Physician Prosthetic Assessment

When you refer patients for prosthetic care, a smooth transition can improve your patient's experience. In an effort to help reduce the risk of inconvenience, delays and unnecessary cost to your patients, we have included an outline of the five pieces of information needed to ensure the prosthetic notes are corroborated in the medical record.

1. Patient's amputation level and any co-morbidities related to ambulatory status.

2. Documented confirmation that patient has the desire to function with a prosthesis.

3. Documented confirmation that patient has or will have the ability to function with a prosthesis.

4. Patient's ***current and expected*** Medicare Functional Level as one of the following:

K4	HIGH ACTIVE ATHLETIC AMBULATOR: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills: high impact, stress, or energy levels.
K3	COMMUNITY AMBULATOR: Has the ability or potential for ambulation with variable cadence, to traverse most environmental barriers, and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
K2	LIMITED COMMUNITY AMBULATOR: Has the ability or potential for ambulation and to traverse low level environmental barriers such as curbs, stairs or uneven surfaces.
K1	HOUSEHOLD AMBULATOR: Has the ability or potential to use prosthesis for transfers /ambulation on level surfaces at fixed cadence.

5. Provide specific examples to validate your opinion as to why the patient meets the standard of the expected functional level you have selected, for example:

   EXAMPLE OF A K4 VALIDATION STATEMENT

   The patient is an active athletic ambulator participating in activities such as riding a bike, taking long walks, or golf for recreation and exercise

   EXAMPLE OF A K3 VALIDATION STATEMENT

   The patient is a community ambulator and walks at varying speeds in the community on a regular basis for activities of living such as shopping and attending community events. Patient requires the ability to change speeds while walking in public places and also will be required to walk on uneven surfaces such as grass, gravel, curbs, ramps and stairs.

   EXAMPLE OF A K2 VALIDATION STATEMENT

   This patient is a limited community ambulator living in a home and that has entrance stairs or ramps and also needs to step over floor rugs causing uneven surfaces inside the home.

   EXAMPLE OF A K1 VALIDATION STATEMENT

   This patient is a household ambulator who resides in an assisted living home and walks indoors with the aid of a walker.

Please evaluate this patient and document the 5 key required pieces of information and place it in the patient's permanent medical record.

The attached Physician Prosthetic Assessment (PPA) form is a tool to assist with Medicare prosthetic care documentation

Upon completion of the PPA form, place the original in the medical records and send a copy to the prosthetic care provider.

Physician Prosthetic Assessment

Patient Information			
Name:			
Sex: ❑ Male ❑ Female	DOB:	Height:	Weight:

1. Medical Necessity:

RIGHT SIDE	LEFT SIDE
Upper Limb	**Upper Limb**
Lower Limb	**Lower Limb**

Is there any comorbidity that will impact the patient's mobility and ability to function with a prosthesis?	☐ Yes	☐ No
If Yes, please explain:		
If Yes, is the patient able to function and benefit from a prosthesis to accomplish activities of daily living?	☐ Yes	☐ No

If patient currently has a prosthesis, explain the reasoning for replacement:
☐ NA, patient does not have a prosthesis, proceed to #2

2. Desire to function with a Prosthesis

How has the patient specifically communicated or demonstrated a desire to function with a prosthesis?

3. Ability to function with a Prosthesis

Patient is **currently** using the following for mobility. *(check all that apply)*	☐ Prosthesis	☐ None
	☐ Cane	☐ Walker
	☐ Crutches	☐ Wheelchair
How has the patient specifically demonstrated a potential or ability to function with a prosthesis?		
Once fit with a prosthesis, it is expected the patient will need the assistance of the following aids. *(check all that apply)*		☐ None
	☐ Cane	☐ Walker
	☐ Crutches	☐ Wheelchair

Original – Patient Medical File

Copy – Prosthetic Provider

4. Current and Expected Functional Level

Functional K Levels & Definitions	
K4	**High Active Athletic:** 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.
K3	**Unlimited Community:** Has the ability or potential for ambulation with variable cadence. Typical of the community ambulatory who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
K2	**Limited Community:** 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
K1	**Household:** 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.

Current Functional Level	**Expected Functional Level**
_____	_____
Explanation if the Current and Expected K-levels are not the same:	

5. Validate Functional Level

Describe expected Activities of Daily Living of the patient to support the proposed K-Level:

Multi-Discipline Corroboration

In development of assessment and recommendations for this patient, I have considered information from the following health care professionals:	□ Surgeon	□ Psychiatrist/Psychologist
	□ Physical Therapist	□ Occupational Therapist
	□ Social/Case Worker	□ Prosthetist/Orthotist
	□ Other	

By signing below, I confirm that this form has been: *(initial one)*	
Initial	Completed by me personally
Initial	Filled in by a staff member under my direction/supervision, the information contained on this form is accurate and reflects my personal observations and professional opinion.

Physician Name (Print: _____

Signature_____ Date: _____

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