HOME medical SUPPLY

Tel: 919.522.5221
Fax: 919.874.5123
homedicalsupply.com

☐ Private Insurance: _____

☐Medicaid ☐ Medicare ☐Self Pay

Policy #_____

Medicare requires the following documentation for prescribing a Power Mobility Device

PATIENT INFORMATION:

_____

Last Name First Name Middle Initial

_____

DOB Height Weight

_____

MOBILITY EXAMINATION DATE

_____

PHYSICIAN NAME

Physician Use Only

Instructions for Prescribing a Power Mobility Device:

1 **Please document the Mobility Examination in the patient's chart note.**
* Please see the mobility examination requirements on next page.

* Medicare requires **quantitative** strength measurements for upper and lower extremity strength be documented in the chart note **at the time** of the exam (i.e. RUE=2/5, LUE=3/5, RLE=2/5, LLE=3/5)

2 **Please write a Prescription for a Power Mobility Device.**
* Please complete the attached 7-element Written Order for a Power Mobility Device.

3 **Please provide the last 12 months of chart notes for your patient if possible.**

4 After receiving all required paperwork such as Face to Face Mobility Examination, a completed 7 Elements written order, we will prepare and provide a Detailed Product Description (DPD) and forward to Physician for review and sign off. The treating Physician must sign, date and return to Mission Medical Supply prior delivery Power Mobility Device to Patient.

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PMD CHART NOTE CHECKLIST

Per Patient's Health Plan*

**Please note that the requirements noted below are not Home Medical Supply, but those of your patients health plan.*

EACH item below MUST be documented in your patient's CHART NOTE at the time of the Mobility Examination.

A Reason for Visit

Please document in chart note

1. Chief Complaint/HP1: The major reason for visit was to conduct a **MOBILITY EXAMINATION.**
2. What has changed to now require a Power Mobility Device (PMD)?

B Physical Assessment

Please document in chart note

3. Height and Weight
4. O2 Saturation / Edema/ History and location of Pressure Sores / Ability to Shift Weight
5. Cardiopulmonary, Musculoskeletal, Neurological and Ambulatory Examination
6. Upper & Lower Extremity Assessment:

	Upper & Lower
Strength	i.e RUE (1/5) & LUE (1/5 and RLE 2/5 & (2/5)
Pain	i.e. (8/10)
Range of Motion	Degree of limitation
Gait Pattern	Ataxic, shuffling, non-ambuatory

C The Plan *All questions MUST BE answered in complete sentences:*

Please document in chart note

7. Please describe the **Medical Conditions (Diagnosis)** that impact patient's mobility needs.
8. Please dscribe the **MRADLs** impaired IN THE HOME (must be specific & include at lease ONE.

Examples:
- PMD is necessary to..... get to the bathroom to toilet / bathe.
- PMD is necessary to..... get to the kitchen to prepare meals / cook / eat.
- PMD is necessary to..... get to the bathroom to groom / dress .. ect.

9. **Cane or Walker** - Why will it not medically meet your patient's mobility needs in the home?

~~Examples:~~
- Patient can not use a cane / walker due to history of falls and RLE of 2/5 & LLE of 2/5
- Patient can not use a cane / walker due to poor balance and desaturates to 87%.

10. **Manual Wheelchair** - Why will it not medically meet your patient's mobility needs in the home?

~~Examples must include~~ quantitative support.
- Patient can not use a MWC due to RUE 1/5, LUE 1/5, grip strength 2/5.
- Patient can not use a MWC due to contractures of hands and pain level of 9/10.

11. **Scooter (POV)** - Why will it not medically meet your patient's mobility needs in the home?

~~Examples:~~
- Patient can not use a POV due to lack of postural stability.
- Patient can not operate the tiler of a POV.
- Patient requires special seating due to pressure sore that come in control with the seating area.

12. Describe how the prescribed equiment (name equipment) will improve your patient's ability to perform their MRADLs in the home (i.e. A Power Wheelchair will improve patient's ability to get from the bed to bath to toilet to kitchen.
13. Please state whether your patient can **SAFELY** operate the Power Wheelchair device both mentally and physically.
14. Please state if your patient is **willing & motivated** to use the Power Wheelchair device in the home.

If ALL the above are not documented in the chart note, your patient's health plan will not allow us to move forward and your patient may have to return for another mobility examination.

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Power Mobility Device - 7 Element Written Order

NOTE: *Medicare requires ALL 7 elements **must be handwritten by the ordering physician.*
** NOTE: *All corrections must be initialed and dated(White out/ Correction Tape is NOT permitted.)*

1 _____
Patient Name / Beneficiary Name

2 _____
Equipment Ordered

3 _____
Date of Face-to-Face Mobility Examination

4 Condition / Diagnosis relating to device prescribed

Weight:_____

Height: _____
(to select correct equipment)

ICD-10 CODE DIAGNOSIS

_____ _____

_____ _____

_____ _____ _____

_____ _____

_____ _____

5 Length of Need: _____ # of months (99= lifetime)

6 _____
Physician's Signature No signature stamps

_____
Physician Printed Name

7 _____
Date of Physician's Signature

Before you send completed written order, does it include ALL 7 Elements

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RETURN FAX COVER SHEET

From: _____ **To:** **Home Medical Supply NC.**

Fax: _____ **Fax:** **919-874-5123**

Phone: _____ **Phone:** **919-522-5221**

Please fill in your patient's information

Patient Name: _____

Last Name First Name DOB

_____

Address City State Zip

Patient Phone: ( ) _____

Mobility Examination Date: _____

PLEASE USE THIS SHEET AS A MOBILITY CHECKLIST AND A RETURN FAX COVER SHEET.

Please check all the items that are being faxed back to Home Medical Supply NC.

- ☐ Chart Notes From Face-To-Face Mobility Examination
  * Includes all documentattion as required by Medicare
- ☐ Prescription for Power Mobility Device
  * Includes all 7 Elements
- ☐ Please provide the last 12 months of chart notes for your patient if possible

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Examples of Medical Record Documentation: Potentially Sufficient and Insufficient to Support Coverage of Power Mobility Devices

This document provides examples of portions of the medical record essential for supporting the medical necessity of the PMD in the beneficiary's home. Please note that it does not describe all of the necessary documentation required for a PMD.

These examples are solely for educational purposes and to help physicians understand the types of information which Medicare believes is critical to suppliers. Refer to the links listed in the Related Links section for more information on the Power Mobility Device Face-to-Face Examination Checklist, NCD, and LCDs.

Insufficient (May likely result in DENIAL)

Mr. Smith is a male, age 72, with Chronic Obstructive Pulmonary Disease (COPD) who over the last few weeks has been having more Shortness of Breath (SOB). He states he is unable to walk for me today because he is too tired. Therefore he needs a PMD.

Sufficient (May likely result in an APPROVAL if other requirements are met)

Mr. Smith is a 72 yo male with COPD, worsening gradually over the past year despite compliant use of XYZ meds, nebulizers and rescue inhalers. PFT's (attached) demonstrate the decline in lung function over the last 12 months. Now with the constant use of 2-3L NC O2 at home for the last month, he still can no longer walk to the bathroom, about 30 feet from his bed without significant SOB and overall discomfort. The kitchen is further from his bed. He says his bed/bath doorways and halls are wide enough for a scooter that will bring him to his toilet, sink and kitchen, all of which are on the same floor. VS 138/84, Ht rate 88 RR 16 at rest on 3L NC

Vision - sufficient to read newspaper with glasses on

Ht XX ***Wt*** YY

Ambulation - Sit to stand was done without difficulty. Patient attempted to ambulate 50' in hallway, but needed to stop and rest 2 x's before he could accomplish. HR at first stop point (about 25') was 115 and RR was 32. Patient became slightly diaphoretic.

Lung exam - Hyper-resonant percussion and distant breath sounds throughout. Occ wheezes.

Neuro- Hand grips of normal strength bilat. Patient able to maintain sit balance when laterally poked. Steps carefully around objects in the room.

Alternative MAE equipment - Pt has attempted to use cane, walker or manual wheelchair unsuccessfully due to extreme fatigue with slight exertion described above.

Assessment - Pt seems good candidate for a POWER MOBILITY DEVICE to carry him the necessary distances in his home to use toilet/sink and kitchen facilities. Home seems amenable to this device.