

**Suggested Electronic Clinical Template Elements of a
Progress Note Documenting a
Face-to-Face PMD Evaluation
DRAFT v9.1**

PMD: Power Mobility Device¹
MRADL: Mobility Related Activities of Daily Living²

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

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.
 - C1c. Describe any abuse of drugs/medications/alcohol/etc that could interfere with the safe use of PMD.
 - C1d. Does patient have congenital limb loss? If yes, describe.

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. Provide the patient's description of the **architectural layout** of his/her home.
- D2. Can MRADLs be performed on **one level** of the home?
- D3. 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 recover.
- E1c. During last month, how many **hours in a typical day** did patient spend:
 - E1ci. In bed?
 - E1cii. Sitting in chair?
 - E1ciii. Sitting in wheelchair?
 - E1civ. Walking in the home?

E2. Eyes

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

E3. Respiratory

- E3a. If the patient is thought to require PMD due to **respiratory, illness or injury**:
- E3b. Does patient uses **home O2**? If yes, at what frequency? For what duration? Using what delivery system? What flow rate?
- E3c. How far does the patient report that she/he can walk or self-propel a manual wheelchair before becoming **short of breath** (with best O2 provided)?
- E3d. Does patient get SOB in home while performing MRADLs? If yes:
 - E3di. Describe MRADLs that make patient SOB in the home (with best O2 provided);
 - E3dii. Describe interventions that palliate SOB while performing MRADLs,
 - E3diii. Describe how these symptoms have changed over time.

E4. Cardiovascular

- E4a. If the patient is thought to require 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 a 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. Added highlight.
- E5d. How far does the patient report that she/he can walk or self-propel a manual wheelchair before these signs/symptoms interrupt that activity, detail how they have changed over time?

E6. Neurological

- E6a. If the patient complains of **dizziness, syncope** or **seizures**, state how these symptoms have changed over time.
- E6b. 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 **decubitus ulcer(s)** or other loss of skin integrity, describe the location(s); the treatment(s).
- E7b. If the patient has a **history** of a **decubitus ulcer(s)** or other loss of skin integrity, describe the event.

E8. Psychiatric

- 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 either to himself/herself or others?

F. Physical Exam

NOTE: 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. 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 oxygen
 - 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**

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
 - F3ai. Indicate if supplemental O2 was used? If it was, list the frequency, duration delivery system and flow rate denoted.
 - F3aii. Describe patient's respiratory effort (use of accessory muscles, intercostal retractions, etc.)
 - F3aiii. Was a Cardiopulmonary exam conducted?
 - F3aiv. Was mobility aid used? If yes, describe

F4. Cardiovascular

- F4a. Is **jugular venous distention** present (with the patient reclined at 30 degrees)? If yes, describe
- F4b. Describe the patient's **lower extremity edema** if present

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.
- F5c. Describe any pertinent abnormalities of joint range of motion and joint architecture (e.g. joint swelling, erythema, subluxation).
- 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 supported and unsupported (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 (with the use of current mobility aides).
- F5h. Provide Detailed Description of patient's demonstrated ability/inability to **transfer (with the use of current mobility aides)**.
- F5i. Provide Detailed Description of patient's demonstrated ability/inability to **walk (with the use of current mobility aides)**.

F6. Neurological

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

F7. Skin

- F7a. Does patient have current areas of **open wounds**? If yes, describe
- F7b. Does patient have **scars**? If yes, describe
- F7c. Does patient have other pertinent **skin lesions**? If yes, describe

F8. Psychiatric

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

G. Patient Assessment

1. 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 :
2. **Why the patient can not** accomplish MRADLs with the use of **other assistive devices** (cane, crutch, walker, manual wheelchair, upper/lower limb prosthetics/orthotics, etc)?
3. 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.
4. If the patient **requires assistance** using the PMD, , describe the availability of the anticipated level of aid required

H. Plan

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
6. Digital Signature

Add a field to capture: cross-reference to order