POS0604-10/08

Power Mobility Equipment & Patient Home Evaluation
Functional Assessment & Plan of Service

(to be preformed on all Medicare patients prior to receiving power mobility products)

Note: This functional evaluation must be completed by a Home Medical Equipment dealer technician, home healthcare nurse, Physical/Occupational Therapist or other qualified healthcare practitioner whom has received an order for mobility assistive equipment from a physician, physicians assistant, or nurse practitioner following a face to face examination. The evaluator has been into the home, seen and assessed the patient's functional needs for Mobility Assistive Equipment. Medicare requirements for coverage of Mobility Assistive Equipment are tied directly to the ability of the patient to perform mobility related activities of daily living (MRADL) in the home setting. Please make any required changes in orders in the Physician Notes, Changes and Comments section, sign and date page 4.

Patient's Name____Date of Evaluation______________________

Patient's HIC#__________________________DOB__________________Ht:____________Wt:_________

Address Evaluated_____________________________________City:___________State/Zip:______________

Type of Equipment Practitioner has originally ordered:____

Date of Face to Face examination and order of equipment:____

MEDICAL HISTORY

List the mobility limitation that requires and assistive device. Diagnosis, Physical condition etc. *(include any ICD-9 codes)*

Are there limitations related to MRADLs such as poor vision, hearing, communication, eating, positioning, spasticity, environment, etc. that the patient has, which would prevent him/her from utilizing the ordered mobility assistive equipment, that need to be addressed? Yes ❑ ________________(list) No ❑

Describe the patient's mental or cognitive status? *(check all that apply)*
Oriented ❑ Comatose ❑ Dementia/disoriented ❑
Forgetful ❑ Lethargic ❑ Agitated ❑

If there are limitations or the patient has a cognitive deficit, can the ordered mobility assistive equipment still be used safely and effectively with the assistance of a caregiver?
❑ Does Not apply ❑ Yes ❑ No

Can this patient's functional limitations adequately be resolved with the prescription of a cane or walker alone?
Yes ❑ No ❑

IF YES STOP HERE

Is there history of decubitus/skin breakdown? Yes ❑ No ❑ ❑ Unknown
Has a cushion or support surface been ordered by the physician Yes ❑ No ❑
If breakdown exists and a cushion has not been ordered, follow up with physician.

Describe **orthopedic conditions** and / or range of motion limitations requiring special consideration (i.e., contractures; degree of spinal curvature, recent or past surgery):

Describe other **physical limitations** or concerns (i.e. respiratory, I.V. enteral feeding):

Describe any recent or **expected changes** in medical/physical /functional status, (ie expected patient weight gain/loss, scheduled surgery etc):

Will these changes require a different type/size of wheelchair/POV in the future, and is the product being provided capable of being adjusted to compensate for this expected change? Yes ❑ No ❑
If no, Explain:

FUNCTIONAL ASSESSMENT

Ambulatory Status:
- ❑ Non-Ambulatory
- ❑ Ambulatory but is at risk for falls or is extremely slow
- ❑ Transfers only
- ❑ Community Ambulatory
- ❑ Gaits Short Distances Only (Define)____
- ❑ With Assistance Only (if yes, is a caregiver always available) ❑ Yes ❑ No

Wheelchair Ambulation:
Is the patient totally dependent upon a wheelchair? ❑ Yes ❑ No
If **no**, Please explain, give details such as why a wheelchair would be required instead of a walker etc. Does the patient have mobility limitation(s) that significantly impairs his/her ability to perform on or more MRADLs in the home. Explain in detail **what prevents** the accomplishment of **the MRADLs or places the patient at risk, or prevents completion of the MRADLs in a reasonable time frame:**

Type of Wheelchair
Can the patient safely self propel a properly configured manual wheelchair to complete all MRADLs? ❑ Yes ❑ No
If Answer is Yes and a POV or Power Chair has been ordered STOP HERE or recommendation should be for a change to a manual wheelchair, patient does not qualify for power.

Indicate the **patient's capabilities** to transfer, perform feeding/meal preparation, toileting, and other **MRADLs** in the home without the use of mobility assistive equipment.
- ❑ Needs Maximum Assistance
- ❑ Needs Moderate Assistance
- ❑ Needs Minimum Assistance
- ❑ Patient is Independent with all MRADLs

Would the use of prescribed mobility assistive equipment allow the patient to become more independent with MRADLs, or allow for increased safety and/or speed in the completion of the MRADLs?
❑ Yes ❑ No

Does the beneficiary or caregiver demonstrate the capability and the **willingness** to consistently operate the prescribed MAE safely?
❑ Yes ❑ No

HOME ENVIROMENTAL ASSESSMENT

Describe where the patient **resides**:
- ❑ Apartment
- ❑ Single Story residence
- ❑ Multi-level residence
- ❑ Mobile or manufactured home

Describe **surfaces** in the home:
- ❑ Carpet
- ❑ Vinyl
- ❑ Hardwood
- ❑ Tile
- ❑ Other:______________________

Is the home **accessible** to a wheelchair (have ramps, elevator etc)?
❑ Yes ❑ No

Describe **Outside** Access:
- ❑ Paved Driveway
- ❑ Dirt
- ❑ Gravel
- ❑ Grass

Does the patient's typical **environment support the use of wheelchairs** including scooters/power-operated vehicles (POVs)? *(Determine whether the beneficiary's environment will support the use of these types of MAE. Keep in mind such factors as physical layout, surfaces, and obstacles, which may render MAE unusable in the patient's home.)*
❑ Yes ❑ No ❑ The home could be suitable with some modifications or additional equipment
List modifications or additional equipment required:

Describe **other** types of **equipment** that will interface with the wheelchair/POV?(i.e. oxygen equipment, hospital beds, ventilator, patient lifts, etc.)

