Advanced Home Medical Inc

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Face-to-Face Mobility Examination Report
For a Power Wheelchair

Patient Information | **Date of Face to Face Examination:** _____

Name:					HICN:
Mailing Address:					Telephone: ( )
City:	State:	Zip:	DOB:	Age:	Male Female

Physician or Treating Practitioner Information

Name:		UPIN:
Mailing Address:		Telephone: ( )
City:	State:	Zip:

Current Symptoms, Related Diagnosis, and History (Must Be Completed by Treating Practitioner)

What medical conditions/diseases limit your patient's mobility in their home?

- ☐ Cerebral Vascular Disease / CVA
- ☐ COPD
- ☐ CHF
- ☐ Degenerative Joint Disease
- ☐ Diabetes/Neuropathy
- ☐ Other, Please describe:
- ☐ Hemiplegia/Hemiparesis
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Paraplegia/paresis
- ☐ Parkinson's Disease
- ☐ Renal Failure
- ☐ Rheumatoid Arthritis

How do the above conditions interfere with their ability to perform Activities of Daily Living (ADLs) in their home?

- ☐ Abnormality of Gait
- ☐ De-conditioning
- ☐ Edema
- ☐ Fatigue
- ☐ Numbness
- ☐ Pain
- ☐ Shortness of Breath
- ☐ Tremor
- ☐ Weakness

☐ Other, Please describe: _____

Physical Exam (Must Be Completed by Treating Practitioner)

Ht:	**Wt:**	**B/P:**	**Pulse (resting):**	**Pulse (exertion):**
Shortness of Breath at Rest? Y N	**Shortness of Breath w/exertion?** Y N	**Is O2 required?** Y N	**Number of Liters?**	**O2 Sats?**
Any current pressure sores? Y N	**History of pressure sores?** Y N	**Location?**	**Stage?**	**Able to shift weight?** Y N
Poor Balance Y N	**Poor Endurance** Y N	**History of Falls** Y N	**Risk of Falls** Y N	**Significant Edema** Y N

Upper Body Weakness: ____ Mild ____ Moderate ____ Severe
Upper Body Pain: ____ Mild ____ Moderate ____ Severe
Lower Body Weakness: ____ Mild ____ Moderate ____ Severe
Lower Body Pain: ____ Mild ____ Moderate ____ Severe
Contracture: RUE / LUE RLE / LLE

Gait Pattern: ____ Non-Ambulatory
____ Max Assist
____ Mod Assist
____ Ataxic
____ Shuffling

FAX COMPLETED FORM TO: 888-518-7568

Face-to-Face Examination Report
For a Power Wheelchair

Patient Name: _____ Treating Practitioner: _____

1. Please select all of the Activities of Daily Living (ADLs) that your patient is unable to perform inside their home without the aid of powered mobility equipment.

- ☐ Feeding
- ☐ Bathing
- ☐ Grooming
- ☐ Moving from Room to Room
- ☐ Dressing
- ☐ Toileting
- ☐ Other, Please describe_____

2. Why can't a cane or walker meet this patient's mobility needs in the home?

3. Why can't a manual wheelchair meet this patient's mobility needs in the home?

4. How has your patient's condition changed so that they now require a Power Wheelchair to complete their ADLs?

5. Please indicate why a Power Operated Vehicle (POV)/Scooter will not meet this patient's mobility needs in the home

- ☐ Patient Requires Joy Stick Controller
- ☐ Patient Presents Poor Trunk Stability
- ☐ Patient Requires Adjustable Height Armrests
- ☐ Patient Unable to Safely Operate a POV
- ☐ Patient Requires Elevating Leg Rests
- ☐ Patient Requires Fully Reclining Back
- ☐ Patient's Home Presents Insufficient Space for Maneuverability
- ☐ Other, Please describe_____

6. Does your patient have the physical and mental abilities to safely operate a Power Wheelchair in the home?

☐ Yes ☐ No

7. Is your patient willing and motivated to use a power wheelchair in the home?

☐ Yes ☐ No

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Face-to-Face Examination Report
For a Power Wheelchair

Patient Name: _____ Treating Practitioner: _____

If you intend to prescribe a power mobility device (PMD) for your patient, you should:

I. Complete this form for your patient's medical record;
II. Enter a specific chart note in the patient's medical record indicating that you have:
    a) Conducted a Face-to-Face Examination;
    b) Completed a Face-to-Face Mobility Evaluation Report;
    c) Completed a Prescription for a specific PMD.
III. Provide copies of the prescription, the report, and the chart note detailed above to the power mobility device provider.

If you do not believe that the documentation listed above provides adequate support for the PMD prescription, you may provide additional supporting documentation. Additional documentation may include physician office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals, and test reports.

NOTE:

The Centers for Medicare and Medicaid Services (CMS) recognizes the increased documentation burden for PMDs. Therefore, code (G0372) has been established to recognize the additional physician service and resources required to establish and document the need for PMDs. The payment amount for this documentation preparation is $21.60 in addition to the office visit. Additional information can be obtained through CMS' *MedLearn Matters Number 4121 (http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4121.pdf).*

I certify that the information provided is a true and accurate representation of my patient's current condition and that a major reason for the visit was a mobility examination. I hereby incorporate this document into my patient's medical record.

Physician or Treating Practitioner

Signature:_____ **Date:**_____

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