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

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:

- 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

<table>
<thead>
<tr>
<th>Balance</th>
<th>Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting balance</td>
<td>Standing balance</td>
</tr>
<tr>
<td>□ WFL – static and dynamic</td>
<td>□ WFL</td>
</tr>
<tr>
<td>□ Uses UE for balance in sitting</td>
<td>□ Minimal assistance</td>
</tr>
<tr>
<td>□ Minimal assistance</td>
<td>□ Moderate assistance</td>
</tr>
<tr>
<td>□ Moderate assistance</td>
<td>□ Maximum assistance</td>
</tr>
<tr>
<td>□ Maximum assistance</td>
<td>□ Unable</td>
</tr>
<tr>
<td>□ Unable</td>
<td>□ Device needed:</td>
</tr>
<tr>
<td>Motor skills:</td>
<td>Functional Reach:</td>
</tr>
</tbody>
</table>
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/Patient1ST
• Correct date of service(s)
• Correct procedure code(s)
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/Ref 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 weight gain/lose: ___________
Vision: ___________ Cognition: ___________

Current Wheelchair / Seating System
- None ________ Dependent ________ Manual Tilt in Space ________ Manual Scooter ________ Power ________

Manufacturer: ___________ Model: ___________ Serial #: ___________

Age of chair: ________ Provider: ___________ Source: ___________

Frame width: ________ Overall width: ________ Overall length: ________
Cushion style: ________
Solid back: ________ 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: ________

# of hours spent in current WC: ________ Goal for time to be in WC: ________
Other: ________ - E-owned?: ________

Home Environment: Lives with: ________
- House _______ Apartment _______ Condo/Townhome _______ Mobile Home _______ Assisted 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: ___________
Thank you for your participation