Electronic Clinical Template Background
Final DRAFT v9.8 (11/02/2012)

CMS is working in collaboration with the DHHS Office of the National Coordinator for Health IT (ONC) to develop an electronic template that will assist providers with data collection during the Powered Mobility Devices (PMD) Face-to-Face Examination. This template may also facilitate the electronic submission of medical documentation. The attached document describes the data elements that CMS believes would be useful in supporting the documentation requirements for coverage of a PMD. Once finalized these proposed data elements will be delivered to ONC for consideration and/or inclusion in ONC's development process. This list of data elements is NOT intended to be a final data entry form.

Documentation of the Face-to-Face Examination should accurately reflect the patient's individual condition(s) that necessitate the use of a PMD. As such not all data elements will be applicable to all patients and answers to all of these data elements in any given record would not generally be expected. Only those data elements that pertain to the individual's need for a PMD would be relevant.

In evaluating a patient's need for a PMD, a healthcare provider can incorporate the evaluation and report of a licensed/certified medical professional (LCMP) (e.g. PT, OT or Physiatrist) as part of face to face examination. In such cases there must also be a signed and dated attestation by the consulting clinician that they have no financial relationship with a supplier.

Note: Text in ***red italics*** represents additional text inserted and striking represents text deletion from last posted version

Suggested Electronic Clinical Template Elements of a Progress Note Documenting a Face-to-Face PMD Examination

DRAFT v9.8 (11/02/12)

PMD: Power Mobility Device[1]
MRADL: Mobility Related Activities of Daily Living[2]

A. Chief Complaint

A1. Indicate that this visit is a face-to-face examination for the purpose of evaluating the patient for a PMD.

A2. Describe, in patient's own words, the symptoms/problems/conditions that impair his/her ability to perform MRADLs.

B. History of Present Illness

B1. **History of Present Illness** -- Why does the patient require a PMD **in the home** to safely and effectively accomplish MRADLs?

- B1a. Describe the patient's functional abilities/limitations on a **typical day**.
- B1b. Describe **MRADLs** which are currently limited by the patient's mobility impairment.
- B1c. Describe **areas of the home** in which the MRADLs will be accomplished with a PMD.
- B1d. Describe the **mobility aides** (cane, walker, rollator) that are currently being used or have been tried.
- B1e. Describe the **reason** mobility aides are no longer adequate.
- B1f. Describe the **medical condition(s)** that contribute to the patient's impairment:
  - B1fi. Primary diagnosis
  - B1fii. Secondary diagnoses
- B1g. Indicate whether this is a **longstanding condition**. If it is, describe factors that aggravate the patient's medical condition(s) over time and provide supporting documentation (test results, X-ray reports, etc) of one or more quantitative characteristics that is associated with the patient's decline.
- B1h. Describe **prior treatments** attempted to improve the patient's medical condition(s) (medications, therapies, etc).
- B1i. Indicate whether patient is motivated to use PMD in the home.

C. Past Medical History

C1. **Past Medical History** – What are the medical history factors that contribute to the patient's mobility limitations?

- C1a. List the patient's co-morbid medical conditions and current medications.
- C1b. Describe any abuse of drugs/medications/alcohol/etc that could interfere with the safe use of PMD.

[1] For a list of PMD codes, see https://questions.cms.hhs.gov/app/answers/detail/a_id/10917

[2] CMS covers Mobility Assistive Equipment for beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations within the home.

D. Social History

D1. What is the patient's living situation (lives alone, lives with family, attendant care and the hours/week, assist provided)?

D2. Provide a brief description of the patient's physical layout of his/her home (e.g. steps to enter, 1 story vs. multi-story home, etc.)

D3. Can MRADLs be performed on **one level** of the home?

D4. If the patient cannot safely operate the PMD, describe the availability of a willing caregiver to operate this equipment in order to aid the patient in the accomplishment of his/her MRADLs in the customary locations of the home.

E. Review of Systems (ROS)

Each face to face examination must be individualized to the particular patient. The ROS below is designed to remind the practitioner of the concerns that commonly indicate the need for a power mobility device. The face to face examination of any given individual may not necessitate that every element below is addressed. Additional details describing the patient's condition may be added. If the information from the ROS is already contained in another section of the face to face examination, it need not be repeated here.

E1. Constitutional

E1a. Has patient experienced a recent **change in weight** of greater than 10 pounds? If yes, explain.

~~E1b. Are any **medical or surgical procedures anticipated** to occur in the near future that will affect the patient's mobility capabilities? If yes, describe: type of procedure, expected length of time of patient's recovery.~~

E1c. During the last month, on a **typical day** how many **hours** did the patient spend sitting in a wheelchair? Where is the rest of the time spent?

- E1ci. In bed?
- E1cii. Sitting in chair?
- E1ciii. Sitting in wheelchair?
- E1civ. Walking in the home?

