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VIA ELECTRONIC COMMUNICATION: eclinicaltemplate@cms.hhs.gov

Melanie Combs-Dyer
Deputy Director, Provider Compliance Group
Centers for Medicare and Medicaid Services
7500 Security Blvd
Room C3-09-07
Baltimore, MD 21244

Re: Electronic Clinical Medical Template

Dear Director Combs-Dyer:

The American Association for Homecare (AAHomecare) would like to share our comments on the electronic clinical-medical template for the required face-to-face examinations for power mobility devices (PMD). AAHomecare supports efforts by CMS to implement electronic health records, including the electronic template for the PMD face-to-face examination. Successful implementation of an electronic-clinical template will decrease the PMD error rate as well as provide a valuable documentation collection tool for physicians.

In response to the draft e-clinical template developed by CMS, AAHomecare convened providers, clinicians, and compliance experts into a workgroup to develop a set of question for an electronic template that incorporates elements of CMS' draft template, coverage policies, and pertinent medical information to paint a thorough picture of the beneficiaries mobility needs. Our alternative (attached) serves as our initial comments on CMS' draft template v9.8, and is structured to evaluate the necessary body systems in order to determine whether the coverage criteria has been met for a PMD.

AAHomecare thanks you for consideration our template question set. If you have any questions regarding our draft electronic template, please contact Peter Rankin at peterr@aahomecare.org, or (202) 732-0755.

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Mobility Evaluation

1. **Demographics**
   - **1.1.** Patient Information
   - **1.2.** Physician or Treating Practitioner Information

2. **Chief Mobility Complaint and Mobility Limitations within the Home**
   - **2.1.** Patient reports limited mobility when accessing the following areas of the home (address all that apply)
     - **2.1.1.** Bathroom
     - **2.1.2.** Kitchen
     - **2.1.3.** Bedroom
     - **2.1.4.** Other, describe
   - **2.2.** Patient reports difficulty when attempting to perform or participate in the following mobility related activities of daily living (MRADLs) such as (address all that apply)
     - **2.2.1.** Bathing
     - **2.2.2.** Dressing
     - **2.2.3.** Feeding
     - **2.2.4.** Grooming
     - **2.2.5.** Toileting
     - **2.2.6.** Other, describe
   - **2.3.** Describe, in the patient's own words, the specific mobility challenges within the home and how long these challenges have been present
   - **2.4.** Patient CURRENTLY uses the following mobility assistive equipment within the home (address all that apply)
     - **2.4.1.** N/A
     - **2.4.2.** Cane
     - **2.4.3.** Crutches
     - **2.4.4.** Walker
     - **2.4.5.** Manual Wheelchair
     - **2.4.6.** Scooter (POV)
     - **2.4.7.** Power Wheelchair
     - **2.4.8.** Other, describe
   - **2.5.** Describe the length of use and why, according to the patient, the device is no longer helpful, safe or timely to operate

3. **Medications** (List all medications the patient is currently taking related to the need for a power mobility device)

4. **Social History**
   - **4.1.** Current Living Environment
     - **4.1.1.** Home
     - **4.1.2.** Apartment
     - **4.1.3.** Assisted Living
     - **4.1.4.** ICF/MR
     - **4.1.5.** SNF
     - **4.1.6.** Other, describe
   - **4.2.** Patient's living situation
     - **4.2.1.** Lives alone
     - **4.2.2.** Lives with (describe)

4.2.3. Hours home alone daily
4.2.4. Attendant care utilized? ☐ Yes ☐ No If YES, describe hours/week and assistance
4.3. Is the current living environment expected to change? ☐ Yes ☐ No If YES, explain

