Noridian Healthcare Solutions

# Documentation Checklist
# Lower Limb Prostheses

**References: L33787, A52496**

## All Lower Limb Prostheses

- ☐ Dispensing Order (if applicable)
- ☐ Detailed Written Order (DWO)
- ☐ Beneficiary Authorization
- ☐ Refill Requirements
- ☐ Proof of Delivery (POD)
    - ☐ Method 1 - Direct Delivery to the Beneficiary by the Supplier
      **The date the beneficiary/designee signs for the prosthesis is to be the date of service of the claim.**
    - ☐ Method 2 - Delivery via Shipping or Delivery Service
      **The shipping date is to be the date of service of the claim.**
    - ☐ Method 3 - Delivery to Nursing Facility on Behalf of a Beneficiary
- ☐ Continued Need
- ☐ Continued Use

## Medical Records

- ☐ Lower Limb prosthesis is covered when the beneficiary:
    - ☐ Will reach and maintain a defined functional state within a reasonable period of time; **and**
    - ☐ Is motivated to ambulate.
- ☐ Functional level documentation for certain components and additions is based on beneficiary's potential functional abilities, as determined based on the reasonable expectations of the prosthetist and treating physician, considering factors including, but not limited to:
    - ☐ Past history (including prior prosthetic use if applicable); **and**
    - ☐ Current condition including the status of the residual limb and nature of other medical problems; **and**
    - ☐ Desire to ambulate
- ☐ Clinical assessments of beneficiary rehabilitation potential is based on the following functional classification levels:
    - ☐ Level 0
    - ☐ Level 1
    - ☐ Level 2

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- ☐ Level 3
- ☐ Level 4

☐ Clinical documentation of functional need for the technologic or design feature of the given type of prosthesis:

- ☐ Foot
  - ☐ External keel SACH foot (L5970) or single axis ankle/foot (L5974) – functional level 1 or above
  - ☐ Flexible-keel foot (L5972) or multiaxial ankle/foot (L5978) – functional level 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) – functional level 3 or above
- ☐ Knee
  - ☐ Fluid, pneumatic, or electronic/microprocessor knee (L5610, L5613, L5614, L5722-L5780, L5814, L5822-L5840, L5848, L5856, L5857, L5858) – functional level 3 or above
  - ☐ High activity knee control frame (L5930) – functional level 4
  - ☐ L5859 (Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, includes any type of motor(s)) is only covered when beneficiary meets all the following criteria:
    - ☐ Has a microprocessor (swing and stance phase type (L5856)) controlled (electronic) knee; **and**
    - ☐ K3 functional level only; **and**
    - ☐ Weight greater than 110 lbs and less than 275 lbs; **and**
    - ☐ Has a documented comorbidity of the spine and/or sound limb affecting hip extension and/or quadriceps function that impairs K-3 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
  - ☐ Other knee systems (L5611, L5616, L5710-L5718, L5810-L5812, L5816, L5818) – functional level 1 or below
- ☐ Ankle
  - ☐ Axial rotation unit (L5982-L5986) – functional level 2 or above
- ☐ Hip
  - ☐ Pneumatic or hydraulic polycentric hip joint (L5961) – functional level 3 or above

## Repair or Replacement

### Repair

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

- ☐ Code L7510 is used to bill for any “minor” materials used to achieve the adjustment and/or repair.
- ☐ Code L7520 is used to bill for labor associated with adjustments and repairs that either do not involve replacement parts or that involve replacement parts billed with code L7510. Code L7520 must not be billed for labor time involved in the replacement of parts that are billed with a specific HCPCS code. Labor is included in the allowance for those codes.
- ☐ One (1) unit of service of code L7520 represents 15 minutes of labor time. The time reported for L7520 must only be for actual repair time.

**Replacement**

- ☐ Replacement of a prosthesis or major component is covered if the treating physician orders a replacement device or part because of any of the following:
  - ☐ 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**
  - ☐ Irreparable change in the condition of the device, or in a part of the device resulting in the need for a replacement; **or**
  - ☐ 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.
- ☐ Replacement of a prosthesis or prosthetic components required because of loss or irreparable damage may be reimbursed without a physician’s order when it is determined that the prosthesis as originally ordered still fills the beneficiary’s medical needs.

## Billing Reminders

- Claims billed for knees, feet, ankles and hips (L5610-L5616, L5710-L5780, L5810-L5840, L5848, L5856-L5859, L5930, L5961, L5970-L5987) must be submitted with modifiers K0 – K4
  - Expectation of functional ability information must be clearly documented and retained in prosthetist’s records. Information should include:
    - Patient’s history
    - Current condition supporting designation of function level
- Claims for the prosthesis must include the RT (right) or LT (left) modifier
- When providing same code(s) for bilateral amputees on the same day, bill on same line with LTRT modifiers and two units of service
- Following items are included in reimbursement for prosthesis and are not separately billable
  - Evaluation of residual limb and gait
  - Fitting of 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 prosthesis or prosthetic component made when fitting prosthesis or component and for 90 days from date of delivery when adjustments are not necessitated by changes in residual limb or patient’s functional abilities

- Adjustments and repairs must be documented and are billed with HCPCS code L7520
  - Precise adjustment(s) and/or repair(s) performed
  - Actual laboratory time involved with repair and associated evaluation
  - Evaluation not associated with repair/adjustment is not covered
- Submitted charges for replacement components include both the cost of the component and the labor associated with the removal, replacement, and finishing of that component. Labor associated with replacement must not be reported using code L7520.
- With the exception of items described by specific HCPCS codes, there is no separate billing or separate payment for a component or feature of a microprocessor controlled knee, including but not limited to real time gait analysis, continuous gait assessment, or electronically controlled static stance regulator.

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**Go Back to Front Page**