E2. Eyes

E2a. Is the patient's **vision sufficient to safely operate** PMD?

E3. Respiratory

E3a. Describe the patient's respiratory/breathing symptoms that contribute to the need for a PMD.

E3b. Does patient use **home O2**? If yes, at what frequency (daily, 6 hours a day, etc)? For what duration? Use what delivery system? What flow rate?

E3c. Does patient get SOB in home while performing MRADLs? If yes:

- E3ci. Describe MRADLs that make patient SOB in the home (with best oxygenation provided);
- E3cii. Describe interventions that palliate SOB while performing MRADLs,
- E3ciii. Describe how these symptoms have changed over time.

E4. Cardiovascular

E4a. Describe the patient's ***cardiovascular*** symptoms that contribute to the need for a PMD.

E4b. Describe clinically significant increased **heart rate, palpitations**, or **ischemic pain** that occurs or worsens when the patient attempts or performs MRADLs within the home (with best oxygenation provided)?

E4c. Describe what ~~palliates~~ *measures have been taken in the past that have worked or failed to alleviate* these symptoms.

E4d. How far does the patient report that she/he can walk or self-propel an optimally configured manual wheelchair before experiencing these signs/symptoms?

E4e. How have these signs/symptoms changed over time?

E5. Musculoskeletal

E5a. Describe the patient's Musculoskeletal symptoms that contribute to the need for a PMD.

E5b. If the patient has a history of falls in the home, detail where in the home they occur; the reason the patient believes that she/he falls; the frequency and timing of the falls. Also note if after a fall the patient is able to arise to a seated/standing position without the help of another person.

E5c. If the patient experiences joint/bone pain, describe the signs/symptoms (decreased range of motion, etc.) that occur or worsen when the patient attempts or performs MRADLs within the home, detail how these symptoms have changed over time in relation to the patient's functional state. *Describe management of the patient's chronic pain symptoms, including use of analgesics, particularly narcotics?*

E5d. If the patient complains of abnormalities in strength, coordination or tone, as it relates to MRADLs, detail how these symptoms have changed over time in relation to the patient's functional state.

E5e. How far does the patient report that she/he can walk or self-propel an optimally configured manual wheelchair before these signs/symptoms interrupt that activity? Detail how they have changed over time.

E6. Neurological

E6a. Describe the patient's Neurological symptoms that contribute to the need for a PMD.

E6b. If the patient complains of **dizziness, syncope** or **seizures**, state how these symptoms have changed over time. Describe.

E6c. If the patient complains of **lack of coordination or abnormal sensation**, state how these symptoms have changed over time.

E7. Skin

E7a. If the patient **currently** experiences a **skin ulcer(s)** or other loss of skin integrity, describe the location(s); the treatment(s), the size and cause.

E7b. If the patient has a **history** of a **decubitus ulcer(s)** or other loss of skin integrity, describe the event.

E8. Cognitive/Behavioral

E8a. Describe any **behaviors** or **cognitive impairment** (including a memory deficit/poor compliance with medications) exhibited by the patient, that might reasonably prevent the safe use of a PMD. Describe potential safety risks for either the patient or others?

F. Physical Exam

Each face to face examination must be individualized to the particular patient. The Physical Exam below is designed to remind the practitioner of the various organ systems that commonly relate to the patient's ambulatory capabilities and the resultant need for a power mobility device. The face to face examination of any given individual may not necessitate that every element below be addressed in every examination however, acknowledging that it was considered and not applicable is beneficial. Also, additional details describing the patient's condition may be added. However, when conducting the physical exam:

Provide quantifiable, objective measures/tests of observed abnormal characteristics;

F1. Constitutional

F1a. List Height, Weight, Blood Pressure, Heart Rate.

F1b. Does patient **use oxygen** chronically? If yes

F1bi. List Pulse Rate, Resp Rate, Pulse Ox (at rest) without oxygenation.

F1bii. List Pulse Rate, Resp Rate, Pulse Ox (at rest) with best oxygenation.

F1biii. List Pulse rate, Blood Pressure and Resp Rate (at rest and with exertion).

F2. Eyes

F2a. Describe patient's **visual acuity**.

F2b. Describe patient's **depth perception**.

F2bi. Field of vision (any field cuts or diplopia)?

F3. Respiratory

F3a. Describe the patient's general respiratory/pulmonary exam.

F3b. **After walking the maximum distance** possible on level ground (up to 50 ft) with current best mobility assistance and best oxygenation, list pulse rate, Resp rate, pOx.

F3bi. Indicate if supplemental O2 was used? If it was, list the frequency, duration delivery system and flow rate.

F3bii. Describe patient's respiratory effort (use of accessory muscles, intercostal retractions, etc.).

F3biii. Was mobility aid used? If yes, describe.

F4. Cardiovascular

F4a. Describe the patient's general cardiovascular exam.

