Mobility Assessment and Prior Authorization (PA) Request

For Mobility Devices, Wheelchair Accessories and Seating Systems

Upload this request through the Provider Web Portal. **Questions? Call: (800) 525-2395**

Before completing this form, refer to the detailed instructions (FA-1B-I).

Completion of this form does not guarantee approval or reimbursement for the items requested.

NOTES:

SECTION I: PRIOR AUTHORIZATION (PA) INFORMATION
(This section is to be completed by the Medicaid provider requesting PA.)

1. PA Request Date:	2. Assessment Date:	3. Prescription/Order Date:

4. Request Type: ☐ Initial ☐ Continued Services ☐ Retrospective ☐ Unscheduled Revision

5. For "retrospective" requests only, enter the Medicaid Eligibility Determination Date:

6. For children under age 21 only, is this request a result of, or pursuant to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Healthy Kids services? ☐ Yes ☐ No ☐ Unknown

RECIPIENT INFORMATION *(Recipient name must match Medicaid card/records.)*

7. Name *(last, first)*:		8. Recipient ID:
9a. Date of Birth:	9b. Age:____ years ____ months	10. Sex: ☐ Female ☐ Male

11. Phone:

12. Address *(include city, state and zip)*:

13. Recipient's place of residency
☐ Hospital ☐ Nursing Facility ☐ ICF / MR ☐ Group Home ☐ Assisted Living ☐ Private Home
☐ Apartment ☐ Temporary Lodging ☐ Other *(specify)*: _____
Length of Residency:_____

14. For recipients in or being discharged from a medical facility, enter actual or anticipated discharge date:

15a. *Check all that apply and provide identification numbers as applicable*:
The recipient is covered by: ☐ Medicare Part A ☐ Medicare Part B Medicare Number: _____
☐ Other Insurance Name *(if applicable)*: Group ID Number: _____

15b. Does this recipient meet the standard Medicare criteria for the requested item(s)? ☐ Yes ☐ No ☐ Not applicable
(If "No", PA will be processed. The provider agrees to obtain a signed Advance Beneficiary Notice (ABN) for any services Medicare does not cover due to medical necessity.)

ORDERING PHYSICIAN/PRACTITIONER INFORMATION *(Must be treating physician)*

16. Name:	17. NPI:

18. Address *(include city, state and zip)*:

19. Phone:	20. Fax:

21. Contact Name:

SERVICING DME PROVIDER / SUPPLIER INFORMATION
(This section may be completed by any Medicaid provider involved in this request.)

22. Name:	23. NPI:

24. Address *(include city, state and zip)*:

25. Phone:	26. Fax:

27. Contact Name:

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SECTION II: CURRENT EQUIPMENT / DEVICES
(This section must be completed by the Medicaid provider requesting PA.)

1. Identify equipment recipient currently has / uses relevant to this request. *(Check all that apply.)*

☐ Manual Wheelchair ☐ Power Wheelchair ☐ Scooter / POV ☐ Power Assist or Other Mobility Device

☐ Mobility Base ☐ Seating and Positioning Device(s) ☐ Cane ☐ Crutches

☐Walker ☐Geri Chair ☐Other:_____

2. Make:_____ Model:_____ Serial #:_____

Age of Equipment:_____ Within Manufacturer's Warranty? ☐ Yes ☐ No

3. If requesting a replacement device issued less than five years ago, check the appropriate box and explain below.

☐ N/A ☐ Growth ☐ Change in Condition ☐ Weight gain _____lbs. ☐ Weight loss_____lbs. ☐ Other

Explain:

4. Which specific MRADLs is the recipient unable to adequately complete using their current mobility devices and why?

5. Can the current equipment be modified to accommodate the recipient's needs? ☐ Yes ☐ No

If yes, describe:

6. Has this equipment already been modified to accommodate the recipient's needs? ☐ Yes ☐ No

If yes, describe:

EQUIPMENT/DEVICE(S) REQUESTED

7. Identify the requested equipment / device(s). *(Check all that apply.)*

☐ New Mobility Device ☐ Manual Wheelchair ☐ Power Wheelchair ☐ Power Operated Vehicle / Scooter

☐ Wheelchair Accessory ☐ Seating and Positioning Items ☐ Growth of Current Device

☐ Replacement Mobility Device ☐ Modification or Changes ☐ Other Equipment

Enter a brief description and product code for each piece of equipment being requested. Submit an unaltered complete order form specific to the manufacturer and the model of the items being requested here.

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8. Is this request for a pediatric device? ☐ Yes ☐ No If no, skip the rest of this item.
   Can this equipment be enlarged or reduced in size, width and depth? ☐ Yes ☐ No ☐ N / A
   Enter Available Seat Width Range *(if applicable)*: _____
   Enter Available Seat Depth Range *(if applicable)*: _____
   If this request is for a pediatric device, describe any additional growth capabilities associated with this equipment:

9. List the name, credentials and professional license number of the person who completed Section II.

SECTION III: CLINICAL ASSESSMENT
(This section must be completed by the ordering physician / practitioner.)

1. List pertinent diagnosis and describe conditions, symptoms or medical complaints that contributed to this request:
   (Attach additional sheets if additional space is needed.)

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2. If primary medical condition preventing functional ambulation is related to conditions such as Congestive Heart Failure (CHF) or Chronic Obstructive Pulmonary Disease (COPD), 1) attach the progress notes from the last six office visits with the prescribing physician and 2) attach all pertinent documentation of severity of illness, which may include diagnostic tests such as, but not limited to:
   a. Echocardiogram report
   b. Cardiolyte report
   c. Cardiac catheterization report
   d. Pulmonary function test
   e. ABG's and/or O2 saturation on current oxygen flow rate

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3. If primary medical condition preventing functional ambulation is related to conditions such as Degenerative Joint Disease, Degenerative Disc Disease or Spinal Stenosis, 1) attach all imaging reports documenting severity of illness, 2) attach the progress notes from the last six office visits with the prescribing physician 3) describe all failed conservative treatments and include assessments, documentation and/or progress notes from those entities and 4) provide dates of each set of treatments. Treatments may include but are not limited to:
   a. PT/OT
   b. Pain management
   c. NSAIDS
   d. Bracing and injections
   e. Surgical treatments

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4. Diagnosis code(s):
5. Describe any recent or anticipated changes in the recipient's medical, physical, mental and/or functional status:
6. Describe cognitive and/or developmental deficits:
7. Does the recipient have any hearing and/or vision deficits that should be considered? ☐ Yes ☐ No If yes, is the deficit compensated by corrective devices? ☐ Yes ☐ No If yes, describe the recipient's compliance with use of the corrective devices:
8. Describe the recipient's ability to effectively communicate their needs and comfort level:
9. Does the recipient have any sensory or motor developmental delays/deficits? ☐ Yes ☐ No If yes, describe the recipient's abilities and limitations:
10. Describe *age-appropriate* bowel and bladder continence/incontinence *(include toilet training, frequency of incontinent episodes, interventions, need for self catheterizations, indwelling catheters, etc.)*:
11. Describe skin integrity, sensation, existing wounds and include current history of pressure ulcers *(include number, size and location)*:
12. Describe current or recent wound care plan for ongoing treatment *(if applicable)*:

13. Recipient's *Actual* Height:	14. Recipient's *Actual* Weight:

15. Describe how the ordered/prescribed item(s) will enable the recipient to perform MRADLs that cannot be completed with current equipment. Which specific MRADLs will the recipient be able to complete with use of the requested equipment?
16. Length of need for requested device(s):
17. Who will *operate* the equipment being requested? ☐ Recipient ☐ Caregiver ☐ Both If both, explain:

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18. List the name, credentials and professional license number of the prescribing practitioner who completed Section III.

SECTION IV: PHYSICAL ASSESSMENT

(This section must be completed by the ordering physician/practitioner, PT, OT or a seating specialist not associated with the DME provider/supplier. If a standardized assessment form was used, please indicate which one. Current information (within past 6 months) may be copied into this document. If attaching/submitting additional supportive documentation, please indicate the corresponding number of the question(s) the information responds to.)

