

Face to Face Evaluation

Medicare requires that the following questions be answered by the physician or a physical therapist. Please use your own letterhead for your answers as *Medicare has deemed any supplier created forms unacceptable*. Physicians can be compensated for the Face To Face Evaluation by using the HCPCS code G0372. Please contact **Mobility Warehouse** if you need any assistance with this process. We appreciate your business!

Patient Name _____ DOB _____

Insurance _____ ID# _____

Address _____

Phone _____ SEX/HT/WT _____

Please use your own letterhead to provide the following questions.

The face-to-face mobility evaluation must be conducted by the treating physician prior to writing the order. The power chair supplier must receive the written order within 45 days of this evaluation.

The face-to-face examination report must address the following:

- Patient's mobility limitation and how it interferes with the performance of activities of daily living
- Why can't a cane or walker meet this patient's mobility needs in the home?
- Why can't a manual wheelchair meet this patient's mobility needs in the home?
- Why can't a mobility scooter meet this patient's mobility needs in the home?
- Does this patient have the physical and mental abilities to operate a power wheelchair safely in the home?
- Is the patient willing and motivated to use a power wheelchair?

The report shall provide pertinent information about the following elements, but may include other details.¹

- Symptoms & related diagnoses
- How long the condition has been present
- History & clinical progression
- Interventions (including medications) that have been tried and the results
- Past use of walker, manual wheelchair, power wheelchair or mobility scooter and the results
- Physical exam & weight
- Impairment of strength, range of motion, sensation or coordination of arms and legs
- Presence of abnormal tone, deformity of arms, legs or trunk
- Neck, trunk, and pelvic posture and flexibility
- Sitting and standing balance
- Functional assessment - problems performing the following activities including the need to use a cane, walker or aid of another person:
 - Transferring between a bed or chair and power mobility product
 - Walking to & from bathroom, kitchen, living room, etc.
 - Distance patient is able to walk without stopping; speed, and balance

Determining your Patients' Mobility Needs

CMS has implemented a National Coverage Determination for all mobility assisted equipment which includes power wheelchair and power operated vehicles. Listed below is a summary of the questions that must be addressed and *charted in your progress notes during your office face-to-face mobility evaluation.*

1. What medical condition(s) limit your patient's ability to participate in Mobility Related Activities of Daily Living (MRADLs) in their home?

2. List what MRADLs in the home are IMPAIRED due to your patient's mobility limitation?

Some examples are:

- Moving from room to room
- Dressing, Grooming, Toileting, Feeding, Bathing

3. Why can't a cane or walker meet your patient's mobility needs in the home? Some examples are:

- Unsteady gait - history of 3 falls over past month
- Upper Extremity (UE) and Lower Extremity (LE) strength of 2/5
- Desaturates to 87%
- Poor balance

4. Why can't a manual wheelchair meet your patient's mobility needs in the home? Some examples are:

- UE strength of 1/5
- Right sided weakness of 1/5 due to CVA
- Decreased ROM of shoulder & joints
- Grip strength of 2/5
- Contractures of the hands
- Pain level - 8/10 in shoulder and hands

5. Why can't a scooter (POV) meet your patient's mobility needs in the home? Some examples are:

- Cannot safely transfer in/out of POV
- Home environment does not provide adequate access for maneuvering POV
- Cannot operate tiller of POV
- Lacks postural stability
- UE strength of 1/5

6. Does the patient have the physical and mental abilities to operate a power wheelchair safely in the home?

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

Detailed Product Description/Prescription

Name _____

ICD's _____

DOB _____

Ht _____ **Wt** _____

Detail Product Description	HCPCS	Medicare Allowable	Suppliers Charge

Date of Face to Face Evaluation _____

Length of Need _____

Physician's Signature _____ **Date** _____

Printed Name _____ **NPI** _____

Address _____
