



Lower Limb Prosthesis Documentation Packet

Lower Limb Prosthesis Documentation Packet

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If you need help:

Contact the Ottobock Reimbursement Team

- Call 800-328-4058 and ask for reimbursement, or
- Email your request to Reimbursement911@Ottobock.com

Ottobock Reimbursement North America

P 800 328 4058 F 800 962 2549

professionals.ottobockus.com

professionals.ottobock.ca

reimbursement911@ottobock.com

Documentation Checklist

Patient Name: _____

Date: _____

Completed by: _____

FROM THE PHYSICIAN

History of Amputation

- ☐ Date and Cause of amputation(s)
- ☐ Affected side(s)
- ☐ Clinical course, interventions & results, prognosis

Physical Examination

- ☐ Height, weight, recent loss/gain
- ☐ Cognitive ability to use & care for new prosthesis
- ☐ Condition of residual limb
- ☐ Cardiopulmonary, Musculoskeletal, Neurological
- ☐ Strength, ROM, gait, balance, coordination

Functional Limitations

- ☐ Limitations caused by current condition/comorbidities
- ☐ Diagnoses causing the symptoms.

Ambulatory assistance

- ☐ Used currently/prior to amputation
- ☐ Situational/temporary?
- ☐ Plan to be free of assistive devices (if applicable).

Functional Level

- ☐ Patient's activities prior to amputation
- ☐ Patient's current activities & impact of the limitations identified above.
- ☐ Desired & potential activities using new prosthesis

Prosthetic Use

- ☐ Past: components tried & result
- ☐ Current: History and condition of each component
- ☐ Reason for replacement

For Repair, Replacement, or Refill

- ☐ Patient continues to use a prosthesis
- ☐ The prosthesis is medically necessary

Desire and Motivation

- ☐ To ambulate and use new prosthesis

Functional State

- ☐ K-Level (based on prior activities, current condition, and motivation to ambulate).
- ☐ Recommendation for new prosthetic components
- ☐ For potential K-level, include explanation & plan to reach desired K-Level & approx. how long it will take

DISPENSING ORDER (RX)

Effective 1/1/20 not required for Medicare

- ☐ Patient's name
- ☐ Date of order (prescription date/date of call)
- ☐ Description of item being dispensed
- ☐ Printed name and signature of physician or person who took the call.
- ☐ Meets your state's requirement for orders

STANDARD WRITTEN ORDER (SWO) –supplier generated

Effective 01/01/2020 – replaces DWO

- ☐ Date of Order: **on/prior to the delivery date**
- ☐ Narrative description, HCPCS code, HCPCS code narrative, or Brand Name/Model Number.
- ☐ Physician demographics/**NPI ok for Medicare**
- ☐ Physician's hand written signature, date
- ☐ Quantity & RT/LT
- ☐ Meets your state's requirement for orders
- ☐ Patient name on each page/**MBI ok for Medicare**

PROSTHETIST'S DOCUMENTATION

Functional Level – should match physician's determination

- ☐ Testing
- ☐ Activities prior to amputation
- ☐ Current Activities
- ☐ Future activities
- ☐ For potential K-Level: explanation for the difference

History of Prosthetic Use Over Time

- ☐ Brand, how long used, result

History of Current Components

- ☐ History of components being replaced (age, condition, result)
- ☐ Description of Labor (casting, modification, time, tools, materials & where applied)
- ☐ Reason for Replacement

Recommendation for Type and Brand of Prosthesis

- ☐ Based on physician's recommendation
- ☐ Medical Necessity and Justification for each component

Desire and Motivation

- ☐ To ambulate and use new prosthesis

Additional

- ☐ Chart note for each visit
- ☐ Signature of signee

For Refills (liners, socks, etc)

- ☐ Continued Need: MD note within 12 mo. (or substitute new verbal/written order).
- ☐ Continued Use: Document the refill request and condition of the item being replaced.

PROOF OF DELIVERY

- ☐ Delivery Date
- ☐ Patient's Name
- ☐ Delivery Address
- ☐ Narrative description, HCPCS code, HCPCS code narrative, or Brand Name/Model Number.
- ☐ Signature and Printed name of signee
- ☐ Relationship to patient and reason why patient cannot sign
- ☐ Signature time, if signed on same day as SWO obtained.

☐ BENEFICIARY AUTHORIZATION

☐ ABN IF REQUIRED

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Following is Medicare's criteria for coverage of LL Prosthetics, which also can be found in other medical coverage policies.

