



## POWER KNEE™

The step-by-step guide  
to a successful claim

# STEP 1: INSURANCE INTAKE (“KNOW YOUR PAYER”)

Before you can do anything for new patients, you must first understand what their insurer will pay for and what the patient’s financial responsibility is. The checklist on the following page helps verify the most essential payer information.

## INSURANCE INTAKE CHECKLIST

Have you identified...	
<input type="checkbox"/> The insurance company/payer?	<input type="checkbox"/> Medicare <input type="checkbox"/> Private insurance (e.g., Aetna, United HC, BCBS) <input type="checkbox"/> Workers compensation <input type="checkbox"/> Medicaid <input type="checkbox"/> Other <input type="checkbox"/> Secondary insurance (e.g., “Medigap” policy)
<input type="checkbox"/> Policy effective date?	Policy effective: _____
<input type="checkbox"/> Patient’s payment responsibility?	<input type="checkbox"/> Deductible Deductible amount paid YTD                      \$ _____ <input type="checkbox"/> Co-pay (if applicable)                                      \$ _____ <input type="checkbox"/> Coinsurance (if applicable)                                      % _____ <input type="checkbox"/> Max. out of pocket (if applicable)                                      \$ _____ Included in deductible?                                      Yes      No
<input type="checkbox"/> Delivery requirements?	<input type="checkbox"/> Deliver & bill <input type="checkbox"/> Prior-authorization (e.g. Medicare)
<input type="checkbox"/> Policy limits?	<input type="checkbox"/> Annual limit    \$ _____ Amount exhausted YTD    \$ _____
<input type="checkbox"/> LCD/Medical policy requirements?	<input type="checkbox"/> Medicare LCD (refer to Power Knee-specific LCD requirements listed in Steps 2 and 3 of this Guide) <input type="checkbox"/> Private Payer Medical Policy
<input type="checkbox"/> Final level of appeal?	<input type="checkbox"/> Self-insured plan (ID plan’s external review agency) <input type="checkbox"/> Employer not self-insured (final appeal usually through applicable state’s Department of Insurance)
<input type="checkbox"/> Who you spoke to?	<input type="checkbox"/> Payer representative’s employee id#                      _____ <input type="checkbox"/> Date & exact time of talk                                      _____

# STEP 2: THE PATIENT'S STORY (“KNOW YOUR PATIENT”)

Now that you understand the scope of your patients' insurance coverage you need to understand *them*. What's their story? What kind of life do they want to live with a prosthesis? What's their current and potential functional level? To accurately and completely tell your patient's story, you need both social and personal patient information on the one hand, and clinical information on the other. Review the following two checklists – one for the “patient story”, the other for clinical notes – to help you make sure that you get everything you need. Remember, you need both types of information to get your claim approved and to survive an audit or prepayment claim review!

## PATIENT STORY CHECKLIST

Have you...	Hints/Explanations/Examples
<input type="checkbox"/> Asked only open-ended questions when interviewing patients?	<input type="checkbox"/> <i>What</i> time do you wake up? <input type="checkbox"/> <i>Where</i> is your bedroom in the house? <input type="checkbox"/> <i>Who</i> do you live with? <input type="checkbox"/> <i>When</i> do you put on your prosthesis every morning? <input type="checkbox"/> <i>Why</i> do you dislike walking to the end of your driveway? <input type="checkbox"/> <i>How</i> do you go down the stairs at your office? <input type="checkbox"/> <i>When</i> do you take the prosthesis off at night?
<input type="checkbox"/> Used the “day in a life” technique?	<p>Start by asking patients what time they wake up most mornings. Then ask them what they do next. Continue through their day until they report taking off their prosthesis before bed.</p> <p>Listen to their answers and ask appropriate follow-up questions. For example:</p> <p>Q: What do you do after you put on your prosthesis?            A: I go to the kitchen.</p> <p><i>Follow-up Q: Where is the kitchen in relation to the room where you put on your prosthesis?</i></p>
<input type="checkbox"/> Closed the loops?	<p>You should have a list of questions that you need answers to for all patients. After completing your “open-ended”/“day in a life” interview, make sure you've got answers to all of these questions. Only ask these questions at the end of the interview!</p> <p>Examples: How often do you fall? Do you take any prescriptions for amputation-related pain? Do you have any pain in your sound foot, ankle, knee or hip? Etc.</p>
<input type="checkbox"/> Spoken to significant others?	<p>Caregivers who attend patient appointments often have detailed and relevant information about the patient's condition. Include them in the interview process (with the patient's permission).</p>

