PROSTHETIC DOCUMENTATION: Functional Level

(Please check www.theregionalpro.com for the most recent version of this guideline)

Medicare has stated that it is not enough to claim "patient is K-level X". Instead, all justification for determining this level of activity must be layed out as a narrative description within your notes. In developing a K-Level for your patient, please focus on the following:

1. Past history (including prior prosthetic use if applicable)
2. Current condition (including the status of the residual limb and nature of other medical problems)
3. Focus on vocational, hygienic, therapeutic and independent living needs.
4. Recreational and exercise activities don't necessarily carry sufficient weight for medical need on their own, but they do help paint the overall narrative picture.

Examples of specific needs include negotiation of steps in the home, uneven terrain or specific obstacles at home or in the community. Specific needs such as waterproof components specific to job requirements may also be important.

Going a step further:

1. Medicare has identified K-levels from 0 to 4 in the chart below. Use this language in your documentation. Describe daily activities in great detail that require ambulation with "variable cadence", "environmental barriers" your patient must traverse, or activities demanding prosthetic utilization "beyond simple locomotion."

2. If the patient has other functional limitations (e.g. vascular/ cardiovascular disease, cognitive issues, osteoarthritis, etc.), explain why these issues may or may not limit the patient's ability to use the device to perform the activities.

3. It may be helpful to describe specific functional goals for your patient such as shock absorption, axial rotation, stumble recovery, water proof, toe clearance in swing, etc. Please don't worry about having complete knowledge of all possibilities here. Simply identify a functional need, set the goal, and allow us to meet that need. Often times these needs aren't clear until the patient begins to use a prosthesis. Many of these features can be incorporated down the road as they become necessary.

4. Bilateral amputees often cannot be strictly bound by functional level classifications, however your notes must still document these unique specific functional needs (ie fluid/smooth roll-over and sufficient standing balance).

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.

PROSTHETIC DOCUMENTATION

(Please check www.theregionalpro.com for the most recent version of this guideline)

This is where the real work is done, which Medicare places squarely on your shoulders, so thank you for your time and attention to detail here. There are **three** key elements to your documentation which aim to evaluate both the medical necessity of a prosthesis and functional capability of your patient.

1. Sufficient Documentation.

Medicare wants to see in your chart notes the need for care. In general, you are covering four concepts.

A: Rule out conditions which may make use of a prosthesis not possible.

B: Establish medical need for the device. This means you have built a plan for the patient to achieve a certain level of function, and also identifying medical need for the device. Medicare is looking for assurance that no other device with similar function (like a wheelchair) supercedes the role of the prosthesis (there are situations where both are possible, but it is understandable that a highly functional prosthesis may be inappropriate for a patient who relies primarily on their wheelchair). Please see the documentation check list included and consider incorporating it into any evaluation templates you may already have. Be advised, however, that Medicare wants to see this documented as a narrative in your notes, and not simply a series of checked boxes.

C: Patient's desire to ambulate. This can be as simple as asking your patient the obvious question and documenting their answer, but this is an extremely important element that must be in your notes.

D: Medicare has recently begun stressing the importance of documenting continued need and use. Make sure you are showing in your notes that you are certain the patient continues to not only need the item, but that he/she is also using it. See below for additional information on what Medicare agrees is adequate proof of this.

2. Functional level evaluation. This is where you assign a K-level (activity level) for your patient based on activities of daily living, work requirements and household requirements. This K-level is the functional range we will use in selection of components appropriate for your patient, and as such must be accurate and objective. Please see the K-level attachment (included in this packet) for specific details.

3. General requirements.

Each chart note must:

1. Be signed by the treating physician, to include the physician's printed name and credentials.
2. Electronic signatures and date are only allowed on electronic documents. Medicare states that these signatures and dates must be present prior to the delivery date, so your prompt cooperation as we seek to ecure all documentation prior to delivery is appreciated.
3. Each page/chart note must clearly identify the patient.
4. You are allowed to sign notes provided by other healthcare providers and thereby incorporate them into the medical record as long as they don't have a financial interest in the provision of care (such as us). In the event that a provider has financial interest in the outcome, you will not be able to sign the paperwork into the record, but will rather have to absorb the information and reflect it in your own chart notes.

How often must an evaluation be conducted?

1. For every new amputee.
2. For an amputee new to Medicare (their prosthesis must now meet Medicare's guidelines, and therefore

must be completely re-evaluated).
3. Each time medical necessity requires a major component to be changed (such as new socket due to limb volume changes or weight gain/loss, functional capability changes, revision surgeries, etc.). Medicare uses this as an opportunity to identify any issue which may prevent successful use of the prosthesis.
4. If no face-to-face evaluation has been conducted in the past 6 months. Date of face-to-face must be on or before the date of the Dispensing Prescription and no more than six months prior to the Dispensing Prescription.
5. For repairs/replacements of worn/lost/stolen items.

Keep in mind... you don't have to re-write the entire checklist. Simply go through an evaluation to identify new conditions/comorbidities which may prevent use or alter the treatment plan.

<u>When do I write a prescription, and what needs to be on it?</u>

If in doubt, write a prescription. Medicare sees this as your informed permission to begin work. If you have a patient in to see you and you are unsure, simply write a prescription for the needs as you see them. Once we receive the prescription, we will send you a detailed written order (if required) for you to sign. This order will contain a listing of all components which will be used (typically used when delivering a complete prosthesis). Once your documentation is complete, and the DWO is signed and returned to us, we can deliver the definitive prosthesis or components to your patient.

The Prescription must contain:

- ☐ Patient's name
- ☐ Date of order and start date (if applicable)
- ☐ Description of item (as detailed as possible)
- ☐ Physician's printed name
- ☐ Prescribing practitioner's NPI
- ☐ If written: Physician's signature & date (verbal orders are an option)
- ☐ Compliance with State Law

Continued Need

Medicare requires continual confirmation that the patient still needs the device. The following items are sufficient for providing this documentation.

1. A recent order by the treating physician
2. A recent change in prescription
3. Documentation in the patient's medical record showing usage of the item.

Continued Use

Medicare also requires confirmation that not only is the device still needed, but that it continues to be used. The following items are sufficient for providing this documentation.

1. Timely documentation in the patient's medical record showing usage of the item
2. Supplier records documenting the request for refill/replacement of supplies in compliance with the Refill Documentation Requirements