F4b. Is **jugular venous distention** present (with the patient reclined at 30 degrees)? If yes, describe.

F4c. Are there blood pressure fluctuations noted with mobility?

F4d. Describe the patient's **lower and upper extremity edema** if present. Describe how the edema makes it difficult to use assistive devices (e.g. walker) for mobility?

F5. Musculoskeletal

F5a. Describe the patient's demonstrated muscle tone as it affects movement necessary to accomplish MRADLs.

F5b. Describe any pertinent abnormalities of joint range of motion and joint architecture (e.g. joint swelling, erythema, subluxation contractures, heterotopic ossifcans, etc).

F5c. Describe the patient's muscular strength as it relates to the accomplishment of MRADLs on a scale of 0-5:

0: no muscular contraction detected

1: a trace muscular contraction detected

2: active movement of the muscle accomplished with gravity eliminated

3: active movement of the muscle accomplished against gravity with no resistance applied

4: active movement of the muscle accomplished against gravity with less than full resistance applied

5: active movement of the muscle accomplished against gravity and against full resistance

F5d. Describe patient's tone, coordination and reflexes.

F5e. Describe patient's demonstrated control of the **postural alignment** of the head/neck and trunk during <u>supported</u> and <u>unsupported</u> (without the use of his/her hands and/or the use of the wheelchair back or seating) sitting.

F5f. Describe the patient's demonstrated standing balance, ambulation capacity and ability to transfer and weight shift and ability to carry necessary items for ALD/IADL (with the use of current mobility aides).

F5g. Provide Detailed Description of patient's demonstrated ability/inability to **transfer (include the use of current mobility aides** mechanical lift, one or two person assistance, and transfer board**) and/or change from sit to stand position**.

F5h. Provide Detailed Description of patient's demonstrated ability/inability to **walk (with the use of current mobility aides)**.

F5hi. Describe distance, speed, safety, surfaces, and prosthetics/orthotics.

F5i. Is the patient a candidate for physical rehabilitation? Yes/No

F5ii. If no, describe why not.

F5j. Is the patient having fatigue? How is it measured (i.e. Brief Fatigue Inventory BFI)?

F6. Neurological

F6a. Record any abnormalities of Cranial Nerves, peripheral sensation, coordination, deep tendon reflexes or spasticity as it relates to the accomplishment of MRADLs.

F6b. Record limitations of function and impairments related to the presence of hemiparesis or hemiparalysis.

F6c. Can the patient walk in tandem, (heel to toe, walk a straight line)?

F6d. Is the patient at risk for falls due to a neurological condition? If yes, describe.

F7. Skin

F7a. Does patient have current areas of **open wounds**? If yes, describe.

F7ai. Describe location, size and stage.

F7b. Does patient have **scars**? If yes, describe.

F7c. Does patient have other pertinent **skin lesions**? If yes, describe.

F7d. Swelling or edema? If yes, describe.

F7e. Cyanosis, rash, or scarring? If yes, describe.

F7f. Venous stasis changes? If yes, describe.

F8. Psychiatric

F8a. Describe the patient's **mental status, judgment, insight, and memory**.

F8b. Was a mental status examination performed? If yes, report findings.

G. Patient Assessment

G1. Provide a brief **statement of the patient's need** for the PMD which is being recommended, based on the findings of the face to face examination. Make certain to include:

G1a. **Why the patient cannot** accomplish MRADLs with the use of **other assistive devices** (cane, crutch, walker, optimally configured manual wheelchair, upper/lower limb prosthetics/orthotics, etc)?

G1b. If a **power wheelchair** is being recommended, describe impairment and/or environmental conditions that make a **scooter** insufficient to provide the required mobility assistance for the patient.

G1c. If the patient **requires assistance** using the PMD, describe the availability of the anticipated level of aid required.

G1d. Did the patient require a specialty examination, (seating and positioning)? If yes, describe exam findings and recommendations.

G1e. Physicians need to refer to OT/PT or other healthcare provider who can provide necessary information for the completion of the mobility assessment.

G1f. Is the patient at risk for falls due to a musculoskeletal condition? If yes, describe.

H. Plan

H1. Indicate intent to order PMD.

I. Physician or Treating Practitioner's

1. First Name
2. Last Name
3. Credentials
4. NPI
5. Date of Face-to-Face Examination (in cases where the physician refers the patient to a PT/OT, this date is the date of the completion of the face to face examination (e.g. after surveying and documenting concurrence with the PT/OT's recommendation)
6. Digital Signature

Add a field to capture: cross-reference to order

Seven element order

Beneficiary's name
Description of the item that is ordered. This may be general – e.g., "POWER operated vehicle", "POWER wheelchair", or "POWER MOBILITY DEVICE"- or may be more specific.
Date of the face - to - face examination.
Pertinent diagnoses/conditions that relate to the need for the POV or POWER wheelchair
Length of need
Physician's signature
Date of physician signature