REQUIRED DOCUMENTATION

☐ Documentation of a Dispensing Order (preliminary written or verbal order) that contains:
  □ Description of the item
  □ Name of the beneficiary
  □ Prescribing physician/practitioner’s name
  □ Date of the order
  □ Prescribing physician/practitioner’s signature (if a written order) or supplier signature (if verbal order)

  NOTE: A dispensing order is only required if the items are delivered before obtaining a detailed written order.

☐ Detailed Written Order that includes:
  □ Beneficiary’s name
  □ A description of all items, options, accessories or additional features that are separately billed or require an upgraded code. 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 – list all supplies that are separately billable, and for each include the frequency of use (if applicable), and the quantity dispensed
  □ Date of the order
  □ Prescribing physician/practitioner’s signature (and date if applicable*)

  * Someone other than the physician/practitioner may complete the DWO of the item unless statute, manual instructions, the contractor’s LCD or policy articles specify otherwise. However, the prescribing physician/practitioner must review the content and sign and date the document.

☐ Physician’s signature on the written order meets CMS Signature Requirements

☐ 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 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):
- 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. Replacement components (except sockets) should be billed using the code for the component and modifier RB.
4. 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.

5. 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.

6. 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.

7. Adjustments to a prosthesis required by wear or by a change in the beneficiary’s condition do not require a new physician’s order.

8. 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**

- **Local Coverage Determinations (LCDs) and Policy Articles**
  - JB: [https://www.cgsmedicare.com/jb/coverage/lcdinfo.html](https://www.cgsmedicare.com/jb/coverage/lcdinfo.html)
  - JC: [https://www.cgsmedicare.com/jc/coverage/LCDInfo.html](https://www.cgsmedicare.com/jc/coverage/LCDInfo.html)

- **DMEPOS Consolidated Billing Tool**

**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.