtained from the Pediatric Neurologic Physical Therapy (2nd ed., pp. 313) New York: Churchill Livingston

PITTING EDEMA SCALE



Referenced picture obtained from Cleveland Clinic Website: my.clevelandclinic.org