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Kenevo Selection & Documentation Guide

Table of Contents:

C-Leg® and Kenevo® Selection Guide

MPK Functional Differences for K2 and K3 Patients

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Features	Kenevo	C-Leg
Patient indication	**K2; Low-K3** functional level	**K3** functional level
Variable cadence	Yes; up to 1.9 mph	Yes; up to 4 mph
Stance control	Yes; varies according to chosen mode (A, B, C)	Yes; yielding resistance
Stumble recovery	Microprocessor-controlled stumble recovery active in swing flexion and extension	Microprocessor-controlled stumble recovery active in swing extension
Sitting function	Flexion resistance increases with increasing knee angle (progressive)	Flexion resistance constant at all knee angles during sitting
Standing function	Knee flexion blocking for support if sit-to-stand is interrupted	Functionality not indicated for C-Leg
Stance release	Releases from stance to swing later in the gait cycle to improve stability during weight transfer	Releases from stance to swing earlier in gait cycle to facilitate weight transfer between steps
Donning function	Donning possible in the standing or seated position, as the knee can freely flex in the A, B, and B+ modes	Donning possible in standing position
Advanced features	Wheelchair and stationary cycling for rehabilitation activities	Three user-defined modes and weatherproofing for recreational activities

Kenevo Features and Benefits

Microprocessor Swing and Stance Phase Control (L5856)

The single-axis hydraulic unit of the Kenevo microprocessor knee is controlled by a microprocessor that continuously adjusts two independent servo motors, allowing for independent control of the valves controlling flexion and extension resistances during both stance and swing phase.

Input signals for the control algorithms of the Kenevo microprocessor are knee angle, axial load, and the three-dimensional movement of the knee in space detected by a knee angle sensor, an axial load sensor, and an inertial motion unit (IMU), which consist of accelerometers, gyroscopes and it's own microprocessor, with all sensors located within the prosthetic knee. All sensor signals are sampled at a frequency of 100 Hz, allowing the microprocessor to precisely determine the exact phase of the gait cycle, stumbles, and the terrain the user is walking on. As a result, the microprocessor continuously and separately adjusts the necessary flexion and extension resistances of the hydraulic unit to safely and almost physiologically control stance and swing resistances in all gait situations [2, 3].

Stumble Recovery Plus

The microprocessor swing control of the Kenevo provides an enhanced stumble recovery feature. Stumble Recovery Plus allows for even higher weight-bearing capacity than adjusted for a regular stance phase and unique protection during swing knee flexion (heel rise). Like the C-Leg microprocessor knee, the hydraulic of the Kenevo employs two motorized valves to control resistance for knee flexion and extension separately. That allows for easy swing forward to ambulate while making sure, at the same time, that the knee can be loaded with the full body weight to recover from a stumble and prevent a fall. In addition to the Stumble Recovery feature of the C-Leg, the Kenevo further ramps-up knee flexion resistance (loading capacity) above the level for a regular stance phase in case of a disruption of gait during the entire swing phase including the phase of heel rise. In addition, swing release is based on the loading profile of each step and activated later than in microprocessor knees designed for higher-functioning individuals. This is because limited community ambulators usually walk slower, with more irregular gait (bigger variations from step-to-step), shuffling steps, or with additional walking aids such as crutches or a walker that result in reduced loading of the prosthesis. This function delivers much needed increased stability during late stance but makes sure that swing is released in every step to provide sufficient toe clearance. MPKs for higher-functioning individuals often fail to release swing in lower-functioning individuals with irregular gait patterns. Also, at terminal swing, the microprocessor controls the dampening of the knee extension movement, preventing a hard impact that might impair the balance of the user.

