Alabama Medicaid's DME Program, Clinical Services & Support Division and Qualis Health

Wheelchair/Seating Evaluation Form (Form 384)

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Wheelchair /Seating Evaluation Form (Form 384)

Primary Objective

- Provide training on how to complete the Form 384
- Discuss elimination of a separate letter of medical necessity
- Review instructions for completing Form 384
- Describe sections that may be completed by an ATP
- Explore tips for efficient review

Qualis Health's Role

Alabama-based staff will review requests submitted based upon Alabama Medicaid prior authorization criteria

- Eight registered nurses (five review PAs)
- Two medical directors
- Three consultant physical therapists

General Instructions for Completing Form 384

- Form designed for evaluating children and adults needing wide range of WC/Seating needs
- Must be filled out by licensed PT or OT
- Thoroughly complete sections that apply to the individual patient
  - If an area does not apply, use N/A

General Instructions for Completing Form 384 (cont')

- Complete electronically, print and fax **OR** print, complete and fax
- Must be legible
- To fill out electronically, you will need Adobe Professional on your computer
- The Start Time and End Time are not required but available for services that have to record this (i.e., outpatient/home health)

Sections Vendor Can Complete

- Page 1 – NPI number
- Page 1 - Current WC/Seating system specifications
- Page 4 – measurements

Referral Information Section

Referral Information

Are you receiving services of any kind (therapy, nursing, school, etc.)? ________________

Physician: ___________________________ Phone: _________________ Fax:___________

Vendor/Rep Name: ________________________ Phone: __________________ NPI#: ___________

Case Manager / VR/IL counselor: ____________________________________ Phone: _________

Reason for Referral: ____

Acronyms in this Section

- VR = Vocational Rehabilitation Counselor
- IL = Independent Living (SAIL) Counselor
- NPI = NPI number

Current Wheelchair/ Seating System Section

Current Wheelchair / Seating System

□ None □ Dependent □Manual Tilt in Space □ Manual □Scooter □ Power

Manufacturer: ____________________ Model: __________________ Serial #:________________

Age of chair: _____________________Provider:_________________ Funding: ________________

Frame width: ________Frame depth: ________Overall width: _______ Overall length: _________

Cushion: style__________________________ age: ____________

Solid back: □yes □ no Type: ________________________ age: ____________ __________

Back height: __________Front seat to floor height: _______Rear seat to floor height: _________

Power: Drive Control Type: ________________________________

Other seating components? ____

Problems with chair? ____

Goals for new WC/Equipment: ____

____

□ Modifiable □ Requires Replacement Comments: ____

# of hours spent in current WC: _______________ Goal for time to be up in WC: ________________

Other DME owned? ____

Tips for completing Wheelchair/Seating Section

- This section helps to describe the current WC and why you may make changes for a new WC
  - Fill in what you can
  - Vendor can help with this section
- List problems with current WC
  - Vendor may need to supply cost of repair versus cost of new WC
- Number of hours in the WC may be different than the goal number of hours in the WC if patient has been experiencing complications of illness

Skin Condition/Integrity Section

Skin Condition/Integrity

□Independent for pressure relief □Needs Assistance for pressure relief □Unable to self position

Method of pressure relief: ______________________________ Frequency: ________________________

Sensation: □ Intact □ Impaired □ Absent   Level of sensation: ______________________________

Skin breakdown present: □Yes □ No Description/Comments: __________________________________

PMH of pressure ulcer: □Yes □ No Description/Comments: __________________________________

Other risk factors: Check all that apply: □bony prominences □ impaired nutritional status

□ impaired circulation □ fecal incontinence □urinary incontinence □smoking: □Yes □ No

Tips for Completing Skin Condition/Integrity Section

- Document if patient has physical ability to do an independent pressure relief or requires power functions to be independent
- Sensation does not have to be formally tested; can use patient report or doctor's notes

Current Mobility Status

Current Mobility Status:

□ Gait: Distance: ____ Device: _______ Bracing: ______ Assist: _______ Gait Speed (m/s): ________
Deviations____________________________________ Timed Up and Go Test: ___________________
□ Unable to ambulate Comments: ____
□ History of falls? ____

