Wheelchair/Scooter/Stroller Seating Assessment Form (CCP/Home Health Services) (8 pages)

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *Texas Medicaid Provider Procedures Manual* (TMPPM).

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in the relevant Texas Medicaid Provider Procedures Manual and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ We Agree

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Instructions
A current wheelchair/scooter/stroller seating assessment conducted by a physician or a physical or occupational therapist must be completed for purchase of or major modifications (including new seating systems) to a wheeled mobility system. A Qualified Rehabilitation Professional (QRP) must be present and participate in the seating assessment for all wheeled mobility systems and major modifications. Please attach manufacturer information, descriptions, and an itemized list of retail prices of all additions that are not included in base model price. Complete Sections I-VII for manual wheeled mobility systems. Complete Sections I-IX for power wheeled mobility systems. Complete the Home Health/CCP Measuring Worksheet for all requests.

Client Information	
First name:	Last name:
Medicaid number:	Date of birth:
Diagnosis:	
Height:	Weight:

I. Neurological Factors
Indicate client's muscle tone: ☐ Hypertonic ☐ Absent ☐ Fluctuating ☐ Other
Describe client's muscle tone:
Describe active movements affected by muscle tone:
Describe passive movements affected by muscle tone:
Describe reflexes present:

II. Postural Control				
Head control:	☐ Good	☐ Fair	☐ Poor	☐ None
Trunk control:	☐ Good	☐ Fair	☐ Poor	☐ None
Upper extremities:	☐ Good	☐ Fair	☐ Poor	☐ None
Lower extremities:	☐ Good	☐ Fair	☐ Poor	☐ None

III. Medical/Surgical History And Plans:
Is there history of decubitis/skin breakdown? ☐ Yes ☐ No *If yes, please explain:*
Describe orthopedic conditions and/or range of motion limitations requiring special consideration (i.e., contractures, degree of spinal curvature, etc.):
Describe other physical limitations or concerns (i.e., respiratory):
Describe any recent or expected changes in medical/physical/functional status:
If surgery is anticipated, please indicate the procedure and expected date:

IV. Functional Assessment:		
Ambulatory status:	☐ Nonambulatory	☐ With assistance
	☐ Short distances only	☐ Community ambulatory
Indicate the client's ambulation potential:	☐ Expected within 1 year	
	☐ Not expected	
	☐ Expected in future within _____ years	

IV. Functional Assessment:		
Wheelchair Ambulation: Is client totally dependent upon wheelchair? ☐ Yes ☐ No *If no, please explain:*		
Indicate the client's transfer capabilities:	☐ Maximum assistance ☐ Minimum assistance	☐ Moderate assistance ☐ Independent
Is the client tube fed? ☐ Yes ☐ No *If yes, please explain:*		
Feeding:	☐ Maximum assistance ☐ Minimum assistance	☐ Moderate assistance ☐ Independent
Dressing:	☐ Maximum assistance ☐ Minimum assistance	☐ Moderate assistance ☐ Independent
Describe other activities performed while in wheelchair:		

V. Environmental Assessment		
Describe where client resides:		
Is the home accessible to the wheelchair?	☐ Yes	☐ No
Are ramps available in the home setting?	☐ Yes	☐ No
Describe the client's educational/vocational setting:		
Is the school accessible to the wheelchair?	☐ Yes	☐ No
Are there ramps available in the school setting?	☐ Yes	☐ No
If client is in school, has a school therapist been involved in the assessment? ☐ Yes ☐ No		
Name of school therapist:		
Name of school:		

V. Environmental Assessment
School therapist's telephone number:
Describe how the wheelchair will be transported:
Describe where the wheelchair will be stored (home and/or school):
Describe other types of equipment which will interface with the wheelchair:

VI. Requested Equipment:
Describe client's current seating system, including the mobility base and the age of the seating system:
Describe why current seating system is not meeting client's needs:
Describe the equipment requested:
Describe the medical necessity for mobility base and seating system requested:
Describe the growth potential of equipment requested in number of years:
Describe any anticipated modifications/changes to the equipment within the next three years:

