

Wheelchair and Wheelchair Seating System Equipment Selection Report

1. CLIENT INFORMATION:

Name _____
 Medicaid Number _____
 Birthdate _____ Height _____ Weight _____
 Medical Diagnoses _____

 Date of Onset/Exacerbation _____
 Nursing Facility _____
 Discharge From Nursing Facility Anticipated? Yes No
 Prescribing Physician Specialty _____
 Date Last Seen by Physician _____
 Individuals present at wheelchair evaluation _____

2. EVALUATOR INFORMATION:

Name _____
 Title/credentials _____
 Facility _____
 Address _____
 City _____ State _____ Zip _____
 Daytime Telephone (_____) _____
 E-mail address _____
 Date of eval. for this requested equipment _____
 Name and e-mail address of medical equipment supplier
 representative _____

3. CLIENT'S CURRENT PHYSICAL STATUS USING EXISTING EQUIPMENT

Yes No

Does client walk independently with or without an assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, throughout residence? <input type="checkbox"/> Yes <input type="checkbox"/> No
			If yes, throughout community? <input type="checkbox"/> Yes <input type="checkbox"/> No
If client walks independently but is limited in time or distance, fill in data to right.			Maximum Distance _____ Time Required _____ Frequency _____
Does client walk only with personal assistance?	<input type="checkbox"/>	<input type="checkbox"/>	If yes: Maximum Distance _____ Time Required _____ Frequency _____
Propels Manual Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	If yes, is client independent to desired destinations? <input type="checkbox"/> Yes <input type="checkbox"/> No
			If no, what is max distance? _____ Method and reason for limitation: _____
How Does Client Transfer to/from Wheelchair?		<input type="checkbox"/>	Independently
			<input type="checkbox"/> With Assistance Only Amount and Method: _____
How Does Client Relieve Sitting Pressure?		<input type="checkbox"/>	Independently
			<input type="checkbox"/> With Assistance or Technology Only Method: _____
Current Pressure Ulcers?	<input type="checkbox"/>	<input type="checkbox"/>	Number, Stages and Locations: _____
History of Pressure Ulcers?	<input type="checkbox"/>	<input type="checkbox"/>	Number, Stages and Locations: _____
Risk of Pressure Ulcers?	<input type="checkbox"/>	<input type="checkbox"/>	Reasons for risk: _____
Amputations?	<input type="checkbox"/>	<input type="checkbox"/>	Number and Location: _____
Pertinent Range of Motion Impairments/Contractures?	<input type="checkbox"/>	<input type="checkbox"/>	Location, Type, and Severity: _____
Cognitive/Vision/Hearing Impairments?	<input type="checkbox"/>	<input type="checkbox"/>	Type and Severity: _____
Recent/Anticipated Changes in Physical/Cognitive Status?	<input type="checkbox"/>	<input type="checkbox"/>	Specify, including surgeries, weight changes, new impairments, etc.: _____
Describe Current Sitting Postural Impairments/Abnormalities: _____ _____ _____			

4. CURRENT WHEELCHAIR:

Describe Wheelchair Currently Used by Client _____

Client Owned? Yes No

Date Purchased (If client owned) _____

Specific Reason for Replacement/Modification _____

5. CURRENT SEATING SYSTEM:

Describe Sitting Support Components Currently Used by Client _____

Client Owned? Yes No

Date Purchased (If client owned) _____

Specific Reason for Replacement/Modification _____

6. WHAT COMPONENTS CURRENTLY IN USE BY CLIENT WILL BE USED WITH REQUESTED EQUIPMENT? _____

7. EQUIPMENT RECOMMENDATION AND JUSTIFICATION (Additional information may be submitted on separate sheet)

Equipment Recommended

(include brand, model, pertinent dimensions if not provided elsewhere)

Wheelchair frame _____

Wheelchair Specialty Features _____

Seat support _____

Back Support _____

Trunk Supports _____

Chest Support _____

Armrests _____

Legrests _____

Footplates _____

Headrest _____

Other, including pelvic support (seat belt) as needed _____

Total Charge for Equipment \$ _____

Medical Justification

(Includes how a client's medically-related impairments/ activity limitations will be reduced or prevented by these non-standard items)

8. OTHER EQUIPMENT CONSIDERED THAT MIGHT MEET CLIENT'S NEEDS AND RATIONALE FOR ELIMINATION:

9. IS NURSING FACILITY WHEELCHAIR AVAILABLE TO MEET CLIENT'S NEEDS? Yes No Not applicable

10. EXPECTED CLIENT BENEFITS OF RECOMMENDED EQUIPMENT

Expected Length of Need: 1 - 3 Months 3 - 6 Months 6 - 8 Months 8 - 12 Months > 12 Months

Hours/Day Wheelchair/Seating System To Be Used:: < 2 Hours 2 - 6 Hours 6 - 12 Hours > 12 Hours

Accessibility with Equipment:

- Residence Yes No
- Transportation Yes No
- School Yes No
- Community Yes No
- Client Trial/Demonstration with Equipment: Yes No

Results of Trial: _____

Provide information regarding quantitative goals, expected outcomes or specific benefits for client use of requested equipment in functional terms (reduction of activity limitations or participation restrictions):

Additional Information not provided elsewhere justifying medical need of requested equipment: _____

11. SIGNATURES

Therapist's Signature / Credentials

Date

Physician's Signature

Date

THERAPIST/PHYSICIAN: Submit the completed Form MS-79 to the Equipment Supplier.