Tips for Completing Current Mobility Status

- Document if gait is functional as primary mode of mobility
- Indicate bracing, need for assist, deviations, etc.
- History of Falls:
  - Consider subjective history no longer than 3-6 months back from patient or caregiver

10 Meter Walk Test (10MWT)

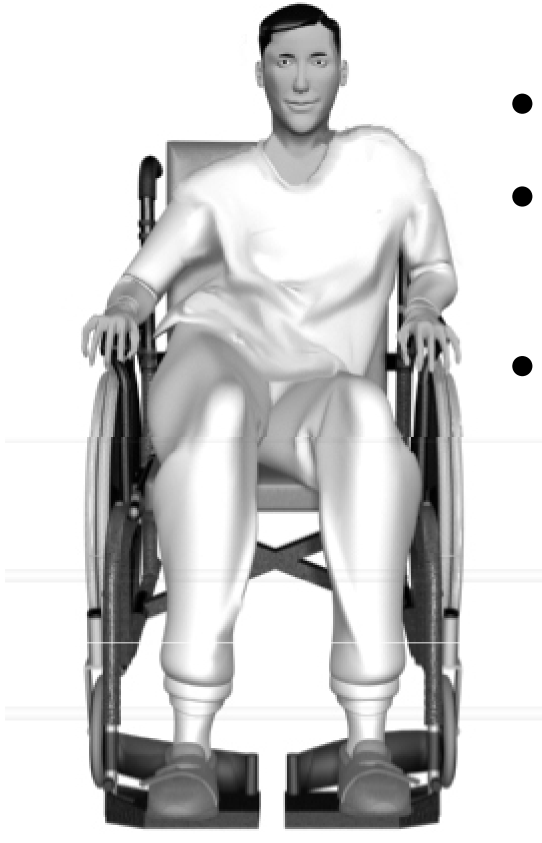
- Mark a space of 10 meters (33 feet) with extra 2-3 meters (6-10 feet) on either end for acceleration and deceleration
- Time patient's comfortable gait speed
- Divide 10/gait speed in seconds to get m/s
- Household gait speed is <.34 m/s
- Limited Community Amb speed is 0.34-0.79m/s
- Full Community Amb Speed is >0.79 m/s

Reference: Schmidt, Duncan et al Stroke; 2007

Timed Up and Go

- Timed Up and Go (TUG) Test

Posture Evaluation
Pelvic Obliquity



- One ASIS is higher than the other
- Compensatory C-shaped curve in the lumbar and thoracic spine
- The shoulder on the side of obliquity tends to be elevated

The obliquity is named for the side that is lower

Posture Evaluation
Pelvic Rotation

- One side of the pelvis is more forward than the other
- Some level of pelvic rotation is usually found with a pelvic obliquity

Balance Section

Balance		Transfers
Sitting balance	**Standing balance**	□ Method:
□ WFL – static and dynamic	□ WFL	□ Device
□ Uses UE for balance in sitting	□ Minimal assistance	□ Independent
□ Minimal assistance	□ Moderate assistance	□ Supervision
□ Moderate assistance	□ Maximum assistance	□ ________________ assist
□ Maximum assistance	□ Unable	
□ Unable	□ Device needed:	
Motor skills:		Functional Reach:

Tips for Completing Balance Section

- The Motor Skills section is for describing any abnormal movement patterns, developmental milestones or other functional patterns to describe the patient
- You can use this blank to add any more information on sitting or standing balance such as time able to hold balance, etc.

Functional Reach

- Can be used as objective measure for balance
- Standing or sitting functional reach instructions:

http://www.rehabmeasures.org/PDF%20Library/Functional%20Reach%20Test.pdf

Assessment/Trial of Equipment

Assessment/Trial of equipment (Chairs/Cushions/Backs):

____

____

Pressure mapping performed: □Yes □ No Results: ________________________________

____

Outpatient follow up required: □Yes □ No Education provided on various options? □Yes □ No
Photos taken? □Yes □ No (note: if yes, include consent form)
Patient and/or caregiver in agreement with recommendations? □Yes □ No

Tips for Completing Assessment/ Trial of Equipment

- Take measurements in the position you plan to seat your patient
- A trial on demonstration equipment is HIGHLY recommended, especially if the patient has never pushed MWC or driven a PWC or you are changing types of WCs from what was previously used
- Vendors and manufacturer representatives can assist in obtaining demonstration equipment