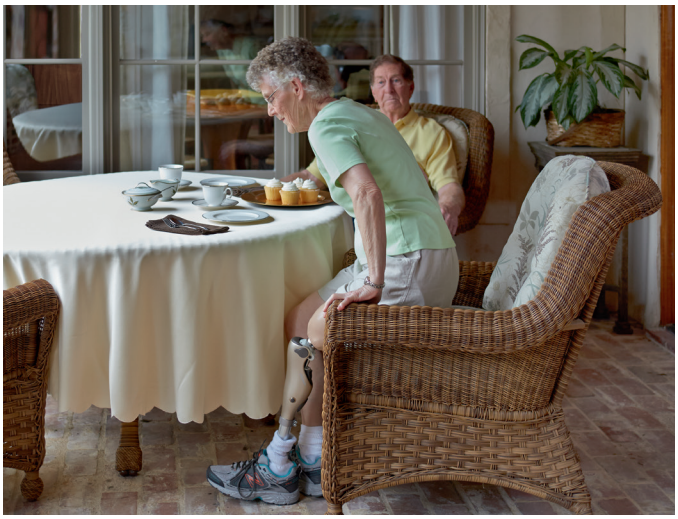
Supported Safe Stand-to-Sit Function

The Kenevo automatically detects when your patient begins to sit down, adjusting the hydraulic resistance so the knee joint provides progressive support during sitting. This allows the amputee to shift the body weight to both legs and complete the sit down motion in a smooth, controlled manner at a controlled rate.

Once the amputee is seated, if the knee is still extended, Kenevo will relax into a seated position and will switch to energy-saving mode.

Benefits include:

- Supports safety and balance during sitting down
- Automatic unlock allows for hands-free operation without the need to unload the prosthesis, which is especially important for those who use walking aids such as canes or walkers.
- Relieves the contralateral side and increases the area of support by shifting load to both legs.



Supported Safe Sit-to-Stand Function

The Kenevo also automatically detects when the patient begins to stand up.

If the patient pauses during the standing-up motion, the knee will not collapse as long as the patient has made it at least half way (prosthesis has reached at least 45° flexion), which allows the patient to rest on the prosthesis and reposition their weight to the sound limb if standing up in a single motion is too tiring.

The knee switches automatically to Supported Stand-to-sit

function if the patient tends to fall backward.

Inertial Motion Unit (IMU) Control

Backward Walking

This patented microprocessor control technology provides safety and stability when your patient is forced to step backward (e.g. when opening a door). Many microprocessor knees do not accommodate backward stepping, which may cause the knee to collapse if a backward step is taken.

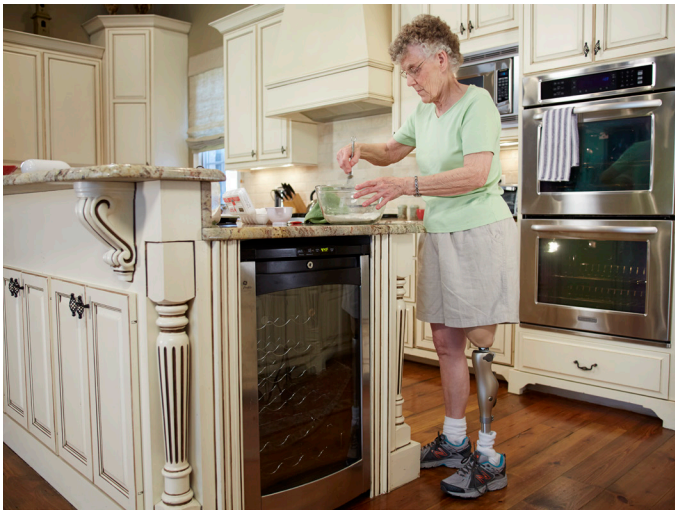
Intuitive Standing

Maintaining safety and balance while standing is critical for K2 and low-K3 patients. Kenevo allows the patient to intuitively stand on a flexed and stable knee when on level, uneven, or inclined surfaces (e.g. ramps and hills).

Contrast this to traditional K2 prosthetic knees, which require the user to extend the hip to stabilize the knee or cognitively ensure that their center of mass stays ahead of their knee axis to prevent unexpected buckling of the prosthetic knee.

Unlike mechanical knees, Kenevo offers clinicians a range of programmable stance stability options that can be customized to support each patient's individual capabilities.

Hydraulic Swing and Stance (L5828)



Hydraulic Stance Control

Hydraulic stance control provides resistance against knee flexion to support the body weight of the patient and prevent knee collapse. Knee flexion during weight-bearing is damped and controlled, mimicking the eccentric contraction of the quadriceps muscle during gait, to provide for shock absorption during level walking to minimize hip and low-back stress. It also enables step-over-step slope and stair descent and uneven terrain ambulation, allowing patients to "ride" the knee when descending stairs and slopes.

Hydraulic Swing Control

The hydraulic swing phase control of Kenevo accommodates walking speeds of up to 3 km/h (1.9 mph). It also provides for terminal swing extension damping that prevents a hard terminal impact that would be hard to control for the patient by decelerating the prosthetic shank prior to heel strike. This mimics the eccentric contraction of the anatomical hamstrings and gluteus maximus muscle. Full extension is then reached smoothly in preparation for heel strike.

Hydraulic Stance Flexion (L5845)

Knee flexion during stance, i.e. during weight bearing, is important for level-walking as well as for the negotiation of uneven terrain, slopes and stairs. Non-amputated subjects control knee stance flexion with their muscles, specifically with the quadriceps muscle, and walk with a knee stance flexion of 15-25° on level ground. Individuals with an above-knee amputation can be fit with a prosthetic knee joint that allows for stance flexion during loading to improve shock absorption and relief of the hip and lumbar spine. The Kenevo has been proven to enable the patient to walk with stance flexion on level surfaces, uneven terrain, and obstacle courses. [2] Furthermore, Kenevo users can descend slopes and stairs with reciprocal (step-over-step) gait. All these activities require knee stance flexion during weight bearing.

Hydraulic Stance Extension Damping (L5848)

After the knee is flexed during stance phase (stance flexion), it needs to extend again to advance the body forward through mid-stance. This feature provides a smooth extension of knee. Without this function, the patient would feel a pronounced "snap back" or "jerk" at the knee, and would also present with an unnatural looking gait pattern. Energy is conserved by having this feature, as the patient will not have to attempt to control this motion with his residual limb muscles.

Knee Extension Assist

The knee extension assist is used in promoting knee extension at the beginning of swing phase extension. This function allows the user to walk more efficiently at variable cadence, since the spring extension assist mechanically limits the knee flexion at the end range and begins to bring the knee into extension for a more symmetrical gait at faster walking speeds. It also ensures the knee comes to full extension for the beginning of stance phase for a more secure loading condition during level walking, but in particular when descending stairs where full extension facilitates the positioning of the foot on the edge of a stair.

Physician Documentation Guide

A recent physical evaluation is required. The focus should be the amputation, prosthesis, and ambulatory difficulties.

A. History of the Amputation

- Diagnosis/etiology of amputation(s)
- Date, affected side(s), level of amputation(s)
- Clinical course
- Therapeutic interventions and results
- Prognosis

B. Physical Examination Relevant to Functional Limitations

- Height, weight, recent loss/gain
- Cognitive ability to use & care for the prosthesis/components you are prescribing.
- Description of the residual limb (e.g. local and/or phantom pain; wound healing issues; skin irritation, breakdown, infection; limb volume changes or swelling; weight fluctuations; muscle atrophy or contractures; osteoarthritis, or other arthritic conditions of the residual limb joints).
- Cardiopulmonary, musculoskeletal, neurological, arm and leg strength, ROM, gait, balance, coordination.

