Wheeled Mobility Assessment Form

Regulation and Guidance

TAC Rule 353.409

(a) An MCO must provide covered services to members. The MCO is not responsible for providing or paying for non-capitated services or members' cost sharing obligations, if any.

(b) HHSC will establish the scope and level of benefits, which all MCOs must agree to provide as a condition for participation. In accordance with 42 C.F.R. §438.210, the scope of benefits must be provided at least in an amount, duration, and scope available to Medicaid fee-for-service clients, unless otherwise explicitly authorized by HHSC through a waiver. The amount, duration, and scope of benefits may exceed the scope of fee-for-service in accordance with subsection (f) of this section. These requirements will be contained in all contracts entered into by an MCO and HHSC.

Texas Health and Human Services Commission (HHSC) Guidance for Managed Care Organizations: Qualified Rehabilitation Professional (QRP)

QRP Provider Qualifications

Providers that render custom durable medical equipment (DME) wheeled mobility systems to Texas Medicaid clients must enroll in Texas Medicaid as a specialized/custom wheeled mobility provider group and must have at least one qualified rehabilitation professional (QRP) performing provider.

A QRP meets one or more of the following criteria:

- Holds a certification as an Assistive Technology Professional (ATP) or a Rehabilitation Engineering Technologist (RET) issued by, and in good standing with, the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)
- Holds a certification as a Seating and Mobility Specialist (SMS) issued by, and in good standing with, RESNA
- Holds a certification as a Certified Rehabilitation Technology Supplier (CRTS) issued by, and in good standing with, the National Registry of Rehabilitation Technology Suppliers (NRRTS)

The QRP is responsible for:

- Being present at and involved in the seating assessment of the client for the rental or purchase of a wheeled mobility system.
- Being present at the time of delivery of the wheeled mobility system to direct the fitting of the system to ensure that the system functions correctly relative to the client.

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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**

Wheeled Mobility Assessment Form

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.

Member Information	
First Name	Last Name
Member ID 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 reflexes present:				

Wheeled Mobility Assessment Form

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:

Indicate client's muscle tone: ☐ Hypertonic ☐ Absent ☐ Fluctuating ☐ Other

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:

FirstCare™
HEALTH PLANS

Wheeled Mobility Assessment Form

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

Wheelchair Ambulation: Is client totally dependent upon wheelchair? ◯ Yes ◯ No
If no, please explain:

Indicate the client's transfer capabilities:
☐ Maximum assistance ☐ Moderate assistance ☐ Minimum assistance ☐ Independent

Is the client tube fed? ◯ Yes ◯ No
If yes, please explain:

Feeding:
☐ Maximum assistance ☐ Moderate assistance ☐ Minimum assistance ☐ Independent

Dressing:
☐ Maximum assistance ☐ Moderate assistance ☐ Minimum 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

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V. Environmental Assessment		
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:		
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:

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VI. Requested Equipment:

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. 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
Is self-propulsion possible but contrary to treatment regimen?	◯ Yes	◯ No

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

Has the client been evaluated with the proposed drive controls?	◯ Yes	◯ No
Does the client have any condition that will necessitate possible change in access or drive controls within the next five years?	◯ Yes	◯ No
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

If Yes, please explain:

How will training for the power equipment be accomplished?

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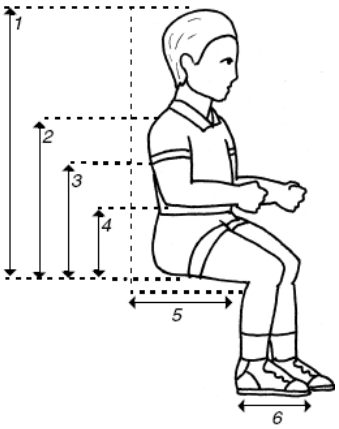
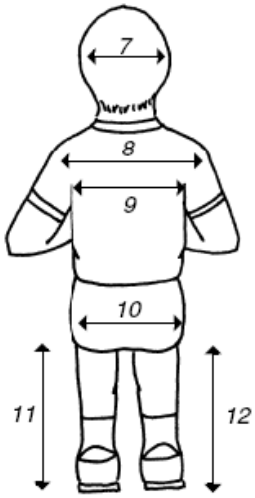
VIII. Measurement Worksheet





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

Measurers name:	Measurer's Telephone number:
Measurer's Signature:	Date:

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IX. Signatures Therapist/Physician/Qualified Rehabilitation Professional (QRP)	
Physician/Therapist's name:	Employer:
NPI:	TPI:
Physician/Therapist's signature:	Date:
Physician/Therapist's telephone number:	
QRP name:	Employer:
NPI:	TPI:
QRP signature:	Date:
QRP telephone number:	