K2-K3 Transition;

How to work with your doctors to get the documentation you need

Molly McCoy, L/CPO

- "The benefits of [pre-authorization] include a changed billing practice that also
  - **Enhances the coordination of care for the beneficiary**
  - **For example, requiring prior authorization for certain items requires that the primary care provider and the supplier collaborate more frequently in order to deliver the most appropriate DMEPOS…**
  - **Improper payments made**
    - because the practitioner [MD] did not order the DMEPOS
    - Or did not evaluate the patient,
    - Would likely be reduced by the requirement that a supplier submit clinical documentation created by the [MD] as part of it's prior authorization request"

Federal Register/Vol.80, No.250/12.30.15/Rules & Regulations pg. 81704

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- "The status quo is not a desirable alternative to [Pre-authorization] because current payment practices have not affected unnecessary utilization appreciably"
- "Evidence of this is found in the CERT Improper payment rates…which…have remained high for the last several years (53.1% in 2014)."
- "By…creating a master list of DMEPOS items known to be the subject of GAO/OIG reports and/or high improper payment rates, we hope to positively affect unnecessary utiliztion and improper payments for DMEPOS in general."

Federal Register/Vol.80, No.250/12.30.15/Rules & Regulations pg. 81704

Translation:

- Pre-payment audit & post-payment audit have not decreased errors or unnecessary payments enough
- Pre-auth gives suppliers more time to get the necessary documentation
  - **Thus, it could delay payment**

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What do doctors need to write?

- K-Level
  - **The ordering physician's medical documentation must support the medical necessity, within the context of his/her overall medical condition**
- Medical need
  - **Medical condition(s) that necessitate the use of the specifically ordered lower limb prosthesis**
  - **Medical conditions that would impact ability to effectively utilize the specifically ordered lower limb prosthesis in achieving a defined functional state**
- Need for replacement

CMS LLP Electronic Clinical Template Draft
V4 July 2013

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K1 - Lower extremity prosthesis functional Level 1 - 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 need for a prosthesis over a wheelchair or power mobility device

Overall health benefits from use of a prosthesis (ex. weight loss, exercise, independent living)

Problems with current prosthesis

History of conditions relevant to functional deficits that prevent the patient from walking in the community

Symptoms & Diagnoses limiting ambulation and how use of a prosthesis will help (vs. a wheelchair or power mobility device)

Co-morbidities impacting function or requiring the use of a prosthesis over other mobility devices

Description of ADLs that require a prosthesis

Documentation of recent weight loss/gain

Does the patient have cardiopulmonary capacity and musculoskeletal capability to use a prosthesis? If not, is there a plan to improve with use of a prosthesis? What tests or measures were used to assess this?

Balance & coordination is at a level that allows use of a prosthesis? What tests or measures were used to assess this?

Functional need for a prosthesis over a power mobility device?

Does the patient have cardiopulmonary capacity and musculoskeletal capability to use a prosthesis? If not, is there a plan to improve with use of a prosthesis?

