Instructions for Completing Form FA-1B

(Mobility Assessment and Prior Authorization Form for Mobility Devices, Wheelchair Accessories and Seating Systems)

PURPOSE

To request prior authorization (PA) for purchase or rental of mobility device(s), wheelchair accessories and seating systems that require PA per the DMEPOS Fee Schedule and have a purchase rate or usual and customary billed charge of **$500.00 or more per item**. For items that require PA and have a rate **less than $500.00, do not use form FA-1B**, rather complete and submit form FA-1, the DMEPOS Prior Authorization Request form.

Form FA-1B is a comprehensive assessment tool for collecting and recording pertinent, complete information regarding a recipient's needs.

This form also:

- Provides the PA reviewer with detailed, accurate information for use in determining the recipient's qualification and medical necessity for the requested device(s)
- Reduces the number of denials and fair hearings resulting from incomplete request information
- Expedites PA turnaround times

GENERAL INSTRUCTIONS

a.) This form must be completed within 45 days of the prescribing physician/practitioner's order.

b.) Completion of this form **may be initiated by any provider** involved in the process; however, it must be submitted by the DMEPOS provider (provider type 33).

c.) This form must be submitted with **all applicable sections complete and with all required attachments**.

d.) Each section of the form identifies the **appropriate entity responsible for completing that section**. Some sections of this assessment must be completed by a qualified licensed/certified medical professional who has experience and training in mobility evaluations, such as a physical therapist (PT), occupational therapist (OT) or a physician who has been specifically trained in wheelchair, seating and positioning evaluations. Some sections *may not* be completed by the DME provider/supplier.

e.) The completed form must be **reviewed and accepted by the ordering/prescribing physician/practitioner** to ensure the device(s) being requested is/are consistent with the physician's plan of care.

f.) Evaluative medical documentation completed within the last six months may be used to complete this document by cutting and pasting into the appropriate fields or by submitting the information as an attachment.

g.) Attachments must identify the section and question number it is intended to answer. On the form, identify attachments using the space provided in the corresponding question number.

h.) You may use your computer keyboard to type information into this form. The "Tab" key allows you to move from field to field. Information entered into the document cannot be saved to a computer - print the pages as you complete them. The form may be legibly handwritten, if desired. All form submissions must be legible or they will be returned to requestor without approval.

i.) When the entire form has been completed, upload it through the Provider Web Portal (PWP). **Any distribution of this form must be done in HIPAA-compliant format.**

NOTES

Providers may use this section to communicate any special requests or additional information the Nevada Medicaid reviewers may find helpful.

SECTION I: PRIOR AUTHORIZATION (PA) INFORMATION

This section must be completed by the Medicaid provider requesting PA.

1. **PA Request Date:** Enter the date the PA is submitted.
2. **Assessment Date:** Enter the date the assessment was completed.
3. **Prescription/Order Date:** Enter the date the item(s) were prescribed/ordered. If the start date (the date use of product is to begin) is different from the order date, use the start date.
4. **Request Type:** Check the appropriate box to indicate the type of request**.**
5. **Retrospective requests** only, enter the Medicaid Eligibility Determination Date.
6. **EPSDT (Healthy Kids) services:** On requests for children under the age of 21 years, identify if this request is a result of an EPSDT screening.

RECIPIENT INFORMATION

7. **Name:** Enter the recipient's name (last name, first name) as it appears on their Medicaid card/records, and/or in the PWP. Do not use nicknames.
8. **Recipient ID:** Enter the recipient's full 11-digit Recipient ID with no spaces, slashes or dashes. Do not omit leading 0s.
9. **a. Date of Birth:** Enter the recipient's date of birth using mm/dd/yyyy format.
   b. Age: Enter the recipient's age in years and months.
10. **Sex:** Identify the recipient's gender.
11. **Phone:** Enter the recipient's telephone number or a contact number in which a message can be delivered to the recipient. Include the area code.
12. **Address:** Enter the recipient's physical address, including street address, city, state and zip code.
13. **Recipient's current location and usual place of residency:** Check the appropriate boxes to indicate the recipient's current location *and* place of residency. For example, if the recipient is currently in a hospital, but usually resides at a private home, check both the "Hospital" box and the "Private Home or Apartment" box. Then, enter the length of time the recipient has resided at their *place of residency*. If checking the "Other" box, specify the type of setting.
14. **Actual or Anticipated Discharge Date:** If the recipient's place of residency is an institutional setting, enter the actual or anticipated date of discharge to the community. Otherwise, enter "N/A".
15. **Third Party Liability Information:**
    a. Check all that apply and enter the Medicare and/or Group number if applicable.
    b. Indicate if this recipient meets the Medicare criteria for the requested item(s) by checking either "Yes" or "No." If the recipient is not Medicare-eligible, check "Not applicable."

