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</tbody>
</table>
WHAT’S NEW FOR THE 2019 MANUAL?

Please note the following changes to the Procedure Codes and Coverage Guidelines section of the Durable Medical Equipment, Orthotics, Prosthetics and Supplies (DMEPOS) manual, Version 2018.

Procedure codes new to the manual are **bolded**. See below for any new codes, discontinued codes, frequency changes, and changes in code description.

<table>
<thead>
<tr>
<th>New Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A4222</strong></td>
<td>Infusion supplies for external drug infusion pump, per cassette or bag (list drugs separately)</td>
</tr>
<tr>
<td><strong>A4606</strong></td>
<td>Oxygen probe for use with oximeter device, replacement</td>
</tr>
<tr>
<td><strong>A5514</strong></td>
<td># For diabetics only, multiple density insert, made by direct carving with CAM technology from a rectified CAD model created from a digitized scan of the patient, total contact with patient’s foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each</td>
</tr>
<tr>
<td><strong>A7048</strong></td>
<td>Vacuum drainage collection unit and tubing kit; including all supplies needed for collection unit change, for use with implanted catheter, each</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Change in Authorization Type and Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0445<strong>F26 #</strong></td>
<td>E0445<strong>F3</strong> Oximeter device for measuring blood oxygen levels non-invasively</td>
</tr>
<tr>
<td>E0784<strong>F2 #</strong></td>
<td>E0784<strong>F3</strong> External ambulatory infusion pump, insulin</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Change in Authorization Type Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9276 #</td>
<td>A9276 Sensor; invasive (e.g. subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day</td>
</tr>
<tr>
<td>K0553 #</td>
<td>K0553 Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Change in Maximum Units</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4221</td>
<td>#Supplies for maintenance of non-insulin drug infusion catheter, per week (list drug separately)</td>
<td>4 (1 unit=1)</td>
</tr>
</tbody>
</table>
4.0 GENERAL INFORMATION AND INSTRUCTIONS

1. Fees are published in the Fee Schedule section of the DME Manual, located at http://www.emedny.org/ProviderManuals/DME/index.html

2. Standards of coverage are included for high utilization items to clarify conditions under which Medicaid will reimburse for these items. Also see Section 2 of the DME Policy Guidelines.

3. Any item dispensed in violation of Federal, State or Local Law is not reimbursable by New York State Medicaid.

4. PURCHASES: An underlined procedure code indicates the item/service requires prior approval. When the procedure code's description is preceded by a “#”, the item/service requires an authorization via the dispensing validation system (DVS). When the procedure code's description is preceded by an asterisk (*), the item/service requires an authorization via the Interactive Voice Response (IVR) system. When none of the above described circumstances exist, the procedure code is a direct bill item. Please refer to the DME manual, Policy Guidelines, for additional information.

5. Where brand names and model numbers appear in the DME manual, they are intended to identify the type and quality of equipment expected, and are not exclusive of any comparable product by the same or another manufacturer.
6. **MODIFIERS:** The following modifiers should be added to the five character Healthcare Common Procedure Coding System (HCPCS) code when appropriate.

- **'-BO'** *Orally administered enteral nutrition*, must be added to the five-digit alpha-numeric code as indicated.

- **'-K0'** through **'-K4'** modifiers, used to describe **functional classification levels of ambulation**, must be used for all lower extremity prosthetic procedure codes. The modifier relates to the specific functional classification level of the member. A description of the functional classification levels can be found in section 4.7 of this manual.

- **'-LT'** *Left side* and **'-RT'** *Right side* modifiers must be used when the orthotic, prescription footwear or prosthetic device is side-specific. Do not use these modifiers with procedure codes for devices which are not side-specific or when the code description is a pair. LT and/or RT should also be used when submitted for replacement or repair of an item using the **'-RB'** modifier.

- **'-RB'** *Replacement and Repair*:
  - Allowed once per year (365 days) per device for patient-owned devices only. More frequent repairs to the device require prior approval.
  - Bill with the most specific code available with the modifier for the equipment or part being repaired.
  - Use of **'-RB'** is not needed when a code is available for a specific replacement part; use the specific code only when billing.
  - A price must be listed for the code in the fee schedule in order for **'-RB'** to be reimbursable without prior approval.
  - **'-RB'** is not to be billed in combination with A9900, L4210 or L7510 for repair or replacement of the same device.

  a. Indicates replacement and repair of **Orthotic and Prosthetic devices** which have been in use for some time.
  - Prior approval is not required when the charge is over $35.00 and is less than 10% of the price listed on the code for the device.
  - For charges $35.00 and under, use L4210 or L7510.

  b. Indicates replacement and repair of **Durable Medical Equipment** which has been in use for some time and is outside of warranty.
  - Prior approval is not required when the repair charge is less than 10% of the price listed on the code for the device.
  - If the charge is greater than 10% of the price, prior approval is required.
• If no code is available (i.e. unlisted equipment) to adequately
describe the repair or replacement of the equipment or part, use
A9900 and report K0739 for labor component.
• When repair and replacement is performed by a manufacturer,
the Medicaid provider will be paid the line item labor cost on the
manufacturer’s invoice and the applicable Medicaid fee on the
parts. If labor and parts charges are not separately itemized on
the invoice as required by 18NYCRR 505.5, the Medicaid provider
is not entitled to a markup on the cost of parts and will only be
paid the manufacturer invoice cost of parts and labor.

‘-RR’ **Rental** - use the ‘-RR’ modifier when DME is to be rented.
• Rentals require DVS authorization for each month of rental. All
DVS authorization requests must include the ‘-RR’ modifier,
including continuous rentals.
• Prior Approval is required for rental only when no rental fee is
listed in the DME Fee Schedule or the items HCPCS code in this
manual is underlined.
• Refer to the DME Fee Schedule for rental fees.
• Rental is available up to maximum of 10 months. Monthly rental
fee is calculated at 10% of purchase price, with the exception of
continuous rentals (frequency listed as F26 in the Procedure Code
section).
• The **Length of Need** must be specified by the ordering
practitioner on the fiscal order. If the order specifies a Length of
Need of less than 10 months, the equipment must be rented
initially. If Length of Need is 10 months or greater, the equipment
may be initially rented or purchased.
• All rental payments must be deducted from the purchase price,
with the exception of continuous rentals. Utilization Review (UR)
claims editing limits the sum of all rental payments to the code’s
purchase price.

‘-U3’ **Repair/Replacement to Patient Owned Equipment**, is required
when billing for repairs to patient owned equipment when the
member is in a hospital or skilled nursing facility.

7. For items listed in section 4.1 **Medical/Surgical Supplies**, the quantity
listed is the maximum allowed per 30 days, unless otherwise specified. If
the fiscal order exceeds this amount, the provider must obtain prior
approval.

8. **Frequency**: Durable Medical Equipment, Orthotics, Prosthetics, and
Supplies have limits on the frequency that items can be dispensed to an
eligible member. If a member exceeds the limit on an item, prior approval
must be requested with accompanying medical documentation as to why
the limit needs to be exceeded. The frequency for each item is listed by a superscript notation next to the procedure code. The following table lists the meaning of each notation:

<table>
<thead>
<tr>
<th>Notation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>once/lifetime</td>
</tr>
<tr>
<td>F2</td>
<td>twice/lifetime</td>
</tr>
<tr>
<td>F3</td>
<td>once/5 years</td>
</tr>
<tr>
<td>F4</td>
<td>once/3 years</td>
</tr>
<tr>
<td>F5</td>
<td>once/2 years</td>
</tr>
<tr>
<td>F6</td>
<td>once/year</td>
</tr>
<tr>
<td>F7</td>
<td>twice/year</td>
</tr>
<tr>
<td>F8</td>
<td>three/2 months</td>
</tr>
<tr>
<td>F9</td>
<td>once/month</td>
</tr>
<tr>
<td>F10</td>
<td>twice/month</td>
</tr>
<tr>
<td>F11</td>
<td>four/month</td>
</tr>
<tr>
<td>F12</td>
<td>once/day</td>
</tr>
<tr>
<td>F13</td>
<td>once/3 months</td>
</tr>
<tr>
<td>F14</td>
<td>four/lifetime</td>
</tr>
<tr>
<td>F15</td>
<td>six/lifetime</td>
</tr>
<tr>
<td>F16</td>
<td>once/6 months</td>
</tr>
<tr>
<td>F17</td>
<td>twelve/lifetime</td>
</tr>
<tr>
<td>F18</td>
<td>three/lifetime</td>
</tr>
<tr>
<td>F19</td>
<td>twice/3 years</td>
</tr>
<tr>
<td>F20</td>
<td>two/2 years</td>
</tr>
<tr>
<td>F21</td>
<td>two/6 months</td>
</tr>
<tr>
<td>F22</td>
<td>four/year</td>
</tr>
<tr>
<td>F23</td>
<td>six/2 years</td>
</tr>
<tr>
<td>F24</td>
<td>eight/year</td>
</tr>
<tr>
<td>F25</td>
<td>eight/lifetime</td>
</tr>
<tr>
<td>F26</td>
<td>continuous monthly rental</td>
</tr>
</tbody>
</table>

9. This manual specifies when accessories or components are included in the maximum reimbursement amount (MRA) of certain base codes (i.e. wheelchairs, standers, speech generating devices). These accessories or components should be included at the time of initial dispensing of the equipment. No additional reimbursement will be made for these accessories or components within 90 days of dispensing the base item. If an included accessory is required within 90 days of dispensing the original item, the equipment provider should supply the accessory or component at no additional charge to the member.

### 4.1 MEDICAL/SURGICAL SUPPLIES

#### ADHESIVE TAPE/REMOVER

- **A4450**  
  Tape, non-waterproof, per 18 square inches  
  (up to 300)

- **A4452**  
  Tape, waterproof, per 18 square inches  
  (up to 100)

- **A4455**  
  Adhesive remover or solvent (for tape, cement or other adhesive), per ounce  
  (up to 40)

#### ANTISEPTICS

- **A4244**  
  Alcohol or peroxide, per pint  
  (up to 5)

- **A4245**  
  Alcohol wipes, per box (100’s)  
  (up to 5)

- **A4246**  
  Betadine or Phisohex solution, per pint  
  (up to 3)

#### BREAST PUMPS

- E0602/E0603 include all necessary supplies and collection containers (kit). Rental of hospital grade breast pumps is limited to Durable Medical Equipment vendors.

- **E0602**  
  Breast pump, manual, any type

Version 2019-1 (08/1/2019)
The manual pump must:

- Not be a bulb-type manual pump.
- Have a suction source that is independent of the collection container and the pump cylinder cannot be used as a milk-collecting container.
- Be packaged pre-assembled with all parts necessary for pumping with a minimum of one hand and be intended for a single user.
- Be lightweight and portable requiring no electricity.
- Have safety precautions to prevent suction from getting too high, > 250 mm Hg.
- Have a comfort cushion and spring or similar for easier hand pumping.
- Include breast flanges that are either adjustable/flexible or come in at least two (2) sizes to accommodate different breast sizes with no sharp edges.
- Include a collection bottle of four to six ounces with a spill-proof cap and standard-size opening, and be bisphenol-A (BPA) and DHEP-free.
- Contain collection bottle(s) and flanges made of medical grade quality to allow for repeated boiling and/or dishwasher cleaning which are scratch resistant and non-breakable.

