ottobock.

Lower Limb Physician Documentation Guide.

When Referring Your Patient to a Prosthetist.

Physician Documentation Checklist for Lower Limb Prosthetics.

Patient Name:

Date:

Completed by:

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 prosthesis, medical condition, or comorbidities
- ❑ Diagnoses causing the symptoms.

Ambulatory assistance

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

Functional Levels (K-Levels)

K-0: Lacks ability or potential to ambulate (or transfer safely with/without assistance and a prosthesis. And prosthesis will not enhance quality of life or mobility

K-1: Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence. (home)

K2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces (limited community ambulator)

K3 3: Has the ability or potential for ambulation with variable cadence. (full community ambulator)

Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. (athlete or child)

Functional Level (K-Level)

- ❑ Patient's activities prior to amputation
- ❑ Patient's current activities & impact of the functional limitations identified above.
- ❑ Activities patient desires to resume or has potential for using new prosthesis

Prosthetic Use (socket, knee, ankle, foot, liner)

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

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 and Order for new prostheses/components

- ❑ K-Level (based on prior activities, current condition, and motivation to ambulate).
- ❑ Recommendation for new prosthetic components
- ❑ Statement that patient will maintain current K-level, or for **potential** K-level, include explanation for difference, with treatment plan to reach desired K-Level and estimate how long it will take.

Physician Documentation for Lower Limb Prosthetics.

A recent physical evaluation is required. The focus should be the amputation, prosthesis, and ambulatory difficulties.

A. **History of the Amputation**

- Diagnosis/etiology of amputation(s)
- Date, affected side(s), level of amputation(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 the prosthesis/components you are prescribing.
- 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 functional limitations on a typical day whether from current prosthesis, current medical condition or comorbidities. Explain why these limitations will not affect patient's ability to ambulate with the prosthesis/components you are prescribing.

- 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].

If recent (past 6 months) CPX is available: Failure to achieve a capacity of 5 metabolic equivalents (5-MET) or submaximal oxygen uptake (Vo2 max) of 15.0 mL kg–1 min–1 has been used as criteria for disability by the Social Security Administration and may also indicate that the patient does currently not have the capacity for community ambulation.

Oxygen uptake of ≥6 METs or 21 mL kg–1 min–1 indicates capacity for "vigorous physical exertion" and, thus, is a certain indicator for community ambulation (K3). If no CPX results are available, please provide your professional judgment whether patient is able to walk 400 yards in one bout. If the patient is unable to walk 400 yards in one bout, does he/she have the potential to increase capacity through physical therapy to do so?

- Musculoskeletal conditions (e.g., osteoarthritis sound side leg joints, spinal stenosis, severe low back pain, etc.). Document numerical pain ratings of the joints of the lower extremities and back, if pain is present.
- 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).

Functional Levels (K-Levels) for Lower Limb

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 prosthesis for transfers or ambulation on level surfaces at fixed cadence

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

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.

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.

E. **Functional Capability:**

Describe patient's functional capabilities in terms of K- Levels (described above), as they relate to patient's activities. Focus should be on activities related to ambulation at work, home, during therapy or exercise (e.g. walking the dog, walking on a treadmill, mowing the lawn, catching a bus, carrying items, crossing a busy street, etc.). Document the related environmental and physical barriers that your patient encounters, including when there is a need to change walking speed (e.g. uneven terrain, curbs, stairs, ramps, crowds, public transportation, timed cross walks, etc.).
Avoid sports-related activities as the insurance payer may consider the prosthesis to be a luxury.
Document the following:

- Patient's functional activities prior to the amputation(s) in the K-Level/potential K-Level category.
- Patient's current daily activities and how impacted by the deficits identified above. Is the patient more limited by his/her medical conditions or by the function of the prosthesis? Include:
  - History of falls and fall-related injuries with the current prosthesis.
  - Activity avoidance with the current prosthesis due to fear of falling.
  - Activity avoidance due to functional limitations of the current prosthesis (e.g. prosthetic knee does not allow for reciprocal slope and stair descent).
- **Activities that patient desires to resume** (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), 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 Status of Current Prosthesis:**

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

  Reasons for Replacement allowed by most payers:

  - Patient's functional needs have changed
  - Due to physical changes the component no longer fits
  - Component is irreparably worn

  Additional Reasons Allowed by Medicare

  - Prosthesis is lost or damaged beyond repair in some type of incident
  - 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/ component is no longer appropriate. (e.g., weight gain/loss, falls, increased risk of falling, decreased stability, etc.).
- **If item is damaged or lost**, describe the incident.
- **If the current prosthesis/component** is the most appropriate type of replacement (explain).

G. **Previous Prostheses:**

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

H. **If ordering a repair, replacement prosthesis, prosthetic component, or a refill**

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

I. **Desire and Motivation:**

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

J. **Statement that patient will reach or maintain a defined functional state (K-Level) within a reasonable period of time.**

- The K-Level should be based on patient's prior activities, current condition, and desire to ambulate (determined above).
  - If your patient is currently ambulating at the K-Level required for the componentry being ordered, statement should say patient will maintain the K-Level.
  - If your patient has the "potential" to reach a higher K-level designation in the near future, an explanation for the difference is required. Include a treatment plan that will achieve this increase in functional level, (e.g. physical therapy, strength/ gait training, etc.). For Medicare, the plan must include your professional estimate of how long (days, weeks, months) it will take the patient to function at the potential K-Level.

Ottobock Reimbursement North America
P 800 320 4058 F 800230 3962
US: shop.ottobock.us
CA: shop.ottobock.ca
Reimbursement911@ottobock.com