Medical Necessity

Medical necessity for prosthetic components or additions to the prosthesis is based on:

1. The patient's past history [activities],
2. The patient's current condition [residual limb and any medical conditions that might affect patient's ability to use the new prosthesis], and
3. Desire to ambulate. [desire to use the new prosthesis and get back to those previous activities]

A lower limb prosthesis is covered when:

4. Prescribed by a physician
5. The member will reach or maintain a defined functional state (Potential K-Level) within a reasonable period of time, and
6. The member is motivated to ambulate

Note: For Medicare all 6 criteria must be documented.

- ➔ All documents that support medical necessity must be signed and dated prior to the delivery date.

Item 1: Physician Documentation

Recent physical evaluation (focus should be on the amputation, the prosthesis, and ambulatory difficulties). Elements that should be included:

a. History of the Amputation

- Diagnosis/etiology of amputation(s)
- Date and affected side (s)
- Clinical course
- Therapeutic interventions and results
- Prognosis

b. Physical Examination Relevant to Functional Limitations

- Height, weight, recent loss/gain
- Cognitive ability to use & care for new prosthesis
- Description of the residual limb (e.g. local and/or phantom pain; wound healing issues; skin irritation, breakdown, infection; limb volume changes or swelling; weight fluctuations; muscle atrophy or contractures; osteoarthritis, or other arthritic conditions of the residual limb joints).
- Cardiopulmonary, musculoskeletal, neurological, arm and leg strength, ROM, gait, balance, coordination

c. Functional Limitations

Describe the nature and extent of any functional limitations whether from current condition or comorbidities.

- ➔ You should have on file chart notes reflecting the need for the care (e.g. evaluation, treatment plan, history and physical, etc.) from the patient's medical records charted contemporaneously, in other words, when the patient is present.

- ➔ To be on the safe side, it is recommended that this information be collected up-front to be sure the physician's documentation supports the claim.

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Examples:

- **Cardiopulmonary** conditions that might limit the patient's capacity [e.g. congestive heart failure (CHF), coronary heart disease (CHD), endocarditis, myocarditis, arrhythmias, peripheral arterial (occlusive) disease (PAD/PAOD), chronic venous insufficiency (CVI) with recurring ulcers, lymphedema].
- **Musculoskeletal** conditions (e.g. osteoarthritis sound side leg joints, spinal stenosis, severe low back pain, etc.).
- **Neurological** conditions that cause impairments in gait, balance or coordination (e.g. MS, stroke, SCI, Parkinson's, peripheral nerve lesions, lumbar disc herniation with motor paresis, dementia/Alzheimer's disease, depression, psychiatric disorders/diseases).
- **Other comorbidities** (e.g. chronic kidney failure, chronic liver failure, cancer with chemotherapy/radiation, general deconditioning).

d. **Ambulatory Assistance** prior to the amputation and/or currently used (e.g. cane, walker, wheelchair, caregiver).

- For non-routine/occasional use, describe the situation when the patient uses the assistive device.
- If this is a temporary situation state in your opinion how long it will take the patient to be back to functioning at the desired level (free of the assistive device).

e. Define Patient's Functional State:

Describe patient's functional capabilities in K-Level terms, as they relate to the patient's activities. These should be **real activities**, such as "walking the dog" and related K-level functions that patient encounters (e.g. long-distance ambulation, obstacles, types of terrain, slopes, stairs, ramps, crowds, public transportation).

Functional Levels (K-Levels)

Level 0: Does not have the ability or potential to ambulate (or transfer safely) with or without assistance and a prosthesis does not enhance their quality of life or mobility [*i.e. patient likely will not be able to ambulate at all*].

Level 1: Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence [*i.e. patient likely will be able to use the prosthesis within his/her dwelling only*].

Level 2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces [*i.e. patient will likely be able to use prosthesis within his/her dwelling and a limited radius in the community*].

Level 3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion. [*i.e. patient will likely have a prosthetic ability comparable with that of a non-amputated person with no mobility restrictions*].

Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

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Following is what must be in the record:

- **Patient's activities prior to amputation.**
Identify prior activities in the patient's potential K-Level category.
- **Patient's current activities.** Include the impact of the limitations identified above. Is the patient more limited by his/her medical conditions or by the function of the prosthesis?
- **Activities that patient desires to get back to** (and has the potential for) using the new prosthesis.

Note: If patient was a community ambulator (K3/K4) earlier in life, but not prior to the amputation due to a medical condition (e.g. neuropathy, ulcers, and neuropathic pain) or if patient was never a community ambulator (K3/K4) and now has demonstrated capacity to be one, include why you believe the patient will be a community ambulator with the new prosthesis (e.g. sound limb is asymptomatic, achievements during rehabilitation/physical therapy, diseased limb was the primary cause of the mobility restrictions, etc.).

f. Document the Current Prosthesis:

- **Condition of each component** (e.g. socket, knee, pylon, ankle, foot) should be documented.
- **Reasons for replacement** One of the following reasons should be documented for each component being replaced.