The manual pedal pump must:

- Be an easy-to-assemble wooden pedal pump which requires no electricity and is powered by the leg and foot muscles. This pump can be useful for mothers with compromised hand or arm movements.
- Include an express spring for easier use.
- Work with a double pumping collection kit.

#Breast pump, electric (AC and/or DC), any type

The electric personal use/single-user pump must:

- Be lightweight and portable. The total weight of furnished assembly should not exceed 10 pounds.
- Be packaged pre-assembled with all parts necessary for pumping. Assembly includes but not limited to pump motor unit, minimum 5 feet-long electric cord, and double pumping collection kit.
- Operate on a 110-volt household current and be UL listed.
- Have an adjustable suction pressure between 50 mm Hg and 250 mm Hg at the breast shield during use; a suction range just at the low or high end of the range is not acceptable.
• Have an automatic mechanism to prevent suction greater than 250 mm Hg when used according to manufacturer’s instructions to prevent nipple trauma.
• Have a mechanism for automatic release of suction for safety.
• Have variable/adjustable cycling not less than 30 cycles per minute; one fixed cycling time is not acceptable.
• Have single and double pumping capacity and capable of maintaining a consistent vacuum (no pressure change) as the collection container fills regardless of the container size and whether single or double pumping.
• Have double pumping capacity which is simultaneous, not alternating.
• Have a visible breast milk pathway and no milk is able to contact the internal pump-motor unit parts at any time when the product is used per manufacturer instructions.
• Include breast flanges that are either adjustable/flexible or if rigid, come in at least two (2) sizes to accommodate different breast sizes with no sharp edges.
• Include a collection bottle of four to six ounces with a spill-proof cap and standard-size opening, and be bisphenol-A (BPA) and DHEP-free.
• Include a durable soft-sided carrying case with a storage compartment to hold pumping accessories and an insulated cooling compartment including freezer packs for storing expressed breast milk; this is recommended especially for women returning to work or school.
• Include a battery option and adapter that can be used as an alternate power source other than electric; this is recommended for flexibility of pumping.

**Minimum Breast Pump Specifications for Single-User/Multi-User* Double Pumping Kits**

*Use with hospital grade rentals.

**The kit must:**

• Include breast flanges that are either adjustable/flexible or if rigid, come in at least two (2) sizes to accommodate different breast sizes with no sharp edges.
• Be packaged pre-assembled with all accessories necessary for pumping two breasts simultaneously or only one breast manually.
• Include at least two collection bottles of four (4) to six (6) ounces with a spill-proof cap and standard-sized opening, and be bisphenol-A (BPA) and DHEP-free.
• Contain collection bottle(s) and flanges made of medical grade
quality to allow for repeated boiling and/or dishwasher cleaning which are scratch resistant and non-breakable.

- Have durable tubing designed for long-term pumping use.
- Design and materials of the furnished assembly shall allow viewing the breast milk pathway.
- Include an adapter that can be used as an alternate power source other than electric; this is recommended and may come as part of pump assembly or pumping kit.

### CANES/CRUTCHES/ACCESSORIES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4635</td>
<td>Underarm pad, crutch, replacement, each</td>
<td>(up to 2)</td>
</tr>
<tr>
<td>A4636</td>
<td>Replacement, handgrip, cane, crutch or walker, each</td>
<td>(up to 2)</td>
</tr>
<tr>
<td>A4637</td>
<td>Replacement, tip, cane, crutch, or walker, each</td>
<td>(up to 5)</td>
</tr>
<tr>
<td>E0100</td>
<td>#Cane, includes canes of all materials, adjustable or fixed, with tip</td>
<td></td>
</tr>
<tr>
<td>E0105</td>
<td>#Cane, quad or three-prong, includes canes of all materials, adjustable or fixed, with tips (over 31” height, no rotation option)</td>
<td></td>
</tr>
<tr>
<td>E0110</td>
<td>Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and hand grips (over 23” height, no rotation option)</td>
<td></td>
</tr>
<tr>
<td>E0111</td>
<td>Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrip (over 23” height, no rotation option)</td>
<td></td>
</tr>
<tr>
<td>E0112</td>
<td>Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and hand grips</td>
<td></td>
</tr>
<tr>
<td>E0113</td>
<td>Crutch, underarm, wood, adjustable or fixed, each, with pad, tip and handgrip</td>
<td></td>
</tr>
<tr>
<td>E0114</td>
<td>Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and hand grips</td>
<td></td>
</tr>
<tr>
<td>E0116</td>
<td>Crutch, underarm, other than wood, adjustable or fixed, with pad, tip, handgrip, with or without shock absorber, each</td>
<td></td>
</tr>
</tbody>
</table>

### INCONTINENCE APPLIANCES AND CARE SUPPLIES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4310</td>
<td>Insertion tray without drainage bag and without catheter (accessories only)</td>
<td>(up to 4)</td>
</tr>
<tr>
<td>A4311</td>
<td>Insertion tray without drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.)</td>
<td>each</td>
</tr>
<tr>
<td>A4314</td>
<td>Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.)</td>
<td>each</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Quantity</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>A4320</td>
<td>Irrigation tray with bulb or piston syringe, any purpose</td>
<td>each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(up to 15)</td>
</tr>
<tr>
<td>A4322</td>
<td>Irrigation syringe, bulb or piston, each</td>
<td>each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(up to 15)</td>
</tr>
<tr>
<td>A4326</td>
<td>Male external catheter with integral collection chamber, any type, each</td>
<td>each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(up to 15)</td>
</tr>
<tr>
<td>A4331</td>
<td>Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each</td>
<td>each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(up to 2)</td>
</tr>
<tr>
<td>A4333</td>
<td>Urinary catheter anchoring device, adhesive skin attachment, each</td>
<td>each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(up to 5)</td>
</tr>
<tr>
<td>A4334</td>
<td>Urinary catheter anchoring device, leg strap, each</td>
<td>each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(up to 8)</td>
</tr>
<tr>
<td>A4335</td>
<td>Incontinence supply; miscellaneous</td>
<td>up to 1 per 30 days</td>
</tr>
<tr>
<td>A4338</td>
<td>Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each</td>
<td>each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(up to 4)</td>
</tr>
<tr>
<td>A4344</td>
<td>Indwelling catheter, Foley type, two-way, all silicone</td>
<td>each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(up to 4)</td>
</tr>
<tr>
<td>A4346</td>
<td>Indwelling catheter, Foley type, three-way for continuous irrigation, each</td>
<td>each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(up to 4)</td>
</tr>
<tr>
<td>A4349</td>
<td>Male external catheter, with or without adhesive, disposable, each</td>
<td>each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(up to 40)</td>
</tr>
<tr>
<td>A4351</td>
<td>Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each</td>
<td>each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(up to 250)</td>
</tr>
<tr>
<td>A4352</td>
<td>Intermittent urinary catheter; coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each</td>
<td>each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(up to 250)</td>
</tr>
<tr>
<td></td>
<td>● Covered for self catheterization when the ordering practitioner documents treatment failure with straight tip (A4351) intermittent catheters.</td>
<td></td>
</tr>
<tr>
<td>A4353</td>
<td>Intermittent urinary catheter, with insertion supplies</td>
<td>each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(up to 60)</td>
</tr>
<tr>
<td>A4354</td>
<td>Insertion tray with drainage bag but without catheter</td>
<td>each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(up to 4)</td>
</tr>
</tbody>
</table>

**EXTERNAL URINARY SUPPLIES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4356</td>
<td>External urethral clamp or compression device (not to be used for catheter clamp), each</td>
<td>each</td>
</tr>
<tr>
<td>A4357</td>
<td>Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each</td>
<td>each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(up to 4)</td>
</tr>
<tr>
<td>A4358</td>
<td>Urinary drainage bag; leg or abdomen, vinyl, with or without tube, with straps, each</td>
<td>each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(up to 4)</td>
</tr>
</tbody>
</table>
OSTOMY SUPPLIES (These codes must be billed for ostomy care only)

A4361  #Ostomy faceplate, each (up to 1)
A4362  #Skin barrier; solid 4x4 or equivalent, each (up to 20)
A4363  #Ostomy clamp, any type, replacement only, each (up to 1)
A4364  #Adhesive, liquid, or equal, any type, per ounce (up to 8)
A4366  #Ostomy vent, any type, each (up to 1)
A4367  #Ostomy belt, each (up to 1)
A4368  #Ostomy filter, any type, each (up to 20)
A4369  #Ostomy skin barrier, liquid (spray, brush, etc.), per ounce (up to 4)
A4371  #Ostomy skin barrier, powder, per ounce (up to 2)
A4372  #Ostomy skin barrier, solid 4x4 or equivalent, standard wear, with built-in convexity, each (up to 15)
A4373  #Ostomy skin barrier, with flange (solid, flexible or accordion), with built-in convexity, any size, each (up to 15)
A4375  #Ostomy pouch, drainable, with faceplate attached, plastic, each (up to 2)
A4376  #Ostomy pouch, drainable, with faceplate attached, rubber, each (up to 2)
A4377  #Ostomy pouch, drainable, for use on faceplate, plastic, each (up to 15)
A4378  #Ostomy pouch, drainable, for use on faceplate, rubber, each (up to 2)
A4379  #Ostomy pouch, urinary, with faceplate attached, plastic, each (up to 15)
A4380  #Ostomy pouch, urinary, with faceplate attached, rubber, each (up to 2)
A4381  #Ostomy pouch, urinary, for use on faceplate, plastic, each (up to 10)
A4382  #Ostomy pouch, urinary, for use on faceplate, heavy plastic, each (up to 15)
A4383  #Ostomy pouch, urinary, for use on faceplate, rubber, each (up to 2)
A4384  #Ostomy faceplate equivalent, silicone ring, each (up to 10)
A4385  #Ostomy skin barrier, solid 4x4 or equivalent, extended wear, without built-in convexity, each (up to 15)
A4387  #Ostomy pouch closed, with barrier attached, with built-in convexity (1 piece), each (up to 15)
A4388  #Ostomy pouch, drainable, with extended wear barrier attached, without built-in convexity (1 piece) each (up to 15)
A4389  #Ostomy pouch, drainable, with barrier attached, with built-in convexity (1 piece), each (up to 15)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4390</td>
<td>Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each</td>
<td>(up to 15)</td>
</tr>
<tr>
<td>A4391</td>
<td>Ostomy pouch, urinary, with extended wear barrier attached, (1 piece), each</td>
<td>(up to 15)</td>
</tr>
<tr>
<td>A4392</td>
<td>Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each</td>
<td>(up to 15)</td>
</tr>
<tr>
<td>A4393</td>
<td>Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each</td>
<td>(up to 15)</td>
</tr>
<tr>
<td>A4394</td>
<td>Ostomy deodorant for use in ostomy pouch, liquid, per fluid ounce</td>
<td>(up to 8)</td>
</tr>
<tr>
<td>A4395</td>
<td>Ostomy deodorant for use in ostomy pouch, solid, per tablet</td>
<td>(up to 60)</td>
</tr>
<tr>
<td>A4396</td>
<td>Ostomy belt with peristomal hernia support</td>
<td>(up to 2)</td>
</tr>
<tr>
<td>A4397</td>
<td>Ostomy irrigation supply; sleeve, each</td>
<td>(up to 4)</td>
</tr>
<tr>
<td>A4398</td>
<td>Ostomy irrigation supply; bag, each</td>
<td>(up to 4)</td>
</tr>
<tr>
<td>A4399</td>
<td>Ostomy irrigation supply; cone/catheter, including brush</td>
<td>(up to 1)</td>
</tr>
<tr>
<td>A4400</td>
<td>Ostomy irrigation set</td>
<td>(up to 4)</td>
</tr>
<tr>
<td>A4402</td>
<td>Lubricant, per ounce</td>
<td>(up to 8)</td>
</tr>
<tr>
<td>A4404</td>
<td>Ostomy ring, each</td>
<td>(up to 10)</td>
</tr>
<tr>
<td>A4405</td>
<td>Ostomy skin barrier, non-pectin based, paste, per ounce</td>
<td>(up to 8)</td>
</tr>
<tr>
<td>A4406</td>
<td>Ostomy skin barrier, pectin-based, paste, per ounce</td>
<td>(up to 8)</td>
</tr>
<tr>
<td>A4407</td>
<td>Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 inches or smaller, each</td>
<td>(up to 10)</td>
</tr>
<tr>
<td>A4408</td>
<td>Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each</td>
<td>(up to 10)</td>
</tr>
<tr>
<td>A4409</td>
<td>Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each</td>
<td>(up to 10)</td>
</tr>
<tr>
<td>A4410</td>
<td>Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each</td>
<td>(up to 10)</td>
</tr>
<tr>
<td>A4411</td>
<td>Ostomy skin barrier, solid 4x4 or equivalent, extended wear, with built-in convexity, each</td>
<td>(up to 10)</td>
</tr>
<tr>
<td>A4412</td>
<td>Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), without filter, each</td>
<td>(used after ostomy surgery)</td>
</tr>
<tr>
<td>A4413</td>
<td>Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), with filter, each</td>
<td>(used after ostomy surgery)</td>
</tr>
<tr>
<td>A4414</td>
<td>Ostomy skin barrier, with flange (solid,</td>
<td>(up to 20)</td>
</tr>
</tbody>
</table>
flexible or accordion), without built-in convexity, 4 x 4 inches or smaller, each  
A4415 #Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4 x 4 inches, each  
A4416 #Ostomy pouch, closed, with barrier attached, with filter (one piece), each  
A4417 #Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (one piece), each  
A4418 #Ostomy pouch, closed; without barrier attached, with filter (one piece), each  
A4419 #Ostomy pouch, closed; for use on barrier with non-locking flange, with filter (two piece), each  
A4420 #Ostomy pouch, closed; for use on barrier with locking flange (two piece), each  
A4421 Ostomy supply; miscellaneous  
A4422 #Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each  
A4423 #Ostomy pouch, closed; for use on barrier with locking flange, with filter (two piece), each  
A4424 #Ostomy pouch, drainable, with barrier attached, with filter (one piece), each  
A4425 #Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (two piece system), each  
A4426 #Ostomy pouch, drainable; for use on barrier with locking flange (two piece system), each  
A4427 #Ostomy pouch, drainable; for use on barrier with locking flange, with filter (two piece system), each  
A4428 #Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (1 piece), each  
A4429 #Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each  
A4430 #Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece)  
A4431 #Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (1 piece), each  
A4432 #Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (2 piece), each  
A4433 #Ostomy pouch, urinary; for use on barrier  

