Dear Physician,

In order to document the need for a PMD there are a few specific statutory requirements that must be met ***before*** the prescription is written:

1. An in-person visit between the ordering physician and the beneficiary must occur. This visit must document the decision to prescribe a PMD.

2. A medical evaluation must be performed by the ordering physician. The evaluation must clearly document the patient's functional status with attention to conditions affecting the beneficiary's mobility and their ability to perform activities of daily living within the home. This may be done all or in part by the ordering physician. If all or some of the medical examination is completed by another medical professional, the ordering physician must sign off on the report and incorporate it into their records.

3. Items 1 and 2 together are referred to as the face-to-face exam. Only after the face-to-face examination is completed may the prescribing physician write the prescription for a PMD. This prescription has seven required elements and is referred to as the seven-element order which must be entered on the prescription only by the physician.

4. The records of the face-to-face examination and the seven-element order must be forwarded to the PMD supplier within 45 days of the completion of the face-to-face examination

5. **CMS' National Coverage Determination requires consideration as to what other items of mobility assistive equipment (MAE), e.g., canes, walkers, manual wheelchair, etc., might be used to resolve the beneficiaries mobility deficits. Information addressing MAE alternatives must be included in the face-to-face medical evaluation.**

The evaluation should be tailored to the individual patient's conditions. The medical history should contain a well-documented description of your patient's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the patient's ambulatory difficulty or impact on the patient's ambulatory ability.

Tips to Avoid Denial of PMD Claims

Medical records should contain enough information to support the coverage for a PMD. Currently, audits show medical records commonly lack documentation that justifies the need for payment.

The medical record must contain sufficient information to show that the coverage criteria for a PMD are met. This information must be directly related to the patient's use of a PMD. Key items to be addressed are:

- Why does the patient require the use of a PMD in the home to safely and effectively accomplish Activities of Daily Living (ADLs)?
    - Examples of ADLs include but are not limited to bathing, grooming, dressing, toileting.
    - What are important medical history factors that demonstrate the patient's mobility limitations?
- Do the physical examination findings support the patient's claimed functional status (mobility level)?
    - Physical Examination (PE): The information provided in the PE must support the pertinent history above. The information must not be recorded in vague and subjective terms (e.g. weak, breathless, tired, etc), but instead must provide quantifiable, objective measures or tests of the abnormal characteristic (e.g.

range of motion; manual muscle test scores; heart rate/respiratory rate/pulse oximetry). Each medical record is expected to be individualized to the unique characteristics of the patient. Included in all exams must be a detailed description of the patient's observed ability or inability to transfer and/or walk. Examples of other patient physical findings that would commonly be relevant to describe medical need for and ability to use a PMD include:

- Height and weight;
- Limb abnormalities;
- Strength, tone, coordination, reflexes, balance;
- Heart rate, blood pressure, respiratory rate (at rest and with exertion)
- Joint swelling, range of motion, erythema, subluxation;
- Description of limb loss; and
- Cardiopulmonary exam
- If the patient is thought to require a PMD due to respiratory illness or injury:
    - Does the patient use home oxygen? If yes, what is the frequency, duration, delivery system, and flow rate denoted? How far does the patient report that she/he can walk or self-propel a manual wheelchair before becoming short of breath (with best oxygenation provided)? Describe the ADLs that make him/her short of breath in the home (with best oxygenation provided) and the interventions that palliate them. How have these signs/symptoms changed over time?

- If the patient is thought to require a PMD due to cardiovascular illness or injury:

    - Specifically, describe any clinically significant increased heart rate, palpitations, or ischemic pain that occurs or worsens when the patient attempts or performs ADLs within the home (with best oxygenation provided)? What palliates these signs/symptoms? How far does the patient report that she/he can walk or self-propel a manual wheelchair before experiencing these signs/symptoms? How have these signs/symptoms changed over time?