Reasons allowed by most payers:

- Patient's functional needs have changed

- Due to physical changes the component no longer fits
- Device is irreparably worn

Additional reasons allowed by Medicare

- Device is lost or damaged beyond repair
- Cost to repair will be greater than 60% of the cost (Medicare allowable) to purchase a new device.

- **If the patient's condition has changed,** describe why the current prosthesis is no longer appropriate. (e.g. weight gain/loss, decreased stability, etc.)
- **If the device was damaged or lost,** describe the incident.

g. Previous Prostheses:

- Document patient's past experience with prosthetic components (what has been tried, and the result).

h. For a Repair, Replacement or Refill

- Document that patient continues to use prosthesis.
- And prosthesis is medically necessary.

i. Desire and Motivation:

- Document patient's desire to use the new prosthesis.
- Document patient's motivation to ambulate.

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- j. **Recommendation for the type of new Prosthesis/ Component(s)** and the medical reason for your decision.
- The recommendation should be based on patient's prior activities, current condition, and desire to ambulate (used to determine the K-Level).
 - The Brand name of the prosthetic components is not required.
 - **Important:** If the patient has the potential to reach a higher K-level designation in the future, an explanation for the difference is required. Include a treatment plan that will achieve this increase in functional level, and what it will take to get there (e.g. physical therapy, gait training, etc.). For Medicare, the plan should specify in your opinion approximately how long _____ it will take the patient to be functioning at the potential K-Level.

Item 2: Initial Order (Prescription)

- **Effective January 1, 2020:** For Medicare the initial order is no longer required for orthotics and prosthetics; however, a signed Standard Written Order (SWO) must be obtained prior to billing.
- If an initial order is required by the insurance payer, state, or credentialing agency, the initial order can either be verbal and documented in the patient's chart OR written by the ordering physician.
- It is the supplier's responsibility to ensure compliance with pertinent insurance criteria, credentialing, and state laws.

Elements included on a typical initial order/ prescription when required (best practice):

- a. **Patient's name**
- b. **Date of order**
 - For written order: use the date of the prescription
 - For verbal order: use the date the call was received
- c. **Description of item(s)**
- d. **Signature**
 - For written order: Physician's signature and date , printed name and credential
 - For verbal order: Printed name of person taking order, signature, date, time.

New Item 3: Standard Written Order (SWO)

- The SWO replaces the DWO
- The provider may write the SWO; however, the physician must review and sign it.
- An initial order can be used as a SWO if it contains all elements required below.
- The SWO must meet state prescribing, credentialing and/or other applicable laws.

Minimum elements that must be included on a "supplier generated" SWO: **Effective Jan. 1, 2020**

- a. **Order date** **New:** The SWO must be dated on/prior to the date of delivery
- b. **Describe what is being ordered** (list all items, options or additional features that will be separately billed or require an upgraded code).

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You may use **one** of the following methods:

- **Narrative description** (AK polycentric knee w/friction)
- **HCPCS code** (L5613),
- **HCPCS code narrative** (Addition to lower extremity, endoskeletal system, above knee, knee disarticulation, 4-bar linkage, with friction swing phase control)
- **Brand name/model number** (4R36 Titan polycentric knee joint)

To avoid confusion, we recommend including brand name and model number for items with multiple HCPCS codes.

- c. **Physician's Demographics** printed name, credential, address, phone, NPI
Effective January 1, 2020: only the physician's name/National Provider Identifier (NPI) number is required for Medicare.
- d. **Quantity** to be dispensed
- e. **RT/LT** (recommended)
- f. **Physician's signature**
- g. **Patient's name** on each page (**Effective January 1, 2020:** The Medicare Beneficiary Identifier (MBI) may be used in place of patient's name for Medicare)

Item 4: Liners, Socks, Other Non-Consumable Items

- These are treated as a refill and covered under the original order.
- Note: keep in mind that Medicare and other large payers have medically unlikely edits established for liners and socks. Look up your code [here](#).

- Replace only when item is no longer functional and document condition with sufficient detail.
- For documentation requirements, see Item 5.f.

The following items must be included in a liner, sock, or other non-consumable order (information may be included on the SWO).

- a. **Patient's name** (**Effective January 1, 2020:** MBI is allowed in place of name for Medicare)
- b. **Order date**
- c. **Description of item(s)** being ordered
- d. **Quantity** to be dispensed
- e. **RT/LT** (recommended)
- f. **Patient continues to use the orthosis**
- g. **Physician demographics** printed name, credential, address, phone, NPI (**Effective January 1, 2020:** only physician's name or NPI required for Medicare)
- h. **Physician's signature**

Item 5: Prosthetist's Documentation

- Medical records must support that the device is still medically necessary.
 - Medicare expects that a lost/damaged item would be reported to some authority (e.g. police, homeowners insurance, etc.) and requires that a copy of that report be available. If patient did not report the accident/loss, you will need a signed statement from the patient describing the incident.
- a. **Functional Evaluation** (K-level should match physician's evaluation -see Physician Documentation section)
 - b.

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- **Activities prior to amputation**
 - Activities that patient did in the past and would like to get back to using a new device (e.g. home, work, therapeutic, exercise).
- **Current activities.**
 - Focus on activities that the new prosthesis will allow that the current prosthesis does not.
 - Describe difficulties, such as falls, stumbles, not making it across street before light changes, inability to change speed when needed, etc.
 - How will patient be able to do it better with the new prosthesis?
- **Potential future activities.**
 - If these vary from prior activities, an explanation will be required)

c. History of Prosthetic Use

- Your records should have a history of each prosthesis patient has used/trialed in the past.
 - Brand of component
 - How long did patient use it?
 - What was the result?

d. Current Prosthesis

- **History of each component being replaced** (age, condition, how did it work out?)
- **Description of the labor involved** (e.g. casting, modification, time, tools used, materials used, where was material applied, etc.)
- **Reason for replacement** (e.g. change in patient's condition, device no longer fits, device does not meet functional needs, item is worn and cannot be repaired. Medicare and some payers also allow replacement

when the cost to repair is greater than 60% of the Medicare allowable for a new device or item is lost or damaged beyond repair).

e. Recommendation for the type and brand of the new prosthesis:

- Must be based on physician's recommendation
- Include rationale for your decision
- Include medical necessity and justification for each code that will be billed.

f. Patient's motivation and desire to use the new prosthesis (and to ambulate for lower extremity)

g. Document Refill Requests (e.g. liners, socks, other non-consumable items). This can be a written request from the patient or telephone contact between supplier and patient.

The following elements should be included on the refill request:

- **Patient's name** (or authorized representative and relationship)
 - **Date of request** (must be no sooner than 14 calendar days prior to delivery/shipping)
 - **Description** of each item requested
 - **RT/LT**
 - **Quantity and functional condition** of items being replaced
- Note:** Shipment/delivery may not occur sooner than 10 calendar days prior to current supply exhausting.

h. Chart note for each visit with patient with printed name, credential, signature and date on each note.

i. Patient's name on each page.

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Item 6: Proof of Delivery (POD)

- ☞ A signature date is no longer required; however, if there is one on the form, it must be the date of service on your claim.

Elements to be included on the POD when device is delivered direct to the patient:

- Delivery Date**
- Patient's name**
- Address** where item is delivered (your office, patient's home, SNF, etc.)
- Quantity** delivered for each item
- Amputation side** for each item, LT/RT
- Describe what will be delivered. You may use **one** of the following methods:
 - Narrative description** (AK polycentric knee w/friction)
 - HCPCS code** (L5613)
 - HCPCS code narrative** (Addition to lower extremity, endoskeletal system, above knee, knee disarticulation, 4-bar linkage, with friction swing phase control)
 - Brand name/model number** (4R36 Titan polycentric knee joint)
 - Note:** To avoid confusion, we recommend including brand name and model number for items with multiple HCPCS codes.
- Signature and printed name** of the patient or designee

Note: If designee signs, include the designee's relationship to the patient and the reason why patient could not sign. This person cannot have any financial connection to the provider.

Item 7: Beneficiary Authorization

- A new authorization is required anytime a new prosthesis/component(s) is provided. In other words, a new authorization is required anytime a new HCPCS code is billed.
- This authorization should give you:
 - Permission to submit claims on behalf of beneficiary.
 - Permission to pay you directly (assigns the benefits to the provider).
 - Release to authorize the provider to obtain confidential medical information about the beneficiary in order to process the claim.

Example of an Authorization:

- Name of Beneficiary: _____
- HICN: _____
- I authorize (supplier)_____ to submit claims to Medicare on my behalf. I request that payment of authorized Medicare benefits be made either to me or on my behalf to (supplier)_____ for any services furnished me by that supplier.
- I authorize any holder of medical information about me to release to (supplier) _____ and/or the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.
- _____
- Signature _____
Date _____

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Item 8. Advanced Beneficiary Notice (ABN) if required

- **NOTE:** Medicare does not allow “blanket” ABN’s to be issued. In other words, one cannot give an ABN to every patient, in anticipation that Medicare might deny. ABNs are to be used on a case-by-case basis when there is a clear indication that the device will be denied as not medically necessary/not reasonable and necessary. The most common situation would be when a patient does not meet the criteria for coverage.
- **Examples of when an ABN might be used:**
 - Patient does not meet criteria for coverage as stated in LCD
 - Physician clearly has not provided sufficient documentation to meet Medicare’s documentation requirements and there is a high probability that the claim will be denied as not medically necessary.