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4434</td>
<td>#Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each</td>
<td>(up to 15)</td>
</tr>
<tr>
<td>A4435</td>
<td>#Ostomy pouch, drainable, high output, with extended wear barrier (one-piece system), with or without filter, each (used after ostomy surgery)</td>
<td>(up to 15)</td>
</tr>
<tr>
<td>A4456</td>
<td>#Adhesive remover, wipes, any type, each</td>
<td>(up to 50)</td>
</tr>
<tr>
<td>A5051</td>
<td>#Pouch, closed; with barrier attached (1 piece), each</td>
<td>(up to 60)</td>
</tr>
<tr>
<td>A5052</td>
<td>#Pouch, closed; without barrier attached (1 piece), each</td>
<td>(up to 60)</td>
</tr>
<tr>
<td>A5053</td>
<td>#Pouch, closed; for use on faceplate, each</td>
<td>(up to 60)</td>
</tr>
<tr>
<td>A5054</td>
<td>#Pouch, closed; for use on barrier with flange (2 piece), each</td>
<td>(up to 60)</td>
</tr>
<tr>
<td>A5055</td>
<td>#Stoma cap</td>
<td>each (up to 5)</td>
</tr>
<tr>
<td>A5056</td>
<td>#Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each</td>
<td>(up to 20)</td>
</tr>
<tr>
<td>A5057</td>
<td>#Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (1 piece), each</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A5061</td>
<td>#Pouch, drainable; with barrier attached (1 piece), each</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A5062</td>
<td>#Pouch, drainable; without barrier attached (1 piece), each</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A5063</td>
<td>#Pouch, drainable, for use on barrier with flange (2 piece system), each</td>
<td>(up to 50)</td>
</tr>
<tr>
<td>A5071</td>
<td>#Pouch, urinary; with barrier attached (1 piece), each</td>
<td>(up to 50)</td>
</tr>
<tr>
<td>A5072</td>
<td>#Pouch, urinary; without barrier attached (1 piece), each</td>
<td>(up to 50)</td>
</tr>
<tr>
<td>A5073</td>
<td>#Pouch, urinary; for use on barrier with flange (2 piece), each</td>
<td>(up to 50)</td>
</tr>
<tr>
<td>A5081</td>
<td>#Stoma plug or seal, any type</td>
<td>each (up to 31)</td>
</tr>
<tr>
<td>A5082</td>
<td>#Continent device; catheter for continent stoma</td>
<td>each (up to 120)</td>
</tr>
<tr>
<td>A5083</td>
<td>#Continent device, stoma absorptive cover for continent stoma</td>
<td>each (up to 5)</td>
</tr>
<tr>
<td>A5093</td>
<td>#Ostomy accessory; convex insert</td>
<td>each (up to 5)</td>
</tr>
</tbody>
</table>

**ADDITIONAL INCONTINENCE APPLIANCES/SUPPLIES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4458</td>
<td>#Enema bag with tubing, reusable</td>
<td>(up to 5)</td>
</tr>
<tr>
<td>A5105</td>
<td># Urinary suspensory with leg bag, with or without tube, each</td>
<td>(up to 5)</td>
</tr>
<tr>
<td>A5112</td>
<td>Urinary leg bag; latex</td>
<td>each (up to 5)</td>
</tr>
<tr>
<td>A5113</td>
<td>Leg strap; latex, replacement only, per set</td>
<td>(up to 2 pair)</td>
</tr>
</tbody>
</table>

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A5114  Leg strap; foam or fabric, replacement only, per set (up to 2 pair)
A5120  Skin barrier, wipes or swabs, each (up to 50)
   • Billed for ostomy care only
A5121  Skin barrier; solid, 6x6 or equivalent, each (up to 20)
A5122  Skin barrier; solid, 8x8 or equivalent, each (up to 20)
A5126  Adhesive or non-adhesive; disc or foam pad each (up to 30)
A5131  Appliance cleaner, incontinence and ostomy appliances, per 16 oz.
A5200  Percutaneous catheter/tube anchoring device, adhesive skin attachment each (up to 30)

COMMODE ACCESSORIES

E0160#  Sitz type bath, or equipment, portable, used with or without commode
E0167#  Pail or pan for use with commode chair, replacement only
E0275#  Bed pan, standard, metal or plastic
E0276#  Bed pan, fracture, metal or plastic
E0325#  Urinal; male, jug-type, any material
E0326#  Urinal; female, jug-type, any material

DIABETIC DIAGNOSTICS

A4233#  Replacement battery, alkaline (other than j cell), for use with medically necessary home blood glucose monitor owned by patient, each (up to 2)
A4234#  Replacement battery, alkaline, j cell, for use with medically necessary home blood glucose monitor owned by patient, each
A4235#  Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each
A4250#  Urine test or reagent strips or tablets, (100 tablets or strips) each (up to 2)
A4252#  Blood ketone test or reagent strip, each (up to 100)
A4253#  Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips (up to 4)
   • Only the coordinating blood glucose test strips for E2100 are reimbursed using HCPCS code A4253.
   • The supporting documentation and fiscal order must indicate the patient uses E2100, glucometer with voice synthesizer.

A4256#  Normal, low and high calibrator solution/chips
E2100#  Blood glucose monitor with integrated voice synthesizer
   • Covered for diabetic members with a diagnosis of
blindness or low vision.

**A9275**

#Home glucose disposable monitor, includes test strips
each (up to 2)

**Coverage Criteria:**
- Disposable glucometers are reimbursable when the ordering practitioner documents in the member’s file one of these diagnoses or situations:
  1. Person newly diagnosed with diabetes.
  2. Diagnosed with gestational diabetes.
  3. Diagnosed with Type 2 diabetes.
  4. In medical need of a treatment plan change from a traditional to disposable home glucometer.
  5. In medical need of an emergency replacement glucometer while awaiting prior approval of a traditional glucometer.
  6. A child who requires testing in school.

**Non-Covered Indications:**
- Disposable glucometers are not reimbursable as a back-up glucometer.
- Medicaid payment is only available for either a traditional glucometer or a disposable glucometer. If a disposable glucometer is dispensed, no additional strips are reimbursable.

### DIABETIC DAILY CARE

**A4230**

#Infusion set for external insulin pump, non needle cannula type
each (up to 30)
(60 day supply)

**A4231**

#Infusion set for external insulin pump, needle type
each (up to 24)
(60 day supply)

**A4244**

Alcohol or peroxide, per pint
(60 day supply)
(up to 5)

**A4245**

Alcohol wipes, per box (100’s)
(up to 5)

**A4258**

Spring-powered device for lancet, each
(up to 2)

**A4259**

Lancets, per box of 100
(up to 2)

### FAMILY PLANNING PRODUCTS

**A4267**

Contraceptive supply, condom, male, each
(up to 108)

**A4268**

Contraceptive supply, condom, female, each
(up to 108)

### GLOVES

**A4927**

#Gloves, non-sterile, per 100
(up to 1)

**A4930**

#Gloves, sterile, per pair
(up to 30)

**Coverage Criteria:**
• Gloves are reimbursable only when medically necessary for use by the member.
• Sterile gloves are only reimbursable when medically necessary to perform a sterile procedure.
• Gloves are not reimbursable as personal protective equipment for employees/caregivers or when included in a kit or tray (e.g., catheter or tracheostomy).

HEAT/COLD APPLICATION

- E0210 F4 #Electric heat pad, standard
- E0215 F4 #Electric heat pad, moist
- A9273 F6 Hot water bottle, ice cap or collar, heat and/or cold wrap, any type (ice cap/or collar not reimbursable)

1 per 365 days

SYNTHETIC SHEEP SKIN AND DECUBITUS CARE

- E0188 F13 Synthetic sheepskin pad
- E0191 Heel or elbow protector, each (up to 4)

MASTECTOMY CARE

- L8000 F24 Breast prosthesis, mastectomy bra, without integrated breast prosthesis form
- L8001 F24 Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral, any size, any type
- L8002 F22 Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral, any size, any type
- L8020 F22 Breast prosthesis, mastectomy form
- L8030 F22 Breast prosthesis, silicone or equal, without integral adhesive
- L8031 F22 Breast prosthesis, silicone or equal, with integral adhesive
- S8460 F24 Camisole, post-mastectomy

RESPIRATORY/TRACHEOSTOMY CARE SUPPLIES

NOTE: Supplies/parts are for patient-owned equipment only

- A4605 Tracheal suction catheter, closed system, each (for mechanical ventilation patient) (up to 15)
- A4481 #Tracheostoma filter, any type, any size, each (i.e., “artificial nose,” heat and moisture exchanger, (up to 30)
Thermavent, Humid-vent, Povox stomafilter, Bruce-Foam stomafilter).