PATIENT CLINICAL NOTES CHECKLIST

Have you...	Hints/Explanations/Examples
<input type="checkbox"/> Captured all elements of the patient interview in your clinical notes?	<p>Avoid general medical jargon!</p> <p><i>Do not</i> say that the patient “performs all ADL’s independently.” Instead, include all the specific examples of <i>this patient’s</i> ADL’s (e.g., shopping for food, maintaining their yard, walking between buildings for work, etc.).</p>
<input type="checkbox"/> Recorded video of the patient walking in her current prosthesis?	<p>Video can provide objective verification of the prosthetist’s and physician’s functional level assessment.</p>
<input type="checkbox"/> Recorded video of the patient transitioning from sit to stand and stand to sit in his current prosthesis?	<p>Video can provide objective verification of limitations impairing a patient’s ability to live independently.</p>
<input type="checkbox"/> Recorded the data collected by the device itself?	<p>Power Knee records the number of steps taken by the user, total time spent walking, etc. You should collect this data during every patient visit and record it in your records to document patient progress.</p> <p>If your patient isn’t yet in Power Knee but will be fit with the device in the future, have the patient use a pedometer to monitor their pre-Power Knee activity level and compare it to the Power Knee data post-delivery to document patient progress.</p>
<input type="checkbox"/> Used validated tests to document the patient’s condition?	<p>For example, the AMP Pro, PEQ, Berg Balance Test, etc.</p>
<input type="checkbox"/> Listed the patient’s name on each page of clinical notes?	<p>Suppliers <i>are</i> seeing denials on this basis.</p>
<input type="checkbox"/> Signed and dated chart notes with your clinician’s credentials for every patient visit?	<p>Suppliers <i>are</i> seeing denials on this basis.</p>
<input type="checkbox"/> Documented the patient’s current K level, potential functional level, and explanation for the difference, if any?	<p>NOTE: Medicare requires that Power Knee users be K3 patients. (See LCD for Lower Limb Prostheses.)</p>
<input type="checkbox"/> Documented any potential weight gain or lost, plus or minus 10 pounds?	<p>NOTE: Medicare requires that Power Knee users be between 110 and 275 pounds. (See LCD for Lower Limb Prostheses.)</p>
<input type="checkbox"/> Documented that patient can use a product that requires daily charging?	<p>NOTE: Medicare requires that Power Knee users have this ability. (See LCD for Lower Limb Prostheses.)</p>
<input type="checkbox"/> Documented that patient can understand and respond to Power Knee error alerts and alarms?	<p>NOTE: Medicare requires that Power Knee users have this ability. (See LCD for Lower Limb Prostheses.)</p>

# STEP 3: MATCHING THE PATIENT & PRODUCT

Every patient has unique clinical needs. And every product offers unique clinical outcomes. Making sure that you map the two to each other is essential if you want (a) a happy and functional patient, and (b) to process your claim successfully. The next checklist maps Power Knee's functional benefits to your patient's clinical needs, helping ensure that they're aligned.

