DOCUMENTATION CHECKLIST

JURISDICTIONS B & C

LOWER LIMB PROSTHESES

REQUIRED DOCUMENTATION

- ☐ **Standard Written Order** that includes:
  - ○ Beneficiary's name or Medicare Beneficiary Identifier (MBI)
  - ○ General description of the item
    - ☐ The description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number
    - ☐ For supplies – In addition to the description of the base item, the DMEPOS order/ prescription may include all concurrently ordered supplies that are separately billed (List each separately)
    - ☐ For equipment - In addition to the description of the base item, the SWO may include all concurrently ordered options, accessories or additional features that are separately billed or require an upgraded code (List each separately).
  - ○ Quantity to be dispensed, if applicable
  - ○ Order Date
  - ○ Treating Practitioner Name or NPI
  - ○ Treating Practitioner's signature
- ☐ Practitioner's signature on the written order meets **CMS Signature Requirements** 100-08 Program Integrity Manual (PIM), Chapter 3, Section 3.3.2.4
- ☐ Proof of Delivery
  - ○ Beneficiary's name
  - ○ Delivery address
  - ○ A description of the item(s) being delivered. The description can be either a narrative description (e.g., lightweight wheelchair base), a HCPCS code, the long description of a HCPCS code, or a brand name/model number.
  - ○ Quantity delivered
  - ○ Date delivered
  - ○ Beneficiary (or designee) signature

NOTE: 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 practitioner'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 practitioner'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 the beneficiary's functional level is 3 or above; or,
- ○ The medical record supports the beneficiary's functional level is 2; and,
  - ☐ Meets the functional level 2 coverage criteria for a fluid, pneumatic, or electronic/microprocessor control addition for a prosthetic knee; and,
  - ☐ A higher-level (i.e., functional level 3) foot is required for the safe and proper use of the prescribed knee system.
- ○ Foot is required for the safe and proper use of the prescribed knee system.

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/microprocessor knee (L5610, L5613, L5614, L5615, L5722, L5724, L5726, L5728, L5780, L5814, L5822, L5824, L5826, L5828, L5830, L5840, and L5841, or L5848, or L5856, L5857, L5858). The medical record supports that the beneficiary's functional level is 3 or above and is also covered under limited circumstances for beneficiaries whose functional level is 2, when all of the following criteria are met:
- ○ The beneficiary has had a clinical evaluation to determine their functional level; and,
- ○ Supporting documentation in the medical record outlines, in the context of the beneficiary's overall medical health, the rationale for selection of a fluid, pneumatic, or electronic/microprocessor-controlled knee, including (at minimum) how the selected knee will:
  - ☐ Improve the beneficiary's functional health outcomes (e.g., fall reduction, injury prevention, lower energy expenditure); and,
  - ☐ Help the beneficiary accomplish their activities of daily living (ADLs); and,
- ○ Lower-level knee systems have been considered and ruled out based on the beneficiary's specific functional and medical needs.

☐ In addition, for coverage of an electronic/microprocessor-controlled knee system (L5856, L5857, or L5858) for beneficiaries whose functional level is 2, all of the following criteria must also be met:
- ○ The electronic/microprocessor knee is indicated for functional level 2; and,
- ○ The electronic/microprocessor knee has integrated technology that allows the knee to detect when the user trips or stumbles and can automatically adjust to stabilize the knee unit; and,
- ○ The beneficiary is able to make use of a product that requires daily charging; and,

- ○ The beneficiary is able to understand and respond to error alerts and alarms indicating problems with the function of the unit.

☐ 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.

☐ HCPCS code L5859 is only covered if all the following criteria are met:
- ○ Has a microprocessor (swing and stance phase type (L5856)) controlled (electronic) knee; and
- ○ K3 functional level only; and
- ○ Has a documented comorbidity of the spine and/or sound limb affecting hip extension and/or quadriceps function that impairs K3 level function with the use of a microprocessor-controlled knee alone; and
- ○ Is able to make use of a product that requires daily charging; and
- ○ Is able to understand and respond to error alerts and alarms indicating problems with the function of the unit.