- If ventilator-dependent, included in the 30 day ventilator rental fee.
- Not to be billed in conjunction with E0465 or E0466

**A4614** F8 **Peak expiratory flow meter, hand held**

**A4615** Cannula, nasal each (up to 1)

- For patient owned respiratory equipment

**Tubing, (oxygen), per foot**

**A4616** For patient owned respiratory equipment (up to 30)

**A4619** Face tent each (up to 1)

- For patient owned respiratory equipment

**A4620** Variable concentration mask each (up to 1)

- For patient owned respiratory equipment

**A4623** Tracheostomy, inner cannula each (up to 5)

**A4624** Tracheal suction catheter, any type, other than closed system, each (up to 250)

**A4625** Tracheostomy care kit for new tracheostomy each (up to 90)

- Consists of all necessary supplies for tracheostomy care. Includes but not limited to: tray, gloves, brush, gauze sponges, gauze tracheostomy dressing, pipe cleaners, cotton tip applicators, 30” twill tape, gauze roll and tracheostomy tube holder.

**A4626** Tracheostomy cleaning brush each (up to 2)

**A4628** Oropharyngeal suction catheter, each (e.g., Yankauer) each (up to 5)

**A4629** Tracheostomy care kit for established tracheostomy each (up to 90)

- Consists of all necessary supplies for tracheostomy care. Includes but not limited to: tray, gloves, brush, gauze sponges, gauze tracheostomy dressing, pipe cleaners, cotton tip applicators, 30” twill tape and tracheostomy tube holder.

**A7000** Canister, disposable, used with suction pump, each (up to 5)

**A7002** Tubing, used with suction pump, each (suction connection tubes) (up to 30)

**A7003** Administration kit, with small volume nonfiltered pneumatic nebulizer, disposable each (up to 2)

**A7004** Small volume nonfiltered pneumatic nebulizer, disposable each (up to 5)

**A7005** F7 Administration set, with small volume non filtered pneumatic nebulizer, non-disposable

**A7007** Large volume nebulizer, disposable, unfilled, used with aerosol compressor each (up to 5)

**A7013** Filter, disposable, used with aerosol compressor each (up to 5)

**A7014** F8 Filter, non-disposable, used with aerosol compressor or ultrasonic generator

**A7015** F8 Aerosol mask, used with DME nebulizer
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>A7038</td>
<td>Filter, disposable, used with positive airway pressure device (for replacement only)</td>
<td>each (up to 2)</td>
</tr>
<tr>
<td>A7039</td>
<td>Filter, nondisposable, used with positive airway pressure device (for replacement only)</td>
<td>each (up to 1)</td>
</tr>
<tr>
<td>A7048</td>
<td>Vacuum drainage collection unit and tubing kit; including all supplies needed for collection unit change, for use with implanted catheter, each • For use with implanted pleural or peritoneal catheter, not for use with peritoneal dialysis.</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A7523</td>
<td>Tracheostomy shower protector, each</td>
<td>(up to 4)</td>
</tr>
<tr>
<td>A7525</td>
<td>Tracheostomy mask, each</td>
<td></td>
</tr>
<tr>
<td>E0605</td>
<td>#Vaporizer, room type • Covered for the treatment of respiratory illness; warm or cool mist.</td>
<td>(up to 4)</td>
</tr>
<tr>
<td>L8512</td>
<td>Gelatin capsules or equivalent, for use with tracheoesophageal voice prosthesis, replacement only, per 10</td>
<td>(up to 9)</td>
</tr>
<tr>
<td>L8513</td>
<td>Cleaning device used with tracheoesophageal voice prosthesis, pipet, brush, or equal, replacement only, each</td>
<td>(up to 6)</td>
</tr>
<tr>
<td>S8100</td>
<td>#Holding chamber or spacer for use with an inhaler or nebulizer; without mask</td>
<td>each (up to 2)</td>
</tr>
<tr>
<td>S8101</td>
<td>#Holding chamber or spacer for use with an inhaler or nebulizer; with mask</td>
<td>each (up to 2)</td>
</tr>
<tr>
<td>S8189</td>
<td>Tracheostomy supply, not otherwise classified</td>
<td>1 per 30 days</td>
</tr>
</tbody>
</table>

**SUPPORT GOODS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4463</td>
<td>Surgical dressing holder, reusable, each</td>
<td>(up to 5)</td>
</tr>
<tr>
<td>A4495</td>
<td>#Surgical stockings thigh length (compression 18-35 mmHg)</td>
<td>each (up to 4)</td>
</tr>
<tr>
<td>A4500</td>
<td>#Surgical stockings below knee length (compression 18-35 mmHg)</td>
<td>each (up to 4)</td>
</tr>
<tr>
<td>A4510</td>
<td>#Surgical stockings full length, each (e.g., pregnancy support, compression 18-35 mmHg)</td>
<td>each (up to 2)</td>
</tr>
<tr>
<td>A4565</td>
<td>Slings</td>
<td>each (up to 2)</td>
</tr>
<tr>
<td>A4570</td>
<td>Splint</td>
<td></td>
</tr>
<tr>
<td>L0120</td>
<td>#Cervical, flexible, non-adjustable, prefabricated, off-the-shelf (foam collar)</td>
<td></td>
</tr>
</tbody>
</table>

**THERMOMETERS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4931</td>
<td>Oral thermometer, reusable, any type, each</td>
<td>one</td>
</tr>
<tr>
<td>A4932</td>
<td>Rectal thermometer, reusable, any type, each</td>
<td>one</td>
</tr>
</tbody>
</table>
UNDERPADS/DIAPERS/LINERS

Coverage Criteria:
- Diapers/Liners and underpads are covered for the treatment of incontinence only when the medical need is documented by the ordering practitioner and maintained in the member’s clinical file.

Non-Covered Indications:
- Diapers/Liners will not be covered for children under the age of three as they are needed as part of the developmental process.
- Incontinence liners are not menstrual pads. Personal hygiene products such as menstrual pads are not covered.

General Guidelines:
- The dispenser must maintain documentation of measurements (e.g., waist/hip size, weight) which supports reimbursement for the specific size of diaper/liner dispensed.
- Up to a total of 250 disposable diapers and/or liners are allowed per 30 days, providing for up to 8 changes per day. Claims for any combination of diapers and/or liners over 250 per 30 days will be denied.
- The quantity limits reflect amounts required to meet the medical need for a member’s incontinence treatment plan.
- In an effort to assist practitioners with ordering incontinence products, a draft ordering tool has been developed for monthly quantities for each covered diagnosis. Please refer to the draft ordering tool for additional information.
  - See following link to: [Incontinence Supply Management Program - 8-17-16.pdf](https://www.emedny.org/ProviderManuals/communications/IncontinenceSupplyManagementProgram_-_8-17-16.pdf)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Units (up to)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4335</td>
<td>Incontinence supply; miscellaneous</td>
<td>each (up to 30)</td>
</tr>
<tr>
<td>A4554</td>
<td>#Disposable underpads, all sizes, (e.g., Chux’s)</td>
<td>each (up to 300)</td>
</tr>
<tr>
<td>T4521</td>
<td>#Adult sized disposable incontinence product, brief/diaper, small, each</td>
<td>(up to 250)</td>
</tr>
<tr>
<td></td>
<td>(waist/hip 20”-34”)</td>
<td></td>
</tr>
<tr>
<td>T4522</td>
<td>#Adult sized disposable incontinence product, brief/diaper, medium, each</td>
<td>(up to 250)</td>
</tr>
<tr>
<td></td>
<td>(waist/hip 28”-47”)</td>
<td></td>
</tr>
<tr>
<td>T4523</td>
<td>#Adult sized disposable incontinence product, brief/diaper, large, each</td>
<td>(up to 250)</td>
</tr>
<tr>
<td></td>
<td>(waist/hip 40”-59”)</td>
<td></td>
</tr>
<tr>
<td>T4524</td>
<td>#Adult sized disposable incontinence product, brief/diaper, extra large, each</td>
<td>(up to 250)</td>
</tr>
<tr>
<td></td>
<td>(waist/hip 60”-62”)</td>
<td></td>
</tr>
<tr>
<td>T4529</td>
<td>#Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each (12-23 lbs)</td>
<td>(up to 250)</td>
</tr>
</tbody>
</table>
Durable Medical Equipment, Orthotics, Prosthetics and Supplies
Procedure Codes and Coverage Guidelines

**T4530**  #Pediatric sized disposable incontinence product, brief/diaper, large size, each (24-35 lbs) (up to 250)

**T4533**  #Youth sized disposable incontinence product, brief/diaper, each (>35 lbs) (up to 250)

**T4535**  #Disposable liner/shield/guard/pad/undergarment, for incontinence, each (up to 250)

**T4537**  #Incontinence product, protective underpad, reusable, bed size, each (up to 3)

**T4539**  #Incontinence product, diaper/brief, reusable, any size, each (up to 5)

**T4540**  #Incontinence product, protective underpad, reusable, chair size, each (up to 3)

**T4543**  Adult sized disposable incontinence product, protective brief/diaper, above extra large, each (waist/hip ≥ 62”) (up to 250)

**WOUND DRESSINGS**

**A6010**  #Collagen based wound filler, dry form, sterile, per gram of collagen (up to 30)

**A6011**  #Collagen based wound filler, gel/paste, sterile, per gram of collagen (up to 30)

**A6021**  #Collagen dressing, sterile, size 16 sq. in. or less, each (up to 5)

**A6022**  #Collagen dressing, sterile, size more than 16 but less than or equal to 48 sq. in., each (up to 5)

**A6023**  #Collagen dressing, sterile, size more than 48 sq. in., each (up to 5)

**A6024**  #Collagen dressing wound filler, sterile, per 6 inches (up to 3)

**A6196**  Alginate or other fiber gelling dressing, wound cover, sterile, pad size 16 sq. in. or less, each dressing (up to 30)