1. Complete the following table to describe postural control and functional abilities.

Postural Control	**Good**	**Fair**	**Poor**	**None**	**Indicate presence of pain, scoliosis, obliquity, rotation, tone, contractures, spasticity, deformity, absence of extremity, etc.**
Head	☐	☐	☐	☐	
Neck	☐	☐	☐	☐	
Shoulders	☐	☐	☐	☐	
Arms (UEs)	☐	☐	☐	☐	
Trunk	☐	☐	☐	☐	
Back/Spine	☐	☐	☐	☐	
Legs (LEs)	☐	☐	☐	☐	
Ankles/Feet	☐	☐	☐	☐	
Balance	☐	☐	☐	☐	
Functional Ability	**Good**	**Fair**	**Poor**	**None**	**List limitations if applicable, e.g., manual muscle test, grip strength, limits in ROM and functional use.**
Upper extremities (L) (R)	☐ ☐	☐ ☐	☐ ☐	☐ ☐	
Hands (L) (R)	☐ ☐	☐ ☐	☐ ☐	☐ ☐	
Lower extremities (L) (R)	☐ ☐	☐ ☐	☐ ☐	☐ ☐	

2. Describe dexterity (fine and gross motor skill) issues related to the types of devices being requested:

3. Describe extremity tone, strength, spasticity, coordination and range of motion:

4. Describe sitting posture and balance *(head and shoulder/scapula position, pelvic tilt, obliquities, leg position, rotation, etc.)*:

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5. Describe contractures / scoliosis / kyphosis / lordosis:

6. Describe mobility-related endurance status *(e.g., functional propulsion speed and distance, amount of exertion)*:

7. Describe weight shift or repositioning ability:

8. Check the appropriate box to describe the recipient's ability to perform each activity:

Stand: ☐ Independent ☐ Limited assistance ☐ Extensive assistance ☐ Fully dependent
Transfer: ☐ Independent ☐ Limited assistance ☐ Extensive assistance ☐ Fully dependent
Pivot: ☐ Independent ☐ Limited assistance ☐ Extensive assistance ☐ Fully dependent
Bear Weight: ☐ Independent ☐ Limited assistance ☐ Extensive assistance ☐ Fully dependent

9. Describe ambulation ability *(include distance, stability, endurance, respiratory/cardiac status)*:

10. Describe how deficits are currently managed or compensated:

11. Is the recipient O2 dependent? ☐ Yes ☐ No If yes, enter LPM:_____
☐ Gas cylinders / tanks ☐ Portable (shoulder bag) system ☐ Portable liquid system

12. Is the recipient ventilator dependent? ☐Yes ☐ No

13. Indicate if there are any attachments to further support the above clinical information:
☐ PT report or letter ☐ OT report or letter ☐ Physician / Practitioner notes, report(s) or letter ☐ Other

14. List the name, credentials and professional license number of the person who completed Section IV.

SECTION V. MOBILITY RELATED ACTIVITIES OF DAILY LIVING (MRADLs)
(This section must be completed by the ordering physician/practitioner, PT, OT or a seating specialist who is not associated with the DME provider/supplier.)

1. Describe the recipient's current, usual daily routine:

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2. Describe the recipient's current living situation; include who lives with the recipient and who provides assistance/care.

3. Does the recipient receive supportive services? If so, which services and include frequency?

4. *Complete the following table to indicate the recipient's abilities to perform MRADLs: Independent = self performs, Limited Assist = does most with set up/cueing, Extensive Assist = limited performance with hands-on assist/support, Unable = full/total assist of others*

MRADL	Inde-pendent	Limited Assist	Extensive Assist	Unable	Comments and Assistive Devices
Continence: Bowel Bladder	☐ ☐	☐ ☐	☐ ☐	☐ ☐	Continence devices used: ☐ None ☐ Catheter (indwelling) ☐ Catheter (intermittent) ☐ Ostomy ☐ Diapers ☐ Other
Toileting	☐	☐	☐	☐	Location: ☐ Bedside commode ☐ Bathroom ☐ Bed/Chair
Eating	☐	☐	☐	☐	
Dressing	☐	☐	☐	☐	
Grooming	☐	☐	☐	☐	
Bathing	☐	☐	☐	☐	
Transfers					
Bed to Chair	☐	☐	☐	☐	Devices Used:
Chair to Bed	☐	☐	☐	☐	Devices Used:
Toilet (on/off)	☐	☐	☐	☐	Devices Used:
Home to Community	☐	☐	☐	☐	Devices Used:

