Southern Mobility and Medical

ACHC Accredited – Authorized Medicare & Preferred BCBS Provider
Phone:1-800-681-8831 Fax:1-877-611-3500

General Insurance Guidelines For a Power Wheelchair

(for Medicare, Medicaid, Humana, BCBS HMO, Medicare replacement plans)

Dear Physician,

Please find enclosed the guidelines for completing the face to face mobility exam and prescription for insurance. To save time, please be sure to follow instructions carefully, as missing or vague medical documentation will need to be corrected and will cause more time and paperwork.

IMPORTANT MINIMUM INSURANCE CRITERIA:

1. Primary need is for assistance with ADL's inside of the home due to inability to use other devices
2. EVERY detail on the enclosed checklist must be documented within the official exam notes.
3. Ordering Physician/Provider must personally hand-write all elements of the prescription

Please fax completed exam notes and & 7 Element Rx to 1-877-611-3500 or call with any questions.

Get reimbursed for your time: Most insurance have authorized reimbursement for your time and effort under billing code G0372 which covers the cost of compiling the required documents.

Insurance Paperwork Guidelines for Power Mobility Devices

SAVE TIME and avoid future requests for missing information by addressing ALL elements below in an objective, detailed manner within the official exam notes (not a separate letter).

STEP 1: FACE TO FACE WHEELCHAIR EVALUATION. Official exam notes must SPECIFICALLY address ALL of the following, even details that seem obvious:

- ☐ Under Chief Complaint or Reason for visit, list "Face to Face Mobility Evaluation "
- ☐ Describe all medical conditions and symptoms relating to ambulatory difficulties and any declining health issues, to paint a picture of their limitations and daily difficulties in the home
- ☐ Include patient's current measured weight and height
- ☐ Describe what device (cane, walker, manual or power chair, etc) is currently being used at home.
- ☐ **Why** is the current device no longer adequate in the home (Record specific medical reasons or why current PMD requires replacement)
- ☐ Must describe at least 2-3 specific inside activities of daily living they have difficulty completing. (i.e. getting to the bathroom for toileting, meal preparation/ getting to meals, dressing, grooming, etc.)
- ☐ Objectively explain **why** a cane cannot resolve their condition inside the home.
- ☐ Objectively explain **why** a walker cannot resolve their condition inside the home.
- ☐ What are the specific medical reasons the patient cannot self-propel a manual wheelchair in the home? (i.e. "…due to R.A in hands, pain from rotator cuff tear, no use of right side from stroke")
- ☐ Note why a scooter with steering tiller cannot be safely used in the home (i.e. lack of postural stability or upper extremity strength, lack of space in home, need for joystick controller vs. a steering tiller for less upper body exertion, need for elevating leg rests, etc).
- ☐ Explain **how** a power chair will improve the patient's ability to perform the activities listed above.
- ☐ Must give objective, numeric rating for Upper AND Lower extremity strength (example ___/5)
- ☐ As applicable to the patient, include objective numeric data regarding pain levels, extremity range of motion, and/or endurance limitations. Need at least 2.
- ☐ Note if patient is oriented and able to safely use a power wheelchair at home.
- ☐ Whether the patient's condition will improve over time.
- ☐ Progress notes must be electronically or hand-signed, with date

STEP 2: 7-ELEMENT PRESCRIPTION on the enclosed template form.

The entire prescription must be personally handwritten by the ordering physician or treating practitioner

Fax paperwork, with patient demographics, to Southern Mobility & Medical at 1-877-611-3500 after all items are addressed.

Call 800-681-8831 with any questions.

PER INSURANCE: Entire prescription must be personally handwritten by the physician/ treating practitioner

7-Element Order for Power Mobility Devices (PMD)

7 Element Order for PMD
Beneficiary Name:
ICD-10 Diagnosis Codes:
Type of Equipment:
Date of Face to Face Mobility Exam:
Length of Need (99 months = lifetime):
Physician/ Practitioner Name (Printed):
Signature (No stamps please):
Date of Signature:
NPI: