Codify
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Eli's Rehab Report

Report K0-K4 Modifier Series When Ordering Prosthetics

Physiatrists and therapists who order prosthetic limbs should append modifiers -K0 through -K4 to demonstrate medical necessity to the durable medical equipment regional carrier (DMERC).

Although Medicare adopted the HCPCS modifiers K0-K4 (descriptors listed on page 92) in 1995, most PM&R practices are still unaware of how to use them. These functional classification modifiers measure the patient's capacity to return to postrehabilitation functions.

The DMERC then uses the modifiers "to establish medical necessity only of prosthetic knees, feet and ankles," according to the Lower Limb Prostheses Policy for Adminastar Federal, the Region B DMERC carrier for 10 states in the Eastern and Midwestern United States.

"These HCPCS modifiers are used just like the CPT modifiers ," says **Laureen Jandroep, OTR, CPC, CCS-P CPC-H, CCS,** consultant and CPC trainer for A+ Medical Management and Education in Absecon, N.J. Append these modifiers to your claims for prostheses, such as L5620, to demonstrate medical necessity.

In fact, most DMERCs will not accept prosthesis claims without them. For example, Adminastar's policy states, "When submitting a prosthetic claim to the DMERC, the billed code for knees, feet and ankles [e.g., HCPCS codes L5610-L5616, etc.] must be submitted with modifiers K0-K4, indicating the expected patient functional level. This expectation of functional ability information must be clearly documented and retained in the prosthetist's records. The simple entry of a K modifier in those records is not sufficient. There must be information about the patient's history and current condition which support the designation of the functional level by the prosthetist."

Assess Amputee Mobility

The K0-K4 modifiers are not necessary when you initially assess a patient's ability to ambulate, says **Robert Gailey, PhD, PT,** assistant professor of physical therapy at the University of Miami. You should append the modifiers only to actual prosthetic HCPCS codes when submitting bills to the DMERC.

"The -K level determines the category of prosthetic foot or knee for which the person is eligible," Gailey says. "It's helpful to have the -K level when one clinician is speaking to another about the patient. They can say, 'This is a -K2-level 72-year-old diabetic ...' so they immediately know the patient's functional level and ambulation ability."

Instead, report the CPT codes describing the activities you used in your assessment. For instance, a lower-limb amputee presents to your therapy practice for a prosthetic evaluation. The patient performs a series of functional tasks, such as sitting balanced in a chair, transferring from chair to chair, and standing with her eyes closed. The patient then walks unassisted with a prosthesis, first on a flat surface, then over an obstacle.

Although you will probably indicate the patient's functional level in your documentation (with the K0-K4 modifiers), you don't need to report the modifiers with the assessment claim, Gailey says. If the physiatrist leads the prosthetic assessment, bill the appropriate E/M code (99211-99215 for established patients). If the therapist performs the assessment, report 97001 (Physical therapy evaluation) or 97003 (Occupational therapy evaluation).

Sometimes your prosthetic evaluation will continue as part of the plan of care after you have completed the therapy evaluation. In these cases, report the appropriate modality code. For instance, if you are showing the patient how to walk over curbs, bill the gait training code, 97116.

Report K0-K4 Modifiers to DMERC

Once you decide that the patient is a viable prosthesis candidate, append the K0-K4 modifiers to the durable medical equipment (DME) prosthetic code. For instance, if you ordered a total knee prosthetic for a limited community ambulator, report L5611-K2 with the appropriate ICD-9 code, e.g., 897.2, Traumatic amputation of leg, unilateral, at or above knee, without mention of complication.

When you give the patient her prosthetic, report 97703 (Checkout for orthotic/prosthetic use, established patient, each 15 minutes) for ensuring correct fit, making adjustments to the prosthesis and confirming skin integrity. Bill the patient's subsequent prosthetic training visits with 97520 (Prosthetic training, upper and/or lower extremities, each 15 minutes).

Gailey reminds coders that Medicare is the only insurer now requiring the -K modifiers. "Right now, prosthetists have the freedom to order their choice of prosthetic from private insurers," he says. "But if these third-party carriers adopt Medicare's standard of selecting the prosthetic based on the -K level, prosthetists may be more limited in what they are able to prescribe."