

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 $0.34-0.79$ m/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	<input type="checkbox"/> Method:
<input type="checkbox"/> WFL – static and dynamic	<input type="checkbox"/> WFL	<input type="checkbox"/> Device
<input type="checkbox"/> Uses UE for balance in sitting	<input type="checkbox"/> Minimal assistance	<input type="checkbox"/> Independent
<input type="checkbox"/> Minimal assistance	<input type="checkbox"/> Moderate assistance	<input type="checkbox"/> Supervision
<input type="checkbox"/> Moderate assistance	<input type="checkbox"/> Maximum assistance	<input type="checkbox"/> _____ assist
<input type="checkbox"/> Maximum assistance	<input type="checkbox"/> Unable	
<input type="checkbox"/> Unable	<input type="checkbox"/> 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/Patient1ST
- 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 _____



Thank you for your
participation