- If the patient is thought to require a PMD due to neuromusculoskeletal illness or injury or malformed body member:

    - Describe the patient's impairments. For example, does the patient exhibit joint/bone signs/symptoms, changes in strength, coordination or tone? How do these signs/symptoms relate to the patient's functional state and the ability to perform ADLs in specific? How far does the patient report that she/he can walk or self-propel a manual wheelchair before these signs/symptoms interrupt that activity? How have these signs/symptoms changed over time?

Illustrative Example of Medical Record Documentation

This entry may result in a claim DENIED: Mr. Smith is a male, age 72, with Chronic Obstructive Pulmonary Disease (COPD) who over the last few weeks has been having more Shortness of Breath (SOB). He states he is unable to walk for me today because he is too tired. Therefore he needs a PMD.

Instead consider an entry with this level of detail and support:

Mr. Smith is a 72 yo male with COPD, worsening gradually over the past year despite compliant use of XYZ meds, nebulizers and rescue inhalers. PFT's (attached) demonstrate the decline in lung function over the last 12 months. Now with the constant use of 2-3L NC O2 at home for the last month, he still can no longer walk to the bathroom, about 30 feet from his bed without significant SOB and overall discomfort.

The kitchen is further from his bed. He says his bed/bath doorways and halls are wide enough for a scooter that will bring him to his toilet, sink and kitchen, all of which are on the same floor.

- VS 138/84, Ht rate 88 RR 16 at rest on 3L NC
- Vision- sufficient to read newspaper with glasses on
- Cognition- OX3. Able to answer my questions without difficulty.
- Ht XX Wt YY
- Ambulation – Sit to stand was done without difficulty. Patient attempted to ambulate 50' in hallway, but needed to stop and rest 2 x's before he could accomplish. HR at first stop point (about 25') was 115 and RR was 32. Patient became slightly diaphoretic.
- Lung exam – Hyperresonant percussion and distant breath sounds throughout. Occ wheezes.
- Neuro- Hand grips of normal strength bilat. Patient able to maintain sit balance when laterally poked.
- Steps carefully around objects in the room.
- Alternative MAE equipment – Pt has attempted to use cane, walker or manual wheelchair unsuccessfully due to extreme fatigue with slight exertion described above.
- Assessment – Pt seems good candidate for a scooter to carry him the necessary distances in his home to use toilet/sink and kitchen facilities. Home seems amenable to this.

Sample Checklist for the PMD Examination

Please note, this checklist is not mandatory and does not replace the underlying medical records.

The medical record for the patient includes the following history:

_____ Signs/Symptoms that limit ambulation;

_____ Diagnoses that are responsible for these signs/symptoms;

_____ Medications or other treatment for these signs/symptoms;

_____ Progression of ambulation difficulty over time;

_____ Other diagnoses that may relate to ambulatory problems;

_____ How far the patient can ambulate without stopping and with what assistive device, such as a cane or walker;

_____ Pace of ambulation;

_____ History of falls, including frequency, circumstances leading to falls, what ambulatory assistance (cane, walker, wheelchair) is currently used and why it is not sufficient;

_____ What has changed in the patient's condition that now requires the use of a power mobility device;

_____ Reason for inability to use a manual wheelchair; such as assessment of upper body strength;

_____ Why does the patient need a power wheelchair rather than each level of mobility assistive equipment (a cane, walker, optimally configured manual wheelchair, scooter)? What are the reasons that the patient should not or could not use a cane, walker, optimally configured manual wheelchair or power operated vehicle (scooter) in the home to satisfy their needs?; and

_____ Description of the home setting, including the ability to perform activities of daily living in the home, as well as the ability to utilize the PMD in the home.

The physical examination is relevant to the patient's mobility needs and the medical record for the patient contains:

_____ Weight and Height

_____ Musculoskeletal examination

- Arm and leg strength and range of motion;

_____ Neurological examination

- Gait
- Balance and coordination
- If the patient is capable of walking, the report should include a documented observation of ambulation (with use of cane or walker as appropriate)

After the evaluation has been performed, ***then*** the prescription can be written. We have attached a copy of the seven element format that is acceptable to Medicare.