VII: Signatures of Therapist/Physician and Qualified Rehabilitation Professional (QRP)		
Physician/Therapist's name:	Physician/Therapist's title:	
Physician/Therapist's signature:		Date:
Physician/Therapist's telephone number:		
Physician/Therapist's employer (name):		
Physician/Therapist's address (work or employer address):		
QRP Name:	NPI:	TPI:
QRP Signature:		Date:

VIII. POWER WHEELCHAIRS:
Complete if a power wheelchair is being requested

Describe the medical necessity for power vs. manual wheelchair:
(Justify any accessories such as power tilt or recline)

Is client unable to operate a manual chair even when adapted? ☐ Yes ☐ No

Is self propulsion possible but activity is extremely labored? ☐ Yes ☐ No
If yes, please explain:

Is self propulsion possible but contrary to treatment regimen? ☐ Yes ☐ No
If yes, please explain:

How will the power wheelchair be operated (hand, chin, etc.)?

Has the client been evaluated with the proposed drive controls?

Does the client have any condition that will necessitate possible change in access or drive controls within the next five years?

Is the client physically and mentally capable of operating a power wheelchair safely and with respect to others? ☐ Yes ☐ No

Is the caregiver capable of caring for a power wheelchair and understanding how it operates? ☐ Yes ☐ No

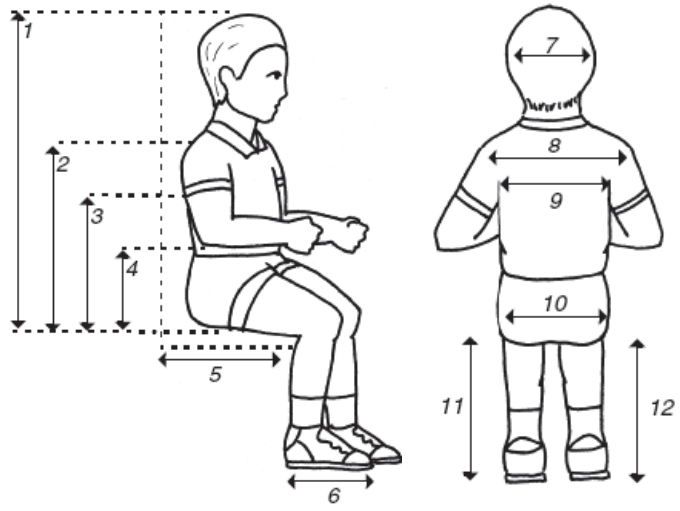
How will training for the power equipment be accomplished?

IX: Signatures of Therapist/Physician and Qualified Rehabilitation Professional (QRP)		
Physician/Therapist's name:	Physician/Therapist's title:	
Physician/Therapist's signature:		Date:
Physician/Therapist's telephone number:		
Physician/Therapist's employer (name):	Physician/Therapist's address (work or employer address):	
QRP Name:	NPI:	TPI:
QRP Signature:		Date:

Home Health/CCP Measuring Worksheet

General Information	
Client's name:	Date of birth:
Client's Medicaid number:	Height:
Date when measured:	Weight:

Measurements



1:	Top of head to bottom of buttocks
2:	Top of shoulder to bottom of buttocks
3:	Arm pit to bottom of buttocks
4:	Elbow to bottom of buttocks
5:	Back of buttocks to back of knee
6:	Foot length
7:	Head width
8:	Shoulder width
9:	Arm pit to arm pit
10:	Hip width
11:	Distance to bottom of left leg (popliteal to heel)
12:	Distance to bottom of right leg (popliteal to heel)

Additional Comments

Signatures of Measurer and Qualified Rehabilitation Professional (QRP)

Measurer's Name:	Measurer's Telephone number:
Measurer's Signature:	Date:
QRP Name:	
QRP Signature:	Date: