Prime Care
MEDICAL EQUIPMENT

Date: _____

To: _____

Fax: _____

Patient Name: _____

DOB: _____

From: KRIS, X6106

Phone: (518) 456-6192, x6__
Fax: (518) 456-6193

# of pages: _____

Date of Mobility Evaluation appt: _____

__ Please schedule appointment with patient
****Telehealth appt must have Audio AND Video**

****

Power Wheelchairs and Power Operated Vehicles - Documentation Requirements from CMS

Your Patient is trying to obtain a powered mobility device (either a scooter/POV or power wheelchair). You must have an evaluation with your patient for the insurance company to provide reimbursement for a power wheelchair (PWC) or scooter/POV. The evaluation should be tailored to the individual patient's conditions. ****If the mobility evaluation is conducted remotely, the appointment must have both Audio AND Video components.**

THE MAIN REASON FOR THE FACE-TOFACE APPOINTMENT MUST **BE A MOBILITY EXAM AND NOT PART OF A FOLLOW-UP FOR ANOTHER CONDITION/AILMENT.**

IMPORTANT: The mobility evaluation should paint a picture of your patient's functional abilities and limitations on a typical day. it should contain as much objective data as possible **(see attached Chart Note Requirements outline).**

*If you are unable to address ALL the items listed in the outline, please consider referring your patient for a Physical Therapy evaluation **AFTER** you conduct the face-to-face exam.*

Examples of vague or subject descriptions of the patient's mobility limitations that **SHOULD NOT** be used include:

- "upper extremity weakness"
- "poor endurance"
- "gait instabilty"
- "weakness"
- "abnormality of gait"
- "difficulty walking"
- "SOB on exertion"
- "pain"
- "fatigue"
- "deconditioned"

ATTACHMENTS:

- Chart Note REQUIREMENTS - *Please be sure to address **ALL** the **REQUIREMENTS** during the visit.* **NOTE:** If a Resident MD conducts the face-to-face exam the supervising MD MUST also be present during exam.
- Difference between Scooter and Power wheelchair. **IMPORTANT:** If ordering a **Scooter/POV**, you must document, in detail, that your patient meets all the criteria for a scooter. If ordering a **Power Wheelchair**, a scooter **MUST** be ruled out.
- Standard Written Order form

You must forward a copy of mobility evaluation to the supplier. You should also include copies of previous notes, consultations with other physicians, and reports of pertinent laboratory, x-ray, or other diagnostic test if they will help to document the severity of your patient's ambulatory problems.

PLEASE FAX FACE-TO-FACE OFFICE VISIT NOTE AND ALL PERTINENT MEDICAL HISTORY TO (518) 456-6193

CHART NOTE REQUIREMENTS FOR POWER MOBILITY DEVICES (PMDs)

If you are unable to document ALL the items listed above during the mobility exam, please consider referring your patient for a PT/OT evaluation.

Your patient's insurance carrier a face-to-face mobility examination be conducted prior to writing a prescription for a power mobility device (either Scooter/POV or Power Wheelchair).

THE CHART NOTE MUST INCLUDE ALL OF THESE REQUIRED ELEMENTS:

A. Reason for visit

a. Primary reason for the office visit was to conduct a mobility evaluation

b. Include diagnoses/symptoms that impact your patient's mobility; what has changed that the patient now requires a mobility device.

c. Include vitals: Height/Weight/Blood Pressure

B. Physical Assessment (Objective measurement MUST be included)

a. Musculoskeletal exam: Evaluate upper & lower extremities

	Upper Extremities	**Lower Extremities**
Strength scale	Example: RUE (2/5), LUE (3/5)	Example: RLE (2/5), LLE (1/5)
Pain scale (0-10)	Example: Pain in R shoulder 8/10	Example: Pain in L hip 4/10
Range of Motion	Document degree of limitation	Document degree of limitation

b. Functional Ambulatory Exam:

i. Gait pattern (ataxic, shuffling, non-ambulatory)

ii. Level of assistance required (mod/max assist)

iii. Distance with cane or walker

iv. If inability to stand from seated position without assist what is used to transfer

v. If edema noted, document location and severity

vi. Current or History of Pressure Sores... document location, stage and size

vii. Perform pulmonary function test... document O2 sat (document whether on room air or on O2)

C. ALL points MUST BE DOCUMENTED IN THE OFFICE VISIT NOTE:

✓ **LIST the medical conditions that limit your patient's ability to participate in Mobility Related Activities of Daily Living (MRADLs) INSIDE their home.**

✓ **LIST which MRALDs in the home are impaired due to your patient's mobilty limitations. This MUST be specific.**
Please include at least 1 MRALDL, such as: dressing, grooming, toileting, feeding, bathing. Please note, this refers to the patient's ability to move to the area where the ADL is performed and not the skill itself. For example: Can the patient mobilize to the kitchen to prepare food? Can the patient get to the bathroom in a timely manner?