Claims for Ankles:

☐ Axial rotation unit (L5982, L5984, L5985, 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, L5620, L5622, L5624, L5626, L5628)
- ○ There is documentation in the medical record that justifies the need.

A Prosthesis Delivered to a Beneficiary, Not for Use During a Medicare Part A Covered Hospital Stay, is Eligible for DME MAC Coverage if the Following Criteria are Met:

☐ The prosthesis is reasonable and necessary for a beneficiary after discharge from a hospital; and

☐ The prosthesis is delivered to the beneficiary no more than two days prior to discharge to home; and,

☐ The prosthesis is **not** used for inpatient treatment or rehabilitation.

Payment by the DME MAC for a Prosthesis Delivered to a Beneficiary During a Part A Covered SNF Stay is Eligible for DME MAC Coverage If:

☐ The prosthesis is reasonable and necessary for a beneficiary's use during the Medicare Part A covered SNF stay; and,

☐ The prosthetic components are classified as major category III codes under the SNFs consolidated billing.

Claims for any lower limb prosthesis provided to a beneficiary during a non-covered Medicare Part A SNF stay, are to be submitted to the DME MAC.

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

☐ Claims involving the replacement of a prosthesis or major component (foot, ankle, knee, socket) must include the following documentation:
- ○ New written order
- ○ The reason for replacement must be documented by the treating physician, either on the order or in the medical record, and must fall under one of the following:
  - ☐ A change in the physiological condition of the patient resulting in the need for a replacement. Examples include but are not limited to, changes in beneficiary weight, changes in the residual limb, beneficiary functional need changes; or,

- ☐ An irreparable change in the condition of the device, or in a part of the device resulting in the need for a replacement; or,
- ☐ The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

☐ The prosthetist must retain documentation of the prosthesis or prosthetic component replaced, the reason for replacement, and a description of the labor involved irrespective of the time since the prosthesis was provided to the beneficiary.

NOTE: Adjustments and repairs of prostheses and prosthetic components are covered under the original order for the prosthetic device.

Billing Reminders

1. Prosthetic claims for knees, feet, ankles, and hips must be submitted with modifiers K0 – K4, indicating the expected beneficiary functional level.
2. The right (RT) and left (LT) modifiers 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 each item on two separate claim lines using the RT and LT modifiers and 1 unit of service (UOS) on each claim line. Do not use the RTLT modifier on the same claim line and billed with 2 UOS. Claim lines billed without the RT and/or LT modifiers, or with RTLT on the same claim line and 2 UOS, will be rejected as incorrect coding.
3. **Effective for dates of service on and after 09/01/24** Claim lines billed without a KX, GA, GY, or GZ modifier will be rejected as missing information.
4. Replacement components (except sockets) should be billed using the code for the component and modifier RB.
5. 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.
6. 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.
7. 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

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. 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 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.

ONLINE RESOURCES

- **DME MAC Supplier Manual**
  - **JB:** https://www.cgsmedicare.com/jb/pubs/supman/index.html
  - **JC:** https://www.cgsmedicare.com/jc/pubs/supman/index.html
- **Local Coverage Determinations (LCDs) and Policy Articles**
  - **JB:** https://www.cgsmedicare.com/jb/coverage/lcdinfo.html
  - **JC:** https://www.cgsmedicare.com/jc/coverage/LCDinfo.html
- **Required Prior Authorization Program**
  - **JB:** https://www.cgsmedicare.com/jb/pa/llp.html
  - **JC:** https://www.cgsmedicare.com/jc/pa/llp.html
- **DMEPOS Consolidated Billing Tool**:
  - **JB:** https://www.cgsmedicare.com/medicare_dynamic/jb/consbill/consbill/index.aspx
  - **JC:** https://www.cgsmedicare.com/medicare_dynamic/jc/consbill/consbill/index.aspx

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 Supplier Manual* and the Local Coverage Determination/Policy Article for full and accurate details concerning policies and regulations.