Tips for Completing Assessment/ Trial of Equipment (cont')

- Pressure Mapping:
  - Specialized equipment to determine pressure readings for cushions
  - It's a good tool but not always necessary
  - Vendors may have this equipment

Tips for Completing Assessment/ Trial of Equipment (cont')

- Outpatient follow up required: Yes/No
- Not required by Medicaid but
  - This is highly encouraged for PT/OT to do once equipment is in. Medicaid does pay for this under WC management billing code (CPT 97542). This code is covered in an outpatient setting for adults.
  - Good way to ensure goals met and equipment met needs and pt/caregiver is educated on care and functional use of the equipment

Tips for Completing Assessment/ Trial of Equipment (Cont')

- The bottom of page 4 is for your patient goals
- On pages 5-6, list what type of equipment, justification for all major pieces of equipment and anything that will be a custom item for children or "upcharge" for either children or adults (vendors can assist)
- Make each justification personal to your patient (e.g., don't describe what power tilt does, discuss why your patient needs it)
- Page 7 is available if you need more room to document

Tips for Efficient Reviews

- Submit clear information
  - Legible handwriting
  - Font size 10-12
  - Do not fax dark or copied pages
- Submit required paperwork in a timely manner
  - Written order or signed prescription from the attending physician
  - Send all required document(s) at the same time
  - Submit supporting documentation, such as H & P and/or progress notes

Tips for Efficient Reviews (cont)

- Review fee schedule
  - The request may not require a PA
  - Some procedures require Early Periodic Screening Diagnostic and Treatment Program (EPSDT) screening
  - Note the unit limitations
  - Use correct modifier
- Referral if needed: EPSDT/Patient1[ST]
- Correct date of service(s)
- Correct procedure code(s)

DRAFT

Patient's Name: ________________

WHEELCHAIR / SEATING EVALUATION

Start Time: ________ **End Time:** ___________ **Today's Date:** ____________

Referral Information
Are you receiving services of any kind (therapy, nursing, etc.)? ______
Physician: ____________________ Phone: ____________ Fax: ________
Vendor/Rep Name: _________________ Phone: ______________________
Case Manager / VR/IL counselor: __________________________ Phone: ______
Reason for Referral: ____

Patient Information: Age: _____
Person accompanying patient: _______________ Employment/School: _____________
Other Daily Activities: ____
Handedness: □ Right □ Left □ N/A Comments: _____________________________
Diagnosis/Medical/Surgical History: ____________________________________
____

Height: _____Weight: _____ Recent wt □ gain □loss: ________________________
Vision: _________________ Cognition: _________________________

Current Wheelchair / Seating System
□ None □ Dependent □Manual Tilt in Space □ Manual □Scooter □ Power
Manufacturer: ______________ Model: _____________ Serial #: ___________
Age of chair: _______________Provider:_____________ Funding: ___________
Frame width: _______Frame depth: _______Overall width: ______ Overall length: _______
Cushion: style_____________________________
Solid back: □yes □ no Type: __________________
Back height: ________Front seat to floor height: ______Rear seat to floor height: ________
Power: Drive Control Type: ___________________
Other seating components? ____
Problems with chair? ____
Goals for new WC/Equipment: _____________________________________
____
□ Modifiable □ Requires Replacement Comments: ___________________________
# of hours spent in current WC: __________ Goal for time to be up in WC: ___________
Other · · E owned? ____

Home Environment Lives with:______________ **# Levels to home:**___________
□ House □ Apartment □ Condo/Townhome □ Mobile Home □Asst Living □ LTCF □ Group Home
□Rural □ Urban **Ramps**: □yes □ no **Sidewalks**: □yes □ no **Paved driveway**: □yes □ no
Terrain: □Flat □rough □hills □grass □gravel □carpet □other: ______________________
Entrance stairs: □yes □ no Number: ____ Rails? _____
Accessibility issues: ____
Accommodation Plans: ____
____

Caretaker: Primary Caregiver: ______________________________________
Patient spends time at home alone: □yes □ no Hours alone: ______
Patient has homecare assistance or personal care attendant? □yes □ no
Caretaker limitations: ____

Form number Therapist name/Date_____________________________

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Thank you for your participation