WHAT CAN CODE DO FOR YOU?

CLINICAL OUTCOMES AND DOCUMENTATION EDUCATION

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**CODE** can help you write notes that incorporate your evaluation findings, the doctor’s data, and the therapist’s measures into a detailed description of the patient’s needs, condition, and prognosis. This supports the prosthetic/orthotic claim by providing a patient specific explanation of how the prosthesis or orthosis will improve overall health and wellbeing, while showing corroboration with doctor and therapist.

![Figure 1.](image_url)

**Patient Specific Justification**

- History of knee pain
- Vertical shock foot absorbs force
- Prevents functional activity
- Decreases knee pain
- Patient returns to functional activity

**Corroboration**

- Doctor charts a need for increased exercise
- History of knee pain with meniscus repair
- Need to decrease high BMI
- Technological feature decreases knee pain
- Increases ability to exercise without knee pain
- Prosthesis allows exercise and helps decrease BMI

**P&O Notes**

**ORGANIZE INFORMATION**

**CODE** documentation packets are your notes re-written and organized to give insurance reviewers a clear road map to find information that supports the claim and is linked to policy.

**CODE** documentation packets also give clear guidance on what additional information is needed, from whom, and why.

**CODE** uses your own cases to help you learn a new way of documenting for success.

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PATIENT PROGRESS NOTE

04/08/14

Patient did see Dr. in regards to receiving a left AK prosthesis with a microprocessor knee unit. Dr. was in agreement. We have already performed two left AK test socket fittings. The second test socket fitting was within parameters. We will order all the appropriate components and fabricate the prosthesis. Patient is to return in one and 1/2 weeks for fitting and delivery. This new prosthesis will accommodate for volume changes in his left AK residual limb and will also incorporate the microprocessor knee unit which will allow the patient to ambulate more safely and comfortably on uneven surfaces. Patient has taken several bad falls and he is very scared of this prosthesis at this time. Some of the falls may be secondary to the largeness of the prosthesis, but the majority is the knee unlocking and that he is walking outside. This new microprocessor knee unit would give him substantially more freedom and allow him to get back to his activities outside.

PROGRESS NOTE

PATIENT: 

DATE: 03/18/14

Since we saw patient last he continues to ambulate significantly. He is a high K3 ambulator. He walks several hours a day just for exercise in itself. He states with his walking, he is wearing 8-10 ply socks. The more he walks, the more he has to wear. He has had several falls secondary to the knee itself giving out! He states he has seen several friends with microprocessor knee units and he was wondering if something like that would be beneficial for him. He is walking extremely well with his rolling walker in the community. His residual limb has continued to do well.

ASSESSMENT:

1. Left above knee amputation with atrophy to his residual limb.

PLAN:

1. Patient continues to make significant progress with his prosthesis. He feels he would like to do more. He feels a new microprocessor knee would get him to the level he would like to be at. He also had significant atrophy, so we need to get him a new socket but would also like to get him a microprocessor knee because we do feel this will help him improve his quality of life and increase his functional status even more than it is at this point in time.

D.O.

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PATIENT: [Redacted]

THERAPIST: [Redacted]

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SUBJECTIVE:

PATIENT COMMENTS:

Patient reports having his left lower extremity amputated above his knee on 14 June 2013. The cause was peripheral vascular disease and collapse of his femoral artery. He then became septic. **Patient reports he has lost 30 pounds since his surgery.** He relates this to antibiotics causing GI problems. The patient was discharged from Greenwood Rehabilitation Hospital this past Friday. Patient reports he has a list of exercises to perform but his wife states his compliance has been questionable. He does report he is sleeping well and can transfer by himself.

PAST MEDICAL HISTORY: **History of poor circulation and high blood pressure.**

PRIOR LEVEL OF FUNCTION: **Patient reports he was able to play 9 holes of golf about 6 months ago but had trouble with going up and down stairs and did not walk very long distances.**

PAIN RATING: Patient reports that he has about 5/10 pain at rest. At best is 3/10.

PAIN DESCRIPTION: No reports the majority of his pain is phantom pain in his left knee that is on and off.

PREVIOUS TREATMENT FOR THIS CONDITION: Patient reports prior to his amputation he had been treated for 9 months at the Wound Clinic.

OBJECTIVE AND PHYSICAL FINDINGS:

GAIT: COMMENTS (assistive device): Using rolling walker and ambulating, the patient’s right lower extremity step length differs, demonstrating some lack of coordination.

POSTURE/GENERAL APPEARANCE: Patient arrives in wheelchair which he is able to self propel. He does appear frail but has a cooperative, friendly manner. These are several contradictions in points of fact about his history and present activities between his report and his wife’s though she reports his thought processing and memory are within normal limits.

