	PMD Coverage Criteria and Documentation Requirements
	Coverage Criteria
1	**Coverage:** The patient must have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that: 1. Prevents the patient from accomplishing an MRADL entirely, or 2. Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or 3. Prevents the patient from completing an MRADL within a reasonable time frame. The patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane, walker, or appropriately configured manual wheelchair.
	Documentation Required:
2	Must have patient height & weight documented
3	ROM, strength, gait, balance, transfers, ambulation ability, and cardiovascular endurance must be addressed. If the patient can ambulate then specifics regarding ambulation must be addressed (pace, assistive device, assistance, and distance)
4	Must document why the patient is unable to ambulate with a cane or walker due to risk of falling or inability to complete one or more MRADLs in a timely manner Must also document why the patient is unable to manually propel an appropriately configured manual wheelchair to complete one or more MRADLs in a timely manner.
5	Must IDENTIFY at least one MRADL that the patient is unable to accomplish with a cane/walker/appropriately configured manual wheelchair and describe the specific limitation. • Bathing • Dressing • Toileting • Meal Preparation/Feeding • Grooming
6	If recommending a power wheelchair, it must be documented why the patient cannot use a POV (scooter) to accomplish the MRADL.
7	Current equipment: • It must be identified why the patient's current equipment is no longer appropriate for them to participate in MRADLs. • What specific medical event (change in medical condition) occurred to render the current equipment no longer appropriate? • What other equipment was either trialed or considered and ruled out and WHY? o ALL less costly alternatives must be ruled out
8	If recommending power seat features (power tilt or power recline), alternate drive controls, or power assist motors for a manual wheelchair a specialty evaluation must be performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), or physician who has specific training and experienced in rehabilitation wheelchair evaluations. This evaluation must be in a **narrative format**, not a simple check box and must individually address the patient's seating needs. The PT, OT, or physician may have no financial relationship with the supplier.
	Notes:

Power Mobility Device (PMD)
Functional Mobility Evaluation/Wheelchair Assessment and Justification/LMN

Patient Information:

Name: **Date:**

Address: **City:** **State:**

Phone #: **Ht:** **Wt:** **Zip:**

Insurance: **Date of Birth:**

Medical Diagnoses:

Written Description	**ICD-10 Code**

Medical History Description:

What is the current mobility equipment that the patient is using and specifically why does it not allow the patient to complete one or more MRADLs completely, safely, or in a timely manner (please identify which MRADL is limited and quantify that limitation):
Current Equipment:

Identify which MRADL is limited:

☐ **Dressing** ☐ **Toileting** ☐ **Bathing** ☐ **Feeding/meal prep** ☐ **Grooming**

Explain the specific mobility limitation:

Patient name:

Describe current ambulation status: ☐ **Non ambulatory**

Right UE ROM ☐ **WFL's**	**Right UE Strength**
Left UE ROM ☐ **WFL's**	**Left UE Strength**
Right LE ROM ☐ **WFL's**	**Right LE Strength**
Left LE ROM ☐ **WFL's**	**Left LE Strength**

Describe Functional Strength, Endurance, or pain limitations in mobility related activities of daily living (MRADLs):

Transfers: (method, device, and assistance required):

Patient name:

Sitting Balance:

Please describe the specific change(s) in medical condition that have occurred that prevent the patient from accomplishing mobility related activities of daily living (MRADL) entirely or prevents the patient from completing the MRADL in a reasonable time frame or safely in their current mobility assistive equipment:

Please describe the reason why the following mobility assistive equipment does not meet the patient's mobility needs:
Cane/Walker:

Optimally configured Manual Wheel Chair:

Scooter/POV:

Other:

Patient name:

Seating and positioning:

Pelvic position:

☐ **Level** ☐ **Obliquity** ☐ **Pelvic Tilt (Sacral sitting – posterior pelvic tilt)** **Explain:**

Head control and Spinal posture:

Muscle tone, spasticity, spasms, trunk strength that impacts posture:

Current Skin Integrity /condition:

Sensation: ☐ **Intact** ☐ **impaired** **Describe:**

Current pressure ulcers (locations and stage):

Past history of ulcers: ☐ **Yes** ☐ **No** **Location(s), stage, & approximately how long ago:**

Edema: (location and grade)

Patient name:

Custom molded/custom fabricated seat cushion of back
(this section must be completed if patient requires molded seat or back)

Does the patient have skeletal and/or physical deformities/abnormalities that require custom molded seating system: (explain):

Does the patient have significant postural asymmetries? (Explain):

Explain why the patient's needs cannot be met by standard seating components:

Tilt and recline seating systems

Is the patient able to perform a functional weight shift? ☐ **Yes** ☐ **No**

Does the patient use intermittent catheterization for bladder management? ☐ **Yes** ☐ **No**

Is the seating required to manage increased tone or spasticity? ☐ **Yes** ☐ **No**
If yes, please explain:

Tilt and recline seating systems
Tilt medical justification (if needed):

Recline medical justification (if needed):

Patient name:

Trial of Equipment:
The results of trial of equipment or rationale why equipment was considered and ruled out:

How will the recommended power wheelchair improve the patient's ability to participate in the MRADL identified on page 1:

How many hours per day will the patient utilize the wheelchair:

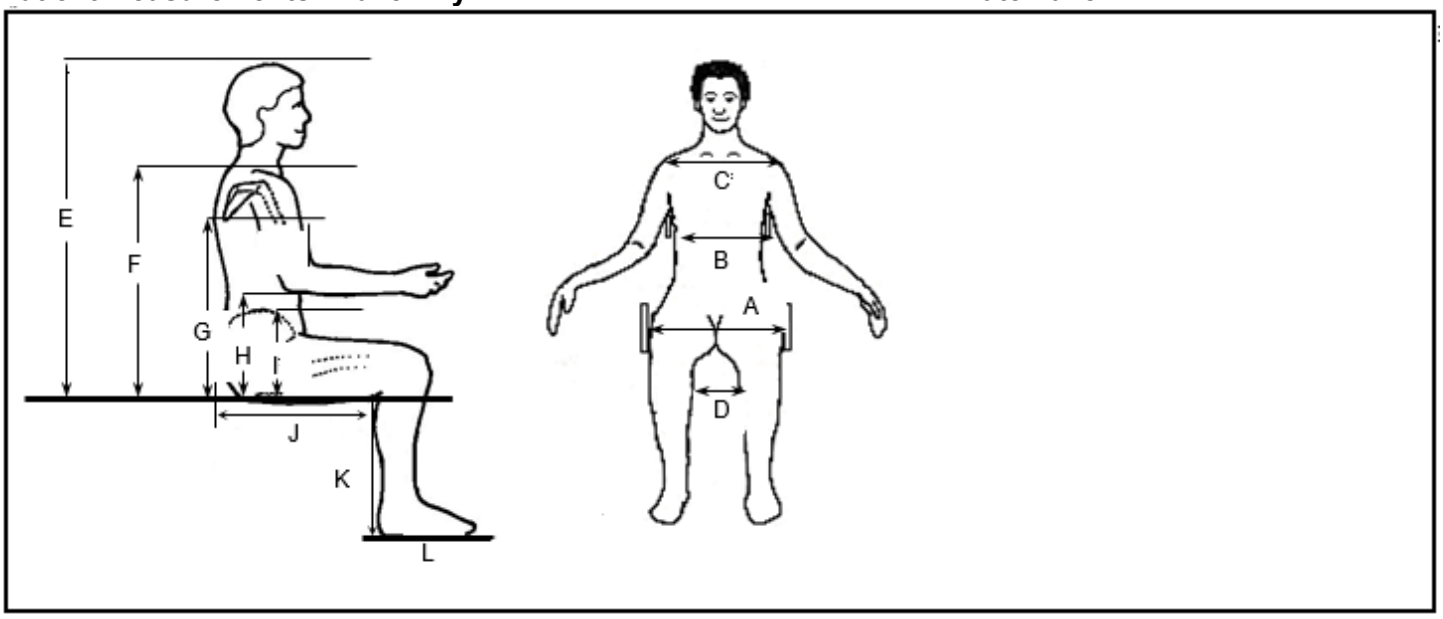
Can the patient safely operate a PMD in the home? ☐ **Yes** ☐ **No**

Is the patient willing and motivated to use the PMD inside the home? ☐ **Yes** ☐ **No**

Additional information:

Patient name:

Patient Measurements: Taken By: **Date Taken:**



	Measurements in Sitting:	Left	Right	
	A: Hip Width			F: Seat to Top of Shoulder
	Overall Width (asymmetrical)			G: Seat to Axilla
	B: Chest Width			H: Seat to Elbow
	Chest Depth			I: Seat to PSIS
	C: Shoulder Width			J: Upper Leg Length
	D: Abduction			L: Lower Leg Length
	E: Seat to Top of Head			M: Foot Length

COMMENTS:

Patient name:

EQUIPMENT	JUSTIFICATION

Patient name:

EQUIPMENT	JUSTIFICATION

Patient name:

EQUIPMENT	JUSTIFICATION

Patient name:

EQUIPMENT	JUSTIFICATION

Therapist:

Therapist printed name: **License #:**

Employer/Company name:

Address: **Phone #:**

City: **State:** **Zip:**

Signature:_____ **Date:**_____

My signature affirms that I completed each section of this evaluation based upon my own clinical knowledge, training and evaluation of the person's medical condition. I attest that there is no financial relationship between the supplier and me.

Physician

Physician printed name: **NPI:**

Address: **Phone #:**

City: **State:** **Zip:**

Signature:_____ **Date:**_____

My signature affirms that I concur with the findings and recommendations of this therapy functional mobility evaluation and will include this in my medical record for this patient.