5. List any other MRADL considerations *(if applicable)*:

6. Did a DME provider/supplier complete or assist with completion of this section? ☐ Yes ☐ No

7. List the name, credentials and professional license number of the person who completed Section V.

SECTION VI: SEATING AND POSITIONING CONSIDERATIONS FOR ANY TYPE OF WHEELCHAIR
(This section may be completed by a DME provider/supplier, an ordering physician/practitioner, a PT, an OT or a seating specialist; note special instructions for Fields 2a-2j.)

1. ☐ This request is not for a seating system(s).***(Skip to Section VII.)***

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2. Provide the recipient's measurements in inches. Items 2a-2j must be completed by the DME provider/supplier.		
2a. Hip Width:	2b. Upper Leg Length:	2c. Lower Leg Length:
2d. Seat to Elbow:	2e. Seat to Scapula:	2f. Seat to Shoulder:
2g. Seat to Occipital:	2h. Seat to Top of Head:	2i. Chest Width:
2j. Other:		
3. Provide the requested measurements in inches to describe the size/specifications of the equipment / device.		
3a. Seat Width:	3b. Seat Depth:	3c. Seat to Footrest:
3d. Seat to Floor Height:	3e. Seat to Armrest:	3f. Back Height:
3g. Equip. Overall Width:	3h.Turn Radius:	3i. Weight Capacity:

4. Requested Seat System Components
(Check all that apply. Attach a medical assessment that includes each checked component.)

☐ Tilt in Space ☐ Reclining Back ☐ ELR / AFP ☐ Seat Elevated

☐ Solid Seat ☐ Solid Back ☐ Cushion ☐ Back ☐ Headrest With Adjustable Mounting Hardware

☐ S/A Lateral Trunk Supports ☐ Positioning Chest Harness ☐ Velcro Chest Belt ☐ Arm Troughs

☐ Positioning Lap Belt ☐ Lateral Hip Supports ☐ Knee Adductors ☐ Foot Positioners

☐ Flip-Down Abductor ☐ Upper Extremity Support Tray

4a. Explain the deficit(s) that each component will ameliorate or correct.

5. List any other seat system or chair components, e.g., joystick midline mount, alternative drive control:

5a. Explain the deficit(s) that each will ameliorate or correct.

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WHEELCHAIR ACCESSORIES

6. List any wheelchair accessories being requested: (include the unaltered complete order form for all accessories/parts specific to the manufacturer and the model of the items being requested)

6a. Explain the deficit(s) that each accessory will ameliorate or correct.

7. Describe features of the requested equipment that allow for modified dimensions/growth accommodations. Can this equipment be enlarged or reduced in size? (Requests for pediatric recipients *must* address growth capabilities.)

8. Did a DME provider/supplier complete or assist with completion of this section? ☐ Yes ☐ No

9. List the name, credentials and professional license number of the person who completed Section VI.

SECTION VII: ENVIRONMENTAL ASSESSMENT

(This section must be completed by the servicing DME provider/supplier.)

1. Describe the recipient's living space in general terms:

2. Describe home residence accessibility and include mapping of rooms, stairs, turning radius, ramps, maneuvering space, access into/out of the home and between rooms, etc. Attach a separate document if necessary.

3. Width of Doorways (please enter measurements in inches):

Entrance:_____ Bedroom:_____ Bathroom:_____ Kitchen:_____

Hallway: _____ Other:_____

4. Describe floor covering throughout the home:

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5. Can this equipment be used inside the home to perform MRADLs? ☐ Yes ☐ No If no, explain:
6. Has the requested equipment been evaluated in this environment? ☐ Yes ☐ No If no, explain:
7. Will the recipient be transported in the requested device/equipment? ☐ Yes ☐ No
8. Describe potential accessibility issues in other settings where the recipient may routinely use this equipment, e.g., accessing transportation, work, school, other:
9. List the name, credentials and professional license number of the person who completed Section VII.