STRENGTH/MUSCLE TONE: Left hip flexion 4+/5, abduction 4/5, extension 4-/5. Strength in his right lower extremity is 4 to 4+ throughout.

RCM:

**A** Justification for new socket due to volume change
**B** Will poor circulation & HBP limit amputation?
**C** Corroboration of prior capability

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PATIENT:  
THERAPIST:  

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CONTRAINDICATIONS/PRECAUTIONS:  A Because of this patient’s COPD and his debilitated state, his oxygen saturation needs to be watched carefully.

ASSESSMENT:

This is a 77 year old male about 4 weeks status post left above knee amputation with deficits in strength, range of motion and pain related to his amputation. A His ambulation is also significantly impacted by his deconditioned state and by his chronic obstructive pulmonary disease in addition to the amputation. This patient’s current G-code status is G8978 for walking and movement problems with an impairment rating of CK based on patient’s manual muscle tests, range of motion and his present ambulatory status. The patient’s functional G-code goal is G8979 for walking and movement problems with an impairment rating of CJ based on prior level of function and co-morbidities that are present and motivation to prior levels of activity. Physical therapy can benefit this patient by addressing his deconditioned state and his COPD with endurance and lower extremity strengthening exercises, his weakness and range of motion. His residual limb and gait deficits will be addressed with a stump care, prosthetic training, therapeutic exercise and gait training. C This patient’s prognosis for obtaining the stated goals is good.

SHORT TERM GOALS:

Time limit: 3 weeks

1. The patient will perform with assistance of his wife a home exercise program of range of motion exercises and conditioning and lower extremity strengthening exercises to improve his activities of daily living skills.

2. Patient will demonstrate 4+/5 hip extension and abduction to prepare for prosthetic ambulation.

3. Patient will ambulate 50 feet with rolling walker and RLE with standby assist in order to progress towards more independent functional mobility.

4. Patient and his wife will perform stump care to successfully improve his stump shape, ROM and strength in order to prepare for ambulating with a prosthesis.

LONG TERM GOALS:

A How could he be a K3 level ambulator with COPD and debilitation?

B What is a “C Impairment Rating” & how does it relate to the prosthetic plan of care?

C Even with all these co-morbidities, the prognosis is good
Let **CODE** connect the dots and decode the data for you! **CODE** documentation packets lay it all out clearly. Below is an excerpt from a **CODE** documentation packet with the information from the doctor’s notes in green, the therapist’s notes in pink, and the prosthetist’s notes in yellow. Bold headers are requirements from the LCD.

**Example Justification for K3 based on LCD requirements, incorporating Prosthetist, Doctor, and Therapist notes:**

Dr. ___’s medical record on Mr. ___ shows there are no co-morbidities which would limit ambulation. Verify this by getting Dr. ___ past notes, if possible, and check to make sure he doesn’t document anything like high blood pressure, depression, COPD, or other medical issues that could be a barrier to ambulation at a K3 level. If the notes do show co-morbidities, you’ll want to address those and tell why they WON’T limit ambulation (ex. “Dr. ___ describes Mr. ___ as having recurring depression however, this will not limit ambulation because it is being medically managed with medication: Zoloft, see Dr. ___’s note dated xx/xx/xx under ‘current medications’ and ‘prognosis’ with good results.”)

The therapist’s notes state the patient has a history of high blood pressure, COPD, and 9 months of wound care prior to amputation. You’ll want to counter that by saying what treatment he is under for the high blood pressure and COPD (ex: “Per patient, he is taking medication for HBP and COPD. Dr. _____ states that Mr. ___ is able to walk for exercise and increase his activity (see note dated 3/18/14”). I’m just guessing on the medication for HBP and COPD, you’ll need to verify that, obviously.

As for the wound care debilitation, that could be addressed by the fact that when the therapist started with Mr. ___ he was at a **CK level (40%-59% mobility impaired)** and the goal was set at **CJ (20% - 39% mobility impaired)** because of his debilitation from trying to heal a wound, his HBP, and COPD. By ½ way through therapy, Mr. ___ was doing so well the therapist changed the goal from **CJ to CI (1%-19% mobility impaired)**!

So you might note that like so: “Patient’s therapist initially set his mobility goal to CJ (20%-39% mobility impaired) on July 11, 2013 due to HBP, COPD and debilitation due to 9 months of wound care however, by August 5, 2013 the therapist amended the goal to CI (1%-19% mobility impaired) because of Mr. ___’s progress in therapy. Despite his deconditioning prior to amputation, Mr. ___ has demonstrated the ability to physically improve and continues to increase his functional capabilities. By November 12, 2013 Mr. ___ was mobile outdoors, had begun painting his house, and was improving his ability to ascend and descend stairs (see therapist notes dated 11/12/13).
“Beneficiary’s Desire to Ambulate:”

Mr. ____ has demonstrated his motivation to ambulate by returning to many of his pre-amputation activities such as daily walking for exercise (as stated in Dr. _____’s progress note, attached, dated 3/18/14), attempting to do yard work, returning to living in his home, in which, he uses the stairs daily. Mr.____ also expressed his desire to increase his activity level to Dr. ______ (see progress note dated 3/18/14 under “plan”). Mr. ____ expressed to his physical therapist the motivation to return to golf (P.T. note dated 7-11-13), ascend and descend stairs to get to his home office (P.T. note dated 10-15-13), and complete home maintenance (P.T. note dated 11-12-13).