EQUIPMENT SUPPLIER: Submit completed Form MS-79 with the Prior Authorization Request (Form MS-77) to:
Nebraska Department of Health and Human Services
Medical Services Division
P.O. Box 95026
Lincoln, NE 68509-5026

COMPLETION INSTRUCTIONS FOR FORM MS-79

USE: Form MS-79 is required for review with requests for prior authorization of wheelchairs and/or wheelchair seating systems as outlined in 471 ANC 7-000.

COMPLETION: Form MS-79 must be completed in entirety by the licensed physical or occupational therapist who has evaluated the client's wheelchair and/or seating needs. Attach separate pages to continue responses, if necessary. Other documentation relevant to the request may also be attached.

Client Information	
Field Name	Instructions
Height	Most current measurement in cm or inches
Weight	Most current measurement in kg or lb
Medical Diagnoses	List all diagnoses pertinent to this equipment request in words, not just code numbers.
Date of Onset/Exacerbation	Month and year if known, at least year.
Individuals present at wheelchair evaluation	All individuals taking part in the evaluation, including supplier, family members and other therapists, as applicable. Include supplier representative's name.
Evaluator Information	
Name	Name of physical or occupational therapist filling out the form. This form may not be filled out by a physical therapist assistant, occupational therapist assistant, or supplier.
Facility	Facility where the wheelchair evaluation took place or practice location of therapist.
Client's Current Physical Status Using Existing Equipment	
Does client walk independently?	Independently means with no assistance by a person.
Maximum distance, time, frequency	Use any distance or time units; frequency can be number of times per day, week, month, etc., or write unlimited if that is the case.
Propels manual wheelchair	If client is not independent in propulsion or cannot reach desired destinations, fill in, using any distance units. Please specify what wheelchair was used to determine this. Was it the current wheelchair or the trial wheelchair? If limited, state what impairments limit propulsion, and does client use hands, hands and feet, one hand and one foot, one-arm drive, or some other propulsion method?
Propels power wheelchair	If client is not independent in propulsion or cannot reach desired destinations, fill in, using any distance units. Please specify what wheelchair was used to determine this. Was it the current wheelchair or the trial wheelchair? If limited, what impairments cause the limitation, and what control interface (standard joystick, head array, etc.) is currently in use by client?
How does client transfer to/from wheelchair?	If not independent, state method of transfer, amount of assistance and technology required.
How does client relieve sitting pressure?	If not independent, state type of assistance required to relieve pressure or technology used (e.g., tilt/recline function of wheelchair).
Current Pressure Ulcers?	Number, stages and locations of any current pressure ulcers.
History of Pressure Ulcers?	Number, stages and locations of any known pressure ulcers from the past.
Risk of Pressure Ulcers?	This could include Braden or other risk scale rating, or information about sensation, nutrition, cognitive ability, incontinence, or poor mobility, other impairments that contribute to pressure ulcer risk.
Amputations?	Number and location; also note if client uses limb prostheses.
Pertinent Range of Motion: Impairments/Contractures?	Location, type, severity: Be sure to describe the affected joint(s) and which directions of motion are limited. Goniometric data are helpful. Only describe if pertinent to the wheelchair request. Describe abnormal muscle tone if it may lead to contractures.
Cognitive/Vision/Hearing Impairments?	Type and severity: If box is checked Yes, please fill in this field.
Recent/Anticipated Changes in Physical/Cognitive Status?	Specify, including surgeries, weight changes, new impairments, etc.: This may include recent or anticipated surgeries, weight gain or loss, bracing, or new diagnoses or impairments.