References: Joint DME MAC Local Coverage Policy L33686 and Policy Articles: A55426 and A52457 effective January 1, 2020; CGS & Noridian Supplier Manuals.

Fax to:		Fax from:	
Company:		Company:	
Phone:	Fax:	Phone:	Fax:
Patient Name:		Date of Birth:	No. Pages:

FAX: Documentation Request for a Lower Limb Prosthesis

This is a request for medical records on the above patient relative to his/her prosthesis.

- **History of Amputation:** Cause, date & side of amputation(s); clinical course, therapeutic interventions & results, prognosis
- **Physical Examination**
 1. Weight, Height, Weight Loss/Gain.
 2. Cognitive ability to use the use and care for the new prosthesis
 3. Condition of residual limb
 4. Cardiopulmonary, musculoskeletal, neurological, strength, ROM, gait, balance, coordination
- **Functional Limitations** Describe nature and extent of any functional limitations, whether from current prosthesis, current condition, or comorbidities (e.g., decreased pulmonary reserve, disabling cardiovascular, neuromuscular, peripheral vascular or musculoskeletal conditions).
- **Ambulatory Assistance Used** prior to the amputation and/or current. Is it routine, situational, temporary? Explain
- **Document Medical Necessity in K-Level Terms:** (see descriptions below)
 1. Patient's activities prior to amputation
 2. Patient's current activities along with any functional limitations as identified above
 3. Activities that patient desires to get back to (and has the potential for) using the new prosthesis.
 4. Describe patient's desire and motivation to ambulate with the new prosthesis
- **Document the condition/status of current prosthesis and reason for replacement of each component.** If worn/broken, describe the condition of each component that needs to be replaced. If patient's physical condition or functional needs have changed, describe why prosthesis/component no longer meets his/her needs.
- **Describe Past Experience with Prostheses/Components** Describe what has been tried in the past and the results.
- **For continuing care (e.g. replacement, repair, or refill)** Document continued medical necessity and continued use.
- **Recommendation for the new components.** Include medical reason for your decision.
- **K-Level.** If the patient has potential to reach a higher K-level designation in the future, include an explanation and treatment plan that will achieve this increase in functional level, and what it will take to get there (e.g. physical therapy, gait training, etc.). The plan should specify in your opinion approximately how long _____ it will take the patient to be functioning at the potential K-Level and address use of the mobility aid if pertinent.
- **Functional Capabilities for Lower Extremity [K-Levels]**
 - Level K-0:** Does not have the ability/potential to ambulate or transfer safely with/without assistance
 - Level K-1:** Home Ambulator with ability/potential for transfers or ambulation on level surfaces at fixed cadence.
 - Level K-2:** Limited Community Ambulator with ability/potential for ambulation and to traverse low level environmental barriers
 - Level K-3:** Full Community Ambulator with ability/potential for ambulation with variable cadence and to traverse higher level barriers
 - Level K-4:** Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

Please FAX the signed and dated Medical Necessity documents to:

_____ at (_____)_____

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Documentation Tips

Justifying Functional Level

Following is Medicare's coverage criteria for a lower limb prosthesis, which is also found in many private insurance policies. For Medicare **all** criteria must be documented!

COVERAGE

A lower limb prosthesis is covered when the beneficiary:

1. Will reach or maintain a defined functional state within a reasonable period of time; and
2. Is motivated to ambulate.

FUNCTIONAL LEVELS:

A determination of the medical necessity for certain components/additions to the prosthesis is based on the beneficiary's potential functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist, and treating physician, considering factors including, but not limited to:

- The beneficiary's past history (including prior prosthetic use if applicable); and
- The beneficiary's current condition including the status of the residual limb and the nature of other medical problems; and
- The beneficiary's desire to ambulate.

CLASSIFICATION LEVELS:

Clinical assessments of beneficiary rehabilitation potential must be based on the following classification levels:

Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility

Level 1: Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.

Level 2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.

Level 3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulatory who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

The records must document the beneficiary's current functional capabilities and his/her expected functional potential, including an explanation for the difference, if that is the case. It is recognized, within the functional classification hierarchy, that bilateral amputees often cannot be strictly bound by functional level classifications. However, the records must still document the beneficiary's past history, current condition, and expected functional potential.

Documentation Tips

Justifying Functional Level

For devices with K3 criteria requirements:

Use “K-Level” language in your documentation. Include “real life” daily activities that require ambulation with variable cadence, and describe with great detail the terrain encountered. Include vocational, therapeutic, and exercise activities that demand prosthetic utilization beyond simple (K2 level) locomotion. Describe why patient has the potential or ability to perform each activity and what is involved, such as how far will the patient walk, when will he/she need to change cadence, and types of barriers encountered. If the patient has other functional limitations (e.g. vascular/ cardiovascular disease, cognitive issues, osteoarthritis, etc.), explain why these issues will not limit the patient’s ability to use the device to perform the activities.