“Beneficiary’s past history including prior prosthetic use”:

Prior to his amputation Mr. ____ was an active member of his community. He was able to complete yard work, do home maintenance, go golfing, and be an active community participant. Mr. ____ has demonstrated ambulation at the K2 level with his current prosthesis however, the mechanical knee unit is limiting his functional abilities due to instability. Mr. ____ has some noted balance impairments (P.T. notes dated July 2013 through November 2013). These impairments are potentially exacerbated by the mechanical knee, which requires Mr. ____ to extend his prosthetic limb before sitting and requires extra muscular coordination to maintain standing. Mr. ____’s balance would improve with a microprocessor knee which, is able to read terrain and knee angles and respond accordingly, freeing Mr. ____ to focus on tasks instead of maintaining his physical position in space. It is expected that Mr. ____ will return to his pre-amputation and pre-wound care treatment level of functioning with a properly fit and functioning prosthesis that includes a microprocessor knee unit with stance extension dampening as shown in the attached “Gait Lab File” report which shows his ability to use the microprocessor knee at variable cadence and without any mobility aids. The stance extension dampening feature is particularly important in addressing Mr. ____’s balance because it allows him to step onto the prosthesis with the knee bent, then when progressing through stance phase on the prosthetic side, the knee gradually extends in a smooth movement. Mr. ____’s current mechanical knee can have a jarring “pop” into extension that potentially compromises his stability in single leg stance on the prosthetic side. Mr. ____ has sufficient strength, range of motion, functional need, and motivation to utilize a prosthesis beyond simple locomotion. Dr. ____, in his note dated 3/18/14, states that the microprocessor knee will “help him improve his quality of life and increase his functional status.” At Mr. ____’s last physical therapy visit (see P.T. note dated 11-12-13) he scored a 17/28 on the Tinetti Gait and Balance test. This put him at 39% gait and balance impairment however, the therapist noted that the patient had a step length inequity. The mechanical knee potentially contributes to the step length issues. A microprocessor knee addresses the step length inconsistencies by changing resistance of knee flexion and extension based on each step and the type of ground the patient is on thereby helping Mr. ____ to even his step lengths and walk safely for functional tasks.
“K3 variable cadence”

Mr. ___ has the ability to ambulate at variable cadence as shown and explained in the attached “Gait Lab File” report.

“K3 vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion”

Mr. ___ lives independently, with his wife, in their two story home. Prior to amputation, Mr. ___ was able to complete all activities of daily living (ADL’s) and maintain his home, both of which now require his prosthetic utilization beyond simple locomotion. A microprocessor knee will allow him to safely return to independence in ADL’s by allowing him to move sideways, backwards, and take small steps in confined areas like a kitchen or bathroom by preventing buckling of the knee during these movements. Mr. ___‘s current mechanical knee requires him to force the knee into extension during these activities, which is difficult for him due to his current but improving, balance issues. Mr. ___ is also still recovering from his hospitalization and continues to improve in endurance and strength.

During home maintenance and golfing (which he does for exercise and community involvement), Mr. ___ needs to be able to kneel and return to standing. The microprocessor knee has hydraulic dampening in flexion to allow a smooth movement when bending down and hydraulic extension dampening, which allows controlled and safe extension when returning to standing, his current mechanical knee does not. These features are especially important for safe movement in confined areas of the home where falling could cause major injury (like the kitchen, bathroom, garage, etc.).

Doctor’s note: Green | Practitioner’s Note: Yellow | Physical Therapist Note: Pink

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Example

“Justification for K3 based on LCD requirements”

“beneficiary’s current condition including nature of other medical problems”:

Dr. _____’s medical record on Mr.____ shows there are no co-morbidities which would limit ambulation. Dr. ____ describes Mr.____ as having recurring depression however, this will not limit ambulation because it is being medically managed with medication: Zoloft, see Dr. ____’s note dated xx/xx/xx under “current medications” and “prognosis” with good results.”

The therapist’s notes state the patient has a history of high blood pressure, COPD, and 9 months of wound care prior to amputation. Per patient, he is taking medication for HBP and COPD. Dr. _____ states that Mr.____ is able to walk for exercise and increase his activity (see note dated 3/18/14).

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Example - continued

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