

# Lower Limb Prostheses

## DOCUMENTATION CHECKLIST

### Required Documentation in Supplier's File

#### Claims for All Lower Limb Prostheses

Documentation of Dispensing Order (preliminary written or verbal order) that contains:

Description of the item	Date of the order
Name of the beneficiary	Physician signature (for written order) or supplier signature (for verbal order)
Prescribing physician's name	

**NOTE:** A dispensing order is only required if the items are dispensed prior to obtaining the detailed written order

Detailed Written Order That Contains:

Beneficiary's name	The treating physician's signature
Physician's name	The date the treating physician signed the order (must be personally entered by physician)
List of all separately billable items ordered	
Date of the order	

Physician's signature on the written order meets **CMS Signature Requirements**

<http://www.cgsmedicare.com/jc/pubs/news/2010/0410/cope12069.html>

Proof of Delivery

Beneficiary's name	Quantity delivered
Delivery address	Date delivered
Sufficiently detailed description to identify the item(s) being delivered	Beneficiary (or designee) signature
	Delivery date

POD may be incorporated into the prosthetist's chart, and not a separate document, as long as all of the above elements are present in the document. This includes a signature from either the beneficiary or a designee accepting delivery.

Treating physician's records assessing the beneficiary's physical and cognitive capabilities (points are not all-inclusive and should be tailored to the individual beneficiary's condition)

History of the present condition(s) and past medical history that is relevant to functional deficits

Symptoms limiting ambulation or dexterity

Diagnoses causing these symptoms

Other co-morbidities relating to ambulatory problems or impacting the use of a new prosthesis

What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used (either in addition to the prosthesis or prior to amputation)

Description of activities of daily living and how impacted by deficit(s)

Physical examination that is relevant to functional deficits

Weight and height, including any recent weight loss/gain

Cardiopulmonary examination

Musculoskeletal examination

Arm and leg strength and range of motion

Neurological examination

Gait

Balance and coordination

The treating physician's and/or prosthetist's medical records document:

The beneficiary's current functional capabilities and his/her expected functional potential, including an explanation for the difference, if that is the case.  
 The beneficiary will reach or maintain a defined functional state within a reasonable period of time.  
 The beneficiary is motivated to ambulate.

**Claims for Feet:**

External keel SACH foot (L5970) or single axis ankle/foot (L5974).

The medical record supports that the beneficiary's functional level is 1 or above.

Flexible-keel foot (L5972) or multiaxial ankle/foot (L5978).

The medical record supports that the beneficiary's functional level is 2 or above.

Microprocessor controlled ankle foot system (L5973), energy storing foot (L5976), dynamic response foot with multi-axial ankle (L5979), flex foot system (L5980), flex-walk system or equal (L5981), or shank foot system with vertical loading pylon (L5987).

The medical record supports that the beneficiary's functional level is 3 or above.

**Claims for Knees:**

High activity knee control frame (L5930)

The medical record supports that the beneficiary's functional level is 4.

Fluid, pneumatic, or electronic knee (L5610, L5613, L5614, L5722-L5780, L5814, L5822-L5840, L5848, L5856, L5857, L5858)

The medical record supports that the beneficiary's functional level is 3 or above.

Other knee systems (L5611, L5616, L5710 – L5718, L5810 – L5812, L5816, L5818)

The medical record supports that the beneficiary's functional level is 1 or above.

**Claims for Ankles:**

Axial rotation unit (L5982 – L5986)

The medical record supports that the beneficiary's functional level is 2 or above

**Claims for Hips:**

Pneumatic or hydraulic polycentric hip joint (L5961)

The medical record supports that the beneficiary's functional level is 3 or above.

**Claims for Test (Diagnostic) Sockets:**

Claims for more than 2 test (diagnostic) sockets (L5618 – L5628)

There is documentation in the medical record that justifies the need.

**Claims for a Prosthesis Delivered to a Hospital or SNF:**

The prosthesis will be medically necessary after the beneficiary is discharged; and  
 The prosthesis was delivered no more than two days prior to discharge; and  
 The prosthesis is not needed for inpatient treatment or rehabilitation, but is left in the room for the beneficiary to take home.

**Claims for Replacement of Prosthesis or Major Component (Foot, Ankle, Knee, Socket):**

The prosthetist's file contains the following documentation:

New written order

List of item(s) replaced

The reason for replacement

Change in the physiological condition of the beneficiary

Irreparable wear

Prosthesis was lost or irreparably damaged

Cost of repairs would be more than 60% of the cost of a replacement

Other \_\_\_\_\_

Description of labor involved

**NOTE:** A new written order is not required if the replacement is due to loss or irreparable damage and the prosthesis as originally ordered still fills the beneficiary’s medical needs.

**Billing Reminders**

- Prosthetic claims for knees, feet and ankles must be submitted with modifiers K0 – K4, indicating the expected beneficiary functional level.
- Modifiers right (RT) and left (LT ) must be used with prosthesis codes. When the same code for prostheses, sockets, or components for bilateral amputees are billed on the same date of service, bill both items on the same claim line using the modifiers LTRT and 2 units of service.
- Replacement components (except sockets) should be billed using the code for the component and modifier RP.
- The following items are included in the reimbursement for a prosthesis and are not separately billable to Medicare:
  - Evaluation of the residual limb and gait
  - Fitting of the prosthesis
  - Cost of base component parts and labor contained in HCPCS base codes
  - Repairs due to normal wear or tear within 90 days of delivery
  - Adjustments of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments are not necessitated by changes in the residual limb or the beneficiary’s functional abilities.
- Do not submit a claim to the DME MAC if the prosthesis is provided to a beneficiary during an inpatient hospital stay prior to the day of discharge and the beneficiary uses the prosthesis for medically necessary inpatient treatment or rehabilitation.
- Do not submit a claim to the DME MAC if the prosthesis is provided to a beneficiary during a Medicare Part A covered SNF stay prior to the day of discharge and the beneficiary uses the prosthesis for medically necessary inpatient treatment or rehabilitation.
- Adjustments to a prosthesis required by wear or by a change in the beneficiary’s condition do not require a new physician’s order.
- With the exception of items described by specific HCPCS codes, no separate payment is available for real time gait analysis or other components/features billed in conjunction with a microprocessor controlled knee.

Functional Levels	
<b>Level 0</b>	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.
<b>Level 1</b>	Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
<b>Level 2</b>	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.
<b>Level 3</b>	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.
<b>Level 4</b>	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.

**Additional Information References on the Web**

- Supplier Documentation Requirements: <http://www.cgsmedicare.com/jc/pubs/pdf/Chpt3.pdf>
- Local Coverage Determinations (LC Ds) and Policy Articles: <http://www.cgsmedicare.com/jc/coverage/LCDinfo.html>

**NOTE**

It is expected that the beneficiary's medical records will reflect the need for the care provided. These records are not routinely submitted to the DME MAC, but must be available upon request. Therefore, while it is not a requirement, it is a recommendation that suppliers obtain and review the appropriate medical records and maintain a copy in the beneficiary's file. As a reminder, Supplier-produced records, even if signed by the prescribing physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.

**DISCLAIMER**

This document was prepared as an educational tool and is not intended to grant rights or impose obligations. This checklist may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either written law or regulations. Suppliers are encouraged to consult the *DME MAC Jurisdiction C Supplier Manual* and the Local Coverage Determination/Policy Article for full and accurate details concerning policies and regulations.