The following checklist represents items that the Centers for Medicare and Medicaid Services (CMS) have required to be documented in the medical record for all patients who are to receive a prosthetic device. Having these items documented in your patient’s medical record will help to ensure that your patient will receive the necessary prosthetic devices and to ensure that the prosthetist will be reimbursed from CMS.

**Documentation in Prescribing Physician’s Medical Records**

Please use the following checklist to indicate that the item has been properly documented in your medical records. Prescribing physicians must adhere to all other applicable Medicare policies regarding DME.

**Physical Assessment of the Patient with:**

Physical Examination
- Weight & height
- Cardiopulmonary exam
- Arm/leg strength & ROM
- Neurologic exam
- Gait assessment
- Balance and coordination

Amputation History
- Diagnosis/cause of amputation
- Date of amputation(s)
- Amputation level
- Prognosis

Patient’s Functional Status
- Description of ADLs and their impact by deficit
- Diagnoses causing ADL deficits
- Other comorbidities related to amputation deficits or that could impact use of new prosthetic device

**Documentation in Prosthetist’s Records**

Prosthetists, please use the following checklist to indicate that the item has been properly documented in your medical record. It is important to remember that each visit should have a separate chart note and the patient’s name should be on each page. The prosthetist’s records must adhere to the guidelines required by Medicare as specified in policy manuals.

**Functional Assessment**
- Pre-amputation functional capabilities
- Current functional capabilities (K-level)
- Expected functional potential (K-level)
- Explanation of difference

**Current Prosthetic Profile**
- History of prosthesis being replaced
- Reason for replacement
- Patient’s desire to ambulate
- Recommendation for new prosthesis (Description and list of components)