PATIENT TO PRODUCT CHECKLIST

Patient Clinical Issue	Power Knee Function
<p>Comorbidity of spine or sound limb that:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> impairs hip extension, or</li> <li><input type="checkbox"/> Impairs quadriceps function</li> </ul> <p>NOTE: YOU MUST BE ABLE TO SHOW 1 OR BOTH OF THE ABOVE FOR ANY MEDICARE CLAIM (See LCD for Lower Limb Prostheses)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> impairs knee function/causes pain</li> <li><input type="checkbox"/> impairs ankle function/causes pain</li> <li><input type="checkbox"/> impairs foot function/causes pain</li> <li><input type="checkbox"/> causes spinal pain/impairs ROM</li> </ul> <p>Comorbidity of upper body that impairs:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> arm function/causes pain</li> <li><input type="checkbox"/> shoulder function/ causes pain</li> </ul>	<p>Motor-powered flexion and extension:</p> <ul style="list-style-type: none"> <li>• allow users to walk with a close approximation to the human gait.</li> <li>• decrease need to aggressively walk over toe of prosthetic foot to initiate knee flexion.</li> <li>• allow for increased (loading) symmetry when exiting chairs.</li> </ul>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Documented fall history</li> </ul>	<p>Motor-powered stance phase stability actively supports user's body weight.</p> <p>Motor-powered swing phase pushes prosthetic foot through obstacles (e.g., rugs, grass, sand, snow) and prevents prosthetic toe from "catching" on underlying terrain, something that passive MPKs and mechanical knees can't.</p>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Inability to walk far enough without stopping</li> </ul>	<p>Power Knee allows for walking with less energy expenditure compared to passive MPKs.*</p>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Difficulty walking up and down inclines</li> </ul>	<p>Motor-powered extension permits users to ascend ramps more easily, as the user doesn't have to physically generate extension momentum in order for the knee to swing through to full extension, something that passive MPKs and mechanical knees can't do.</p> <p>Motor-powered flexion permits users to descend ramps in a controlled, safe manner.</p>

\*references can be found at: [go.ossur.com/powerknee](http://go.ossur.com/powerknee)

Patient Clinical Issue	POWER KNEE Function
<input type="checkbox"/> Gait deviations <ul style="list-style-type: none"> <li><input type="checkbox"/> Circumduction/little-no prosthetic knee bend</li> <li><input type="checkbox"/> Vaulting</li> <li><input type="checkbox"/> Exaggerated hip movement during knee extension (i.e., kicking prosthetic foot forward)</li> </ul>	<p>Motor initiates knee flexion and extension, preventing “stiff leg” walking, to obtain adequate foot-ground clearance.</p> <p>Motor-powered knee extension decreases need for user to kick prosthesis forward in order to obtain full extension, promoting more symmetrical gait.</p>
<input type="checkbox"/> Inability to get out of chair independently	<p>Motor generates force that can actively lift users with arm and/or shoulder deficits out of chair.</p>

# STEP 4: GET PHYSICIAN CONFIRMATION

Getting documentation from a physician confirming the prosthetist's findings and recommendations is an important Medicare requirement. A huge percentage of denied claims since 2011 result from prosthetists' failure to make sure that the physician's records validate their own. The next two checklists help you avoid that negative outcome.

## PHYSICIAN EDUCATION CHECKLIST

Have you...	
Sent the prescribing physician a letter of medical necessity with <i>all</i> of your key findings? See exemplar LofMN, Exhibit A.	<input type="checkbox"/>
Confirmed that the referring physician's face-to-face discusses in detail each of the patient clinical issues and related Power Knee functions addressing those issues referenced in the previous <i>Patient to Product Checklist</i> ?	<input type="checkbox"/>
Sent the prescribing physician a Standard Written Order? (Note: SWO, when compliant with Medicare requirements and signed and dated by the MD, serves as valid prescription.)	<input type="checkbox"/>
Included a cover letter with the LofMN and SWO explaining Medicare's coverage requirements? See exemplar Cover Letter, Exhibit B.	<input type="checkbox"/>

## PHYSICIAN DOCUMENTATION CHECKLIST

Have you confirmed that the physician's face-to-face records* include...	
Documentation re. functional level of patient both before <i>and after</i> amputation?	<input type="checkbox"/>
Explanation of current and potential functional level, including an explanation for the difference between the two, if any?	<input type="checkbox"/>
History of present medical condition(s) and past history relevant to functional deficits?	<input type="checkbox"/>
Symptoms limiting ambulation or dexterity?	<input type="checkbox"/>
Diagnoses causing these symptoms?	<input type="checkbox"/>
Other comorbidities relating to ambulatory problems or impacting use of new prosthesis?	<input type="checkbox"/>
Documentation of ambulatory assistance (cane, walker, wheelchair, caregiver) currently being used by patient (either in addition to prosthesis or before amputation)?	<input type="checkbox"/>
Description of activities of daily living and how impacted by deficit(s)?	<input type="checkbox"/>
Physical examination that's relevant to the functional deficit(s)?	<input type="checkbox"/>
Weight and height, including any recent weight loss/gain?	<input type="checkbox"/>
Cardiopulmonary examination?	<input type="checkbox"/>
Arm and leg strength and range of motion?	<input type="checkbox"/>
Neurological examination – gait?	<input type="checkbox"/>
Neurological examination – balance and coordination?	<input type="checkbox"/>
Diagnosis, side of amputation, date of amputation?	<input type="checkbox"/>
Patient's desire to ambulate?	<input type="checkbox"/>
Identification of patient on each page of the physician's records?	<input type="checkbox"/>
Documentation confirming the patient's motivation to ambulate?	<input type="checkbox"/>
Documentation showing that the physician examined the patient recently?	<input type="checkbox"/>

\*Records of other health care professionals (e.g., other physicians and PT's) can become part of the prescribing physician's medical records if attested to, signed, and dated by her.

# STEP 5: FINAL REVIEW BEFORE CLAIM SUBMISSION

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You've collected all the necessary patient information. You've confirmed that other health care providers' notes corroborate yours. You're ready to proceed to delivery and filing the claim for reimbursement. But you still need to verify that: (1) your patient delivery sheet contains all of the required information, and (2) you have filled out the claim form completely. The next two checklists will assist you with both.

## PATIENT DELIVERY FORM CHECKLIST

Does your patient delivery form include...	
1. The patient's or patient's designee's name?	<input type="checkbox"/>
2. The delivery address?	<input type="checkbox"/>
3. The item(s) being delivered (brand name, serial number, or narrative description)?	<input type="checkbox"/>
4. The number of item(s) being delivered?	<input type="checkbox"/>
5. The delivery date?	<input type="checkbox"/>
6. The patient's or patient's designee's signature?	<input type="checkbox"/>
7. The date of signature (must be the date the patient/designee received the item(s))?	<input type="checkbox"/>

## CMS 1500 FORM CHECKLIST

Have you verified that...	
1. The prescribing physician is listed in PECOS?	<input type="checkbox"/>
2. You've included the prescribing physician's NPI on the claim form?	<input type="checkbox"/>
3. You've listed the appropriate diagnosis code on the claim form?	<input type="checkbox"/>
4. You've included the correct date of service for every L code on the claim form?	<input type="checkbox"/>
5. You've selected the appropriate place of service for this patient on the claim form?	<input type="checkbox"/>
6. You've included the "L" and/or "R" modifier for every L code on the claim form?	<input type="checkbox"/>
7. You've listed the patient's K level for every L code on the claim form?	<input type="checkbox"/>
8. You've billed using Power Knee's Medicare-approved codes: <ul style="list-style-type: none"> <li>• L5856</li> <li>• L5828</li> <li>• L5845</li> <li>• L5848</li> <li>• L5859</li> </ul>	<input type="checkbox"/>

# STEP 6: THE AUDIT RESPONSE/PREPAYMENT CLAIM REVIEW RESPONSE/APPEAL

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You've done everything you're supposed to do. And sometimes, despite that, you still get thrown into prepayment claim review, get subjected to an audit or receive an outright denial from the payer. You're now in "appeal" mode. What steps do you need to take in order to give yourself the best chance of winning? You can start with this checklist.