Describe Current Sitting Postural Impairments/Abnormalities	Be specific in descriptions of postural impairments and state if they are fixed or flexible. Describe scoliosis, kyphosis, pelvic obliquity, head, limb positional impairments and abnormal muscle tone. Measurements or photographs are helpful.
Current Wheelchair	
Describe Wheelchair Currently Used by Client	This is the wheelchair frame the client already owns or is using from the facility, if any. It is not the wheelchair that is being requested. Please provide specific information, such as make and model, frame size, and any special features of the frame.
Specific Reason(s) for Replacement/Modification	Please state exactly why the wheelchair frame does not meet the client's medical needs. Please do not use phrases such as "does not fit" or "does not meet needs." If frame is in disrepair, please state why it cannot be repaired to meet client's needs.
Current Seating System	
Describe Sitting Support Components Currently Used by Client	This includes any seat or back cushion, trunk supports, headrest, or other major components providing body support that the client already owns or is/are provided by the facility. Please include make, model, or type.
Specific Reason(s) for Replacement/Modification	Please state exactly why the seating system, including back or cushion, does not meet the client's medical needs. Please do not use phrases such as "does not fit" or "does not meet needs" without clarification. If seat or back does not fit, state why, and if any attempt has been made to modify or adjust the existing equipment.
What components currently in use by client will be used with requested equipment?	These are items from the existing or current wheelchair or sitting support components that can and will be re-used with the requested items. If new items are requested to replace existing items, please state why existing items cannot be re-used.
Equipment Recommendation and Justification	
Equipment Recommended (include brand, model, pertinent dimensions if not provided elsewhere)	Medical Justification (Includes how a client's medically-related impairments/activity limitations will be reduced or prevented by these non-standard items)
Wheelchair frame: State make, model, and frame dimensions.	State exactly why the wheelchair frame is needed to meet specific medical needs. Medical needs should include activity limitations (e.g., time out of bed, locomotion) or impairments (e.g., range of motion limitations or muscle weakness) or prevention.
Wheelchair specialty features: These can include tilt in space or recline, hemi-height, alternative drive controls for a power wheelchair, retractable joystick, special tires or wheels, etc.	State exactly why specialty features are required to meet client's specific medical needs (e.g., pressure relief, prevent falling out of frame, accommodate range of motion limitations, independent locomotion, etc.).
Seat support: This refers to a specialty seat cushion and/or solid seat pan or adjustable solid drop seat.	State exactly why this seat support is required to meet client's specific medical needs (e.g., risk for pressure ulcers or positioning to prevent or accommodate pelvic/hip alignment impairments).
Back support: This could include any support beyond standard sling upholstery, such as tension-adjustable upholstery, solid padded back, or custom-molded support.	State exactly why back support is needed to meet client's specific medical needs (i.e., prevention or accommodation of spinal alignment impairment, relief of discomfort, etc.).
Trunk supports: Usually means lateral trunk supports that are separate from what might be built-in to the back support.	State exactly why additional trunk supports are required to meet client's specific medical needs (e.g., prevention or accommodation of spinal/trunk alignment impairment).
Chest supports: These include anterior supports such as harnesses.	State exactly why client requires a chest harness to meet specific medical needs, such as forward trunk lean, prevention or accommodation of spinal or trunk alignment impairment, transportation safety, etc.

Armrests: This refers to specialty armrests, such as height adjustable armrests, arm troughs, swivel mounts, etc., that represent an extra cost.	State why specialty feature of armrest is required to meet client's specific medical needs, e.g., client is tall or short of stature, trunk leans to one side, client has weakness of one or both upper limbs, client requires a tray mounted to armrests, etc.
Legrests: This refers to non-standard legrests, such as elevating style.	State why non-standard legrests are required to meet client's specific medical needs, such as edema control, knee range of motion impairment, support of residual limb, etc.
Footplates: Refers to non-standard footplates, such as angle-adjustable, extra large, heavy duty, solid single style, shoe holders, foot protectors, etc.	State why specialized footplates are needed to meet client's specific medical needs, e.g., ankle or foot range of motion impairment, ulcers, discomfort, etc.
Headrest: Describe headrest type or style and any special features associated with it.	State why headrest is required to meet client's specific medical needs, e.g., use of tilt/recline feature, prevention or accommodation of cervical alignment impairment.
Other, including pelvic support (seat belt), as needed: This includes any non-standard feature listed on the supplier request form that hasn't been addressed in other sections.	State exactly why the items mentioned are required to meet client's specific medical needs.
Other Equipment Considered That Might Meet Client's Needs and Rationale for Elimination	Usually, in a comprehensive evaluation, alternative wheelchair frame or wheelchair positioning equipment are considered and rejected for specific reasons, including less expensive equipment. Were potential future needs for different equipment considered?
Is Nursing Facility Wheelchair Available to Meet Client's Needs?	The facility is required to use existing available equipment first; it does not matter if it is not owned by the client.
Expected Client Benefits of Recommended Equipment	
Expected length of need	
Hours/Day Wheelchair/Seating System To Be Used	
Hours/Day of Personal Assistance Required by Client	
Accessibility with Equipment: If not nursing facility, please describe accessibility of client's living environment to requested wheelchair:	State how accessibility has been evaluated, such as home visit by therapist or supplier, report by client, etc., and what specific necessary accommodations have been installed to promote accessibility.
Client Trial With Equipment	Was a trial conducted using similar equipment to see if the client would likely benefit from such equipment? If not, state why.
Results of Trial	State results in terms of addressing activity limitations or impairments. In other words, discuss trial results in terms of mobility-related activities of daily living (e.g., propulsion distance in which environments) or how postural impairments were corrected or comfort improved.
Provide information regarding quantitative goals, expected outcomes or specific benefits for client use of requested equipment in functional terms (reduction of activity limitations or participation restrictions).	State goals in measurable terms with regard to activity limitations reduced, such as distance or destinations reached by independent locomotion, time out of bed, or prevention of pressure ulcers or postural impairment, safety, etc. What will client be able to do only with requested equipment?
Additional Information not provided elsewhere justifying medical need of requested equipment.	Space available at therapist's discretion to provide information that is unique to client or special circumstances that would affect need for requested equipment.