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SECTION VIII: PRIOR AUTHORIZATION (PA) SUMMARY *(This section must be completed by the requestor or DME provider/supplier.)*

1. Use the following table to summarize/specify requested items: **Column 1**: enter the most appropriate HCPCS code; **Column 2**: enter appropriate modifier (modifier RR signifies a rental device and the other modifiers signify an equipment Purchase); **Column 3**: enter description of item(s); **Column 4**: enter the number of requested units; **Column 5**: enter "Y" if item is covered by Medicare or enter "N" if item is not covered by Medicare; **Column 6**: enter requested "Start" date per physician's order; **Column 7**: enter requested "End" date per physician's order. If item requested for lifetime or indefinitely, enter 999.

1	2	3	4	5	6	7
HCPCS CODE	**MODIFIER (NU, UE, RR, RA, RB, KU or blank if no modifier)**	**DESCRIPTION**	**UNITS**	**MEDICARE " Y" OR " N"**	**START DATE**	**END DATE**

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THE FOLLOWING ITEMS MUST BE ATTACHED TO/SUBMITTED WITH THIS FORM: (1) a medical order or prescription signed by the physician/practitioner; (2) any additional documentation that supports medical necessity, including but not limited to specific medical records as required throughout this assessment and documentation of the environmental assessment; (3) the unaltered complete order form specific to the manufacturer and the model of the items being requested; and (4) a copy of the equipment manufacturer's invoice for all appropriate items, codes without pricing, or when requested by Nevada Medicaid and Check Up. Failure of the provider/supplier to submit the required documentation may result in denial.

SECTION IX: ATTESTATION STATEMENTS AND SIGNATURES

This section must be completed by all entities that completed portions of this form. The entities signing this section, whether done pen-to-paper or electronically (signature stamps are not permitted), are attesting that they have no financial, administrative or contractual relationship with, and receive no form of compensation from the billing DME provider/supplier, or that the DME provider/supplier receives no form of compensation from the other entities. Failure to disclose or knowingly providing incorrect information is considered fraud and will be treated as such.

1. **DME Provider/Supplier:**

I acknowledge that the assessor, PT, OT or ordering physician/practitioner may have no financial relationship with the DME provider/supplier. The Mobility Assessment portions of this form and written supportive documentation were provided by an individual who is fiscally, administratively and contractually independent from the DME provider/supplier and who receives no form of compensation from the billing DME provider/supplier. I certify that the equipment requested and to be provided if approval is granted, is appropriate for the recipient and the recipient's residence.

DME Provider/Supplier's Signature:_____ **Date:**_____

Printed name and title:_____

2. **Assessor (PT, OT, Ordering Physician/Practitioner, non-DME provider Wheelchair Seating Specialist):**

I acknowledge the assessor, PT, OT, ordering physician/practitioner may have no financial relationship with the DME provider/supplier. The Mobility Assessment portions of this form and written supportive documentation were provided by an individual who is fiscally, administratively and contractually independent from the DME provider/supplier and who receives no form of compensation from the billing DME provider/supplier.

PT, OT, or other Seating Specialist's Signature:_____ **Date:**_____

Printed name and title:_____

PT, OT, or other Seating Specialist's Signature:_____ **Date:**_____

Printed name and title:_____

3. **Ordering/Prescribing Physician/Practitioner:** (Must be the same as indicated on page 1.)

☐ *I acknowledge the assessor, PT, OT, ordering physician/practitioner may have no financial relationship with the DME provider/supplier. The Mobility Assessment portions of this form and written supportive documentation must be performed by an individual who is fiscally, administratively, and contractually independent from the DME provider/supplier and who receives no form of compensation from the billing DME provider/supplier.*

☐ I have prescribed the items listed in Section VIII, "Prior Authorization (PA) Summary."

☐ I have assessed this recipient face-to-face and have ***(check one or both)*** ☐ **completed and/or** ☐ **received and reviewed** in its entirety this 13 page Mobility Assessment and Prior Authorization Request and any additional documentation indicated as an attachment. I concur with the findings and agree the requested items (as summarized in Section VIII above) are medically necessary and consistent with the plan of care for this recipient.

Ordering/Prescribing Physician/Practitioner's Signature:_____ **Date:**_____

Printed name and title:_____

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.