5. Current Symptoms, Related Diagnosis, and Medical History (Must be completed by Physician / Treating Practitioner)
5.1. Present Medical Condition(s) Contributing to Mobility Limitation
5.1.1. Primary Diagnosis (or ICD-9 Code)
5.1.2. Secondary Diagnosis(or ICD-9 Code)
5.1.3. Other Diagnoses (or ICD-9 Codes)
5.2. What symptoms limit mobility and/or interfere with patient's ability to perform Mobility Related Activities of Daily Living (MRADLs) in their home? (address all that apply)
5.2.1. Gait abnormality
5.2.2. Weakness
5.2.3. Edema
5.2.4. Leg cramps
5.2.5. Orthopedic deformity
5.2.6. Shortness of breath
5.2.7. De-conditioning
5.2.8. Fatigue
5.2.9. Chest pain
5.2.10. Poor balance
5.2.11. Spasticity/tremor
5.2.12. Numbness
5.2.13. Lack of coordination
5.2.14. Pain
5.2.14.1. Location
5.2.14.2. Triggers
5.2.14.3. Best (1-10)
5.2.14.4. Worst (1-10)
5.2.14.5. Frequency
5.2.15. Other, describe
5.3. Detail the mobility deficits and how function in the home is affected by these symptoms

6. Physical Examination (Must be completed by Physician / Treating Practitioner)
6.1. Height
6.2. Weight
6.3. Blood Pressure (resting)
6.4. Pulse (resting)
6.5. Respiratory Rate (resting)
6.6. Has patient experienced a recent change in weight of greater than 10 pounds? ☐ Yes ☐ No If YES, explain

7. Cardiovascular
7.1. Is the mobility impairment due to a permanent or progressive cardiovascular condition? ☐ Yes ☐ No If YES, complete the cardiovascular section below, if NO, proceed to respiratory section
7.2. Detail the patient's cardiovascular exam
7.3. Are there clinically significant blood pressure fluctuations, increased heart rate, palpitations, and/or ischemic pain that occur or worsen with exertion/mobility? ☐ Yes ☐ No If YES, describe

7.4. Is significant upper or lower extremity edema noted? ☐ Yes ☐ No If YES, does the edema make it difficult to use an assistive device (e.g. walker) for mobility? ☐ Yes ☐ No

7.5. Do the legs need to be elevated in sitting? ☐ Yes ☐ No If YES, describe

7.6. Describe how symptoms have changed/progressed over time and/or interfere with participation in MRADLs

7.7. Detail what interventions palliate or have been tried to palliate cardiovascular symptoms

8. Respiratory

8.1. Is the mobility impairment due to a permanent or progressive respiratory condition? ☐ Yes ☐ No If YES, complete the respiratory section below, if NO, proceed to musculoskeletal section

8.2. Does the patient exhibit shortness of breath or respiratory symptoms that occur or worsen with exertion/mobility? ☐ Yes ☐ No If YES, describe

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

8.4. Describe how symptoms have changed/progressed over time and/or interfere with participation in MRADLs

8.5. Detail what interventions palliate or have been tried to palliate respiratory symptoms

8.6. Does the patient use home oxygen? ☐ Yes ☐ No If YES, what is the frequency?

8.6.1. Flow rate

8.6.2. Delivery system

8.6.3. SaO_2 on room air

8.6.4. SaO_2 on oxygen

8.6.5. SaO_2 with exertion (walking maximum distance, self-propelling a MWC)

9. Musculoskeletal

9.1. Is the mobility impairment due to a permanent or progressive musculoskeletal condition? ☐ Yes ☐ No If YES, complete the musculoskeletal section below, if NO, proceed to neurological section

9.2. Quantify muscle strength on a scale of 0 – 5

9.2.1. LUE

9.2.2. RUE

9.2.3. LLE

9.2.4. RLE

9.2.5. Provide detail as appropriate

9.3. Describe and quantify muscle fatigue, endurance issues or pain associated with movement, including severity, what exacerbates it and what relieves it

9.4. The patient presents with the following range of motion

9.4.1. LUE	Normal	Limited*	Significantly Limited*
9.4.2. RUE	Normal	Limited*	Significantly Limited*
9.4.3. LLE	Normal	Limited*	Significantly Limited*
9.4.4. RLE	Normal	Limited*	Significantly Limited*

9.4.5.* Describe and quantify any joint pain, edema, erythmia, instability, subluxation, dislocation and/or contractures

9.5. Does the patient have a history of falls? ☐ Yes ☐ No If YES, detail the reason the patient believes that she/he falls; the frequency and timing of the falls and any injuries related to a fall