Have you...	
1. NOT written ANYTHING in response until first completing steps 2-5, below?	<input type="checkbox"/>
2. Created a list of (a) what information is being requested, or (b) the basis(es) for denial?	<input type="checkbox"/>
3. Gone through the relevant records below and located responsive information? <input type="checkbox"/> Your records <input type="checkbox"/> MD's records <input type="checkbox"/> PT's records <input type="checkbox"/> Other HCP's records <input type="checkbox"/> Clinical studies	<input type="checkbox"/>
4. Organized the evidence appropriately? <input type="checkbox"/> For claims where the payer requests multiple pieces of information, organize consistent with the order of items requested. <input type="checkbox"/> For claims denied on not medically necessary or experimental grounds, organize from your strongest argument to your weakest.	<input type="checkbox"/>
5. Used language that someone who doesn't understand prosthetics can comprehend?	<input type="checkbox"/>
6. Stated the main issue(s) immediately in your appeal?	<input type="checkbox"/>
7. Attached all necessary exhibits to your appeal?	<input type="checkbox"/>
8. Used footnotes in the appeal to refer the reader to your exhibits?	<input type="checkbox"/>

## CONCLUSION

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We hope you have found this guide on how to file a successful Power Knee claim useful. For more information on how to properly document your claims and file successful appeals, please go to [Össur R&R](#) for a list of upcoming Össur reimbursement seminars or to access online versions of those courses.

# EXHIBIT A: EXEMPLAR LETTER OF MEDICAL NECESSITY

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When writing to a physician to obtain a prescription for Power Knee, you should include a detailed letter of medical necessity. This letter should explicitly describe not only the functional characteristics of Power Knee, but how those features will help your patient.

Dear Dr. Smith:

I am the prosthetist treating our mutual patient, Fred Williams. I examined Mr. Williams on August 29th, 2012. Based upon my findings, detailed below, Mr. Williams requires a new prosthetic knee. For ease of reference, I have broken this letter of medical necessity and request for prescription into the following sections:

1. Mr. Williams' Clinical History
2. Clinical Findings
3. Mr. Williams' Medical Needs
4. Requested Prescription

## **1. Mr. Williams' Clinical History**

Mr. Williams is a 46 year-old above-the-knee amputee. He lost his left leg above the knee 2 years ago when he was struck by a car while trying to assist a stranded motorist on the side of the road. Since that time, Mr. Williams has demonstrated a consistent desire and ability to utilize a prosthesis and be a fully functional, contributing member of society.

As a result of the accident, Mr. Williams suffered numerous injuries in addition to the amputation of his left leg. He broke both arms and his right clavicle as a result of the force of the impact. He still has steel rods in both arms and nerve damage in his shoulder that has limited both his range of motion and the strength of his right arm. He also suffered a displaced fracture of his right ankle. The damage was severe enough that doctors were forced to fuse his ankle. The resulting gait deviations from his ankle injury have caused him increased (and documented) lower spine pain that increases the more he walks in his current prostheses.

In particular, he experiences significant hyperlordosis (video available for review) with every step. The resulting pain and cumulative trauma deprives him of full range of motion in his hip, further exacerbating the asymmetry of his gait. He is currently trying to manage the situation by stretching and strengthening exercises. However, his physician has advised him that prescription painkillers will be necessary for him to function if the spinal pain continues to escalate.

Despite the severity of his injuries, Mr. Williams returned to work five months after his accident in the same role he held before it: information technologies specialist at an Orlando hospital. In that capacity, he shuttles between multiple buildings on the hospital campus, walking on average 1-2 miles per day for work. In addition, he is part of a team that performs information technology due diligence regarding potential acquisition opportunities that his hospital system is exploring. In that capacity, he travels, usually by plane, at least once per quarter, to offsite locations for meetings and walkthroughs of acquisition targets. On average, he estimates that he spends at least one-third of his workday on his feet.