**A6197**  Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 sq. in., each dressing (up to 30)

**A6198**  Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 48 sq. in., each dressing (up to 15)

**A6199**  Alginate or other fiber gelling dressing, wound filler, sterile, per 6 inches (up to 60)

**A6203**  Composite dressing, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing (up to 30)

**A6204**  Composite dressing, sterile, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing (up to 30)

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Coverage Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>A6205</td>
<td>Composite dressing, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing</td>
<td>up to 15</td>
</tr>
<tr>
<td>A6206</td>
<td>Contact layer, sterile, 16 sq. in., or less, each dressing</td>
<td>up to 30</td>
</tr>
<tr>
<td>A6207</td>
<td>Contact layer, sterile, more than 16 but less than or equal to 48 sq. in., each dressing</td>
<td>up to 30</td>
</tr>
<tr>
<td>A6208</td>
<td>Contact layer, sterile, more than 48 sq. in., each dressing</td>
<td>up to 15</td>
</tr>
<tr>
<td>A6209</td>
<td>Foam dressing, wound cover, sterile, pad size 16 sq. in., or less, without adhesive border, each dressing</td>
<td>up to 30</td>
</tr>
<tr>
<td>A6210</td>
<td>Foam dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing</td>
<td>up to 30</td>
</tr>
<tr>
<td>A6211</td>
<td>Foam dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing</td>
<td>up to 30</td>
</tr>
<tr>
<td>A6212</td>
<td>Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing</td>
<td>up to 30</td>
</tr>
<tr>
<td>A6213</td>
<td>Foam dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing</td>
<td>up to 30</td>
</tr>
<tr>
<td>A6214</td>
<td>Foam dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing</td>
<td>up to 15</td>
</tr>
<tr>
<td>A6216</td>
<td>Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing</td>
<td>up to 120</td>
</tr>
<tr>
<td>A6217</td>
<td>Gauze, non-impregnated, non-sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing</td>
<td>up to 120</td>
</tr>
<tr>
<td>A6218</td>
<td>Gauze, non-impregnated, non-sterile, pad size more than 48 sq. in., without adhesive border, each dressing</td>
<td>up to 60</td>
</tr>
<tr>
<td>A6219</td>
<td>Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing</td>
<td>up to 120</td>
</tr>
<tr>
<td>A6220</td>
<td>Gauze, non-impregnated, sterile, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing</td>
<td>up to 30</td>
</tr>
<tr>
<td>A6221</td>
<td>Gauze, non-impregnated, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing</td>
<td>up to 15</td>
</tr>
<tr>
<td>A6222</td>
<td>Gauze, impregnated, other than water, normal saline, or hydrogel, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing</td>
<td>up to 30</td>
</tr>
<tr>
<td>A6223</td>
<td>Gauze, impregnated, other than water, normal saline, or hydrogel, sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border,</td>
<td>up to 60</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Limitation</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>A6224</td>
<td>Gauze, impregnated, other than water, normal saline, or hydrogel, sterile, pad size more than 48 sq. in., without adhesive border, each dressing</td>
<td>(up to 15)</td>
</tr>
<tr>
<td>A6228</td>
<td>Gauze, impregnated, water or normal saline, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A6229</td>
<td>Gauze, impregnated, water or normal saline, sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A6230</td>
<td>Gauze, impregnated, water or normal saline, sterile, pad size more than 48 sq. in., without adhesive border, each dressing</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A6231</td>
<td>Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size 16 sq. in. or less, each dressing</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A6232</td>
<td>Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size greater than 16 sq. in. but less than or equal to 48 sq. in., each dressing</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A6233</td>
<td>Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size more than 48 sq. in., each dressing</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A6234</td>
<td>Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A6235</td>
<td>Hydrocolloid dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 sq. in. without adhesive border, each dressing</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A6236</td>
<td>Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A6237</td>
<td>Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A6238</td>
<td>Hydrocolloid dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 sq. in. with any size adhesive border, each dressing</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A6239</td>
<td>Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A6240</td>
<td>Hydrocolloid dressing, wound filler, paste, sterile, per fluid ounce</td>
<td>(up to 20)</td>
</tr>
<tr>
<td>A6241</td>
<td>Hydrocolloid dressing, wound filler, dry form, sterile, per gram</td>
<td>(up to 25)</td>
</tr>
<tr>
<td>A6242</td>
<td>Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing</td>
<td>(up to 30)</td>
</tr>
</tbody>
</table>
A6243 Hydrogel dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing (up to 30)

A6244 Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing (up to 30)

A6245 Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing (up to 30)

A6246 Hydrogel dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing (up to 30)

A6247 Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing (up to 30)

A6248 Hydrogel dressing, wound filler, gel, sterile, per fluid ounce (up to 30)

A6251 Specialty absorptive dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing (up to 30)

A6252 Specialty absorptive dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing (up to 30)

A6253 Specialty absorptive dressing wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing (up to 30)

A6254 Specialty absorptive dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing (up to 30)

A6255 Specialty absorptive dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing (up to 30)

A6256 Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing (up to 30)

A6257 Transparent film, sterile, 16 sq. in. or less, each dressing (up to 30)

A6258 Transparent film, sterile, more than 16 but less than or equal to 48 sq. in., each dressing (up to 30)

A6259 Transparent film, sterile, more than 48 sq. in., each dressing (up to 30)

A6261 Wound filler, gel/paste, sterile, per fluid ounce, not elsewhere classified (up to 30)

A6262 Wound filler, dry form, sterile, per gram, not elsewhere classified (up to 30)

A6266 Gauze, impregnated, other than water, normal saline, (up to 30)
or zinc paste, sterile, any width, per linear yard

A6402 Gauze, non-impregnated, sterile, pad size 16 sq. in. or less without adhesive border, each dressing (up to 180)

A6403 Gauze, non-impregnated, sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing (up to 120)

A6404 Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing (up to 30)

A6407 Packing strips, non-impregnated, sterile, up to two inches in width, per linear yard (up to 30)

A6410 Eye pad, sterile, each (up to 50)

A6411 Eye pad, non-sterile, each (up to 50)

A6412 Eye patch, occlusive, each (up to 30)

A6441 Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard (up to 30)

A6442 Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard (up to 120)

A6443 Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard (up to 120)

A6444 Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to five inches, per yard (up to 120)

A6445 Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard (up to 120)

A6446 Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard (up to 120)

A6447 Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard (up to 120)

A6448 Light compression bandage, elastic, knitted/woven, width less than three inches, per yard (up to 90)

A6449 Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard (up to 90)

A6450 Light compression bandage, elastic, knitted/woven, width greater than or equal to five inches, per yard (up to 90)

A6451 Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50 percent maximum stretch, width greater than or equal to three inches and less than five inches, per yard (up to 90)

A6452 High compression bandage, elastic, knitted/woven load resistance greater than or equal to 1.35 foot pounds at 50 percent maximum stretch, width greater
### Durable Medical Equipment, Orthotics, Prosthetics and Supplies
#### Procedure Codes and Coverage Guidelines

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Cost (up to)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A6453</td>
<td>Self-adherent bandage, elastic, non-knitted/non-woven, width less than three inches, per yard</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A6454</td>
<td>Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than five inches, per yard</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A6455</td>
<td>Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard</td>
<td>(up to 30)</td>
</tr>
<tr>
<td>A6456</td>
<td>Zinc impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard</td>
<td>(up to 24)</td>
</tr>
<tr>
<td>A6457</td>
<td>Tubular dressing with or without elastic, any width, per linear yard</td>
<td>(up to 25)</td>
</tr>
</tbody>
</table>

### VARIOUS MISCELLANEOUS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Cost (up to)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4216</td>
<td>Sterile water, saline, and/or dextrose (diluent), 10ml</td>
<td>(up to 120)</td>
</tr>
<tr>
<td>A4217</td>
<td>Sterile water/saline, 500ml</td>
<td>(up to 10)</td>
</tr>
<tr>
<td>A4221</td>
<td><strong>Supplies for maintenance of non-insulin drug infusion catheter, per week (list drug separately)</strong> (Providers would access DVS once every 30 days for up to 4 units total per month, 1 unit=1 week)</td>
<td>(up to 4)</td>
</tr>
<tr>
<td></td>
<td>Includes supplies used for maintenance of infusion catheter, including but not limited to: flush solutions not directly related to drug infusion, dressings, cannulas and needles, needleless systems, end caps, extension sets.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Catheter site may be peripheral intravenous line, peripherally inserted central venous catheter, centrally inserted intravenous line with either external or subcutaneous port, or epidural catheter.</td>
<td></td>
</tr>
<tr>
<td>A4222</td>
<td>Infusion supplies for external drug infusion pump, per cassette or bag (list drugs separately) (maximum of 1 bag or cassette per day).</td>
<td>(up to 30)</td>
</tr>
<tr>
<td></td>
<td>Supplies required for use with external drug infusion pump, including cassette or bag, diluting solutions, tubing, and other administration supplies.</td>
<td></td>
</tr>
</tbody>
</table>
- Requested units based on number of cassettes or bags prepared.

**Documentation requirements:**
- Diagnosis requiring intravenous infusion, drug name and dose being administered, venous access device, type of pump, and length of treatment;
- Number of bags or cassettes prepared per 30-day period.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4649</td>
<td><strong>Surgical supply; miscellaneous</strong> (up to 30)</td>
</tr>
<tr>
<td>A4660&lt;sup&gt;F5&lt;/sup&gt;</td>
<td>#Sphygmomanometer/blood pressure apparatus with cuff and stethoscope, kit, any type</td>
</tr>
<tr>
<td>A4670&lt;sup&gt;F5&lt;/sup&gt;</td>
<td>Automatic blood pressure monitor (semi or fully automatic)</td>
</tr>
<tr>
<td></td>
<td>Semi-automatic monitors (hand cuff inflation) covered when:</td>
</tr>
<tr>
<td></td>
<td>● The device is ordered by a qualified practitioner as part of a comprehensive treatment plan for member monitoring and recording in the home.</td>
</tr>
<tr>
<td></td>
<td>● The member has a hearing or visual impairment, and/or</td>
</tr>
<tr>
<td></td>
<td>● The member could not be taught to use a manual monitor due to low literacy skills or a learning impairment.</td>
</tr>
<tr>
<td></td>
<td>Fully-automatic monitors (push button operation) covered when:</td>
</tr>
<tr>
<td></td>
<td>● The member meets criteria for semi-automatic and</td>
</tr>
<tr>
<td></td>
<td>● The member has arthritis or other motor disorders involving the upper extremities.</td>
</tr>
<tr>
<td>A9999</td>
<td>Miscellaneous DME supply or accessory, not otherwise specified</td>
</tr>
<tr>
<td>E0710</td>
<td>Restraints, any type (body, chest, wrist or ankle) each (up to 4)</td>
</tr>
<tr>
<td>T5999</td>
<td>Supply, not otherwise specified (limited to the following previously stated-defined codes):</td>
</tr>
<tr>
<td>Z2003</td>
<td>Plastic strips</td>
</tr>
<tr>
<td>Z2351&lt;sup&gt;F10&lt;/sup&gt;</td>
<td>Basal thermometer</td>
</tr>
<tr>
<td>Z2156</td>
<td>Sterile 6” wood applicator w/cotton tips 50’s (up to 5)</td>
</tr>
<tr>
<td>Z2640&lt;sup&gt;F6&lt;/sup&gt;</td>
<td>Incentive spirometer</td>
</tr>
<tr>
<td>Z2744&lt;sup&gt;F21&lt;/sup&gt;</td>
<td>Nasal aspirator 100’s (up to 1)</td>
</tr>
</tbody>
</table>
4.2 ENTERAL THERAPY

ENTERAL FORMULAE AND ENTERAL SUPPLIES

B4034  #Enteral feeding supply kit; syringe fed, per day  up to 30/mo
B4035  #Enteral feeding supply kit; pump fed, per day  up to 30/mo
B4036  #Enteral feeding supply kit; gravity fed, per day  up to 30/mo
• Enteral feeding supply kits (B4034-B4036) include whatever supplies are necessary to administer the specific type of feeding, and maintain the feeding site. Items included in the supply kit codes are not limited to pre-packaged kits bundled by manufacturers or distributors. This includes, but is not limited to: syringes, measuring containers, tip adapters, anchoring device, gauze pads, protective-dressing wipes, tape, feeding bags/container, administration set tubing, extension tubing, and tube cleaning brushes.