What is the maximum distance the patient is required to travel in order to perform any MRADL in his/her home? This distance may include both the distance to the activity and back if it is relevant. Describe the distance and MRADLs in question.

Door / Room Wheelchair Accessibility

Main Entry Door Accessible	☐	Yes	☐ No	Living Area Accessible	☐	Yes	☐ No
Kitchen Accessible	☐	Yes	☐ No	Sleeping Area Accessible	☐	Yes	☐ No
Bathroom Accessible	☐	Yes	☐ No	Hallway Accessible	☐	Yes	☐ No

Are there **architectural obstacles** in the home that would prevent the mobility assistive equipment from being used in the home? Expand on any no answers listed above.

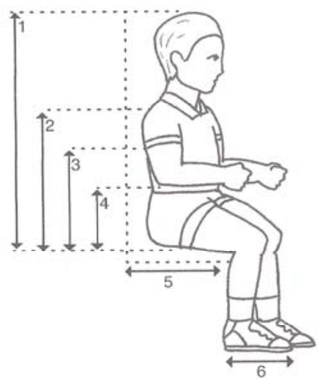
What are the **maximum dimensions** the requested mobility **equipment can be** due to obstructions or other features?

Overall Length of equipment: ☐ less than 30” ☐ 30-48” ☐ no limits
Overall Width of equipment: ☐ less than 25” ☐ 25-30” ☐ no limits
Overall Height of equipment with occupant: ☐ less than 60” ☐ no limits
Total Weight of product and occupant ☐ less than 150 lbs ☐ 150-300 lbs ☐ 301-500 lbs ☐ 501 lbs & Up

Please Indicate below the adequacy of the home environment with regard to the type of equipment ordered				
Is existing Shelter	☐	Adequate	☐	Inadequate
Is Heat, Water, Plumbing	☐	Adequate	☐	Inadequate
Is Refrigeration, Cooking	☐	Adequate	☐	Inadequate
Electrical (Check ground, power operated equip. only)	☐	Adequate	☐	Inadequate
Fire Safety (Has smoke detectors/alarm and/or Extinguisher)	☐	Adequate	☐	Inadequate
Are there Safety or Health Hazards Present	☐	Yes	☐	No
Is the patient suitable for homecare	☐	Yes	☐	No

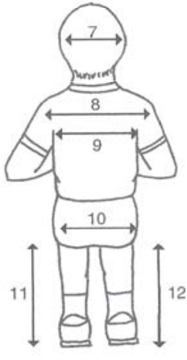
Expand on any inadequacies:

PATIENT MEASURING WORKSHEET



1. ________ 1. Top of head to bottom of buttocks
2. ________ 2. Top of shoulder to bottom of buttocks
3. ________ 3. Arm pit to bottom of buttocks
4. ________ 4. Elbow to bottom of buttocks
5. ________ 5. Back of buttocks to back of knee
6. ________ 6. Foot length
7. ________ 7. Head width
8. ________ 8. Shoulder width
9. ________ 9. Arm pit to arm pit
10. ________ 10. Hip width
11. ________ 11. Distance to bottom of left leg (popliteal to heel)
12. ________ 12. Distance to bottom of right leg (popliteal to heel)

ADDITIONAL COMMENTS: ____________________



POWER OPERATED EQUIPMENT **(Complete only if the physician has ordered a POV, or Power Wheelchair)**

Does the beneficiary have sufficient upper extremity function to propel a standard weight manual wheelchair in the home to participate in MRADLs during a typical day? *The manual wheelchair should be optimally configured for this determination.*

☐ Yes ☐ No

Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?

☐ Yes ☐ No

Is the patient physically and mentally capable of operating a POV/Scooter safely?

☐ Yes ☐ No

Are there additional features provided by a power wheelchair, not available on a POV, needed to allow the beneficiary to participate in MRADLs

☐ Yes ☐ No

(list them in the next box)

EVALUATING TECHNICIANS RECOMMENDATIONS

The items at the top of the list represent the least costly alternative; becoming more expensive as one progresses down the list. After having reviewed this patients home environment and physician's original order, I as the evaluating equipment technician believe the following type of equipment is reasonable and necessary for this patient:

- ☐ Power Operated Vehicle (Scooter)
- ☐ Standard or lightweight Power Wheelchair Group I or II as appropriate for the patient's weight

- ☐ Other:____

Enter a detailed reason why the recommended wheelchair was required for this particular patient in lieu of a less costly alternative:

Please list any accessory items that will be required for safe use of the wheelchair such as elevating legrests, adjustable back, brake extensions, anti-tipping devices etc. and give justification for their use.

PHYSICIAN NOTES, CHANGES & COMMENTS

(Only required when the original order for equipment and the equipment technician's recommendations are in conflict, or if the physician is in disagreement with part of the evaluation)

Evaluator Name & Title:	Physician / Practitioners Name:
Evaluator Signature:	Physician Phone:
Evaluator Phone Number:	Practitioners NPI
Evaluators Employer:	Practitioners Address:

I as the prescribing physician have read and agree with the evaluation of this patient from the evaluator except as noted above. I concurred that the patient requires this medically necessary equipment as recommended excepting any changes noted in the change orders section. I believe this equipment to be medically necessary. I will maintain a copy of this evaluation on file in the patient's permanent medical record.

Physician Signature____Date___________