Capital

POWER WHEELCHAIRS, POWER OPERATED VEHICLES (POVS) AND RELATED ACCESSORIES (MP 6.037)
Preauthorization Request

Please complete all sections of this form:

SECTION I – General Information			
Request Date:	Fax Completed Form To: **(717) 540-2171**		
Evaluation Date:			
SECTION II – Member Information			
Member Name:	Member ID:	Member DOB: / /	
Plan Type: ☐ Traditional ☐ Comprehensive ☐ PPO ☐ POS ☐ KHPC ☐ Special Care ☐ BlueJourney HMO ☐ BlueJourney PPO ☐ BlueJourney Alliance			
SECTION III – Provider Information			
Requesting Provider Name:	CBC ID# | NPI #		
Telephone #:	Fax #:		
Requesting Provider's Specialty:			
If the provider performing the evaluation is not the requesting provider, complete the following:			
Evaluator's Name:	CBC ID# | NPI #		
Telephone #:	Fax #:		
Evaluator Specialty:			
SECTION IV – Supplier Information			
Supplier Name:	Supplier ID #:		
Telephone #:	Fax #:		
SECTION V - Patient Clinical/Functional Evaluation (Completed by MD, DO, PT or OT)			
1. Diagnosis:	Age:	Height:	Weight:
2. Medical History: _____			
3. Estimated time requirement for Power W/C or POV	Lifetime: ☐	Months: ☐	Number of Months:
4. Is the patient ambulatory? Y☐ N☐ If yes, ambulatory distance (feet): _____ Comments (Describe Gait): _____			
5. Does the patient use an assistive device? None ☐ Cane ☐ Walker ☐ Other ☐ Comments: _____			

1/5/2022; Effective date 2/1/2022

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6. Has the patient had an objective trial by a trained evaluator on use of a cane, walker, **AND** an optimally configured Manual W/C? Y☐ N ☐
Comments: _____

_____

7. Did the objective trial demonstrate that the patient is unable to participate in one or more BADLs, even with a cane, walker or manual W/C? Y☐ N ☐
If yes, describe in detail: _____

_____

8. Does the patient currently have a W/C? Y ☐ N☐
If yes, type of W/C, date of purchase: _____

If yes, rationale for new W/C request: _____

_____

Has the patient been self-propelling in a manual wheelchair for at least one year? Y ☐ N☐

9. Amputee Y ☐ N☐ If yes, type of amputation: _____
Artificial Limb(s): _____
Please check if the patient has: Quadriplegia ☐ Paraplegia ☐ or Hemiplegia ☐

10. Is there any limitation of patient's ability to tolerate a sitting position? Y ☐ N ☐
If yes, describe: _____

_____
How many hours/day is it anticipated that patient would spend in the Power W/C or POV?

11. Does the patient have intact trunk sensation/stability? Y ☐ N☐ If no, describe limitation: _____

_____
Trunk Strength (1-5 scale): _____
Does the patient have significant postural asymmetries that are due to a spinal or neurological disorder?
Y ☐ N☐ If yes, describe: _____

_____

12. Is a prefabricated seating system sufficient to meet the patient's seating and positioning needs? Y☐ N☐
If no, describe patient's unique seating and or positioning needs: _____

_____

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_____

13. Does the patient have trunk or lower extremity casts/braces or a fixed hip angle? Y ☐ N☐
If yes describe: _____

_____

Does the patient have a musculoskeletal condition or the presence of a cast or brace that prevents 90-degree flexion of the knee? Y ☐ N☐ If yes, describe: _____

_____

14. Does the patient have sensation or strength limitations of the upper extremities? Y☐ N☐
Upper extremity strength (1-5 scale): Right_____ Left_____
Describe any conditions affecting upper extremity strength: _____

_____

Does the patient have any upper extremity ROM limitations? Y ☐ N☐ If yes, describe: _____

_____

Does the patient have spasticity/uncontrolled arm movements? Y ☐ N☐ If yes, describe: _____

_____

15. Does the patient have the ability to manually adjust the back of the Power W/C or POV? Y☐ N ☐

16. Does the patient have the ability to manually adjust the leg rests of the Power W/C? Y☐ N ☐

17. Does the patient utilize intermittent catheterization for bladder management? Y ☐ N☐

18. Edema: Y ☐ N☐ Comments: (location, severity) _____

_____

19. Does the patient have a chronic pain condition? Y ☐ N☐ If yes, describe: _____

_____

_____

20. Current or history of skin breakdown (ulcer): Y ☐ N☐ If yes, describe skin breakdown (dates, location, stage, duration, treatments): _____

_____

Does the patient have absent or impaired sensation in the area of contact with the seating surface?

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Y ☐ N☐ If yes, describe: _____

_____

Is the patient able to shift their weight while seated? Y ☐ N☐ If no, describe limitations: _____

_____

Has the patient been identified by a healthcare provider, during risk assessment with a validated risk assessment tool (i.e. Braden or Norton scale), to be at high risk of developing a pressure ulcer? Y ☐ N☐

21. If a combination tilt and reclining back is being requested, please include results of Interface-Pressure mapping with this request. _____

22. If this request if for replacement of wheelchair seat cushion, wheelchair back cushion, or wheelchair positioning accessories please check the appropriate reason for request:

☐ The useful life-time has been exceeded (please list the number of years the patient has had the equipment) _____ years

If the useful life-time has not been exceeded then one of the following:

☐ The item has been accidentally, irreparably damaged (other than usual wear and tear); **or**
☐ Irreparable wear such that the item's intended function is no longer effective; **or**
☐ There is a change in the individual's medical condition that requires a different type of seating or positioning item; or
☐ The item has been lost or stolen

SECTION VI - Home/Caregiver Evaluation (Completed by Physician or Physical/Occupational Therapist) **Note: A Power W/C is only indicated if a patient is clearly not capable of using a Power Operated Vehicle (POV).**

1. Does the patient's cognitive/physical abilities allow for safe operation of Power W/C or POV? Y ☐ N☐
Has the patient <u>demonstrated</u> the ability to operate a POV? Y ☐ N☐ Power W/C Y ☐ N☐
Comments: _____

_____

2. Can the patient transfer safely in and out of a POV? Y ☐ N☐ Power W/C Y ☐ N☐
Describe patient transfer status/devices: _____

_____

3. Will the Power W/C or POV be used outside the home? Y ☐ N☐
Comments: _____

4. Will the patient be using ramps? Y ☐ N☐

1/5/2022; Effective date 2/1/2022

5. Does the patient's home provide adequate access for the operation of the POV or Power W/C Y☐ N☐
Comments: _____

_____

6. Does the patient have caregivers/home assistance? Y ☐ N ☐
If yes, are caregivers available during normal waking hours? Y☐ N☐
Is the caregiver capable of propelling an optimally configured manual wheelchair? Y☐ N☐
If no, is the caregiver available, willing, and able to safely operate a Power W/C? Y☐ N☐
Please provide details of caregiver's ability to assist the patient: _____

_____

SECTION VII - Additional Information (Optional)

Additional Comments/Impressions: _____

_____
_____
_____
_____

SECTION VIII - Evaluator (Physician, Physical Therapist or Occupational Therapist) Attestation

I certify that I am not an employee or otherwise paid by a supplier of the power mobility equipment I am recommending.
Physician/PT/OT Signature: _____ Date: / /

SECTION IX - Equipment Requested (Include base, seating, all accessories)

Note- May attach separate document containing Item, HCPCS and charge in lieu of this section

Item	HCPCS	Charge