Limb-Salvage Breakthrough
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Many of our country’s wounded warriors come to put their lives back together. Some of those amputees were returned to active duty...quite a story!

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Osho's words: "When you are accepted as a cripple, you are no longer a cripple."

running blades would give him an unfair advantage over mere human competitors. Cleared at last to compete in 2012, Pistorius was himself found to be merely human, as his best efforts produced also-ran finishes in the finals of the 400 meters and 4x400 relay, and in fact he later was defeated by another “blade runner” in the subsequent Paralympic Games. But those results don’t really matter.

What does matter is that this remarkable athlete who asked only the opportunity to compete on a level playing field (make that running track) through determination and perseverance broke down the barrier separating physically challenged individuals from thoughts impossible just a few years ago, growing government medical insurance “red tape” is denying the prosthetists who delivered that care. We also review the inspir-

Pistorius Pierces Olympic Barrier For Physically Challenged Athletes

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Push-off Power for Amputees

Perhaps the most significant barrier to full mobility for lower-limb amputees is fatigue resulting from the considerable effort and energy-expenditure of powering a prosthetic limb through the gait cycle. Even with a dynamic-response prosthetic foot, amputees use substantially more effort to position their leg and propel themselves forward than their non-amputee counterparts.

The iWalk BiOM is the world’s first prosthetic to provide powered plantar flexion as well as real-time terrain adaptation. In so doing, the system delivers a near-normalized symmetrical gait for amputees at roughly the same metabolic demand of non-amputees...an important breakthrough.

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This newsletter reports on two exciting new developments in O&P componentry, as well as the “elbow sitting in the living room,” the recently implemented Medicare requirement that physicians bear the burden of documenting medical necessity for their patients’ lower-extremity prosthetic care...a role long handled by the prosthetists who delivered that care. We also review the inspir-

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70 Years and Going Strong!

C.R. Newton Company Ltd. wishes to thank the people and medical community of Hawaii for allowing us to serve you for the past 70 years. Today, just as with our founding in 1942, we are fully committed to pro-

viding you with “Quality of Life for Life.”

We are proud of C.R. Newton prosthetist Dan Tatum, who recently volunteered with Aloha Medical Mission, serving indi-

gent patients in the Philippines. While there, Dan fitted a patient with the LN-4 hand, a low-

cost, light, and durable transradial prosthetic, which is finding widespread application in Third World countries.

For more information about C.R. Newton, I invite you to visit our website at www.crnewton.com.

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n August 2011 pronouncement by the Center for Medicare and Medicaid Services (CMS) has upset the long-accepted methodology for determining and providing reimbursement for prosthetic care rendered to amputees. Departing from the practice of accepting the clinical judgment of prosthetists for assessment of functional levels of care required after an initial determination of need by the referring physician, CMS now mandates all essential documentation for Medicare coverage and payment, including justification of medical necessity and a detailed prosthetic prescription, appear in the physician’s patient record. If that documentation is missing or deemed incomplete, the reimbursement for the prosthetic limb already delivered and related patient services already rendered is summarily denied. The result has been turmoil, an avalanche of denied claims for prosthetic services with resulting financial hardship for many O&P practices and significantly reduced access to care by the patients who need it.

Functional Levels

Center for Medicare and Medicaid Services reimbursement criteria now require physician clinical assessment of patients rehabilitation potential based on the following classification levels (commonly referred to as K levels):

- **Functional level 0:** The patient does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance his/her quality of life or mobility.

- **Functional level 1:** The patient has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.

- **Functional level 2:** The patient 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.

- **Functional level 3:** The patient 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 use in a variable gait or simple locomotion.

- **Functional level 4:** The patient 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, adult, or athlete.

The irony of this situation is that physicians now bear the responsibility of documentation for prosthetic limbs but in most cases do not have the time, resources or training to perform a thorough prosthetic assessment. Meanwhile, the O&P providers on whom the physician’s early prosthetic intervention is relied to evaluate, design, deliver, and document their patients’ prosthetic needs are now wholly dependent on the perceived acceptability of the notations in the physician’s medical record to be compensated for their work.

As recently as this summer, reports to the American Orthotic and Prosthetic Association indicated 90 percent or more of initial lower-limb prosthetic claims submitted to CMS were denied. As a result, many O&P providers have become cautious about providing care without first obtaining reasonable assurance that the referring physician is aware of the new requirements and agreeable to adhering to the new documentation standard.

The new requirement has become so onerous, in fact, that some suppliers will not deliver prosthetic services until they receive copies of the physician’s documentation they believe will be acceptable to the Durable Medical Equipment Medicare Administrative Contractor in their area. Predictably, this hesitation has led to significant delays in delivery of service for many Medicare patients, notably new amputees, for whom timely intervention is often a key component of a successful rehabilitation outcome. In some cases, the dilemma has resulted in new amputees being denied the use of a prosthetic limb for many months after their surgery. It is the position of our practice that we will do everything possible to continue to deliver the most appropriate prosthetic component to our Medicare patients in a timely and efficient manner.

However, we need the cooperation of our referring physicians and patients to meet that goal.

Efforts spearheaded by national O&P organizations have been underway for many months to rectify this situation, but short-term relief is far from assured. Meanwhile, we are dedicated to work closely with our referring doctors and their staff personnel to obtain the best possible outcome for their (and our) patients. CMS prosthetic limb documentation guidelines, spelled out in an August 2011 letter to physicians, require that “The prosthetist’s records must be corroborated with information your patient’s medical record.” We will be happy to make full the text of the CMS letter available to any physician practice or patient by request.

As before the CMS change in policy, we are fully prepared to evaluate any patient’s functional capability and recommend a prosthetic course of treatment to any of our referring physicians. This information may be inserted into the physician’s patient record but should be date-stamped and corroborated by a separate physician entry restating the patient’s functional capabilities and the physician’s concurrence or disagreement with the prosthetic surgeon’s recommendation.

The physician’s documentation must include a statement of the patient’s functional capabilities based on the “K-level” classification system (see box at lower left)—pre-surgery, current, and, anticipated with prosthetic support, including an explanation for differences.

It is important that the physician record not underestimate the patient’s potential function with a properly designed prosthetic limb. For example, a patient capable of walking with a variable gait should be classified at the K-3 or K-4 level to ensure he or she receives limb components capable of providing that variable gait. Moreover, if a complicated surgery performed may affect the patient’s pre-amputation level of function, then that is the best indicator of potential function with a prosthetic system. In many instances, inclusion of physical therapy notes in the physician’s record may be helpful in supporting the medical necessity of a prosthetic limb fitting.

We encourage therapists to include in their notes specific assessment of the patient’s ambulatory capacity using the K-level classifications. We also urge to establish ongoing dialogue between physicians and their amputee patients regarding their ambulatory function and any problems they may be having with their prosthetic devices. We look forward to continue working with physicians and patients alike to achieve the best possible prosthetic results for both new and “experienced” amputees.

What Constitutes Acceptable Physician Documentation?

The following excerpt from the August 2011 CMS letter to physicians regarding Documentation of Artificial Limbs provides guidelines for establishing medical necessity for a limb prostheses. The physician’s assessment of a patient’s physical and cognitive capabilities typically includes:

- **Medical history:** Past and current 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**
- **Foot and leg strength and range of motion**
- **Neurological examination**
  - **Gait**
  - **Balance and coordination**

The assessment points above are not all-inclusive, and physicians should tailor their history and examination to the individual patient’s condition, clearly describing the pre- and post-amputation capabilities of the patient.

- **Examination:** Must include a detailed functional and gait examination with the patient walking with and without a prosthesis as well as use of any orthotic devices. Physicians should take a picture of your patient’s functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the patient’s ambulatory or upper-extremity difficulties or impact on the patient’s functional ability.

Note that when physicians are unable to provide the requested documentation to the supplier, they request denial of the items billed, which could result in your patient being financially responsible for all or part of the charges for the items/service received. If a supplier contacts your office to request additional clinical documentation, please partner with the supplier to establish what clinical records are needed to support the service you ordered and medically necessary.
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What’s Coming

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