

**Wheelchair and Wheelchair Seating System  
Equipment Selection Report  
Health and Human Services Finance & Support**



Form MS-79 must be completed in entirety by the evaluating licensed physical or occupational therapist.

<p><b>1. CLIENT INFORMATION:</b></p> <p>Name _____</p> <p>Medicaid Number _____</p> <p>Birthdate _____ Height _____ Weight _____</p> <p>Medical Diagnoses _____</p> <p>Date of Onset/Exacerbation _____</p> <p>Nursing Facility _____</p> <p>Discharge From Nursing Facility Anticipated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prescribing Physician Specialty _____</p> <p>Date Last Seen by Physician _____</p>	<p><b>2. EVALUATOR INFORMATION:</b></p> <p>Name _____</p> <p>Title _____</p> <p>Facility _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Daytime Telephone (_____) _____</p> <p>Date of Evaluation _____</p> <p>Others Present at Evaluation _____</p> <p>_____</p>
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**3. CLIENT'S PHYSICAL STATUS:**

	Yes	No	
Walks Independently	<input type="checkbox"/>	<input type="checkbox"/>	- Maximum Distance _____ Time Required _____ Frequency _____
Walks with Assistance	<input type="checkbox"/>	<input type="checkbox"/>	- Maximum Distance _____ Time Required _____ Frequency _____
Walker/Cane Assisted	<input type="checkbox"/>	<input type="checkbox"/>	- Maximum Distance _____ Time Required _____ Frequency _____
Propels Manual Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	- Maximum Distance _____ Time Required _____ Frequency _____
Propels Power Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	- Maximum Distance _____ Time Required _____ Frequency _____
Able to Relieve Pressure	<input type="checkbox"/>	<input type="checkbox"/>	- <input type="checkbox"/> Independently <input type="checkbox"/> With Supervision
Current Pressure Sores	<input type="checkbox"/>	<input type="checkbox"/>	- Extent and Location: _____
History of Pressure Sores	<input type="checkbox"/>	<input type="checkbox"/>	- Extent and Location: _____
Amputations	<input type="checkbox"/>	<input type="checkbox"/>	- Location: _____
Contractures	<input type="checkbox"/>	<input type="checkbox"/>	- Location, Type and Severity: _____
Cognitive/Vision/Hearing Deficits	<input type="checkbox"/>	<input type="checkbox"/>	- Type and Severity: _____
Caregiver Assistance	<input type="checkbox"/>	<input type="checkbox"/>	- Hours/Day: <input type="checkbox"/> 1-8 <input type="checkbox"/> 8-16 <input type="checkbox"/> > 16
Recent/Upcoming Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	- Specify: _____
Describe Abnormalities in Sitting Posture: _____			
_____			

<p><b>4. CURRENT WHEELCHAIR:</b></p> <p>Describe Current Wheelchair _____</p> <p>_____</p> <p>Client Owned? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date Purchased (If client owned) _____</p> <p>Reason for Replacement/Modification _____</p> <p>_____</p> <p>Total Repair Cost \$ _____</p>	<p><b>5. CURRENT SEATING SYSTEM:</b></p> <p>Describe Current Seating System _____</p> <p>_____</p> <p>Client Owned? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date Purchased (If client owned) _____</p> <p>Reason for Replacement/Modification _____</p> <p>_____</p> <p>Total Repair Cost \$ _____</p>
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**6. LIST CURRENT EQUIPMENT/COMPONENT(S) TO BE USED WITH RECOMMENDED EQUIPMENT:** \_\_\_\_\_

\_\_\_\_\_

**7. EQUIPMENT RECOMMENDATION AND JUSTIFICATION** (Additional information may be submitted on separate sheet)

**Equipment Recommended**

**Medical Justification**

Wheelchair Base \_\_\_\_\_

\_\_\_\_\_

Specialty Features \_\_\_\_\_

\_\_\_\_\_

Seat \_\_\_\_\_

\_\_\_\_\_

Pelvic Support \_\_\_\_\_

\_\_\_\_\_

Back \_\_\_\_\_

\_\_\_\_\_

Trunk Supports \_\_\_\_\_

\_\_\_\_\_

Chest Support \_\_\_\_\_

\_\_\_\_\_

Armrests \_\_\_\_\_

\_\_\_\_\_

Legrests \_\_\_\_\_

\_\_\_\_\_

Footplates \_\_\_\_\_

\_\_\_\_\_

Headrest \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Total Charge for Equipment \$ \_\_\_\_\_

**8. OTHER EQUIPMENT CONSIDERED AND RATIONALE FOR ELIMINATION:** \_\_\_\_\_

**9. Is Nursing Facility Wheelchair Available:**  Yes  No

**10. EXPECTED CLIENT BENEFITS OF RECOMMENDED EQUIPMENT**

Expected Length of Need:  1 - 3 Months  3 - 6 Months  6 - 8 Months  8 - 12 Months  > 12 Months

Hours/Day Wheelchair/Seating System Used:  < 2 Hours  2 - 6 Hours  6 - 12 Hours  > 12 Hours

Accessibility with Equipment:

Residence  Yes  No

Transportation  Yes  No

School  Yes  No

Community  Yes  No

Client Trial/Demonstration with Equipment:  Yes  No

Outcome of Trial: \_\_\_\_\_

Describe in measureable terms, how client's function/independence will be impacted with recommended equipment: \_\_\_\_\_

Additional Information: \_\_\_\_\_

**11. SIGNATURES**

Therapist's Signature / Title

Date

Physician's Signature

Date

**THERAPIST/PHYSICIAN:** Submit the completed Form MS-79 to the Equipment Supplier.

**EQUIPMENT SUPPLIER:** Submit the completed Form MS-79 with the Prior Authorization Request to:

Health and Human Services Finance & Support, Medicaid Division, P.O. Box 95026, Lincoln, NE 68509-5026

## COMPLETION INSTRUCTIONS FOR FORM MS-79

**USE:** Form MS-79 is required for review with requests for prior authorization of wheelchairs and/or wheelchair seating systems as outlined in 471 ANC 7-000.