B4081  #Nasogastric tubing with stylet          one
B4082  #Nasogastric tubing without stylet (up to 2)
B4083  #Stomach tube - Levine type (up to 2)
B4087  #Gastrostomy/jejunosystem tube,
      standard, any material, any type, each
B4088  #Gastrostomy/jejunosystem tube, low-profile, any
      material, any type, each 1/3mo
• For beneficiaries who cannot tolerate the size of a standard gastrostomy tube or who have experienced failure of a standard gastrostomy tube. This code is for replacement in the patient’s home and should not be billed when the tube is replaced in the physician’s office, ER or facility with an all-inclusive rate. This kit includes tube/ button/ port, syringes, all extensions and/or decompression tubing and obturator if indicated.

B4100  #Food thickener, administered orally, per ounce (up to 180)
B4149  *Enteral formula, manufactured blenderized natural
      foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit (up to 600 caloric units)
B4150  *Enteral formula, nutritionally complete with intact
      nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit (up to 600 caloric units)
B4152  *Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include
fiber, administered through an enteral feeding tube, 100 calories = 1 unit

B4153 *Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit (up to 600 caloric units)

B4154 *Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit (up to 600 caloric units)

B4155 *Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g. glucose polymers), proteins/amino acids (e.g. glutamine, arginine), fat (e.g. medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories = 1 unit (up to 300 caloric units)

B4157 *Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit (up to 600 caloric units)

B4158 *Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit (up to 600 caloric units)

B4159 *Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit (up to 600 caloric units)

B4160 *Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit (up to 600 caloric units)

B4161 *Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, (up to 600 caloric units)
carbohydrates, vitamins and minerals, may include fiber, administered through and enteral feeding tube, 100 calories = 1 unit

B4162 *Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit (up to 600 caloric units)

B9998 Not otherwise classified enteral supplies (up to 90)
S8265 #Haberman feeder for cleft lip/palate up to 2 per 30 days

**ENTERAL NUTRITIONAL FORMULA**

**Benefit Coverage Criteria is limited to:**

- Beneficiaries who are fed via nasogastric, gastrostomy or jejunostomy tube.
- Beneficiaries with inborn metabolic disorders.
- **Children up to 21 years of age**, who require liquid oral nutritional therapy when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized.
- Adults with a diagnosis of HIV infection, AIDS, or HIV-related illness, or other disease or condition, who are oral-fed, and who:
  - require supplemental nutrition, demonstrate documented compliance with an appropriate medical and nutritional plan of care, and have a body mass index (BMI) under 18.5 as defined by the Centers for Disease Control, up to 1,000 calories per day; or
  - require supplemental nutrition, demonstrate documented compliance with an appropriate medical and nutritional plan of care, have a body mass index (BMI) under 22 as defined by the Centers for Disease Control, and a documented, unintentional weight loss of 5 percent or more within the previous 6 month period, up to 1,000 calories per day; or
  - require total oral nutritional support, have a permanent structural limitation that prevents the chewing of food, and placement of a feeding tube is medically contraindicated.

**Documentation Requirements:**

Version 2019-1 (08/1/2019)
The therapy must be an integral component of a documented medical treatment plan and ordered in writing by an authorized practitioner. It is the responsibility of the practitioner to maintain documentation in the member's record regarding the medical necessity for enteral nutritional formula.

The physician or other appropriate health care practitioner has documented the member's nutritional depletion.

Medical necessity for enteral nutritional formula must be substantiated by documented physical findings and/or laboratory data (e.g., changes in skin or bones, significant loss of lean body mass, abnormal serum/urine albumin, protein, iron or calcium levels, or physiological disorders resulting from surgery, etc.)

Documentation for beneficiaries who qualify for enteral formula benefit must include an established diagnostic condition and the pathological process causing malnutrition and one or more of the following items:

(a) Clinical findings related to the malnutrition such as a recent involuntary weight loss or a child with no weight or height increase for six months.
(b) Laboratory evidence of low serum proteins (i.e., serum albumin less than 3 gms/dl; anemia or leukopenia less than 1200/cmm);
(c) Failure to increase body weight with usual solid or oral liquid food intake.

Additional Information:

- Non-standard infant formulas are reimbursable by Medicaid under the appropriate enteral therapy code.
- The calculation for pricing enteral formula is as follows: Number of calories per can divided by 100 equals the number of caloric units per can.
- Enteral formula requires voice interactive prior authorization, as indicated by the "**" next to the code description. The prescriber must write the prior authorization number on the fiscal order and the dispenser completes the authorization process by calling (866) 211-1736. For requests that exceed 2,000 calories per day for qualifying beneficiaries, a prior approval request may be submitted with medical justification.
- The New York State Medicaid Program does not cover enteral nutritional therapy as a convenient food substitute.
- Standard milk-based infant formulas are not reimbursable by Medicaid.

Related Links:
The NYS Medicaid Program Enteral Formula Prior Authorization Dispenser Worksheet is available at:
https://www.emedny.org/ProviderManuals/communications/Dispenser%20Worksheet.pdf

The current enteral product classification list is available at: Enteral Product Classification List
4.3 HEARING AID BATTERY

V5266<sup>F9</sup> Battery for use in hearing device (any type) each (up to 24)
(up to a 60 day supply may be dispensed on one date of service)

L8621<sup>F8</sup> Zinc air battery for use with cochlear implant
device and auditory osseointegrated sound processors, replacement, each
(up to 60)

**NOTE:** To be priced by the State on a periodic basis at retail less 20 percent. When billing for batteries on the claim form the “Quantity Dispensed” field refers to the individual number of batteries dispensed not number of packages dispensed.
4.4 DURABLE MEDICAL EQUIPMENT

HOSPITAL BEDS AND ACCESSORIES

General Guidelines:
- A hospital bed is covered if the member is bed-confined (not necessarily 100 percent of the time) and the member's condition necessitates positioning of the body in a way not feasible in an ordinary bed, or attachments are required which cannot be used on an ordinary bed.
- Hospital beds must be Durable Medical Equipment (DME) and used in the home.
- The manufacturer of a hospital bed must be registered with the United States Food and Drug Administration (FDA).
- The hospital bed itself must be listed or cleared to market by the FDA.
- In no instance will an ordinary bed be covered by the Medicaid Program. An ordinary bed is one which is typically sold as furniture and does not meet the definition of DME or a hospital bed.
- A hospital bed as defined must include bed ends with casters, IV sockets, side rails (any type) and is capable of accommodating/supporting a trapeze bar, overhead frame and/or other accessories.
- Side rail pads and shields (E1399) are covered when there is a documented need to reduce the risk of entrapment or injury.
- If a member's condition requires a replacement innerspring mattress (E0271), foam rubber mattress (E0272) and/or side rails (E0305 or E0310); it will be covered for a member owned hospital bed.
- When the extent and duration of the medical need is not known at the time of ordering, hospital beds and related accessories should be rented.

E0251 F3 ‘-RR’ #Hospital bed, fixed height, with any type side rails, without mattress
A standard hospital bed is one with manual head and leg elevation adjustments but no height adjustment, which conforms to accepted industry standards, consisting of a modified latch spring assembly, bed ends with casters, two manually operated foot end cranks, is equipped with IV sockets and is capable of accommodating/supporting a trapeze bar, side rails (any type), an overhead frame and other accessories.

Coverage Criteria:
- A fixed height hospital bed (E0251) is covered if one or more of the following criteria (1-4) are met:
  1. The member has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed; or
  2. The member requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain; or
  3. The member requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure,
chronic pulmonary disease or problems with aspiration. Pillows or wedges must have been considered and ruled out; or
4. The member requires traction equipment, which can only be attached to a hospital bed.

E0256^F3\^'-RR' #Hospital bed, variable height, hi-lo, with any type side rails, without mattress
A variable height hospital bed is one with manual height adjustment and with manual head and leg elevation adjustments.

Coverage Criteria:
- A variable height hospital bed (E0256) is covered if the member meets one of the criteria 1-4 above and:
  5. The member requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.

E0261^F3\^'-RR' #Hospital bed, semi-electric (head and foot adjustment) with any type side rails, without mattress
A semi-electric hospital bed is one with manual height adjustment and with electric head and leg elevation adjustments.

Coverage Criteria:
- A semi-electric hospital bed (E0261) is covered if the member meets one of the criteria 1-4 above and:
  6. The member requires frequent changes in body position and/or has an immediate need for a change in body position (i.e., no delay in change can be tolerated) and the member can independently effect the adjustment by operating the controls.

E0266^F3\^'-RR' #Hospital bed, total electric (head, foot and height adjustments), with any type side rails, without mattress
A total electric hospital bed is one with manual height adjustment and electric head and leg elevation adjustments.

Coverage Criteria:
- A total electric hospital bed (E0266) is covered if the member meets one of the criteria 1-4 and both criteria 5 and 6 above, and:
  7. The member can adjust the bed height by operating the controls to effect independent transfers.

E0301^F3\^'-RR' #Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress (up to 48” width)
A heavy duty extra wide hospital bed is covered if the member meets one of the criteria 1-4 above and:
- The member's weight is more than 350 pounds, but does not exceed 600 pounds.

E0302^F2\^'-RR' #Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress
An extra heavy-duty hospital bed (E0302) is covered if the member meets one of the criteria 1-4 above and:
- The member's weight exceeds 600 pounds.
#Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress (prior approval required for ages less than 3 or over 20. Includes manual articulation and manual height adjustment)

Coverage Criteria:
- A Pediatric hospital bed is covered when the member meets one of the criteria 1-4 above and:
  10. The patient has a diagnosis-related cognitive or communication impairment or a severe behavioral disorder that results in risk for safety in bed; and
  11. There is evidence of mobility that puts the patient at risk for injury while in bed (more than standing at the side of the bed), or the patient has had an injury relating to bed mobility; and
  12. Less costly alternatives have been tried and were unsuccessful or contraindicated (e.g., putting a mattress on the floor, padding added to ordinary beds or hospital beds, transparent plastic shields, medications, helmets); and;
  13. The ordering practitioner has ruled out physical and environmental factors as reasons for patient behavior; such as hunger, thirst, restlessness, pain, need to toilet, fatigue due to sleep deprivation, acute physical illness, temperature, noise levels, lighting, medication side effects, over- or under-stimulation, or a change in caregivers or routine.

Please note: For patients with a behavioral disorder, a behavioral management plan is required.