9.6. Describe how symptoms have changed/progressed over time and/or interfere with participation in MRADLs

9.7. Detail what interventions palliate or have been tried to palliate musculoskeletal symptoms

10. Musculoskeletal – Posture

10.1. Identify any postural abnormalities in sitting

10.2. Describe postural abnormalities noted, and whether they are reducible / non-reducible

10.3. How does the patient perform an INDEPENDENT weight shift in sitting? (address all that apply)

- **10.3.1.** Unable
- **10.3.2.** Lateral lean
- **10.3.3.** Forward lean
- **10.3.4.** W/C push up
- **10.3.5.** Stand from a seated position
- **10.3.6.** Power seat function
- **10.3.7.** Other, describe

11. Neurological

11.1. Is the mobility impairment due to a permanent or progressive neurological condition?

☐ Yes ☐ No If YES, complete the neurological section below, if NO, proceed with the remainder of the evaluation

11.2. Does the patient display any of the following? (address all that apply)

- **11.2.1.** Dizziness
- **11.2.2.** Vertigo
- **11.2.3.** Syncope
- **11.2.4.** Seizures
- **11.2.5.** Neuropathy
- **11.2.6.** Other, describe

11.3. The patient presents with the following muscle tone (address all that apply)

- **11.3.1.** Normal
- **11.3.2.** Spasticity
- **11.3.3.** Rigidity
- **11.3.4.** Ataxia
- **11.3.5.** Athetosis
- **11.3.6.** Dystonia
- **11.3.7.** Clonus
- **11.3.8.** Hypotonia
- **11.3.9.** Flaccidity
- **11.3.10.** Other, describe

11.4. Describe abnormalities in muscle tone for the UEs, LEs and/or neck and trunk

11.5. Describe any deficits in coordination, gross and/or fine motor control of the UEs and LEs

11.6. The patient presents with the following balance

11.6.1. Static Sitting	Normal	Good	Fair	Poor
11.6.2. Dynamic Sitting	Normal	Good	Fair	Poor
11.6.3. Static Standing	Normal	Good	Fair	Poor
11.6.4. Dynamic Standing	Normal	Good	Fair	Poor

11.7. Describe any changes in balance / postural control

11.8. Detail how the neurological findings affect function and mobility, including how they have changed/progressed over time

12. Integumentary

12.1. History of pressure ulcer on the seated surface? ☐ Yes ☐ No

12.2. Current pressure ulcer on the seated surface? ☐ Yes ☐ No

12.3. Describe the location, size, stage, cause and treatment for any past or present pressure ulcer(s) on the seated surface

12.4. Is the patient at risk for the development of a pressure ulcer on the seated surface?

☐ Yes ☐ No If YES, detail or quantify the risk

12.5. Braden Scale
- **12.5.1.** ≤12 High Risk
- **12.5.2.** 13-14 Mod Risk
- **12.5.3.** 15-16 Low Risk

12.6. Skin Assessment

12.7. Skin Sensation
- **12.7.1.** Intact
- **12.7.2.** Impaired
- **12.7.3.** Absent

12.8. Describe any impairment or loss of sensation (light touch, deep touch, pain, proprioception, temperature) including the location (dermatomes) and severity

13. Sensory

13.1. Vision is
- **13.1.1.** Normal
- **13.1.2.** Corrected
- **13.1.3.** Impaired / Pathology
- **13.1.4.** If impaired; does the patient have sufficient vision to safely operate a powered mobility device? ☐ Yes ☐ No

13.2. Hearing is
- **13.2.1.** Normal
- **13.2.2.** Corrected
- **13.2.3.** Impaired / Pathology
- **13.2.4.** If impaired; does the patient have sufficient hearing to safely operate a powered mobility device? ☐ Yes ☐ No

14. Cognition / Behavior

14.1. Does the patient exhibit any cognitive or behavioral impairment that would prevent the independent use of a PMD? ☐ Yes ☐ No If YES, describe

