HMS Hoverround Mobility Solutions

ACHC ACCREDITED

Medicare requires the following documentation for prescribing a Power Mobility Device.

Patient Information:

Last Name First Name DOB

Mobility Examination Date:

Physician's 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 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 Standard Written Order (SWO) for a Power Mobility Device.
- Please include length of need (i.e., 99 = lifetime).

☐ 3 **Please provide the chart notes from the last 3-4 of office visits for your patient.**

☐ 4 After receiving all required paperwork, we will provide another written order for all medically necessary accessories for the treating practitioner to review and approve. The treating practitioner must sign, date, and return prior to delivery.

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Physician Use Only

PMD Chart Note Checklist

Per Patient's Health Plan*

EACH item below MUSTS 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 patients health plan.*

A Reason for Visit

Please document in chart note.

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

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-ambulatory

All questions MUST be answered in complete sentences:

C The Plan

Please document in chart note.

7. Please describe the **Medical Conditions (Diagnosis)** that impact patient's mobility needs.
8. Please describe the **MRADLs** imparired 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 tto 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, Swingaway hardware to move the joystick controller out of the way will allow the beneficiary to perform a slide transfer to a bed or chair, Swingaway hardware will allow the beneficiary to move closer to the table to eat, etc.).*
13. Please state whether your patient can **safely** operate the power mobility device both mentally and physicially.
14. Please state if your patient **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.** STOP

Power Mobility Device - Standard Written Order

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

Weight: _____

Height:_____

(Needed to select the appropriate equipment)

1 **Beneficiary/ Patient Name:** _____

2 **Equipment Ordered:** _____

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

4 **Physician's Signature:** _____
No Signature Stamps

Physician's Printed Name: _____

Physician's NPI: _____

5 **Date of Written Order:** _____

***NOTE: Insurance requires that ALL elements must be handwritten by the ordering practitioner.**

Before you send the complete written order, does it include ALL elements?

Please fax to Clinical Documentation Dept., Hoveround at (800) 455-8556

HMS Hoveround Mobility Solutions®

6015 31st St E Unit 201
Bradenton, FL 34203
www.hoveround.com

Physician Use Only

RETURN FAX COVER SHEET

From: _____ **To:** **Hoveround**

Fax: _____ **Fax:** **800 455-8556 (toll-free)**

Phone: _____ **Phone:** **888-498-5333 (toll-free)**

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 Hoveround:

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

❑ Standard Written Order for Power Mobility Device
- Complete all 5 Sections

❑ Please provide the chart notes from the last 3-4 office visits for your patient.

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