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 Evaluation

DRAFT v9.4

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

Reminder: Physicians can make a referral to a qualified independent clinician (e.g. PT, OT or Psychiatrist) not financially affiliated with a supplier to perform the mobility evaluation portion of the F2F evaluation.

A. Chief Complaint

A1. Indicate that this visit is a face-to-face evaluation 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.

A3. *Description of functional positioning and /or mobility impairment, assistance and devices needed, what has changed to now require a new device?*

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** that are currently being used.

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. Does patient exhibit **cognitive impairment** (memory deficit, poor compliance with meds) indicating patient unsafe to self/others using PMD? If yes, detail how these symptoms have changed over time.

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[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.

C1c. Describe any abuse of drugs/medications/alcohol/etc that could interfere with the safe use of PMD.
C1d. Does patient have limb loss? If yes, describe. *(Suggested to omit this)*
C1e. Is the patient status post CVA with residual hemiparesis? If yes, describe.

D. Social History

D1. ~~Provide the patient's description of the **physical layout** of his/her home~~ *(e.g. steps to enter, stairs inside the home, narrow doorways, floor surface descriptions, Split level house, single/double wide mobile home, etc., typical heights (bed, commode, table, etc).*

D2. Can MRADLs be performed on **one level** of the home?

D3. *What is the patient's living situation (lives alone, lives with family, attendant care and the hours/week, assist provided)?*
Will the following question be under section D or section E (may be E5)?

D4. *Describe the patient's ability/inability to carry, move and handle objects to perform typical daily activities, perform household tasks, and care for household objects, household members and family members.*

D5. *Describe patient's employment /work status (occupation, typical job duties, tasks, functions, work station accessibility needs.*

D6. *Describe general health status – social/health habits (past/current).*

D7. *Describe the patient's transportation-Driver/passenger in vehicle seat/in wheelchair, transfer type, transportation type, wheelchair storage location (passenger seat, trunk, exterior lift), wheelchair securement (tie down, docking system, other), occupant restraint.*

D8. 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** ~~**in a typical day**~~ 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. Does the patient require a PMD due to **respiratory illness** or **injury**?

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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. How far does the patient report that she/he can walk or self-propel *an optimally configured* manual wheelchair before becoming **short of breath** (with best oxygenation provided)?

E3ci. How long can the patient stand at one time before needing to sit?

E3cii. What assistive devices (cane, walker, rollator) are used or have been tried?

E3ciii. Why are they inadequate?

E3d. Does patient get SOB in home while performing MRADLs? If yes:

E3di. Describe MRADLs that make patient SOB in the home (with best oxygenation provided);

E3dii. Describe interventions that palliate SOB while performing MRADLs,

E3diii. Describe how these symptoms have changed over time.

E4. Cardiovascular

E4a. Does the patient require a PMD due to **cardiovascular illness** or **injury**?

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 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. 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.

E5b. If the patient experiences joint/bone 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.

E5c. 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.

E5d. 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.

E5e. Does the patient report having chronic musculoskeletal pain? If yes, where is the pain and what is the level of severity of pain reported? (Pain Scale)

E5ei. Describe management of the patient's chronic pain symptoms, including use of analgesics, particularly narcotics?

E6. Neurological

E6a. If the patient complains of **dizziness, syncope** or **seizures,** state how these symptoms have changed over time.

E6ai. Describe the types (seizures, frequency, date of last seizure, seizure anticipation, postictal recover).

E6b. If the patient complains of **lack of coordination or abnormal sensation,** state how these symptoms have changed over time.

E6c. *Does the patient present with abnormal muscle tone?*

E7. Skin

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

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E7b. Does the patient appropriate DME to help with prevention of pressure ulcers? Yes/No

E7c. If the patient has a **history** of a **decubitus ulcer(s)** or other loss of skin integrity, describe the event.

E7ci. Describe location, grade, risk factors (boney stature, moisture, incontinence, poor nutrition, and smoking), cause, and treatment.

~~E8. Psychiatric~~ *Cognitive/Behavioral*

E8a. Describe any **inappropriate behaviors** or a **cognitive impairment** (including a memory deficit/poor compliance with medications) exhibited by the patient, that would indicate a reasonable potential for unsafe use of ~~POV~~ *PMD* either to himself/herself or others?

E8b. *Do you predict that the patient will have a change in status over time?*

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 evaluation 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)?

F2bii. Ameliorated with glasses?

*F2c. Describe patient's **ocular findings.***

F2ci. Presence of Cataract/corneal scarring/abnormal appearance?

F2cii. Presence of an artificial lens?

F2ciii. Retinopathy?

F2civ. Macular degeneration?

F2cv. Visual deficits be corrected or compensated for to enable safe mobility?

F2cvi. Type of correction needed?

F3. Respiratory

F3a. **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.

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F3ai. Indicate if supplemental O2 was used? If it was, list the frequency, duration delivery system and flow rate.

F3aii. Describe patient's respiratory effort (use of accessory muscles, intercostal retractions, etc.).

F3aiii. Was a Cardiopulmonary exam conducted? If yes, describe.

F3aiv. Was mobility aid used? If yes, describe.

F3b. Does the patient have COPD? If yes, what is the PFTs/GOLD Classification?

F3c. Is the patient a candidate for Pulmonary Rehabilitation? Yes/No

F3ci. If no, describe why not.

F3d. Does the patient have wheezing, rales, crackles, or rhonchi? If yes, describe.

F4. Cardiovascular

F4a. Is **jugular venous distention** present (with the patient reclined at 30 degrees)? If yes, describe.

F4b. *Are there blood pressure fluctuations noted with mobility?*

F4c. Describe the patient's **lower extremity edema** if present.

F4ci. UE edema/lymphedema that impairs mobility (secondary to difficulty using assistive device for mobility, i.e. walker)

*F4d. Presence of **abnormal cardiac findings** on auscultation?*

F4di. Murmur(s), gallops, heeves or thrills?

F4dii. Point of Maximum Impulse (PMI)?

F4diii. Cardiac rhythm?

F4e. NY Heart Classification?

F4f. Was a functional capacity examination performed?

F4fi. Cardiac Stress test? If yes, describe findings.

F4fii. 6 Minute Walk? If yes, describe results.

F4g. Is the patient a candidate for Cardiac Rehabilitation? Yes/No

F4gi. If no, describe why not.

F5. Musculoskeletal

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

F5b. Describe limb loss or other limb abnormality*, including presence of any contractures.*

F5c. Describe any pertinent abnormalities of joint range of motion and joint architecture (e.g. joint swelling, erythema, subluxation *contractures, heterotopic ossifcans*).

F5d. 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

F5e. Describe patient's tone, coordination and reflexes.

F5f. 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.

F5g. 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).

F5h. Is the patient at risk for falls due to a musculoskeletal condition? If yes, describe.

F5hi. Was a Fall Assessment performed? If yes, describe.

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F5i. Provide Detailed Description of patient's demonstrated ability/inability to **transfer (with the use of current mobility aides** *mechanical lift, one or two person assistance, and transfer board*).

F5j. Provide Detailed Description of patient's demonstrated ability/inability to **walk (with the use of current mobility aides).**

F5ji. Describe distance, speed, safety, surfaces, and prosthetics/orthotics.

F5k. Is the patient a candidate for physical rehabilitation? Yes/No

F5ki. If no, describe why not.

F5l. 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. *Does the patient have a negative or positive Rhomberg sign?*

F6d. *Can the patient walk in tandem, (heel to toe, walk a straight line)?*

F6e. *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.

H. Plan

Indicate intent to order PMD.

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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 evaluation (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

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