15. Mobility Skills Skill

15.1. Sit to Stand	Independent	Needs Assistance	Dependent/Unable
15.2. Stand to Sit	Independent	Needs Assistance	Dependent/Unable
15.3. Transfers	Independent	Needs Assistance	Dependent/Unable

- **15.3.1.** Stand Pivot
- **15.3.2.** Sit Pivot
- **15.3.3.** Slide Board
- **15.3.4.** Lift
- **15.3.5.** Other, describe

15.4. Ambulation	Independent	Needs Assistance	Dependent/Unable

- **15.4.1.** Distance: feet
- **15.4.2.** Timed Up and Go Test
  - **15.4.2.1.** Pass
  - **15.4.2.2.** Fail
  - **15.4.2.3.** Not tested
- **15.4.3.** What is the patient's gait pattern (address all that apply)
  - **15.4.3.1.** Non-Ambulatory
  - **15.4.3.2.** Normal
  - **15.4.3.3.** Shuffling
  - **15.4.3.4.** Ataxic
  - **15.4.3.5.** Antalgic

15.4.3.6. Unstable
15.4.3.7. Other, describe

15.5. MWC Propulsion Independent Needs Assistance Dependent/Unable

15.5.1. Method of propulsion
15.5.1.1. BUE
15.5.1.2. BLE
15.5.1.3. RU/LE
15.5.1.4. LU/L E

15.5.2. Pace
15.5.2.1. Slow/Ineffective
15.5.2.2. Moderate/Labored
15.5.2.3. Fast/Effective

15.6. Describe mobility skills and deficits observed and how they have changed/progressed over time

16. Mobility Assessment

Based on the patient evaluation

16.1. Can a cane or walker meet this patient's mobility deficit to allow for safe, timely and independent ambulation to accomplish **ONE OR MORE** MRADL in the home?
☐ Yes ☐ No If NO, explain WHY NOT

16.2. Can an optimally configured manual wheelchair meet this patient's mobility deficit to allow for safe, timely and independent mobility to accomplish **ONE OR MORE** MRADL in the home?
☐ Yes ☐ No If NO, explain WHY NOT

16.3. Has your patient's condition/functional limitations changed so that they now require a power mobility device to complete their MRADLs inside the home? ☐ Yes ☐ No If YES, describe what has changed to such that a power mobility device is now required for independent, safe and/or timely mobility for the completion of one or more MRADLs

16.4. Will a Power Operated Vehicle (POV)/Scooter meet your patient's mobility needs?
☐ Yes ☐ No If NO, please indicate why a POV/Scooter will not meet this patient's mobility needs in their home.

16.4.1. Hand strength insufficient for scooter control
16.4.2. Has poor trunk stability
16.4.3. Unable to safely operate a POV
16.4.4. Unable to transfer safely on and off a POV
16.4.5. Requires elevating leg rests
16.4.6. Requires fully reclining back or tilt in space
16.4.7. Requires adjustable height armrests
16.4.8. Home has insufficient space to maneuver a POV
16.4.9. Other, describe

16.5. Does your patient have the physical and cognitive capacity to safely operate a power mobility device in the home? ☐ Yes ☐ No If NO, please answer question # 6, If YES, skip 16.6 and proceed to 16.7

16.6. If the patient is unable to safely/independently operate a power wheelchair, do they have a caregiver who is willing/able to push an optimally configured manual wheelchair at all times? ☐ Yes ☐ No ☐ Not Applicable If NO, is the caregiver willing/able to operate the power wheelchair to be provided? ☐ Yes ☐ No

16.7. Is your patient willing and motivated to use a power mobility device in the home?
☐ Yes ☐ No

17. Plan of Care

Based on the face-to-face evaluation this patient

17.1. Has functional limitations that support the need for a power mobility device

17.2. Requires a referral for a comprehensive functional mobility or specialty evaluation
17.3. Other, describe

18. Physician or Treating Practitioner Attestation and Signature/Date

I certify that I am the treating practitioner identified on this form and that I have conducted a face-to-face mobility examination of my patient. I also certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may be punishable by law. I hereby enter this document as part of my patient's medical record.

18.1. Signature
18.2. Date
18.3. Print Name