Physician Use Only

PMD-Physician Exam Note Requirements

MEDICAL EQUIPMENT SPECIALISTS

Questions? Call us (772) 283-0440

It is necessary to record the following details in the patient's medical record on the day of their MOBILITY EXAMINATION:

A Reason for Visit

Please document in exam 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 exam 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

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

Please document in exam 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).*
13. Please state whether your patient can **safely** operate the power mobility device both mentally and phycially.
14. Please state if your patient **willing & motivated** to use the power mobility device in the home.

If any of the required documents for a mobility examination are not found in the chart note, the patient's health plan will not permit us to continue and the patient will have to attend 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:**

ICD-10 CODE	DIAGNOSIS
_____ . _____	_____
_____ . _____	_____
_____ . _____	_____
_____ . _____	_____
_____ . _____	_____

WEIGHT _____

HEIGHT _____

(MUST COMPLETE)

5 **Length of Need:** _____ **# of months**

(99 = lifetime)

6 **Physician's Signature:** _____

No Signature Stamps.

_____

Physician Printed Name.

7 **Date of Physician's Signature:** _____

As per the Medicare requirement, no edits or corrections may be made to the prescription.

"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

MEDICAL EQUIPMENT SPECIALISTS

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RETURN FAX COVER SHEET

From: _____ **To:** **MES (DME PROVIDER)**

Fax: _____ **Fax:** **772-283-0440**

Phone: _____ **Phone:** **772-777-8109**

Please fill in your patient's information

Patient Name: _____
Last Name First Name DOB

_____
Address City State Zip

Mobility Examination Date: _____

Please check all the items that are being faxed back to Hoverround:

❑ Exam Notes from Mobility Examination

- Includes all documentation as required by Medicare (see attached Physician Exam Note Requirements Page.)

❑ Prescription for Power Mobility Device

- Includes all completed 7 elements