UTAH DEPARTMENT OF HEALTH MEDICAID
A Bridge to Wellness for Utah's Vulnerable

Wheelchair Initial Evaluation Form

Complete before submitting a prior-authorization request

Member Information:

Members Name: Click here to enter text.

Members Primary Residence: Click here to enter text.

Medicaid ID#: Click here to enter text.

Members Height: Click here to enter text.

Members Date of Birth: Click here to enter a date.

Members Weight: Click here to enter text.

Diagnosis:

Associated ICD-10 CODE(S):

Click here to enter text.

Provider Information:

Date of face-to-face evaluation: Click here to enter a date.

Date of wheelchair evaluation: Click here to enter a date.

Date of physician's order: Click here to enter a date.

Evaluating therapist name: Click here to enter text.

Physician's name: Click here to enter text.

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: Click here to enter text.

Describe reflexes present: Click here to enter text.

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

Does the member demonstrate spasticity? ☐ YES ☐ NO

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): Click here to enter text.

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? Click here to enter text.

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

Head Control: Click here to enter text.

Trunk Control: Click here to enter text.

Asymmetrical posturing and related diagnosis:

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

Upper Extremities

Lower Extremities: Click here to enter text.

5. FUNCTIONAL ASSESSMENT

Has the member or caregiver expressed a willingness to use a wheelchair?

Was a gait assessment performed? ☐ YES ☐ NO

If yes, explain findings:

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

If yes, what device was used: Click here to enter text.

Does the member currently use a wheelchair? ☐ YES ☐ NO

If yes:

- How long has the member had current wheelchair? Click here to enter text.
- 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: Click here to enter text.
- How many hours per day does or will the member use a wheelchair? Click here to enter text.

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

Does the member have a history of numbness or paresthesia? ☐ YES ☐ NO
If yes, what areas of the body are affected and how? Click here to enter text.

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 congenital skeletal deformity? ☐ YES ☐ NO if yes, explain: Click here to enter text.

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: Click here to enter text.

Does the member experience hypoxemia when self-propelling a manual wheelchair? ☐ YES ☐ NO if yes, explain: Click here to enter text.

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**
Kitchen	Click here to enter text.	Click here to enter text.	Click here to enter text.
Bathroom	Click here to enter text.	Click here to enter text.	Click here to enter text.
Bedroom	Click here to enter text.		Click here to enter text.
Hallways	Click here to enter text.	Click here to enter text.	Click here to enter text.

Living room	Click here to enter text.	Click here to enter text.	Click here to enter text.

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

Is the mobility limitation secondary to severe neurological condition, myopathy, or congenital skeletal deformity? ☐ YES ☐ NO

If yes, explain: Click here to enter text.

As a reminder to providers, when requesting authorization for a power wheelchair, a "Wheelchair Training Checklist Form" must be completed.

8. MEASUREMENTS

The following measurments can be taken by the evaluating therapist or a RESNA-certified Assistive Technology Professional (A
Indicate all measurments outlined abov

Body Structure	Measurements	Body Structure	Measurement Left	Measurement Right
A. Shoulder Width	Click here to enter text.	H. Seat to Top of Shoulder		Click here to enter text.
B. Chest Width	Click here to enter text.	I. Acromium Process (tip of shoulder)	Click here to enter text.	Click here to enter text.
C. Chest Depth (front-back)	Click here to enter text.	J. Inferior Angle of Scapula	Click here to enter text.	
D. Top of Head	Click here to enter text.	M. Upper Length of Leg	Click here to enter text.	Click here to enter text.
E. Occiput	Click here to enter text.	N. Lower Length of Leg		Click here to enter text.
		O. Foot Length		Click here to enter text.

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.

Wheelchair Initial Evaluation Form

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.

Click here to enter text.

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): Click here to enter text.
Title: Click here to enter text.
Therapist's Signature: _____
Therapist Signature Date: Click here to enter a date.

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

ATP Name (print): Click here to enter text.
Phone: Click here to enter text.
ATP Signature: _____
ATP Signature Date: 9/18/2020

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

Physician's Name (print): Click here to enter text.

Physician's Signature: _____

Physician's Signature Date: Click here to enter a date.