Per the Medicare LCD for LL Prosthetics, the following codes are covered for K3 and above:

Feet			
L5973	MP Controlled ankle foot system, dorsiflex and/or plantarflex control	L5976	Energy storing foot (Seattle Carbon Copy II or equal)
L5979	Dynamic response foot with multi-axial ankle	L5980	Flex foot system
L5981	Flex-walk system or equal	L5987	Shank foot system with vertical loading pylon
Knees (Endoskeletal Knee Shin System)			
L5610	Hydracadence system	L5613	Knee disarticulation, 4-bar linkage with hyd swing phase control
L5814	Polycentric, hydraulic swing phase control, mechanical stance phase lock.	L5822	Pneumatic swing, friction stance phase control
L5824	Fluid swing phase control	L5826	Hydraulic swing phase control, with miniature high activity knee frame
L5828	Fluid swing and stance phase control	L5830	Pneumatic/swing phase control
L5840	4-bar linkage or multiaxial, pneumatic swing phase control	L5848	Fluid stance extension, dampening feature
L5856	MP control feature, swing and stance phase	L5857	MP control feature, swing phase only
L5858	MP control feature, stance phase only	L5859	Powered programmable flexion/extension assist control (see LCD for additional criteria)
Hips			
L5961	Polycentric hip joint, pneumatic/hydraulic control, rotation control w/w out flexion and/or extension		

Documentation Tips

Justifying Functional Level

For devices with K2 criteria requirements:

Use “K-Level” language in your documentation. Describe “real life” daily activities detailing the terrain encountered, including low-level environmental barriers that the patient encounters, such as a curb, minimal stairs, or slightly uneven surface. Describe why patient has potential or ability to perform these activities. If patient has other functional limitations (e.g. vascular/cardiovascular disease, cognitive issues, osteoarthritis, etc.), explain why these issues will not limit the patient’s ability to use the new prosthesis to perform the activities.

Per the Medicare LCD for LL Prosthetics, the following codes are covered for K2 and above:

Feet			
L5972	Flexible keel Foot	L5878	Multi-axial ankle/foot
Axial Rotation			
L5984	Axial rotation unit, w/ without adjustability	L5985	Dynamic prosthetic pylon
L5986	Multi-axial rotation unit (MCP or equal)		

Example – Changing from a Mechanical knee to a C-Leg

Daily Activities	Current Prosthesis/ Component	Replacement Prosthesis/ Component
List daily activities in great detail, including those that require traversing environmental barriers, changes in gait speed, and prosthetic utilization beyond simple locomotion when applicable.	Describe current prosthesis (e.g. technologic design & features).	Describe replacement prosthesis (E.g. technologic design & features).
Activities (e.g. home, work, therapeutic, exercise, and recreational). <ul style="list-style-type: none"> Describe setting Current Responsibilities Problems with prosthesis Goals 	How does the current prosthesis work for this activity? <ul style="list-style-type: none"> Can patient successfully execute the activity? Any falls or stumbles? Strain to sound side? Other issues? 	How will the replacement prosthesis solve the problem? <ul style="list-style-type: none"> What feature will allow patient to execute the activity? Or do it better? Explain why

Medicare Rules for Replacement of Prosthesis or Components

Documentation Requirements

Correct Prosthesis: The supplier (prosthetist) is responsible to provide the correct prosthesis for the patient. If an incorrect prosthesis is supplied the supplier is obligated to make the situation right (take back the incorrect prosthesis, provide the correct one, and adjust the billing). There is no time limit for this.

Repairs and Adjustments: Repairs and adjustments are covered when necessary to make the prosthesis functional. Repairs and adjustments are covered under the initial order. Note: manufacturer-required repairs and service/maintenance are covered as a repair after the warranty expires.

What about the 5-year Useful Lifetime Rule? This rule does not apply to prosthetics. The Social Security Act was amended in 2001 to exclude Prosthetics from the Useful Lifetime Rule, so amputees could get replacements when needed.

What is a Replacement? A replacement is the provision of an identical or nearly identical item. If the item is different from what you originally provided (e.g. different HCPCS code) the item is not considered a replacement.