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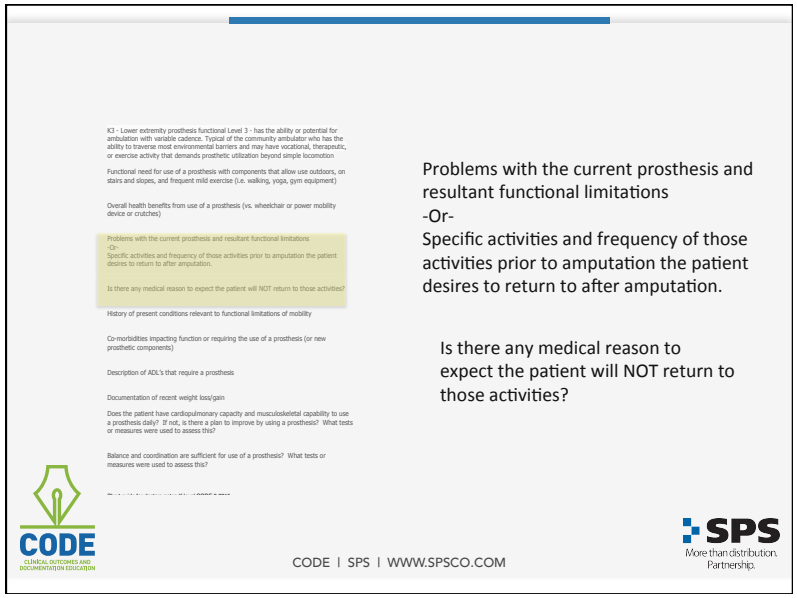
K3 - Lower extremity prosthesis functional Level 3 - has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion
Functional need for use of a prosthesis with components that allow use outdoors, on stairs and slopes, and frequent mild exercise (i.e. walking, yoga, gym equipment)
Overall health benefits from use of a prosthesis (vs. wheelchair or power mobility device or crutches)
Problems with the current prosthesis and resultant functional limitations
-Or-
Specific activities and frequency of those activities prior to amputation the patient desires to return to after amputation.
Is there any medical reason to expect the patient will NOT return to those activities?
History of present conditions relevant to functional limitations of mobility
Co-morbidities impacting function or requiring the use of a prosthesis (or new prosthetic components)
Description of ADL's that require a prosthesis
Documentation of recent weight loss/gain
Does the patient have cardiopulmonary capacity and musculoskeletal capability to use a prosthesis daily? If not, is there a plan to improve by using a prosthesis? What tests or measures were used to assess this?
Balance and coordination are sufficient for use of a prosthesis? What tests or measures were used to assess this?
Problems with the current prosthesis and resultant functional limitations
-Or-
Specific activities and frequency of those activities prior to amputation the patient desires to return to after amputation.
Is there any medical reason to expect the patient will NOT return to those activities?
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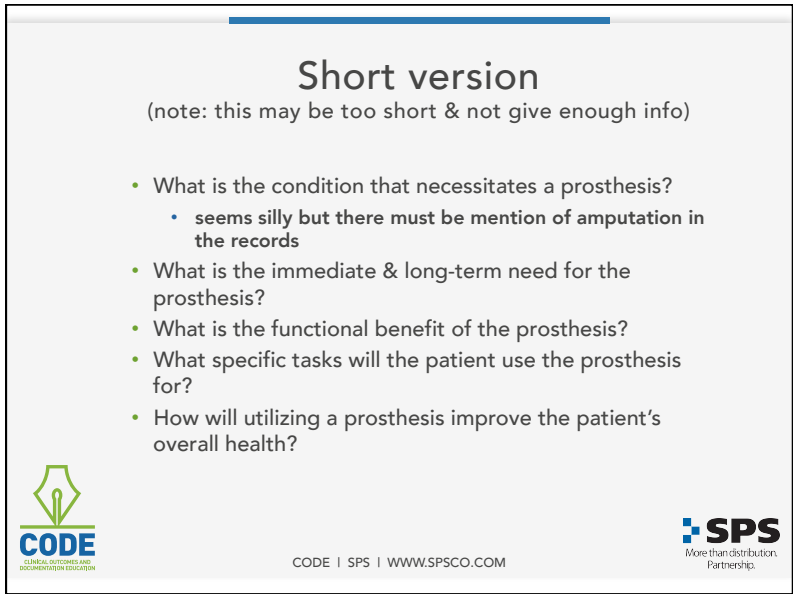
Short version
(note: this may be too short & not give enough info)
What is the condition that necessitates a prosthesis?
seems silly but there must be mention of amputation in the records
What is the immediate & long-term need for the prosthesis?
What is the functional benefit of the prosthesis?
What specific tasks will the patient use the prosthesis for?
How will utilizing a prosthesis improve the patient's overall health?
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Doctors notes on replacement

- Physiological change
  - **Weight change**
  - **Residual limb change**
  - **Functional need change**
- Irreparable change or damage to the device
- Repairs would cost too much

- Prosthetists notes must document
  - **Prosthesis or component being replaced**
  - **Reason for replacement**
  - **Description of labor**

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Example Case

- 68 year old, male, BMI=24
- Medicare & Medicaid
- L Transfemoral 2013, PVD
- R Transtibial 2015, PVD
- Current Rx
  - **L, T.F., socket replacement, liner, vacuum**
  - **R, T.T., prosthesis, custom liner, suction suspension**
  - **K1 now, with R prosthesis expected to be K2**

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Example Case Timeline

- 1/17/16: Primary Care Doctor
- 1/27/16: Prosthetist
- 2/11/16 – 2/25/16: Home Health P.T.
- 2/16/16: Surgeon
- 2/18/16: Prosthetist
- 3/4/16: Prosthetist
- 3/30/16: PM&R Doctor
- 3/30/16: Prosthetist

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Details

- 2013 & 2014
  - **Foot wound L**
  - **History of alcohol abuse, low back pain, smoking**
- 2014 & 2015
  - **Use of T.F. prosthesis with cane**
  - **Continued smoking**
  - **Sore on R foot**
  - **Amputation R T.T.**
  - **Fall=incision opening, infection, revision, slow healing**
- 2016
  - **Healed R T.T.**
  - **Power wheelchair**

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K1-K2 Transition Vs. K2-K3 Transition

- Utilize the information from other healthcare providers
- Understand the whole medical picture
- Explain where prosthetics or orthotics fit in
- Build the case, in laymen's terms (wherever possible)

Questions? Ideas for future webinars? Complaints?

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