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| Department of Labor and Industries  PO Box 44291  Olympia WA 98504-4291  Fax: 360-902-9170 | **state seal** | **L&I Prosthetic Device Request**  *(One prosthetic device per request)* |

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| Client Name | | Claim Number | Date of Injury |
| Height | Weight | Date of Birth | |
| Request Date | | Attending Provider Name | |
| Facility Name | | Clinician | |
| Accepted Diagnosis | | | |

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| **Section 1** | | | | | | | | |
| Type of prosthetic device being requested | | | | Type  New  Repair  Replacement | | | Side of Body  Right  Left | |
| Level of Amputation – Upper Extremity | | | | | | | | |
| Partial Hand | | | Wrist Disarticulation | | | Transradial | | |
| Elbow Disarticulation | | Transhumeral | | | Shoulder Disarticulation | | Fore-Quarter | |
| Level of Amputation – Lower Extremity | | | | | | | | |
| Partial Foot | | | Ankle Disarticulation | | | Transtibial | | |
| Knee Disarticulation | | Transfemoral | | | Hip Disarticulation | | Hemipelvectomy | |
| Length of Residual Limb | | | | | | | | |
| Half of Full Limb | | | Shorter Than Half | | | Longer Than Half | | |
| Has there been a change in the residual limb’s volume and/or length?  No  Yes (If yes, attach supporting documentation.) | | | | | | | | |
| Condition of Residual Limb (check all that apply) | | | | | | | | |
| Redness | Soreness | | Swelling | | Blisters | Infection | | Rash |
| Cysts | Ulcers | | Tumor | | Neuroma | Neuropathy | |  |
| Other: | | | | | | | | |
| Are these conditions acute or chronic? Explain. | | | | | | | | |
| Other Related or Compounding Health Conditions | | | | | | | | |

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| **Section 2 ― Upper Extremity (check all that apply if applicable)** | |
| Client’s should girdle allows for rotation of arm. | Yes  No  NA |
| Client’s residual limb has sufficient strength and range of motion for operation of a body powered prosthetic device. | Yes  No  NA |
| Client’s strength is sufficient to keep external powered prosthesis stable. | Yes  No  NA |
| Client is able to generate sufficient EMG signals to operate a myoelectric prosthesis.  If yes, enter number of plates allowed: | Yes  No  NA |
| Client has range of motion at neck to turn head and operate shoulder switches with chin. | Yes  No  NA |
| Client’s scapula has sufficient strength and range of motion to operate a body powered prosthetic device. | Yes  No  NA |

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| **Section 3 ― Lower Extremity (if applicable)** | | | | | | |
| Client Mobility Level (as per Medicare classification) | | | | | | |
| K0 | K1 | | K2 | K3 | | K4 |
| Hip flexor strength       /5 | | Knee flexor strength (if amputation is below knee)       /5 | | | Knee extension strength (if amputation is below knee)       /5 | |

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| **Section 4** | | | |
| **Work Demands**  Currently employed?  No  Yes | | If yes, list job title | |
| Professional/Public Environment  Office Work  Below Waist Lift/Carry  Heavy Lifting  Work in Tight Spaces  Operating Heavy Machinery  Driving | Working Outdoors  Vibrations  Chemical Handling  Wet Environment  Extreme Temperatures  Manipulating Small Objects  Manipulating Delicate Objects | | Forceful Grasping  Tool Handling  Operating Foot Controls  Dusty Environments  Other: |
| **Mobility Demands ― Work and/or Home** | | | |
| Walking across uneven terrain  Walking up/down stairs  Walking across slick/slippery terrain  Moving at faster than a comfortable walking pace (3.5 + mph) | | Frequent walking  Frequent standing  Walking at varying speeds  Other: | |
| Does the client live in an isolated or rural area?  No  Yes | | | |