✓ **DESCRIBE why a cane or walker can't meet your patient's mobility needs INSIDE the home.** *Some examples of objective responses include: Upper Extremity and Lower Extremity strength is 2/5; patient has a history of falls.*

✓ **DESCRIBE why a manual wheelchair can't meet your patient's mobility needs INSIDE the home.** *Some objective responses include: UE Strength 2/5; grip strength 1/5; R sided weakness 1/5 due to CVA; pain in bilateral shoulders 8/10.*

✓ **SCOOTER OR POWER WHEELCHAIR?**
- **SCOOTER (POV)? Please address all of the criteria on the attached page**
- **POWER WHEELCHAIR? Describe why a scooter can't meet your patient's mobility needs INSIDE the home.** *Some examples: patient cannot transfer safely on/off scooter; doest have the upper extremity strength (or ROM) to operate tiller; home environment does not provide adequate access for maneuvering POV.*

✓ **DESCRIBE how the prescribed equipment will improve your patient's ability to perform their MRADLs INSIDE their home.**

✓ **Does your patient have the physical & mental abilities to operate a power mobility device?**

✓ **Is your patient willing & motivated to use the power mobility device inside their home.**

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The primary reason for providing power mobility equipment is to compensate for a patient's mobility limitation within the home environment.

Assessment of the patient's condition is the first step in determining the proper mobility solution.

The following may help determine if a SCOOTER or POWER WHEELCHAIR is right for your patient.

A **scooter** is appropriate if:

- The patient has adequate strength in the upper extremities to operate the controls and tiller; and
- The patient has adequate strength and stability to sit upright and transfer in and out of the scooter; and
- The patient has adequate strength and stability to maintain proper positioning during operation; and
- The patient has adequate dexterity to jointly operate the steering mechanism (tiller) and speed controls

Note: If you are ordering a SCOOTER, the face-to-face mobility exam note MUST document, in detail, that your patient meets ALL of the above criteria.

You must also document the reason(s) why a cane, walker or manual wheelchair will not meet your patient's mobility needs.

A **power wheelchair** is appropriate if:

You have ruled out the appropriateness of a scooter (based on the criteria above).

Note: If you are ordering a POWER WHEELCHAIR, the face-to-face mobility exam note MUST document, in detail, the reason(s) why your patient is unable to use a scooter based on the criteria above.

You must also document the reason(s) why a cane, walker or manual wheelchair will not meet your patient's mobility needs.

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POWER MOBILITY DEVICE

STANDARD WRITTEN ORDER

** Please complete **ALL** items. Any corrections must be dated and initiated**

1. Patient Name: _____

2. Order Date: _____

3. Equipment Ordered: _____

Can be generic or specific - ie: Power Mobility Device, Scooter/POV or Power Wheelchair)

Power Wheelchair Accessories to be provided (Check those to be provided):

_____Batteries (required to operate power wheelchair)

_____Adjustable height arms (covered if the patient requires an arm height that is different from that available using nonadjustable arms and the patient will spend at least 2 hours per day in the wheelchair)

_____Swing away joystick mount (covered if patient needs to move the component out of the way to perform a slide transfer to a chair or bed)

_____Elevating Legrests _____O2 cylinder holder Other: _____

4. Length of Need: _____ # of Months (99=lifetime)

5. Patient Height: _____ Patient Weight: _____

6. Diagnoses/ Conditions relating to the need for item:

ICD-10	Diagnosis
_____	_____
_____	_____
_____	_____
_____	_____

7. Clinician Signature: _____

Clinician Printed Name: _____ Date: _____

8. Clinician NPI: _____

Only the clinician that performed the face-to-face mobility evaluation can complete this form