Mr. Williams lives alone in a two-story home outside of Orlando. His bedroom is on the second floor and there are five steps leading up to the doorway of his house. He is solely responsible for maintaining the house and its quarter-acre property.

## **2. Clinical Findings**

Mr. Williams complains that he experiences regular pain in his fused ankle that increases in severity during the day. Though he has not yet started taking pain-killers to control the pain, his doctor has recommended that he do so. Mr. Williams has to date refused because of his concerns regarding the possible side-effects.

He reports that he falls on average 2-3 times per month, usually when he is tired. He notes that his falls occur not only when he is walking, but also when the knee buckles while standing still as a result of his inability to hold the knee in full extension due to fatigue.

Visual observation (video available for review) reveals that when walking, Mr. Williams has resorted to gross compensatory measures to stabilize himself. While these strategies minimize his fall risk, they also explain the pain he is experiencing in his sound ankle.

Specifically, Mr. Williams circumducts his prosthetic leg when walking to create extra ground clearance for the toe of his prosthetic foot. This means that he spends significantly more time on his sound leg than the prosthetic one. In addition, due to his fused sound-side ankle, he cannot walk aggressively over the toe of the prosthetic foot, which in turn ensures that the prosthetic knee rarely moves into flexion. While a straight knee helps prevent falls, it results in an asymmetrical gait pattern. The cumulative trauma to his sound limb, even though he has only been walking this way for two years, will result in potentially significant complications in the foreseeable future.

In addition, Mr. Williams complains that he experiences difficulty navigating inclines and declines that he regularly confronts both in the hospital and in airports (i.e., ramps) while traveling for business. He also notes that he has significant difficulty performing the weekly yard work required by his local homeowners association due to the problems he has walking on the uneven, grassy terrain of his back yard.

Finally, Mr. Williams states that he is experiencing regular and pervasive pain in his arms and right shoulder. At our office's request, we asked him to count how many times a day he moves from sit to stand while at work. Over the course of a week, Mr. Williams averages between 40 and 50 chair exits per day. Visual observation (video available for review) reveals that Mr. Williams relies heavily on his arms to push himself out of his chair, as he puts virtually no load into his prosthetic leg when transitioning from sit to stand. Indeed, Mr. Williams cannot load his prosthetic leg during this transition because his passive prosthetic knee has no ability to lift him upwards.

### **3. Medical Needs**

Mr. Williams has multiple complaints arising out of the inadequacy of his current passive prosthetic knee: regular falls; instability that can only be addressed by gross compensatory measures; difficulty navigating uneven terrain both at work and at home; and significant upper body pain resulting from the overuse of his arms and shoulders when exiting chairs. None of these symptoms can be addressed by keeping him another passive prosthetic knee like the device he uses today. In order for him to function safely both at work and at home, he requires a motor-powered prosthetic knee: Össur's Power Knee.

Powered knee joints are the latest version of microprocessor-controlled knee technology available for above-knee amputees. Passive microprocessor-controlled knees have been around since the mid-1990's. In 1999, the FDA ruled that a microprocessor-controlled knee was substantially similar to technology available in the mid-1970's and was therefore exempt from the FDA's 510k application process. More than a decade ago, Medicare created a new code describing microprocessor-controlled knees. According to its own guidelines, Medicare does not pay for experimental or investigational devices, so the creation of the code describing Power Knee implicitly shows its non-experimental/non-investigational nature.

Powered prosthetic knees function in a fundamentally different way from the passive knee that Mr. Williams currently uses. To operate his passive prosthetic knee, Mr. Johnson has to first aggressively push from heel to toe of the prosthetic foot in order to create the momentum and force necessary to initiate knee bend and heel lift. Second, as the passive knee flexes and the foot lifts off the ground, he must "kick" the knee forward to generate the force necessary to swing the knee underneath him and into extension. Forcing the knee into full extension – i.e., completely straight – before the third and

final phase of the gait cycle – heel strike – is critical, because many passive devices collapse immediately if the knee is at all bent during the heel strike phase.