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| **Section 5** |
| Is this request for a secondary prosthesis?  Yes  No  If yes, explain the necessity and purpose of the device: |
| Has the client had a previous prosthetic device?  Yes  No  If yes, list issue date(s), type of device(s), side of body, and when last worn: |
| Is this a request for replacement?  Yes  No  If yes, provide reason for replacement: |
| Is this request for an exact replacement of what was previously provided?  Yes  No  If no, provide additional reason for changes to device: |

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| **Section 6** | | | | | |
| Device Being Requested: | | | | | |
| HCPCS | Device Abbreviation | # | Total Cost | Explanation of Necessity/Benefit | L&I Use Only |
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| Do any of the requested prosthetic components possess a warranty?  Yes  No  If yes, please attach available warranty information. Include if any specific items’ warranty is limited by a weight limit. | | | | | |

Please note – L&I will reimburse per our Fee Schedule. You can find the Fee Schedule online at [www.Lni.wa.gov/FeeSchedules](http://www.Lni.wa.gov/FeeSchedules).

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| Clinician Name |  | Signature |  | Date |

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| **For L&I Use Only** | | | | |
|  |  |  |  |  |
| L&I ONC Authorization |  | Phone Number |  | Date |

**Instructions for Completing L&I Prosthetic Device Request:**

**Section 1:**

* If the amputation is bilateral, please note under “Accepted Diagnosis.”
* Complete all questions within this section. For any question that doesn’t apply, enter either “NA” or “not applicable.”

**Section 2:**

* Fill out this section only if the request pertains to an upper extremity amputation and prosthetic limb.

**Section 3:**

* Fill out this section only if the request pertains to lower extremity amputation and prosthetic limb.
* Definitions of the “K” levels are:
  + **K0 –** Does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis does not enhance their quality of life or mobility.
  + **K1 –** The patient has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of limited and unlimited household ambulatory.
  + **K2 –** 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 ambulatory.
  + **K3 –** Has the ability or potential for ambulation with variable cadence. Typically 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.
  + **K4 –** 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 active adult.
* Strength ratings are based on manual muscle testing. Use the following ratings scale:
  + **1** **–** The limb can’t be voluntarily moved within the range of motion in question.
  + **2 –** The limb can moved through the range of motion in question when gravity doesn’t provide resistance.
  + **3 –** The limb can be moved in the range of motion in question against gravity.
  + **4 –** The can move with the range of motion in question against gravity and light to moderate resistance.
  + **5 –** The limb can move with the range of motion in question against gravity and heavy resistance.

**Section 4:**

* Complete all questions in this section. Check all boxes that apply for each question.

**Section 5:**

* Complete all questions within this section. For any question that doesn’t apply, enter either “NA” or “not applicable.”

**Section 6:**

* Enter the HCPCS and their abbreviated titles on the columns provided as well as the quantity being requested.
* In the Cost column, enter the cost for the total number of items for the HCPCS code requested.
* In the Explanation of Necessity/Benefit column, give a brief statement of the rationale or benefit provided by the requested component.

**Microprocessor Knee and Myoelectric Upper Limb Request Addendums:**

* Complete the corresponding addendum if the request includes one of these devices.

***All attached documentation, such as residual limb measurements and warranty information should be attached on separate pages to this form. Please include the client’s name and claim number on additional each page. If you have questions, please contact your Occupational Nurse Consultant.***

