MISSION MEDICAL SUPPLY

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.

Physician Use Only

PMD CHART NOTE CHECKLIST

Per Patient's Health Plan*

**Please note that the requirements noted below are not Mission 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 **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.

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

MISSION MEDICAL SUPPLY
4444 El Cajon Blvd Ste. 3 - San Diego, CA. 92115 Tel: 619-229-9597 Fax: 619-229-9594
10515 Bellaire Blvd Ste. M - Houston, TX. 77072 - Tel: 281-933-3902 Fax: 281-933-3949

Physician Use Only

RETURN FAX COVER SHEET

From: _____ **To:** **Mission Medical Supply**

Fax: _____ **Fax:** _____

Phone: _____ **Phone:** _____

Please fill in your patient's information

Patient Name: _____
Last Name First Name DOB

_____
Address City Sate 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 Mission Medical Supply

- ☐ 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