In contrast, the Power Knee controls each element of the gait cycle. This results in 6 distinct clinical benefits for Mr. Williams.

First, the motor lifts the prosthetic heel off the ground for the patient and initiates knee bend. As noted in Section 2 above, Mr. Williams walks with a circumducted gait in which the prosthetic knee barely bends at all, as he cannot generate the force to drive the knee into flexion. Because the Power Knee has a motor, the powered knee joint – not Mr. Williams – will initiate knee flexion when he walks with the goal of reducing pressure on his sound limb. Given the serial overuse of his already-compromised sound limb, this is critically important for Mr. Williams' long-term health.

Second, the Power Knee's motor actively powers and controls the transition from a bent knee to an extended knee as the foot swings underneath the patient. Importantly, the motor also maximizes the prosthetic foot's ground clearance during this phase, helping prevent the toe from catching on the ground. Given Mr. Williams' propensity to circumduct and vault on his sound leg in an effort to gain ground clearance that his passive knee joint cannot provide, these benefits provided by Power Knee's motor can assist with problematic compensatory mechanisms and potentially reduce issues to his already compromised sound limb. This is especially true when Mr. Williams walks up ramps for work, where his risk of catching the toe of his prosthetic foot on the ground rises due to the limitations of his passive knee joint.

Third, at heel strike, Power Knee's motor supports the patient's full body weight, permitting him to land with a slightly bent knee while still supporting the patient. Given the fact that Mr. Williams falls between 24 and 36 times a year with his passive knee, providing him an alternative capable of bearing his full body weight is especially useful when he descends ramps, as the motorized support provided by Power Knee prevents knee collapse.

Fourth, powered knee extension offers another benefit during walking that passive devices cannot. Patients walking on grass, gravel, or sand using a passive knee must grossly exaggerate the kicking motion described earlier in this section to try and create enough momentum to get the knee to swing through the obstacle. Amputees who fail to do this with enough power will be unable to get the joint into full extension and will land on a bent knee, destabilizing them and significantly increasing their fall risk.

In contrast, Power Knee's motor pushes the knee from a bent to an extended position. It can therefore power through obstacles like grass, gravel or sand. Given the fact that Mr. Williams is required to maintain his yard by his homeowners association, he requires the ability to ambulate over uneven terrain and overcome environmental barriers.

Fifth, the differences while using a motorized prosthetic knee are not limited to the three main stages of walking. As noted above, Mr. Williams sometimes falls when his passive knee suddenly collapses when he's standing still. But Power Knee's motor permits the user to stand with a bent knee while fully supporting the patient's weight.

Finally, Power Knee's motor helps lift above-knee amputees out of a chair to a standing position. This ability to actively lift the patient upwards is unique to a powered prosthetic knee. Given the fact that Mr. Williams stands up out of a chair, on average, 40-50 times per day, providing him the ability to more fully load his prosthetic foot when standing will relieve pressure on his sound limb. The powered extension will provide Mr. Williams with sit to stand assistance replacing the need for upper extremity involvement.

#### 4. Requested Prescription

The facts and findings listed in sections 1-3 demonstrate why Ms. Jones requires the Power Knee. I am therefore requesting

1. That you perform a detailed physical examination of Mr. Williams, confirm that the history and findings in sections 1-2 are accurate, and document that in your medical records; and
2. The following prescription from you:
  - L5856: ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICRO-PROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE
  - L5828: ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STANCE
  - L5845: ADDITION, ENDOSKELETAL, KNEE-SHIN SYSTEM, STANCE FLEXION FEATURE, ADJUSTABLE
  - L5848: ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM, FLUID STANCE EXTENSION, DAMPENING
  - L5859: ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, POWERED AND PROGRAMMABLE FLEXION/EXTENSION ASSIST CONTROL, INCLUDES ANY TYPE MOTOR(S) (POWER KNEE)

Very truly yours,

# EXEMPLAR STANDARD WRITTEN ORDER

Under established Medicare policy, “[s]omeone other than the physician [i.e., the prosthetist] may complete the SWO. However, the treating physician must review the SWO and personally sign and date the order to indicate agreement.”