C. Functional Limitations

Describe the nature and extent of functional limitations on a typical day whether from current prosthesis, current medical condition or comorbidities. Explain why these limitations will not affect patient's ability to ambulate with the prosthesis/components you are prescribing. Examples:

- Cardiopulmonary conditions that might limit the patient's capacity [e.g. congestive heart failure (CHF), coronary heart disease (CHD), endocarditis, myocarditis, arrhythmias, peripheral arterial (occlusive) disease (PAD/PAOD), chronic venous insufficiency (CVI) with recurring ulcers, lymphedema].

  If recent (past 6 months) CPX is available: Failure to achieve a capacity of 5 metabolic equivalents (5-MET) or submaximal oxygen uptake (Vo2 max) of 15.0 mL kg−1 min−1 has been used as criteria for disability by the Social Security Administration and may also indicate that the patient does currently not have the capacity for community ambulation.

  Oxygen uptake of ≥6 METs or 21 mL kg−1 min−1 indicates capacity for "vigorous physical exertion" and, thus, is a certain indicator for community ambulation (K3). If no CPX results are available, please provide your professional judgment whether patient is able to walk 400 yards in one bout. If the patient is unable to walk 400 yards in one bout, does he/she have the potential to increase distance or range through physical therapy to do so?

- Musculoskeletal conditions (e.g. osteoarthritis sound side leg joints, spinal stenosis, severe low back pain, etc.). Document numerical pain ratings of the joints of the lower extremities and back, if pain is present.
- Neurological conditions that cause impairments in gait, balance or coordination (e.g. MS, stroke, SCI, Parkinson's, peripheral nerve lesions, lumbar disc herniation with motor paresis, dementia/Alzheimer's disease, depression, psychiatric disorders/diseases).
- Other comorbidities (e.g. chronic kidney failure, chronic liver failure, cancer with chemotherapy/radiation, general deconditioning).

D. Ambulatory Assistance prior to the amputation and/or currently used (e.g. cane, walker, wheelchair, caregiver)

- For non-routine/occasional use, describe the situation when the patient uses the assistive device.
- If this is a temporary situation state in your opinion how long it will take the patient to be back to functioning at the desired level (free of the assistive device).

Functional Levels (K-Levels) for Lower Limb

K-0: Does not have the ability or potential to ambulate (or transfer safely) with or without assistance and a prosthesis does not enhance their quality of life or mobility.

K-1: Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence

K-2: Has the ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs or uneven surfaces

K-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.

K-4: 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.

E. Functional Capability:
Describe patient's functional capabilities in terms of K- Levels (described above), as they relate to patient's activities. Focus should be on activities related to ambulation at work, home, during therapy or exercise (e.g. walking the dog, walking on a treadmill, mowing the lawn, catching a bus, carrying items, crossing a busy street, etc.). Document the related environmental and physical barriers that your patient encounters, including when there is a need to change walking speed (e.g. uneven terrain, curbs, stairs, ramps, crowds, public transportation, timed cross walks, etc.). Avoid sports-related activities as the insurance payer may consider the prosthesis to be a luxury.

Document the following:

- **Patient's functional activities prior to the amputation(s)** in the K-Level/potential K-Level category.
- **Patient's current daily activities** and how impacted by the deficits identified above. Is the patient more limited by his/her medical conditions or by the function of the prosthesis? Include:
  - History of falls and fall-related injuries with the current prosthesis.
  - Activity avoidance with the current prosthesis due to fear of falling.
  - Activity avoidance due to functional limitations of the current prosthesis (e.g. prosthetic knee does not allow for reciprocal slope and stair descent).
- **Activities that patient desires to resume** (and has the potential for) using the new prosthesis.

Note: If patient was a community ambulator (K3/K4) earlier in life, but not prior to the amputation due to a medical condition (e.g. neuropathy, ulcers, and neuropathic pain), include why you believe the patient will be a community ambulator with the new prosthesis (e.g. sound limb is asymptomatic, achievements during rehabilitation/physical therapy, diseased limb was the primary cause of the mobility restrictions, etc.).

