



8110 Ulmerton Rd. • Largo, FL. 33771
Phone: 727-535-6100 • Fax: 727-535-6466
Call us toll free at 800-828-4188
www.amimobility.com

Dear Dr. _____
Doctor's Name

Attached is the Power Mobility Device Packet for _____
Patient's Name

You will find a checklist that explains in detail everything that Medicare requires for a PMD. Please feel free to use this as a guide when prescribing the mobility equipment for your patient. You may also use the attached script, or if you would like to use your own, please be sure to include all pertinent information.

Thank you very much for your understanding in this matter.

Sincerely,

AMI Staff

Note:

The Centers for Medicare and Medicaid Services (CMS) recognizes the increased documentation burden for PMD's. Therefore, code (G0372) has been established to recognize the additional physician service and resource required to establish and document the need for the PMD's. 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>)



The SOLUTION to all your mobility needs
Complex Rehab · Wheelchairs · CPAP/BiPAP · Oxygen Equipment



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Power Mobility Device Checklist

- Face-to-Face Mobility Exam**
The Patient must come in for a face to face meeting to discuss the need for a PMD and it must be documented that this was the reason for the visit. Use appropriate E & M code for the face to face as well as the new G code (G0372)

- Script for a PT (Physical Therapy) Mobility Eval**

- Prescription for Power Mobility Device**
You may use the attached script template, or if you would like to use your own please include the following 7 items:
 - Beneficiary's Name
 - Item that is being ordered. (Powerchair, Scooter, PMD)
 - The date of the face to face examination
 - Pertinent diagnosis codes/conditions that relate to the need for a PMD
 - Length of need
 - Physician's signature
 - Date of the physician's signature

- Chart Notes from the Mobility Evaluation**
The following information must be addressed and documented in the chart notes:
 - What is the patient's mobility limitation and how does it interfere with the performance of activities of daily living (ADL's) ?
 - Why won't a cane or walker meet the patient's needs?
 - Why won't a manual wheelchair meet the patient's mobility needs?
 - (If ordering a Powerchair/Electric Wheelchair) Why won't a scooter meet the patient's needs?Does the patient have the physical and mental abilities to transfer into and out of a PMD and to operate it

- PLEASE FAX ALL COMPLETED DOCUMENTS TO:
AMI @ 727-535-6466**

PLEASE NOTE THAT AFTER ALL DOCUMENTS HAVE BEEN RECEIVED WE WILL FAX A DETAILED PHYSICIAN'S ORDER THAT MUST BE SIGNED AND DATED BY THE PHYSICIAN PRIOR TO DELIVERY.





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Prescription for a Powered Mobility Device

Physician: _____ NPI#: _____
 Address: _____
 Phone: _____ Fax: _____
 Patient's Name: _____ Patient Phone: _____
 Address: _____ DOB: _____

Date of the *Face -to-Face* Evaluation: _____ Length of Need in Months(99 = Lifetime): _____

All diagnosis and conditions that the PMD is expected to modify, should be supported by pertinent medical documentation in the patient's progress notes:

Diagnosis: _____ ICD-9 Code: _____

Other Relevant Conditions: _____

ITEM ORDERED

Mobility Item Required _____

Physician's Signature: _____

Date: _____

We can meet all your mobility and seating needs !