**Microprocessor Knee Request Addendum**

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| Identify which specific brand/model of device being requested | | |
| Condition of transfemoral amputation, knee disarticulation or his disarticulation allowed on claim. | | Yes  No |
| Adequate skin integrity. No current skin breakdown, open wounds or infection, or frequent history of such. | | Yes  No |
| Actual or anticipated ability to tolerate wearing prosthesis for at least 6 hours per day. | | Yes  No |
| Ability to don or doff the prosthesis independently. | | Yes  No |
| Sufficient cognitive ability to learn how to properly use the proposed knee in the course of normal daily living. | | Yes  No |
| Adequate hip flexion (less than 20 degree hip flexion contracture). | | Yes  No |
| Documented history of compliance with rehabilitative medical care. | | Yes  No |
| Recommendation comes from a physician (MD or DO) who specializes in functional rehabilitation of amputees (include documentation). | | Yes  No |
| The K functional level was determined by a MD or DO with how the stated K level was derived (include documentation). | | Yes  No |
| The client has access to a prosthetist with documented experience and knowledge of the proposed device, and the capability of performing the necessary maintenance and repairs. | | Yes  No |
| K3 or K4 functional level. | | Yes  No |
| If K2 functional level, which of the following conditions apply? | | |
|  | Need related to physical work demands.   * Permits the client to return to work or be considered employable because use of the knee is expected to advance to a K3 functional level. | |
|  | Need related to fall prevention (include documentation).   * There is a documented safety concern that will be addressed by using the knee such as high risk for falls (e.g. has had documented falls using an advanced swing and stance phase control hydraulic knee unit or has documented medical co-morbidities that impact balance). | |
|  | Has access to training in use of the knee by a physical therapist experienced in prosthetics. | |
| Successful trial using the recommended knee or prior experience if it is a replacement.  Dates of trail:  Description of gait with device: | | Yes  No |
| Agreement to use the device within manufacturers specifications to include:   1. Weight limits – include both the client’s body weight and the weight lifted or carried in daily activities and/or job duties. 2. Environmental exposures – not used in conditions of high moisture/humidity or high levels of dust. | | Yes  No |

**Myoelectric Upper Limb Request Addendum**

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| Identify which specific brand/model of device being requested | | |
| Condition of amputation at the hand or above allowed on the claim. | | Yes  No |
| Adequate skin integrity. No current skin breakdown, open wounds or infections, or frequent history of such. | | Yes  No |
| Actual or anticipated ability to tolerate wearing prosthesis for at least 6 hours per day. | | Yes  No |
| Ability to don and doff the prosthesis independently. | | Yes  No |
| Sufficient upper body strength to keep the prosthesis stable. | | Yes  No |
| Documented history of compliance with rehabilitative medical care. | | Yes  No |
| Recommendation comes from a physician (MD or DO) who specializes in functional rehabilitation of amputees (include documentation). | | Yes  No |
| The client has access to a prosthetist with documented experience and knowledge of the proposed device and the capability of performing the necessary maintenance and repairs. | | Yes  No |
| Is this device necessary mostly related to conditions other than the amputation (i.e. limitations on the sound side) and the issue cannot be resolved with further treatment? If yes, provide supporting documentation. | | Yes  No |
| Functional evaluation by a qualified professional (e.g. prosthetist, occupational therapist). Include copy of evaluation. | | |
|  | Verifies sufficient cognitive ability to learn how to properly use the proposed device in the course of normal daily living. | |
|  | Verifies that the remaining musculature contains the minimum microvolt threshold to allow operation of the myoelectric prosthetic device as demonstrated by testing. | |
|  | Describe how a myoelectric prosthetic device is able to meet the specific functional needs of the individual to perform activities of daily living and/or work activities.   * Addressing frequency and nature of essential activities. * Addressing needs related to durability, control of device, coordination, performance, and usability. | |
|  | Description of how the specific device was chosen and what alternatives (body powered and myoelectric) were ruled out and why. | |
|  | Proposed training goals/plan. | |
| Successful trial using the recommended device or prior experience if it is a replacement.  Dates of trail:  Results of trail: | | Yes  No |
| Agreement to use the device within manufacturers specifications to include:   1. Weight limits – the weight lifted or carried doesn’t exceed the lifting/carrying/force capacity of the device. 2. Environmental exposures – not used in high levels of moisture, humidity, dust, and chemicals. | | Yes  No |
| Additional criteria for individually controlled finger myoelectric prosthesis (include documentation): | | |
|  | Demonstration that a standard myoelectric hand is not adequate for the individual’s daily activities and/or job duties. Include specific self-care and/or work related activities the individual is unable to perform that the individually controlled finger prosthesis will allow. | |
|  | The individual has access to training with a therapist knowledgeable about the requested device. | |