**COMPLETION:** Form MS-79 must be completed in entirety by the licensed physical or occupational therapist who has evaluated the client's wheelchair and/or seating needs. Attach separate pages to continue responses, if necessary. Other documentation relevant to the request may also be attached.

### 1. CLIENT INFORMATION

- Client's FULL NAME
- Client's 11-digit MEDICAID NUMBER
- Client's BIRTHDATE
- Client's HEIGHT and WEIGHT
- Client's MEDICAL DIAGNOSES relevant to seating/mobility needs
- DATE OF ONSET/EXACERBATION of client's medical diagnoses
- If client resides in nursing facility, enter NAME OF FACILITY
- If client resides in nursing facility, indicate if DISCHARGE ANTICIPATED
- Prescribing PHYSICIAN'S NAME
- Prescribing PHYSICIAN'S SPECIALTY
- DATE LAST SEEN by the prescribing physician

### 2. EVALUATOR INFORMATION

- Full NAME OF PHYSICAL OR OCCUPATIONAL THERAPIST who evaluated the client
- TITLE of therapist
- Name of FACILITY/AGENCY with which the evaluator is associated
- Therapist's complete STREET ADDRESS, CITY, STATE and ZIP CODE
- Therapist's daytime TELEPHONE NUMBER
- DATE of evaluation
- Identify all PERSONS PRESENT at evaluation

### 3. CLIENT'S PHYSICAL STATUS

- Check "YES" or "NO" and provide specific information as directed, if applicable.  
Note: "Maximum Distance" must be reported as the time it takes for the client to walk or propel self for a specific distance. "Frequency" is used to report how the skill is functional for the client. Record the frequency which the client can repeat the distance in a day, week or month. Use the frequency which is reasonable for that client.
- Describe any abnormalities in SITTING POSTURE.

### 4. and 5. CURRENT WHEELCHAIR/SEATING SYSTEM

- Describe CURRENT WHEELCHAIR and CURRENT SEATING SYSTEM. Include brand, model and all accessories/features. If client has no current wheelchair/seating system, indicate "none" where applicable.
- Indicate if current wheelchair/seating system is CLIENT OWNED.
- DATE current wheelchair/seating system was PURCHASED, if client owned.
- Describe the REASON(S) FOR REPLACEMENT OR MODIFICATION of current wheelchair/seating system.
- Estimated TOTAL REPAIR COST if replacement needed due to wear or damage.

### 6. Specify any EQUIPMENT/COMPONENTS of the current wheelchair/seating system that will be USED WITH RECOMMENDED EQUIPMENT. If current equipment/components can not be used, indicate "none".

### 7. EQUIPMENT RECOMMENDATION AND JUSTIFICATION

- Describe clearly each component of recommended equipment. List each piece of equipment, accessory or feature, including brand and model. This description should match the equipment supplier's request for authorization.
- Describe the client's condition which relates to and justifies the equipment, accessory or feature. Specify reasons for selection of each item.
- List the estimated TOTAL CHARGE for equipment recommended.

### 8. SPECIFY OTHER EQUIPMENT CONSIDERED AND WHY IT WOULD NOT BE APPROPRIATE.

### 9. IS NURSING FACILITY WHEELCHAIR AVAILABLE? Check 'yes' or 'no' if client resides in nursing facility.

### 10. EXPECTED CLIENT BENEFITS OF RECOMMENDED EQUIPMENT

- Check the box that describes the TOTAL LENGTH OF TIME the client is expected to use the recommended equipment.
- Check the box which describes the TOTAL HOURS the client uses a wheelchair/seating system EACH DAY.
- Check "YES" or "NO" to indicate if equipment will be accessible to the client's RESIDENCE, TRANSPORTATION, SCHOOL and COMMUNITY.
- Check "YES" or "NO" to indicate if the client has had a TRIAL USE with the recommended or similar equipment and describe the OUTCOME of the trial (e.g., client's ability/ success with use). Note: A trial with power equipment is required.
- Describe in measureable terms, how client's FUNCTION/INDEPENDENCE will be impacted with recommended equipment.
- Provide any ADDITIONAL INFORMATION about the equipment recommended or the client's condition. Use this space to tell the reviewer the most important facts about the client in order for a well-informed decision to be made.

### 11. SIGNATURES

- Form MS-79 must be SIGNED and DATED BY THE PHYSICIAN prescribing the equipment.
- Form MS-79 must be SIGNED (with title) and DATED BY THE LICENSED PHYSICAL OR OCCUPATIONAL THERAPIST who evaluated the client's wheelchair and/or seating system needs.

**DISTRIBUTION:** The therapist submits the completed Form MS-79 to the equipment supplier. The equipment supplier submits Form MS-79 with the Prior Authorization Request to: Health and Human Services Finance & Support, Medicaid Division, PO. Box 95026, Lincoln, NE 68509-5026. Keep duplicate copies for your records.