Rules for Replacement

1. **Replacement** is covered if the treating physician orders a replacement of the entire prosthesis or a major component (foot, ankle, knee, socket, etc.) and the replacement falls under one of the following Reasons for Replacement (see examples starting on page 2).
 - a) There is a change in the physiological condition of the beneficiary; or
 - b) There is irreparable wear of the prosthesis/component; or
 - c) The condition of the prosthesis/component requires repairs, and your cost of such repairs is greater than 60% of the cost [Medicare allowable] of the replacement prosthesis/component.
2. **Loss or Irreparable damage (from accident/natural disaster)** is covered without a new physician's order.
3. ***Identical or Nearly Identical:** If the prosthesis/component being replaced is NOT identical or nearly identical (e.g. different HCPCS code), it is considered a NEW prosthesis/component and new documentation & evaluations will be required. See the Documentation Guide in this packet.

Tips:

- Take care when describing the current prosthesis in the medical record, so it does not sound like an incorrect prosthesis was provided.
- Choose one reason (see examples below) for replacing the prosthesis and carefully build a case to support this in the patient's medical record. Explain in great detail why the prosthesis is being replaced. While it is required that the status of the current prosthesis be documented, if the patient's functional need or physiological condition has changed and a different prosthesis is needed, this should be the main focus of the documentation.

Medicare Rules for Replacement of Prosthesis or Components

Documentation Requirements

Documentation Requirements

Reason for Replacement	Documentation Requirement
CHANGE IN PATIENT'S CONDITION PHYSIOLOGICAL OR FUNCTIONAL *Replace with Identical or Nearly Identical Device	Reason for Replacement: The reason for replacement in this case would be a change that has occurred in the patient's physiological condition or a change in the patient's functional need. Documentation should include evidence to support that change (e.g. limb measurements, recorded weight changes, changes in activities, results from gait testing performed & how it has changed from previous results, etc.) Physician: New Standard Written Order (SWO) is required. The reason for replacement can be located either on the order (SWO) or in the physician's medical record. Prosthetist: Document condition of the item(s) being replaced, reason for replacement, and description of labor involved. Proof of delivery & signed SWO must be on file.
IRREPARABLE WEAR/TEAR OF THE DEVICE (REPAIR NOT POSSIBLE). *Replace with Identical or Nearly Identical Device	Reason for Replacement: The reason for the replacement would be wear/tear of an item that cannot be repaired and what caused the wear and tear. Documentation should include information to support that item is worn/torn and why it cannot be repaired. If patient is very active, record daily activities. If patient is overweight, record the weight. If the componentry is worn due to age, include original date of service for the worn component. There may be other reasons. Physician: New Standard Written Order (SWO) is required. The reason for replacement can be located either on the order (SWO) or in the physician's medical record. Prosthetist: Document condition of the item(s) being replaced, reason for replacement, and description of labor involved. Proof of delivery & signed SWO must be on file.

Reason for Replacement	Documentation Requirement
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Medicare Rules for Replacement of Prosthesis or Components

Documentation Requirements

**WEAR/TEAR OF THE DEVICE
WHEN COST OF THE REPAIR IS
GREATER THAN 60% OF THE COST
OF A REPLACEMENT.**

*Replace with Identical or
Nearly Identical Device

Reason for Replacement:

The reason for replacement would be “the cost of repair is greater than 60% of the cost to replace the item (i.e. 60% of the total allowable for the new codes being billed).” If replacing an MPK, we suggest having on file a quotation to support this.

Physician:

New Standard Written Order (SWO) is required. The reason for replacement can be located either on the order (SWO) or in the physician’s medical record.

Prosthetist:

Document condition of the item(s) being replaced, reason for replacement, and description of labor involved. Proof of delivery & signed SWO must be on file.

**IRREPARABLE DAMAGE DUE TO
SPECIFIC ACCIDENT OR NATURAL
DISASTER (E.G. FIRE OR FLOOD)**

OR

DEVICE IS LOST OR STOLEN

Replace with exact same
device as originally ordered.

Physician:

Item may be replaced under the original order.

Prosthetist:

Proof of loss or damage through documentation such as a police report, photograph, or corroborating statement should be submitted with the claim.

Describe in medical record that the prosthesis, as originally ordered, still meets the beneficiary's medical needs.

Retain documentation of item(s) being replaced, reason for replacement, and description of labor involved. Compliant original order, and proof of delivery must be on file.

Reference: LCA. Standard Documentation for All Claims Submitted to the DME MACs (A55426).
[Revised January 1, 2020]

Signature Requirements for Documentation

What is Allowed?

Handwritten, Electronic, and Stamped (only if the signee cannot sign due to a disability)

Handwritten Signatures

- A handwritten signature is a mark or sign for services provided/ordered.
- An illegible signature should be accompanied by a signature log or attestation statement.
- Documentation (other than orders) that lack a signature, require an attestation.
- Orders (e.g. authorizations for tests, plans of care, and procedures) must be validated with a timely signature. Without a signature, they will not be considered.
- It is not allowed to add late signatures to a medical record (beyond the short delay that occurs during the transcription process).

