The major reason for the visit must be documented as a Mobility Examination.

What has changed to now require a power mobility device (PMD)?

**Physical Assessment**
- Height and Weight
- Edema, History of pressure sores, Ability to shift weight
- Cardiopulmonary examination
  - O2 Saturation
- Musculoskeletal examination
  - Quantitative strength measurements = upper and lower body strength
  - Quantitative measurements = pain scale / range of motion / grip
- Neurological examination
  - Gait pattern (ataxic, shuffling, non-ambulatory)
  - Level of assistance (moderate / max)

**Medical Conditions / Symptoms** – that limit your mobility
- Describe to your physician how your health conditions affect you getting around in your home

**Mobility Related Activities of Daily Living that are limited in the home**
- You need the PMD to...get to the bathroom to toilet / bathe
- You need the PMD to...get to the kitchen to prepare meals / cook / eat
- You need the PMD to...get to the bedroom to groom / dress

**Cane / Walker** – why this won’t medically meet your needs

**Manual Wheelchair** – why this won’t medically meet your needs

**Scooter (POV)** – why this won’t medically meet your needs

Must state you have the **Physical & Mental Abilities** to operate a power mobility device

Must state you are **Willing & Motivated** to use a power mobility device

Please be sure you discuss all of the above with your doctor and that they are DOCUMENTED in your patient chart note.
Medicare requires the following documentation for prescribing a Power Mobility Device.

Patient Information:

Last Name    First Name    DOB

Mobility Examination Date:

Physician’s Name

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 included within this packet.
   - 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.

4. After receiving all required paperwork, we will provide a Detailed Product Description (DPD) finalizing the physician’s order. The treating practitioner must sign, date and return prior to delivery.

The information contained in this packet is privileged and confidential, and intended for the sole use of the addressee. If the reader is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.
PMD Chart Note Checklist
Per Patient’s Health Plan*

EACH item below MUST be documented in your patient’s CHART NOTE at the time of the Mobility Exam. Please see the attached CMS Dear Physician Letter for more details.
* Please note that the requirements noted below are not Hoveround requirements, but those of your patient’s health plan.

**A** Reason for Visit

1. Chief Complaint/HPI: 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

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:

<table>
<thead>
<tr>
<th></th>
<th>Upper &amp; Lower</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strength</td>
<td>i.e. RUE (1/5) &amp; LUE (1/5 and RLE (2/5) &amp; (2/5)</td>
</tr>
<tr>
<td>Pain</td>
<td>i.e. (8/10)</td>
</tr>
<tr>
<td>Range of Motion</td>
<td>Degree of limitation</td>
</tr>
<tr>
<td>Gait Pattern</td>
<td>Ataxic, shuffling, non-ambulatory</td>
</tr>
</tbody>
</table>

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

7. Please describe the **Medical Conditions (Diagnosis)** that impact patient’s mobility needs.
8. Please describe the **MRADLS** impaired IN THE HOME (must be specific & include at least 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 bedroom to groom / dress.

9. **Cane or Walker** — Why will it not medically meet your patient’s mobility needs in the home?
   **Examples** must include quantitative support:
   - Patient cannot use a cane / walker due to history of falls and RLE of 2/5 & LLE of 2/5.
   - Patient cannot 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 cannot use a MWC due to RUE 1/5, LUE 1/5, grip strength 2/5.
    - Patient cannot 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 cannot use a POV due to lack of postural stability.
    - Patient cannot operate the tiller of a POV.
    - Patient requires special seating due to pressure sore that come in contact with the seating area.

12. Describe how the prescribed equipment (name equipment) will improve your patient’s ability to perform their **MRADLS** in the home (i.e. A PWC will improve my patient’s ability to get from the bed to bath to toilet).

13. Please state whether your patient can **safely** operate the power mobility device both mentally and physically.

14. Please state if your patient is **willing & motivated** to use the power mobility device in the home.

**STOP**  
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 that ALL 7 elements must be handwritten by the ordering practitioner. *NOTE: All corrections must be initialed and dated (white-out/correction tape is NOT permitted).

1. Beneficiary/Patient Name: 

2. Equipment Ordered: 

3. Date of Face-to-Face Mobility Examination: 

4. Diagnosis/Condition relating to the need for item:  

<table>
<thead>
<tr>
<th>ICD-10 CODE</th>
<th>DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WEIGHT  

HEIGHT  
(To select the appropriate equipment)  

5. Length of Need:  

# of months  
(99 = lifetime)  

6. Physician’s Signature:  

No Signature Stamps.  

Physician Printed Name.  

7. Date of Physician’s Signature:  

STOP Before you send the completed written order, does it include ALL 7 elements? STOP

We cannot accept any edits or corrections to the prescription, as per the Medicare requirement listed below:  
“If a supplier believes the prescription is inadequate, it should send it back to the physician or treating practitioner or call the physician or treating practitioner and request that the physician or treating practitioner send a new prescription.”  
- Federal Register/Vol. 71, No. 65
RETURN FAX COVER SHEET

From: ___________________________ To: Hoveround

Fax: ___________________________ Fax: 888-498-5140 (toll-free)

Phone: ___________________________ Phone: 888-498-5333 (toll-free)

Please fill in your patient’s information

Patient Name: ___________________________

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 Hoveround:

- Chart Notes from Mobility Examination
  - Includes all documentation as required by Medicare (see attached Chart Note Requirements Page.)

- Prescription for Power Mobility Device
  - Includes all 7 elements

- Please provide the last 12 months of chart notes for your patient.

The information contained in this facsimile is privileged and confidential, and intended for the sole use of the addressee. If the reader is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this fax in error, please immediately notify the person listed above, and call the number listed above for disposition.