#Mattress, inner spring

#Mattress, foam rubber

#Over-bed table

#Bedside rails, half-length (telescoping per pair, replacement only)
#Bedside rails, full-length (telescoping per pair, replacement only)

Safety enclosure frame/canopy for use with hospital bed, any type

Coverage Criteria:
- A hospital bed safety enclosure frame/canopy is covered when criteria 10-15 are met, and 16 and 17, if applicable:
  14. The member's bed mobility results in risk for safety in bed that cannot be accommodated by an enclosed pediatric manual hospital bed; and
  15. A written monitoring plan approved by the ordering and all treating practitioners has been completed which describes when the bed will be used, how the member will be monitored at specified time intervals, how all of the member's needs will be met while using the enclosed bed (including eating, hydration, skin care, toileting, and general safety), identification by relationship of all caregivers providing care to the member and
an explanation of how any medical conditions (e.g., seizures) will be managed while the member is in the enclosed bed; and

16. In the absence of injury relating to bed mobility, a successful trial in the home or facility; and

17. For beneficiaries residing in an OMRDD certified residence, approval as a restraint with the agency’s Human Rights Committee.

PRESSURE REDUCING SUPPORT SURFACES

General Guidelines:
● Covered benefit when a member is bedridden or wheelchair-bound and/or has a documented history of decubitus where conventional cushioning methods have failed.
● Air fluidized beds are not covered for the home setting.
● Medicaid reimbursement for pressure reducing support surfaces is based on the following coding assignments and coverage criteria.

For Group 1 surfaces (codes A4640, E0181, E0182, E0184, E0185, E0186, E0187, E0188, E0196, E0197, E0198, E0199 {see Section 4.1 for E0188}):
● Completely immobile, i.e. member cannot make changes in body position, or
● Limited mobility, i.e. member cannot independently make changes in body position significant enough to alleviate pressure and
● Has any stage pressure ulcer on the trunk or pelvis and
● One or more of the following:
   1. Impaired nutritional status,
   2. Fecal or urinary incontinence
   3. Altered sensory perception

For Group 2 surfaces (codes E0193, E0277, E0371, E0372):
● Multiple Stage II pressure ulcers located on trunk or pelvis and the member has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate Group 1 support surface and the ulcers have worsened or remained the same over the past month or
● Large or multiple Stage III or IV pressure ulcers on the trunk or pelvis or
● Recent myocutaneous flap or skin graft surgery (past 60 days) for a pressure ulcer on the trunk or pelvis and the member has been on at least a Group 2 support surface immediately prior to a recent discharge (past 30 days) from a hospital or nursing home.

A4640\textsuperscript{F6} #Replacement pad for use with medically necessary alternating pressure pad owned by patient
E0181\textsuperscript{F3} #Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty
E0182\textsuperscript{F3} #Pump for alternating pressure pad, for replacement only
E0184\textsuperscript{F6} #Dry pressure mattress
Durable Medical Equipment, Orthotics, Prosthetics and Supplies
Procedure Codes and Coverage Guidelines

-RR’
E0185^F6 #Gel or gel-like pressure pad for mattress, standard mattress length and width
E0186^F6 #Air pressure mattress
-RR’
E0187^F6 #Water pressure mattress
-RR’
E0190^F6 #Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories
E0193^F2 #Powered air flotation bed (low air loss therapy)
-RR’
E0196^F6 #Gel pressure mattress
-RR’
E0197^F6 #Air pressure pad for mattress, standard mattress length and width
E0198^F6 #Water pressure pad for mattress, standard mattress length and width
E0199^F6 #Dry pressure pad for mattress, standard mattress length and width
E0277^F2 #Power pressure reducing air mattress
-RR’
E0371^F2 #Non-powered advance pressure reducing overlay for mattress, standard mattress length and width
E0372^F2 #Powered air overlay for mattress, standard mattress length and width

IPPB MACHINES

A4618^F11 Breathing Circuits
E0500^F6 IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source

• Intermittent Positive Pressure Breathing Machines are covered if the member's ability to breathe is severely impaired and medical necessity is supported by diagnosis. The level of sophistication of the machine should be compatible with the member's need and be appropriate for home use.

OXYGEN SYSTEMS

Coverage Guidelines:
• Oxygen therapy is covered by the New York State Medicaid Program under the following conditions:
  1. The oxygen therapy must be an integral component of a documented medical treatment plan and ordered in writing by an authorized practitioner.
  2. The practitioner has determined that the member suffers from a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, the member's blood gas levels indicate the
need for oxygen therapy, the alternative treatment measures have been tried or considered and been deemed clinically ineffective.

3. Coverage is provided for beneficiaries with significant hypoxia evidenced by any of the following blood gas levels/oxygen saturation levels:
   (a) An arterial PO2 at or below 55 mm Hg or an oxygen saturation at or below 88 percent taken at rest (awake), or
   (b) An arterial PO2 at or below 55 mm Hg, or an oxygen saturation at or below 88 percent, for at least 5 minutes taken during sleep for a patient who demonstrates an arterial PO2 at or above 56 mm Hg or an oxygen saturation at or above 89% while awake, or
   (c) A decrease in arterial PO2 more than 10 mm Hg, or a decrease in oxygen saturation more than 5 percent, for at least 5 minutes taken during sleep associated with symptoms or signs reasonable attributable to hypoxemia (e.g., cor pulmonale, “P” pulmonale or EKG, documented pulmonary hypertension and erythrocytosis), or
   (d) An arterial PO2 at or below 55 mm Hg or an oxygen saturation at or below 88 percent, taken during exercise for a patient who demonstrates an arterial PO2 at or above 56 mm Hg or an oxygen saturation at or above 89 percent during the day while at rest. (In this case, oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air).

4. Coverage is available for PO2 56 to 59 mm Hg or oxygen saturation is 89% if any of the following are documented:
   (a) Dependent edema suggesting congestive heart failure; or
   (b) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale of EKG (P wave greater than 3mm in Standard Leads II, III, or AVF); or
   (c) Erythrocythemia with a hematocrit greater than 56%

5. Liquid oxygen therapy coverage is limited to the following conditions:
   (a) Member requires constant (24 hours per day) liter flow greater than 5LPM; or
   (b) Member must be away from the home for long periods of time on a daily basis (e.g., school);
   (c) Beneficiaries who qualify for coverage of liquid oxygen will not receive coverage for any other delivery system during the same time period.

● Oxygen and related supplies are covered when prescribed for home oxygen therapy to treat a demonstrated severe breathing impairment. For many high volume oxygen users an oxygen concentrator represents a less expensive, medically appropriate alternative to containerized oxygen, quantity consumed should be a consideration in the type of equipment dispensed.
● Portable oxygen systems are covered when the practitioner’s order specifies that the portable system is medically necessary.
● E0431 and E0434 may not be billed in combination.
The DMEPOS provider must maintain the practitioner's documentation of medical necessity on file with the written order.

Oxygen therapy must be re-ordered once every 365 days or more frequently if the member's need for oxygen changes, as well as all medical documentation to substantiate coverage criteria.

All home oxygen therapy services are reimbursed on an all-inclusive rate that may be billed once per 30 days.

A “spot check” pulse oximeter for intermittently checking oxygen levels is included in the monthly rental reimbursement for all oxygen systems.

As with all rentals the 30 day fee includes all necessary equipment (e.g. oxygen tank holder).

- **E0424**
  - **F26**
  - #Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing

- **E0431**
  - **F26**
  - #Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing (includes contents)

- **E0434**
  - **F26**
  - #Portable liquid oxygen systems, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing

- **E0439**
  - **F26**
  - #Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing (per unit) (one unit= one liter per minute) (up to six units)

- **E1390**
  - **F26**
  - #Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at prescribed flow rate

  - The 30 day rate for code E1390 includes portable/emergency gaseous supply. This supply would be in place for a power outage, malfunction of the concentrator, etc. for the homebound member, and is included in the 30 day rate. However, portable oxygen can be billed in addition to the concentrator when the member requires portable oxygen (E0431) to go out of the house for normal (non-emergency) activities such as appointments or grocery shopping, etc.

- **E1392**
  - **F26**
  - #Portable oxygen concentrator, rental

  - The 30 day rate includes all oxygen needs: stationary, portable and emergency gaseous supply in place for a power outage, malfunction of the concentrator, or other emergency situations.

  - Code E1392 is not reimbursable in conjunction with any other oxygen system (codes E1390, E0424, E0431, E0434 or E0439).

### RESPIRATORY CARE

- **A7027**
  - **F7**
  - #Combination oral/nasal mask, used with continuous positive airway pressure device, each

- **A7028**
  - **F7**
  - #Oral cushion for combination oral/nasal mask, replacement only, each
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A7029</td>
<td>Nasal pillows for combination oral/nasal mask, replacement only, pair</td>
</tr>
<tr>
<td>A7030</td>
<td>Full face mask used with positive airway pressure device, each</td>
</tr>
<tr>
<td>A7031</td>
<td>Face mask interface, replacement for full face mask, each</td>
</tr>
<tr>
<td>A7032</td>
<td>Cushion for use on nasal mask interface, replacement only, each</td>
</tr>
<tr>
<td>A7033</td>
<td>Pillow for use on nasal cannula type interface, replacement only, pair</td>
</tr>
<tr>
<td>A7034</td>
<td>Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap</td>
</tr>
<tr>
<td>A7035</td>
<td>Headgear used with positive airway pressure device (for replacement only)</td>
</tr>
<tr>
<td>A7036</td>
<td>Chinstrap used with positive airway pressure device</td>
</tr>
<tr>
<td>A7037</td>
<td>Tubing used with positive airway pressure device (for replacement only)</td>
</tr>
<tr>
<td>A7044</td>
<td>Oral interface used with positive airway pressure device, each</td>
</tr>
<tr>
<td>A7045</td>
<td>Exhalation port with or without swivel used with accessories for positive airway devices, replacement only</td>
</tr>
<tr>
<td>E0445</td>
<td>Oximeter device for measuring blood oxygen levels non-invasively</td>
</tr>
</tbody>
</table>

### General Guidelines

- A “spot check” pulse oximeter for intermittently checking oxygen levels is included in the monthly rental reimbursement for all oxygen systems (E0424, E0431, E0434, E0439, E1390, and E1392) and should not be billed separately.

- A “continuous” monitoring oximeter, required for more than spot-checking oxygen levels (e.g., required for continuous monitoring, recording/trending, alarms), must be submitted through prior approval.

- A “continuous” oximeter for short-term use less than 6 months is rented. The monthly rental amount includes probes, cables, repair, and maintenance. If medical need for “continuous” oximeter extends beyond the initial 6 months, submit through prior approval for purchase. All rental fees must be deducted from purchase price.

- A “continuous” oximeter for long-term use, greater than 6 months is purchased. The maximum reimbursement amount for the continuous oximeter includes all probes, cables, and supplies necessary for use of the device.

- Once purchased, supplies require prior approval.

### Coverage Criteria for “Continuous” Oximeter:

Covered in combination with oxygen therapy under the following circumstances:

- Weaning from oxygen;
- Changes in physical condition requiring adjustments in oxygen therapy;
- Maintaining oxygen levels within a narrow range;
- As part of a primary care provider’s or physician specialist’s treatment plan requiring frequent monitoring/assessment of
oxygen levels that cannot be achieved using a “Spot check” oximeter.

Covered without oxygen therapy under the following circumstance:

- In cases of complex cardiac conditions, such as, but not limited to, univentricular heart or unrepaired cyanotic heart disease.