Signature Dates

Signatures do not need to be dated if there is enough information to determine the date when the service was performed or ordered. Example: entries immediately above or below the signature.

Signature Log/Key

- A signature log accompanies one set of medical records.
- Lists the printed name (and credentials) associated with initials or an illegible signature.
- The signature log can be a separate document (or it can be on the actual page where the initials or illegible signature are used).
- A signature log may be created at any time.
- This may include yourself and/or your office staff.

Example:

Name	Signature	Initial	Date of Signature
John Doe, MD	<i>John Doe, MD</i>	<i>JD</i>	8/31/2019
A. Prosthetist, CPO	<i>A. Prosthetist, CPO</i>	<i>AP</i>	8/31/2019
I.M. Manager	<i>I.M. Manager, Office Manager</i>	<i>IMM</i>	8/31/2019

Signature Requirements for Documentation

Signature Attestation Statement Example

Patient Name: I.M. Patient
 Medicare Number: 555555555A

I, John Doe, hereby attest that the medical record entry for July 1, 2019 accurately reflects signatures/notations that I made in my capacity as MD when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission or concealment of material fact may subject me to administrative, civil, or criminal liability.

John Doe, MD
 Signature

08/12/2019
 Date

Note: In order to be a valid attestation, it must be signed by the person who authored the medical record entry. It cannot be a partner in the same group practice or other staff member.

Electronic Signature

Examples of electronic signature notations (not all inclusive):

Electronically signed by	Finalized by
Authenticated by	Signed by
Approved by	Validated by
Completed by	Sealed by

References

DME MAC Joint Publication. Medicare Record Authentications – Tips for Physicians. July 2011
 CMS Pub. 100-08, Medicare Program Integrity Manual, Chap. 3-Section 3.3.2.4 (Rev. 751; Issued: 10-20-17; Effective 11-20-17; Implementation 11-20-17)
 Medicare Learning Network. Complying with Medicare Signature Requirements. ICN 905364. May 2018

Changes to the Medical Record

Amendments, Corrections and Delayed/Late Entries

The CMS Program Integrity Manual, instructs the Medicare Auditors to consider all properly written amendments, corrections and late/delayed entries in patient medical records. This means that the physician can add clarification to the medical record after-the-fact if something was missed when the patient was there; however, there are specific record keeping principles that need to be followed.

“All services provided to beneficiaries are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not properly documented. In this event, the documentation will need to be amended, corrected, or entered after rendering the service. When making review determinations the MACs, CERT, Recovery Auditors, SMRC, and ZPICs shall consider all submitted entries that comply with the widely accepted Recordkeeping Principles.” (CMS Program Integrity Manual)

What are Recordkeeping Principles?

“Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to MA, CERT, Recovery Auditors, and UPICs containing amendments, corrections or addenda must:

- Clearly and permanently identify any amendment, correction or delayed entry as such, and
- Clearly indicate the date and author of any amendment, correction or delayed entry, and
- Clearly identify all original content, without deletion” (CGS JC)

Specific Rules for Amendments, Corrections and Late Entries

Late Entries

“A late entry supplies additional information that was omitted from the original entry. The late entry bears the current date, is added as soon as possible, is written only if the person documenting has total recall of the omitted information and signs the late entry.” (Noridian JE)

Addendums:

“An addendum is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum.” (Noridian JE)

[An example would be a lab test not yet available at the time of the exam.]

Changes to the Medical Record

Amendments, Corrections and Delayed/Late Entries

Corrections:

“Paper Medical Record

- Use a single line strike through so the original content is still readable, and
- The author of the alteration must sign and date the revision.

Electronic Health Records (EHR):

- Distinctly identify any amendment, correction or delayed entry, and
- Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.” (CGS JC)

What is Considered Falsified Documentation?

“Examples of falsifying records include:

- Creation of new records when records are requested
- Back-dating entries
- Post-dating entries
- Pre-dating entries
- Writing over, or
- Adding to existing documentation (except as described in late entries, addendums and corrections)” (Noridian JE)

References

CMS Program Integrity Manual. 3.3.2.5 Amendments, Corrections and Delayed Entries in Medical Documentation. (Rev. 732; Issued: 07-21-17; Effective: 08-22-17; Implementation: 08-22-17)

CGS Jurisdiction C. Entries in Medical Records: Amendments, Corrections, and Delayed Entries. (January 19, 2016 – revised 03.21.19)

Noridian JE Part B Medical Review. Documentation Guidelines for Amended Medical Records: Amended Medical Records. (Last Updated Aug 14, 2018)

Reimbursement, Ottobock North America

P 800 328 4058 F 800 962 2549

professionals.ottobockus.com

professionals.ottobock.ca

reimbursement911@ottobock.com