Washington State Health Care Authority

Medical Necessity for Wheelchair Purchase for Nursing Facility (NF) Clients

All spaces MUST be completed by the Physical/Occupational Therapist within 60 days of request.

Please fax responses to: **1-866-668-1214**

CLIENT INFORMATION		
Client name	Client ID	RX on file ☐ Yes ☐ No
Nursing facility (if applicable)		
Therapist name	Fax number	
Diagnosis/Specific /Disabilities as applies to requested equipment including relevant degree of contractures and history of pressure wounds with dates, site, and stage.		
Indicate if applicable ☐ Scoliosis ☐ Kyphosis Degree of curvature	Patient height (inches)	Patient weight (LBS.)
Lower leg length (inches)	Upper leg length (inches)	Hip width measurement (inches)
What is the anticipated length of use of this equipment in **months and/or years?** Please describe the client's ambulation status and limitations: Does the client use mobility aids (crutches/walker)? ☐ Yes ☐ No Distance client ambulates in feet: What is the client's transfer status?		
Plan of use: Full time, exclusive, permanent? ☐ Yes ☐ No	Hours per day	
MANUAL wheelchair – can client effectively, independently, without cues propel the wheelchair? ☐ Yes ☐ No Yes, number of feet propelled at one time in the requested wheelchair: Does client propel with: ☐ arms ☐ feet ☐ both **POWER wheelchair** – can client safely utilize/drive the chair? Yes, number of feet at one time: If a power wheelchair is requested, tell us why the client is unable to operate a manual wheelchair.		
Will client be driving the power wheelchair independently in the community, outside the facility? ☐ Yes ☐ No Will a caregiver be required to accompany the client? ☐ Yes ☐ No For what purpose will the client be in the community? How many hours per day/week?		

Indicate client specific medical justification for each of the following: (Photos and or videos are helpful)

Make and model of equipment

All accessories and modifications: (You may submit additional attachments)

Does client currently own a wheelchair? ☐ Yes ☐ No	If YES, ☐ Manual ☐ Power	Purchased by ☐ Private ☐ HCA ☐ donated	Date purchased
Approximate age	Make	Model number	Serial number

Does client's current wheelchair meet his/her medical needs? ☐ Yes ☐ No

If the client's current wheelchair does not meet the medical need, why not?

Physical/occupational therapist's signature	Date
Prescribing physician's signature	Date

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INSTRUCTIONS

1. All spaces must be completed, by the Physical/Occupational Therapist.
2. RX on file means: You must have a physician's prescription in the client's file for any a) new equipment, or b) new accessories on existing equipment
3. List only those diagnoses and disabilities that apply to the equipment being requested.
4. The information regarding Scoliosis and Kyphosis must be completed when a custom back or wheelchair with tilt-in-space or recline feature is being requested.
5. Indicate length of use in **months and/or years**. General statements, such as *lifetime* and *indefinite* are not acceptable.
6. When indicating how far the client can independently propel the wheelchair, indicate as applies to the equipment being requested.
7. The make/model of wheelchair and each accessory/modification requested must be justified separately. You may use the lines on the physical therapy evaluation form or you may submit an additional attachment listing each item and the medical necessity for them.

The following information is necessary when justifying the equipment and accessories:

   a. Indicate what other less expensive alternatives have been tried or considered and why they will not meet the client's medical needs.
   b. All justifications must be client specific General statements as to standards of care or industrial standards for generalized equipment use are not appropriate to justify specific equipment needs.
   c. When requesting a specialized back or a wheelchair with a tilt-in-space or recline feature, indicate the degree of curvature requiring the modification (e.g. Scoliosis, Kyphosis or Lordosis).
   d. Indicate if the client has excessive extensor tone/muscle spasticity of the trunk/upper body muscles requiring support or impacting the degree of hip flexion/extension.
   e. For specialized cushions, indicate what other cushions have been tried, what the documented outcome was and the length of trial or what other cushions were considered and why they will not meet the client's medical needs. Also document if client has an existing decubitus and if so what the stage is. If the client has a history of decubitus, indicate dates, stage, site and duration.
   f. Indicate if the client has any musculoskeletal conditions, cast or brace that prevents 90-degree flexion of the knee or hip.

8. If the already owns a wheelchair, and new wheelchair is being requested, indicate the medical reasons the existing wheelchair no longer meets the client's needs. Indicate if it can be repaired or modified to meet the client's needs and if not, why not. If the chair can be repaired or modified to meet the client's needs, the vendor supplying the equipment will need to submit a cost comparison for repairs vs. purchase.
9. The Physical/Occupational Therapist's signature and date goes on this line. HCA **must** receive this form within 60 days from the date placed on this line.
10. Once a therapy evaluation is on file with HCA for the client, it is valid for 1 year to allow for repairs. A **new** therapy evaluation will be required after 1 year has lapsed.
11. The prescribing physician must sign the evaluation before submittal to HCA.