Standard Written Order: Power Knee	
DATE: ____ / ____ / ____	O&P Inc. 123 Green Street Somewhere, USA 12345 (123) 456-7890  Federal Tax #: _____  NPI: _____
Patient Name: _____	
Medicare #: _____	
Address: _____	
Code: _____	
Phone #: _____	
DOB: _____	
Email: _____	

Patient Height: _____	Place of Service: _____
Patient Weight: _____	Diagnosis (ICD-9): _____

HCPCS Code:	Narrative Equipment Description
<b>L5856</b>	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE
<b>L5828</b>	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STANCE PHASE CONTROL
<b>L5845</b>	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, STANCE FLEXION FEATURE, ADJUSTABLE
<b>L5848</b>	ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM, FLUID STANCE EXTENSION, DAMPENING FEATURE, WITH OR WITHOUT ADJUSTABILITY
<b>L5859</b>	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, POWERED AND PROGRAMMABLE FLEXION/EXTENSION ASSIST CONTROL, INCLUDES ANY TYPE MOTOR(S)

Check here if additional items are listed on attached pages

Physician Attestation

Physician's Name, Address & Telephone

UPIN #: \_\_\_\_\_

NPI: \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

I certify that I am the physician identified above. I have received this standard written order, including a full narrative description with HCPCS code and pricing. I certify that the diagnosis information shown above is to the best of my knowledge true and accurate and justifies the medical necessity of the item(s) shown.

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

You must have the signed SWO in your file before delivering POWER KNEE to your patient.

# EXHIBIT B: EXEMPLAR COVER LETTER

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The Medicare Program Integrity Manual, the MAC “Dear Physician” letters from September, 2011, and the LCD for Lower Limb Prosthetics outline documentation details that are required in both the prosthetist’s and physician’s records. It is important that you explain to the physician the need for his/her records to corroborate the patient’s medical history, functional level and desire to ambulate.

Dear [doctor name]:

I am the prosthetist who treats [patient name], a Medicare beneficiary. Medicare has recently set forth specific requirements regarding physician documentation for prosthetic devices. Without that documentation, I cannot deliver medically necessary care and treatment to our mutual patient, [patient name]. The purpose of this letter is to give you a quick summary of Medicare’s latest requirements so that we can together work for the benefit of [patient name].

Generally speaking, Medicare wants to see that your medical records corroborate my findings/recommendations. Your records can be in the form of previous chart notes and/or a full, current patient physical evaluation. At a minimum, Medicare requires that the physician notes contain the following information:

1. Documentation supporting

- a. [patient name]’s functional abilities, including your specific findings regarding whether [patient name] has the potential to ambulate with variable cadence and has a lifestyle that demands more than simple locomotion;
- b. [patient name]’s past history, including prior prosthetic use and other assistive device use (if applicable);
- c. [patient name]’s current condition, including the status of [his/her] residual limb;
- d. the nature of any other medical problems [patient name] has; and
- e. [patient name]’s desire to ambulate.

2. Your signature and the date of that signature on the attached Standard written order.

If you deem it appropriate or necessary, [patient name] can be referred to a PM&R specialist and/or a physical therapist for a full evaluation and report. Once a report from either of those specialists is sent to you, reviewed, acknowledged by you in the form of your signature on the report, and placed in the medical records, it constitutes appropriate documentation based upon Medicare’s guidance.

If I can answer any questions you may have about Medicare’s documentation requirements for prosthetic care, please do not hesitate to contact me directly. Otherwise, thank you in advance for providing the Medicare-required documentation that will permit me to deliver [patient name] the medically necessary prosthetic care and treatment [he/she] requires in a timely fashion.

Very truly yours,