DME DOCUMENTATION TEMPLATES

Wheelchair	Hospital bed	Gel overlay	Oxygen
• Patient has mobility limitation that significantly impairs ability to participate in ADLs (activities of daily living). • Patient is unable to use cane or walker. • Patient has sufficient upper extremities function and mental capabilities needed to safely self-propel manual wheelchair.	• Due to [diagnosis] patient requires a semi-electric hospital bed to position the body in ways not feasible with an ordinary bed. AND MORE THAN ONE OF THE FOLLOWING: • Patient requires positioning of body to relieve pain. • Patient requires traction equipment, which can only be attached to a hospital bed. • Patient requires frequent changes in body position. • Patient has an immediate need for a change in body position. • Patient requires the head of the bed to be elevated more than 30 degrees most of the time due to CHF, CPD, or problems with aspiration.	• Gel overlay is required due to limited mobility. AND MORE THAN ONE OF THE FOLLOWING: • Patient has pressure ulcer on trunk or pelvis. • Patient has impaired nutrition status. • Patient has incontinence. • Patient has altered sensory perception. • Patient has compromised circulatory status.	• Patient is at 88% or below oxygen saturation (O2 sat) on room air at rest. OR: • Patient has impaired O2 sat with ambulation (six-minute walk test). (Add "on [amount] liters per minute" to document need for increased flow if patient is already on oxygen.)

Power mobility devices

For Medicare to reimburse for a power wheelchair (PWC) or power operated vehicle (POV) such as a scooter, several requirements must be met:

1. In-person visit with physician to address mobility needs.

2. History and physical exam by physician or other medical professional (recommend consulting physical therapist) focused on assessment of mobility limitations and needs. Exam results must be recorded in medical record.

3. Order (prescription) may be written after in-person visit and mobility exam. (Required elements below.)

4. Order and documentation of visit and exam must be sent to supplier within 45 days of exam.

Order template

– Order specifics –

EQUIPMENT DESCRIPTION: Power mobility device

Dispense: 1 with 0 refills.

Anticipated length of need: 99

DIAGNOSIS (and ICD-10 code):

Height:

Weight:

– Demographics –

Patient name:

DOB:

Home address:

Insurance info:

Member ID:

History template

• Patient requires a power mobility device due to diagnosis of: [diagnosis]

• Patient requires power mobility device now due to change in: [condition]

• Patient has history of falls/poor balance.

• Patient has decreased upper extremity strength and/or grip strength.

• Patient is currently unable to get to the bathroom to toilet/bathe at home.

• Patient is currently unable to get to the kitchen to prepare meals at home.

• Patient is currently unable to get to the bedroom to groom/dress at home.

• Patient is willing to use power mobility device in home.

Physical exam template

Diagnosis of medical condition requiring power mobility device: [condition]

• Patient has received the following treatment: [treatment]

• Patient is currently using the following medications: [medications]

• General: no apparent distress, well-kempt.

• Neuro: gait, balance to be evaluated by physical therapist.

• Musculoskeletal: sitting in wheelchair.

[Insert rest of exam.]

Assessment/plan template

Ambulatory dysfunction due to: [diagnosis]

• See history/exam for diagnosis that requires patient to have power mobility device.

• Patient is being evaluated for power mobility device.

• Patient cannot use a cane/walker due to history of falls and [lower extremities % function].

• Patient cannot use a cane/walker due to poor balance.

• Patient cannot use a manual wheelchair due to [upper extremities % function and/or grip strength].

•Patient cannot use a manual wheelchair due to contracture of hands and pain level of [x/10].

• Power mobility device is necessary in the home to get to the bathroom to bathe/toilet.

• Power mobility device is necessary in the home to get to the kitchen to prepare meals.

• Power mobility device is necessary in the home to get to the bedroom to groom/dress.

• Patient cannot use a POV due to lack of postural stability.

• Patient cannot operate POV tiller.

• Patient requires special seating due to pressure sore.

• Power mobility device will improve patient's ability to get from bed to bath.

• Patient can safely operate power mobility device.

• Patient is willing and motivated to use device in home.

• Referring patient to PT/OT clinic for face-to-face exam.

• After evaluation by PT/OT will order power mobility device.

AAFP FPM

***FPM* Toolbox** To find more practice resources, visit https://www.aafp.org/fpm/toolbox.

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