F. Document Status of Current Prosthesis:

- **Condition of each component** (e.g. socket, knee, pylon, ankle, foot).
- **Reasons for replacement** One of the following reasons should be documented for each component being replaced.

  Reasons for Replacement allowed by most payers:
  - Patient's functional needs have changed
  - Due to physical changes the component no longer fits
  - Component is irreparably worn

  Additional Reasons Allowed by Medicare
  - Prosthesis is lost or damaged beyond repair in some type of incident
  - Cost to repair will be greater than 60% of the cost (Medicare allowable) to purchase a new device
- **If the patient's condition has changed,** describe why the current prosthesis/component is no longer appropriate. (e.g. weight gain/loss, falls, increased risk of falling, decreased stability, etc.).
- **If item is damaged or lost,** describe the incident.
- **If the current prosthesis/component is the most appropriate** type of replacement (explain).

G. Previous Prostheses:

- Document patient's past experience with prosthetic components (what has been tried, and the result).

H. If ordering a repair, replacement prosthesis, prosthetic component, or a refill:

- Document that patient continues to use prosthesis and prosthesis is still medically necessary.

I. Desire and Motivation:

- Document patient's desire and motivation to use the new prosthesis and ambulate in the community.

J. *Additional (If ordering a microprocessor knee for a K2 patient that does not have potential for K3):

- Include history of falls and stumbles (if applicable).
- State why improved stability in stance will allow increased independence for your patient.
- State why you believe your patient has the potential for use a less restrictive walking device (if applicable).

**Allowed by some private insurance payers. Not allowed by Medicare.*

K. Statement that patient will reach or maintain a defined functional state (K-Level) within a reasonable period of time:

- The K-Level should be based on patient's prior activities, current condition, and desire to ambulate (determined above).
- If your patient is currently ambulating at the K-Level required for the componentry being ordered, statement should say patient will maintain the K-Level.
- If your patient has the "potential" to reach a higher K-level designation in the near future, an explanation for the difference is required. Include a treatment plan that will achieve this increase in functional level, (e.g. physical therapy, strength/ gait training, etc.). For Medicare, the plan must include your professional estimate of how long (days, weeks, months) it will take the patient to function at the potential K-Level.

Physician Documentation Checklist

Patient Name:_____

Date:_____

Completed By:_____

History of Amputation

- ❒ Date and Cause of amputation(s)
- ❒ Affected side(s)
- ❒ Clinical course, interventions & results, prognosis

Physical Examination

- ❒ Height, weight, recent loss/gain
- ❒ Cognitive ability to use & care for new prosthesis
- ❒ Condition of residual limb
- ❒ Cardiopulmonary, Musculoskeletal, Neurological
- ❒ Strength, ROM, gait, balance, coordination

Functional Limitations

- ❒ Limitations caused by current prosthesis, medical condition, or comorbidities
- ❒ Diagnoses causing the symptoms.

Functional Levels (K-Levels)

K-0: Lacks ability or potential to ambulate (or transfer safely with/without assistance and a prosthesis), and prosthesis will not enhance quality of life or mobility.
K-1: Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence. (home)
K-2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. (limited community ambulator)
K-3: Has the ability or potential for ambulation with variable cadence. (full community ambulator)
K-4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. (athlete or child)

Ambulatory Assistance

- ❒ Used currently/prior to amputation
- ❒ Situational/temporary?
- ❒ Plan to be free of assistive devices (if applicable).

Functional Level (K-Level)

- ❒ Patient's activities prior to amputation
- ❒ Patient's current activities & impact of the functional limitations identified above.
- ❒ Activities patient desires to resume or has potential for using new prosthesis

Prosthetic Use (socket, knee, ankle, foot, liner)

- ❒ Past components tried & result
- ❒ Current components: history and condition of each component
- ❒ Reason for replacement for each

For Repair, Replacement, or Refill

- ❒ Patient continues to use a prosthesis
- ❒ The prosthesis is medically necessary

Desire and Motivation

- ❒ To ambulate and use new prosthesis

Functional State and Order for New Prostheses/Components

- ❒ K-Level (based on prior activities, current condition, and motivation to ambulate).
- ❒ Recommendation for new prosthetic components
- ❒ Statement that patient will maintain current K-level, or for **potential** K-level, include explanation for difference, with treatment plan to reach desired K-Level and estimate how long it will take.

Prosthetist's Documentation Guide

a. Functional Evaluation (K-level should match physician's evaluation

- Activities prior to amputation
  - Activities that patient did in the past and would like to get back to using a new device (e.g. home, work, therapeutic, exercise).
  - Current activities.
  - Focus on activities that the new prosthesis will allow that the current prosthesis does not.
  - Describe difficulties, such as falls, stumbles, not making it across street before light changes, inability to change speed when needed, etc.
  - How will patient be able to do it better with the new prosthesis?

- Future/potential future activities.
  - If these vary from prior activities, an explanation will be required)

- Testing to corroborate K-Level evaluation
  - This could be a walking speed test, timed walking test, Timed Up and Go (TUG), Prosthetic Evaluation Questionnaire (PEQ), Amputee Mobility Predictor (AMP), or other.

- *Additional (If ordering a microprocessor knee for a K2 patient that does not have potential for K3):
  - Include history of falls and stumbles (if applicable).
  - State why improved stability in stance will allow increased independence for your patient.
  - State why you believe your patient has the potential for use a less restrictive walking device (if applicable).

**Allowed by some private insurance payers. Not allowed for Medicare plans.*

Functional Levels (K-Levels) for Lower Limb
K-0: Does not have the ability or potential to ambulate (or transfer safely) with or without assistance and a prosthesis does not enhance their quality of life or mobility
K-1: Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence.
K-2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces.
K-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.
K-4: 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.

b. History of Prosthetic Use
Your records should have a history of each prosthesis patient has used/trialed in the past.
- Brand of component
- How long did patient use it?
- What was the result?

c. Current Prosthesis

- History of each component being replaced (age, condition, how did it work out?)

- Description of the labor involved (e.g. casting, modification, time, tools used, materials used, where material was applied, etc.)

- Reason for replacement
  - Change in patient's condition
  - Item no longer fits
  - Does not meet functional needs
  - Worn (cannot be repaired)
  - (Medicare) Cost to repair will be greater than 60% of the Medicare allowable for a new device
  - (Medicare) item is lost or damaged beyond repair in an incident (e.g. accident, natural disaster)

d. Recommendation for the type and brand of the new prosthesis/components:
- Must be based on physician's recommendation
- Include rationale for your decision
- Include medical necessity and justification for each HCPCS code, including addition codes.

e. Patient's motivation and desire to ambulate.

f. Documentation of the Refill Request
Items such as socks and liners are considered non consumable and may be treated as a refill item. If the SWO identifies them with quantity and frequency, they may be dispensed as needed without obtaining a new order.

In this situation, there must be documentation of the request for the refill, SWO, and proof of delivery.

The following elements should be included when documenting the request.
- Patient's name (or authorized representative and relationship)
- Date of request (must be no sooner than 14

calendar days prior to delivery/shipping)
- Description of each item requested
- RT/LT
- Quantity
- Condition of items being replaced

Note: Shipment/delivery may not occur sooner than 10 calendar days prior to current supply exhausting.

g. **Fitting, Adjustment, and Delivery note(s)** for all items delivered.

h. **Chart note for each visit** with patient with printed name, credential, signature and date on each note.

i. **Patient's name on each page** and pages organized and numbered in a manner to avoid mix up during an audit/medical review.