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

16. Complete the name of the ordering physician/practitioner.
17. Enter the ordering physician/practitioner's National Provider Identifier (NPI).
18. Enter the ordering physician/practitioner's address.
19. Enter the ordering physician/practitioner's phone number.
20. Enter the ordering physician/practitioner's fax number.
21. Enter a contact name for the ordering physician/practitioner's office.

* Treating physician is defined as a physician treating the condition for which this item is needed and has a relationship with the recipient which entails knowledge of their medical history.

SERVICING DME PROVIDER/SUPPLIER INFORMATION

22. Enter the company name of the servicing DME provider/supplier.
23. Enter the DME provider/supplier's National Provider Identifier (NPI).
24. Enter the DME provider/supplier's servicing address.
25. Enter the DME provider/supplier's phone number.
26. Enter the DME provider/supplier's fax number.
27. Enter a contact name for the DME provide/supplier's office.

SECTION II: CURRENT EQUIPMENT/DEVICES

This section must be completed by the Medicaid provider requesting PA.

1. To the fullest extent possible and by interviewing the recipient/recipient representative, check applicable boxes to identify all current equipment being used by the recipient. If "Other" is checked, enter specific information to identify the equipment.
2. Enter the make, model, serial number, age of equipment and check "Yes" or "No" to indicate whether the equipment is currently under warranty (manufacturer's or provider's warranty).
3. If request is for replacement of a device issued less than five years ago, check all appropriate boxes and provide a detailed explanation of why replacement is needed. If not applicable, check the "N/A" box.
4. Provide an explanation of why the recipient's current equipment is not able to meet the recipient's specific Mobility Related Activities of Daily Living (MRADL) needs.
5. Identify if current equipment can be modified to meet the recipient's current needs. Provide specific rationale for either response.
6. Identify if current equipment has already been modified to meet recipient needs. If yes, describe the modification.

EQUIPMENT/DEVICE(S) REQUESTED

7. Identify the type of equipment being requested by checking all applicable boxes. Then, 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.
8. Identify whether this equipment is a pediatric device. If yes, complete the rest of this question to describe all product modification capabilities including seat width/depth range.
9. Provide the name, credentials, and professional license number of the person who completed information in Section II.

SECTION III: CLINICAL ASSESSMENT

This section must be completed by the ordering physician/practitioner.

1. List or describe the pertinent diagnosis, conditions, symptoms and/or medical complaints that contributed to this request. Provide a clear clinical picture as to the medical need for ordered/prescribed equipment.
2. If the primary medical condition preventing functional ambulation is related to conditions such as CHF or COPD, attach the progress notes from the last six office visits with the prescribing physician and include supportive reports to describe severity of illness.
3. If the primary medical condition preventing functional ambulation is related to conditions such as DJD, DDD or Spinal Stenosis, attach all imaging reports documenting the severity of illness, attach the progress notes from the last six office visits with the prescribing physician and describe all failed conservative treatments including assessments, documentation and/or progress notes from those entities. Lastly, provide dates of each set of treatments.
4. Enter up to six (6) International Classification of Diseases (ICD) codes (using 000.00 format) which are relevant to the need for the device(s) requested. These should be listed in the order of relevance.
5. Describe any recent or anticipated changes in the recipient's medical, physical, mental and/or functional status. Include information about progressively declining and/or improving conditions/diagnoses.
6. Describe cognitive and/or developmental deficits.
7. Identify any hearing and/or vision deficits that should be considered for the ordered/prescribed item(s), and whether the deficit is compensated by corrective devices, such as wearing hearing aids or eyeglasses. Include recipient's compliance with use of corrective devices.
8. Describe the recipient's ability to make known his/her needs and comfort level.
9. Indicate whether the recipient has any sensory or motor developmental delays/deficits. If yes, describe the recipient's abilities and limitations.
10. Describe **age-appropriate** bowel and bladder continence/incontinence issues, including toilet-training, frequency of incontinent episodes, interventions, need for self catheterizations, indwelling catheters, etc.

11. Describe skin integrity, sensation, existing wounds and current history of pressure ulcers (including number, size and location).
12. Identify if there are any active treatments for the wounds identified in Question 11. If yes, provide a detailed description of the treatment ordered and provided, including mobility-related factors. For example, include turning and repositioning schedule, time and frequency allowed out of bed and/or in chair, etc.
13. Record an actual height obtained within the past 45 days.
14. Record an actual weight obtained within the past 45 days.
15. Describe how the requested equipment will improve the functional ability/mobility and/or enable the recipient to perform MRADLs that are not possible with current equipment.
16. Provide the anticipated length of need for each item in terms of months needed. If needed for lifetime, enter 999.
17. Identify who will **operate** the equipment requested by checking the appropriate box. If both the recipient and caregiver will operate the equipment, describe how this duty will be shared.
18. Provide the name, credentials, and professional license number of the prescribing practitioner who completed this section.

SECTION IV: PHYSICAL ASSESSMENT

This section must be completed by the ordering/prescribing physician/practitioner, PT, OT or a seating specialist not associated with the DME provider/supplier.

Note: If a national standardized assessment form was used, please indicate which one. Current information (within past 6 months) may be copied into the form. If attaching/submitting additional supportive documentation, please indicate the corresponding number of the question(s) the information responds to.

1. Complete the table to describe the recipient's postural control and functional abilities. Check the appropriate box to indicate Good, Fair, Poor or None for each area. Include a narrative explanation of any limitations, presence of pain, scoliosis, obliquity, rotation, tone, contractures, spasticity, deformity, absence of extremity, etc.
2. Address dexterity issues (fine and gross motor skills) related to the types of devices being requested and the recipient's ability to use/manipulate the device(s).
3. Describe extremity tone, strength, spasticity, coordination and range of motion issues that affect the functional abilities of the recipient.
4. Describe sitting posture and balance (including head position, shoulder/scapula position, pelvic tilt, obliquities, leg position, rotation, etc.).
5. Describe any contractures, scoliosis, kyphosis or lordosis.
6. Describe recipient's mobility-related endurance status as it relates to MRADL performance, such as functional propulsion speed and distance and the amount of exertion. For example, describe measurable episodes of cardiac or respiratory compromise or inability to sustain (e.g., becomes short of breath after ambulating 5 ft., complains of chest pain with any activity, unable to maintain sitting position independently, gait becomes unsteady and shuffled after 10 steps, knees buckle after a few steps).
7. Describe recipient's ability to shift weight or reposition to obtain comfort and/or relieve pressure.
8. Check the appropriate box to describe the recipient's ability to stand, transfer, pivot and bear weight.
9. Describe recipient's ability to ambulate with or without use of devices, and if devices are used, describe the device and its effectiveness. Include distance, stability, endurance, respiratory and cardiac status when performing.
10. Describe how deficits are currently managed or compensated.
11. Identify if the recipient is O2 dependent. If yes, indicate the LPM. Check boxes that apply.
12. Identify if the recipient is ventilator dependent.
13. If there are any attachments, check all boxes that apply.
14. Provide the name, credentials, and professional license number of the prescribing practitioner who completed this section.

SECTION V: MOBILITY RELATED ACTIVITIES OF DAILY LIVING (MRADLs)

This section is to be completed by the ordering physician/practitioner, PT, OT or a seating specialist not associated with the DME provider/supplier.

1. Describe recipient's current, usual daily routine within the home and include outdoor/community activities that the recipient participates in, such as attending school, working or shopping. Specify the frequency of activities, recipient's ability to participate and current method of accessing these activities.
2. Describe the current living situation. Include who lives with recipient and whether they provide assistance and/or care for the recipient.
3. Describe any supportive services the recipient receives, e.g., family, friends, medical facility care, Personal Care Services and/or Meals on Wheels. Specify the frequency of each service.
4. Check the appropriate boxes to describe the recipient's ability to self-perform listed MRADLs and transfers. Identify any assistive devices used to accomplish tasks and provide comments as needed.
5. If there are any other MRADL issues to be considered, complete this question.
6. Check the appropriate box to identify if the DME provider/supplier assisted in the completion of this section.
7. Provide the name, credentials, and professional license number of the person who provided information in or who completed this section.

SECTION VI: SEATING AND POSITIONING CONSIDERATIONS

This section may be completed by a DME provider/supplier, ordering physician/practitioner, a PT, an OT or a seating specialist.

1. If the item being requested is not for a seating system(s), check the box and skip Questions 2-8 in this section. Skip to Section VIII, Question 1.
2. **a.-j.** Provide all seating measurements as indicated. Measurements should be in inches based on the recipient's body measurements.
3. **a.-i.** Provide the evaluation information for all areas described to support the medical necessity for the device(s) being requested.
4. Check all applicable boxes to identify the specific device(s) being requested. Explain the deficit(s) that each component will ameliorate or correct. Attach a medical assessment to support the medical necessity for reach device being requested.
5. Describe any other requested seating systems or chair components that were not identified in Question 4. Explain the deficit(s) that each component will ameliorate or correct. Attach a medical assessment to support the medical necessity for reach device being requested.

WHEELCHAIR ACCESSORIES

6. List any wheelchair accessories requested. Include the unaltered complete order form for all accessories/parts specific to the manufacturer and the model of the items being requested. Explain the deficit(s) that each component will ameliorate or correct. Attach a medical assessment to support the medical necessity for each device being requested.
7. Describe the features of the requested equipment that allow for modified dimensions/growth accommodations. All requests for pediatric device(s) must include the growth capabilities of the equipment and address how that equipment can accommodate for the recipient's growth over the 60-month period that follows approval. This information may be obtained by working collaboratively with the DME provider/supplier.
8. Check the appropriate box to identify if the DME provider/supplier assisted in the completion of this section.
9. Provide the name, credentials, and professional license number of the person who provided information in or who completed this section.

SECTION VII: ENVIRONMENTAL ASSESSMENT

This section must be completed by the DME provider/supplier, since the DME provider/supplier is responsible for completing a home assessment for mobility devices.

1. Provide a general description of the recipient's living space.
2. Identify if the home is accessible with the equipment being requested. 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. Provide width of specified doorways in inches.
4. Provide a description of floor coverings throughout the home.
5. Identify whether the requested equipment will be suitable for use inside the recipient's home to perform MRADLs. If the equipment is not suitable, provide an explanation.
6. Has the recipient been provided an opportunity to try, and has the recipient been evaluated using this equipment in this environment? If no, provide explanation.
7. Check the appropriate box to indicate whether or not the recipient will be transported in requested device/equipment.
8. Address accessibility issues for other types of environments the recipient is likely to encounter on a routine basis. Include accessing transportation, work, school and community activities.
9. Provide the name, credentials, and professional license number of the person who completed this section.

SECTION VIII: PRIOR AUTHORIZATION (PA) SUMMARY INFORMATION

This section must be completed by the requestor or DME provider/supplier.

1. All item(s) being requested on this PA must be summarized in this section. Complete the table as indicated to identify the HCPCS code, modifier, description of requested item(s), number of units being requested, Medicare coverage, start and end dates. The end date must be obtained from the ordering physician/practitioner. If the item is needed indefinitely or for lifetime, enter "999."

Note: Once Sections I-VIII of the form are complete, the requestor collects all supportive documentation and submits the form to Nevada Medicaid for review and processing. When separate attachments are submitted as supportive documentation, the documents must include the recipient's name and when known, the corresponding Authorization Number. The requester (DME supplier/provider) sends form and all attachments to prescriber for final review and completion of their portion of Section IX.

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 assessment/PA.

By signing this section, whether done pen-to-paper or electronically, the assessor attests 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, and did not solicit the recipient as described in Medicaid Services Manual Chapter 3300. Failure to disclose or knowingly providing incorrect information is considered fraud and will be treated as such.

1. If completed electronically, the DME provider/supplier must enter the name of the person who completed the information and the date completed. If not completed electronically, the DME provider/supplier must sign and date the form.
2. If completed electronically, the PT, OT, ordering physician/practitioner or other qualified/certified non-DME provider seating specialist must enter their name and the date completed. If not completed electronically, the assessor must sign and date the form.
3. The ordering physician/practitioner must check the appropriate boxes to indicate if they "completed" the entire form or that they have "received and reviewed" the completed form and all additional attachments. By signing the form, they concur with the findings and agree to the item(s) being requested on the PA. If completed electronically, the ordering physician/practitioner must enter their name and the date completed. If not completed electronically, the ordering physician/practitioner must sign and date the form.