Fax to:		**Fax from:**	
Company:		**Company:**	
Phone:	**Fax:**	**Phone:**	**Fax:**
Patient Name:		**Date of Birth:**	**No. Pages:**

FAX: Documentation Request for a Lower Limb Prosthesis

Please be advised the determination of medical necessity for a prosthesis is generally based solely on information in the physician's records. Therefore we need the following information from your medical records in order to be in compliance and provide a prosthesis to your patient that allows him/her to live a mobile and independent life to the greatest extent possible.

- **History of Amputation** Etiology of amputation(s); Date of amputation(s); Side of amputation(s); Clinical course; Therapeutic interventions and results; and Prognosis.

Functional Capabilities for Lower Extremity [K-Levels] - Summary

Level K-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. (i.e. Patient will likely not be able to walk with a prosthesis at all.)

Level K-1: Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence. (i.e. Patient will likely be able to use the prosthesis within his/her dwelling only.)

Level K-2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. (i.e. Within his/her dwelling and a limited radius in the community.)

Level K-3: Has the ability or potential for ambulation with variable cadence. Typical of someone who can traverse obstacles, stairs, uneven terrain. (i.e. prosthetic mobility that is comparable with that of a non-amputated person with no mobility restrictions.)

Level K-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.

- **Document Medical Necessity** All must be documented
  1. Describe patient's activities prior to amputation in terms of functional capabilities above. What activities does patient want to get back to?
  2. Physical Examination:
     a. Weight, Height, Weight Loss/Gain.
     b. Document condition of residual limb**:** Local and/or phantom pain; Wound healing issues, skin irritation, breakdown, infection; Limb volume changes; swelling, weight fluctuation, muscle atrophy, contractures, osteoarthritis or other arthritic conditions of the residual limb joints.
     c. Describe any medical conditions that could potentially interfere with maintaining the selected functional level (e.g., decreased pulmonary reserve, disabling cardiovascular, neuromuscular, peripheral vascular or musculoskeletal conditions). Does the functional K level need to change as a result?
  3. Describe patient's current activities and future potential activities (if different) in terms of the functional capabilities listed above. For future potential, an explanation for the difference (e.g. deconditioned state is reversible by physical training/therapy) is required.
  4. Describe patient's desire and motivation to ambulate with the new prosthesis
  5. Treatment plan that includes new prosthetic components appropriate for the selected functional capability
- **Prognosis** that includes statement that [in your opinion] patient will reach a defined functional state (K-Level) within a reasonable [specified] amount of time using the new prosthesis.
- **Document any use of Assistive Device(s)** Note: Payers may not consider a person who permanently uses ambulatory assistance to be a community ambulator (K3). If this is a temporary situation, your treatment plan should include a plan for being free of the assistive device in a specified amount of time.
- **Document the condition/status of current prosthesis** If worn/broken, describe the condition of each component that needs to be evaluated. If patient's physical condition or functional needs have changed, describe why prosthesis/component no longer meets his/her needs.
- **Describe Past Experience with Prostheses/Components** Describe what has been tried in the past and the results.

Please FAX the signed and dated Medical Necessity documents to:

_____ at (_____)_____