Medicare 7-Element Written Order

Medicare requires completion of a 7-Element Written Order for all Power Mobility Devices. ***Please use your own prescription pad and complete as shown:***

Your own
Rx pad

Name_____ DOB_____

Power Mobility Device

Date of face-to-face _____

Diagnosis _____

Length of Need: 99 months

M.D./D.O. Signature_____ Date _____

Physician's NPI# _____

M.D./D.O. co-signature required on all P.A./N.P. signatures

7 Elements Required:

1. Patient Name
2. Item Ordered
3. Date of face-to-face appointment***
4. Diagnoses
5. Length of Need
6. Physician's Signature
7. Date of Signature

******Physician's NPI <u>Must</u> be written or printed on Rx******

***If the patient was seen for a P.T. Evaluation <u>after</u> face-to-face appt. with the physician, then the *date of face-to-face* will be recorded on this Order as the date physician concurred with P.T. (ie. Date of face-to-face = date P.T. evaluation is signed by Dr.)

Please fax 7-Element Written Order, along with Chart Notes, to QTeam @ (661)327-5503

Medicare Power Wheelchair CHART NOTE Requirements

Please note, there are *NO generic forms* to be completed; *NO fill-in-the-blanks*. Medicare expects Power Mobility Device evaluations to be documented in your **own** record-keeping format. Not only do they find forms to be insufficient in painting a clear picture of your patient's mobility deficits, but they can also be construed as a form of "coaching," which is against the rules. CMS states that instead of completed forms, "*What is required is a thorough **narrative** description of your patient's current condition, past history, and pertinent physical examination that clearly describes their mobility needs **in the home** and why a cane, walker, or optimally configured manual wheelchair is not sufficient to meet those needs.*"

Please address these 7 Criteria in your Chart Notes:

1. Reason for Visit
    a. Face-to-face Power Mobility Evaluation
2. Evidence of physical evaluation
    a. Height
    b. Weight
    c. Upper Extremity Strength (__/5)
    d. Lower Extremity Strength (__/5)
    e. Gait— Unsteady? Fall&Fx risk?
    f. O2 Sat—(% w/exertion)
    g. Pain Ratings—shoulders, hands/wrists, hips, back, knees, ankles, etc. (__/10)
    h. Restricted ROM anywhere?
    i. Quantity of falls—in the past month or two? Consequences?
3. Rule out cane or walker
    a. **Include 2-3 reasons why a cane/walker is insufficient**
    b. Include *quantifiable* justification
        i. **Example**: Patient cannot use a cane or walker because of lower extremity weakness of 3/5, history of falls with a walker (2 in the last month), and bilateral knee pain of 6/10.
4. Rule out manual wheelchair
    a. **Include 2-3 reasons why patient cannot self-propel**
    b. Include *quantifiable* justification
        i. **Example**: Patient cannot self-propel in a manual wheelchair because of upper extremity weakness of 3/5, decreased grip strength of 3/5, and declining endurance. Patient cannot self-propel more than 5 ft.
5. Rule out electric scooter/POV
    a. **If the patient is not appropriate for a scooter it must be ruled out**
        i. **Example:** Not enough operating room in the home, Pt. is unsafe in transfers to/from scooter, Scooter may exacerbate patient's back/ shoulder pain, Scooter doesn't offer enough postural support, Patient has strength in the upper extremities of less than 3/5
6. Indicate that patient is capable and motivated to use power wheelchair
    a. **Include your assessment of the patient's capabilities and motivation to use the power wheelchair in the home**
        i. **Example:** Patient is physically and mentally capable of using a power wheelchair, and motivated to do so.
7. How will the patient use the power wheelchair in their home
    a. **Include the MRADL's the patient will perform in the power wheelchair**
        i. **Example:** Toileting, grooming, eating, meal preparation, transferring room-to-room, housekeeping

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