Prosthetist's Documentation Checklist

Patient Name:_____

Date:_____

Completed by:_____

FROM THE PHYSICIAN (within 6 mo. for PA)

History of Amputation

- ❒ Date and Cause of amputation(s)
- ❒ Affected side(s) and level(s) of amputation
- ❒ Clinical course, interventions & results, prognosis

Physical Examination

- ❒ Height, weight, recent loss/gain
- ❒ Cognitive ability to use & care for new prosthesis
- ❒ Condition of residual limb
- ❒ Cardiopulmonary, Musculoskeletal, Neurological
- ❒ Strength, ROM, gait, balance, coordination

Functional Limitations

- ❒ Limitations caused by current condition/comorbidities
- ❒ Diagnoses causing the symptoms.

Ambulatory Assistance

- ❒ Used currently/prior to amputation
- ❒ Situational/temporary?
- ❒ Plan to be free of assistive devices (if applicable).

Functional Level

- ❒ Patient's activities prior to amputation
- ❒ Patient's current activities & impact of the limitations identified above.
- ❒ Desired & potential activities using new prosthesis

Prosthetic Use

- ❒ Past: components tried & result
- ❒ Current: History and condition of each component
- ❒ Reason for replacement

For Repair, Replacement, or Refill

- ❒ Patient continues to use a prosthesis
- ❒ The prosthesis is medically necessary

Desire and Motivation

- ❒ To ambulate

Functional State

- ❒ K-Level (based on prior activities, current condition, and motivation to ambulate).
- ❒ Recommendation for new prosthetic components
- ❒ For potential K-level, include explanation & plan to reach desired K-Level & approx. How long it will take

MPK for K2 Patient without Potential for K3 (private payer only):

- ❒ History of falls and stumbles
- ❒ Improved stability in stance will allow increased independence
- ❒ Patient has the potential to use a less restrictive walking device

STANDARD WRITTEN ORDER (SWO) –supplier generated

- ❒ Date of Order: on/prior to the delivery date
- ❒ Narrative description, HCPCS code, HCPCS code narrative, or Brand Name/Model Number.
- ❒ Physician demographics/NPI ok for Medicare
- ❒ Physician's hand written signature, date
- ❒ Quantity & RT/LT
- ❒ Meets your state's requirement for orders
- ❒ Patient name on each page/MBI ok for Medicare

PROSTHETIST'S DOCUMENTATION

Functional Level – should match physician's determination

- ❒ Testing
- ❒ Activities prior to amputation
- ❒ Current Activities
- ❒ Future activities
- ❒ For potential K-Level: explanation for the difference

MPK for K2 Patient without Potential for K3 (private payer only):

- ❒ History of falls and stumbles
- ❒ Improved stability in stance will allow increased independence
- ❒ Patient has the potential to use a less restrictive walking device

History of Prosthetic Use Over Time

- ❒ Brand, how long used, result

History of Current Components

- ❒ History of components being replaced (age, condition, result)
- ❒ Description of Labor (casting, modification, time, tools, materials & where applied
- ❒ Reason for Replacement

Recommendation for Type and Brand of Prosthesis

- ❒ Based on physician's recommendation
- ❒ Medical Necessity and Justification for each component

Desire and Motivation

- ❒ To ambulate and use new prosthesis

Additional

- ❒ Fitting, Adjustment, & Delivery note(s)
- ❒ Chart note for each visit
- ❒ Signature of signee

For Refills (liners, socks, etc)

- ❒ Continued Need: MD note within 12 mo. (or substitute new verbal/written order).
- ❒ Continued Use: Document the refill request and condition of the item being replaced.

PROOF OF DELIVERY

- ❒ Delivery Date
- ❒ Patient's Name
- ❒ Delivery Address
- ❒ Narrative description, HCPCS code, HCPCS code narrative, or Brand Name/Model Number.
- ❒ Signature and Printed name of signee
- ❒ Relationship to patient and reason why patient cannot sign
- ❒ Signature time, if signed on same day as SWO obtained.

- ❒ BENEFICIARY AUTHORIZATION
- ❒ ABN IF REQUIRED

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