**Documentation Requirements for “Continuous” Oximeter**

The following documentation is necessary to support prior approval of a “continuous” oximeter:

- Diagnosis/medical condition justifying the need to monitor blood oxygen levels;
- Current oxygen orders, if applicable (note: Medicaid guidelines require oxygen orders to be renewed every 12 months);
- Treatment plan listing the required parameters and interventions for abnormal readings, including corresponding oxygen titrations if applicable;
- Availability of caregivers trained to appropriately manage the listed treatment interventions;
- If used with a ventilator, CPAP, BiPAP, or other respiratory assist device, the type, make, and model of the respiratory assist device must be provided to ensure oximetry is not already available on that device.

**A4606F6 Oxygen probe for use with oximeter device, replacement**

- Pulse oximeter probes are used with the “Continuous” Oximeter (E0445) and are included in the reimbursement for the pulse oximeter rental or at initial issue of the device if purchased.
- Prior approval for oxygen probes (A4606) is required when replacement is necessary for member-owned equipment.
- Disposable pulse oximeter probes are limited to four per month.
- Reusable pulse oximeter probes are limited to one every twelve months.
- Submit fiscal order and invoice with prior approval request.

**VENTILATORS**

E0465, E0466, and BiPAP ST devices (E0471 and E0472) will:

- Only be rented and are not to be billed in combination, and
- As with all rentals, the 30 day fee includes all necessary equipment, delivery, maintenance and repair costs, parts, supplies (e.g. tracheostoma filters, any type) and services for equipment set-up, maintenance and replacement of worn essential accessories or parts, loading or downloading software, and backup equipment as needed.
**E0465**
#Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)

**E0466**
#Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)

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**CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE (CPAP)**

**CPAP Coverage Guidelines:**
A CPAP (E0601) device is covered for the treatment of **OSA** if the following criteria are met:

- The patient must have a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based, as defined by Medicare polysomnogram **and** meet the following criteria:
  - The apnea-hypopnea index (AHI) or Respiratory Disturbance Index, (RDI) is greater than 15 events per hour with a minimum of 30 events; **or**
  - The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events **and**
  - Documentation of:
    - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia **or**
    - Hypertension, ischemic heart disease, or history of stroke.

A BIPAP (E0470) is covered for patients with **OSA** who have tried a single level positive airway pressure device (CPAP) and the trial has proven ineffective, based on a therapeutic trial conducted in a facility.

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**RESPIRATORY ASSIST DEVICES**

**BiPAP – E0470**

**BiPAP ST- E0471 and E0472**

Refer to [Medicare LCD for Respiratory Assist Devices (L11504)](http://www.medicarenhic.com/dme/mrlcdcurrent.aspx) Document for the qualifying coverage criteria of BIPAP and BIPAP ST for the following diagnoses:

- Restrictive Thoracic Disorders
- Severe COPD
- Central Sleep Apnea
- Hypoventilation Syndrome

Refer to the following:

**E0601**

#Continuous positive airway pressure (CPAP) device

- For purchase, filter, tubing and headgear are included with all new CPAP units and should NOT be billed with the initial setup. Supplies (filter, tubing and headgear) are also included if CPAP is initially rented.
**AIRWAY CLEARANCE DEVICES**

E0480, E0481, E0482, E0483

- Requests for a high frequency chest wall oscillation system (E0483) must be supported with documentation of a diagnosis and treatment plan.
- All airway clearance devices (E0480, E0481, E0482, and E0483) require an order from a Physically Handicapped Children’s Program (PHCP)-approved Cystic Fibrosis Center or a board-certified pulmonologist.
- Treatment failure with regular chest physical therapy, suctioning, nebulization, medication, spacers, and positive expiratory pressure devices must be documented along with other measures attempted to address contributing conditions (e.g., aspiration).
- The equipment ordered must have been successfully used in a hospital or other care setting and training provided to caregiver or member on use of the equipment.
- These devices are rented initially. A three month trial is required for chest compression systems and continued only with documented treatment success.

E0480

- **Percussor, electric or pneumatic, home model**

E0481

- **Intrapulmonary percussive ventilation system and related accessories**
  - Purchase price reached at 720 days (24 months).

E0482

- **Cough stimulating device, alternating positive and negative airway pressure (manual or automatic)**
  - Purchase price reached at 720 days (24 months).

E0483

- **High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each**
  - Purchase price reached at 1800 days (60 months).
A7025\(^{F2}\) #High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each
A7026\(^{F2}\) #High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each
E0550\(^{F3}\) ‘-RR’ #Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery
E0561\(^{F3}\) ‘-RR’ #Humidifier, non-heated, used with positive airway pressure device
   ● For member-owned equipment only
E0562\(^{F3}\) ‘-RR’ #Humidifier, heated, used with positive airway pressure device
   ● For member-owned equipment only. Not to be billed in combination with a rental.
E0565\(^{F3}\) ‘-RR’ #Compressor, air power source for equipment which is not self-contained or cylinder driven
   ● A compressor is covered only as an air power source for medically necessary durable medical equipment that is not self-contained.
E0570\(^{F6}\) #Nebulizer, with compressor
E0575\(^{F3}\) #Nebulizer, ultrasonic, large volume
   ● Ultrasonic nebulizers are covered where the presence of chronic obstructive pulmonary disease necessitates the greatest possible degree of nebulization in order to affect a therapeutic response.
E0580\(^{F9}\) Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter
E0600\(^{F3}\) Respiratory suction pump, home model, portable or stationary, electric
K0730\(^{F9}\) #Controlled dose inhalation drug delivery system
   ● Covered with a diagnosis of pulmonary arterial hypertension with Class III or IV symptoms, for administration of iloprost inhalation.
   ● The 30 day rate includes all supplies.
S8185\(^{F6}\) #Flutter device (positive expiratory pressure device)
S8999\(^{F3}\) Resuscitation bag (manual resuscitator for use by patient on artificial respiration during power failure or other catastrophic event)

TRACTION EQUIPMENT, VARIOUS

● Trapeze/traction equipment is covered if the member needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed. Heavy duty trapeze equipment is covered if the member meets the criteria for regular trapeze equipment and the member's weight is more than 250 pounds.
E0849\(^{F2}\) ‘-RR’ #Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible
E0855\(^{F2}\) ‘-RR’ #Cervical traction equipment not requiring additional stand or frame
E0860\(^{F3}\) Traction equipment, overdoor, cervical
WALKERS (ANY WIDTH)

E0130^F2  #Walker, rigid (pick-up), adjustable or fixed height
E0135^F2  #Walker, folding (pick-up), adjustable or fixed height
E0140^F3 Walker, with trunk support, adjustable or fixed height, any type

● Home walkers with trunk support provide complete adjustment to the center of gravity and trunk angle and support, and stimulate walking movements for an adult who requires gait training or retraining due to severe motor and balance dysfunction.
● Clinical documentation from a trial period must be submitted with the prior approval request.

Coverage Criteria:
● The member is unable to stand or ambulate independently due to conditions such as, but not limited to, neuromuscular or congenital disorders, including acquired skeletal abnormalities.
● The alignment of the member’s lower extremities are such that they can tolerate a standing or upright position.
● The member does not have complete paralysis of the lower extremities (Walkers with trunk support have no proven value for persons with complete paralysis of the lower extremities).
● The member does not have orthostatic hypotension, postural tachycardia syndrome, osteogenesis imperfecta, osteoporosis and other brittle bone diseases.
● The member has demonstrated improved mobility, function and physiologic symptoms or has maintained status with the use of the requested walker with trunk support (when other alternatives have failed) and is able to follow a home ambulation program incorporating the use of the walker with trunk support (as documented by a clinical ambulation program or a home trial with the requested walker).
● There is a home therapy plan outlining the use of the requested walker with trunk support.
● The member does not require a home standing device in addition
to a walker or gait trainer. Provision of both a standing device and walker/gait trainer is typically considered a duplication of service, as both address weight bearing.

**Documentation requirements:**
- A prescription including the walker and any modifications/accessories requested
- A detailed letter of medical necessity (LMN) that includes:
  1. A comprehensive history and physical exam by a licensed physician, physical therapist or occupational therapist.
  2. A summary of the existing medical condition, age at diagnosis, prognosis and co-morbid conditions.
  3. The member’s functional and physical assessment including strength, range of motion, tone, sensation, balance, ADL’s, and functional status.
  4. Documentation of failure of less costly alternatives (include make and model of alternatives tried as well as the length of the trial with each alternative).
  5. A home therapy plan outlining the planned use of the requested walker with trunk support.
  6. Documentation that the member does not have sufficient access to equipment in an alternative setting, e.g. clinic, outpatient therapy, etc.
  7. Documentation regarding the level of caregiver assistance available and/or needed on daily basis.
  8. Documentation that the member’s home can accommodate the requested walker with trunk support and that the family/caregiver has been trained in the use and maintenance of the requested walker.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0141F2</td>
<td>#Walker, rigid, wheeled, adjustable or fixed height</td>
</tr>
<tr>
<td>E0143F4</td>
<td>#Walker, folding, wheeled, adjustable or fixed height</td>
</tr>
<tr>
<td>E0144F3</td>
<td>#Walker, enclosed, four sided framed, rigid or folding, wheeled with posterior seat</td>
</tr>
<tr>
<td></td>
<td>● Provides safety and promotes unassisted walking.</td>
</tr>
<tr>
<td></td>
<td>● May include brake and/or variable resistance wheels.</td>
</tr>
<tr>
<td></td>
<td>● For an adult or child who requires enclosure and seat due to motor and balance dysfunction.</td>
</tr>
<tr>
<td>E0147F3</td>
<td>#Walker, heavy duty, multiple braking system, variable wheel resistance</td>
</tr>
<tr>
<td>E0148F3</td>
<td>#Walker, heavy duty, without wheels, rigid or folding, any type, each</td>
</tr>
<tr>
<td>E0149F3</td>
<td>#Walker, heavy duty, wheeled, rigid or folding, any type</td>
</tr>
<tr>
<td>E0153F7</td>
<td>#Platform attachment, forearm crutch, each (supports arm)</td>
</tr>
<tr>
<td>E0154F7</td>
<td>#Platform attachment, walker, each (supports arm)</td>
</tr>
<tr>
<td>E0155F7</td>
<td>#Wheel attachment, rigid pick-up walker, per pair</td>
</tr>
<tr>
<td>E0156F4</td>
<td>#Seat attachment, walker</td>
</tr>
<tr>
<td>E0157F7</td>
<td>#Crutch attachment, walker, each</td>
</tr>
</tbody>
</table>
E0159 F7  #Brake attachment for wheeled walker, replacement, each
E8000 F3  Gait trainer, pediatric size, posterior support, includes all accessories and components
E8001 F3  Gait trainer, pediatric size, upright support, includes all accessories and components
E8002 F3  Gait trainer, pediatric size, anterior support, includes all accessories and components

● Home pediatric gait trainers provide support and encourage upright positioning for children requiring gait training/retraining due to motor and balance dysfunction.
● Additional prompts, provide adjustment to the center of gravity and trunk angle and support, and stimulate walking movements for a child who requires gait training or retraining due to severe motor and balance dysfunction.
● Clinical documentation from a trial period must be submitted with the prior approval request.

Coverage Criteria:
● The member is unable to stand or ambulate independently due to conditions such as, but not limited to, neuromuscular or congenital disorders, including acquired skeletal abnormalities.
● The alignment of the member’s lower extremities are such that they can tolerate a standing or upright position.
● The member does not have orthostatic hypotension, postural tachycardia syndrome, osteogenesis imperfecta, osteoporosis and other brittle bone diseases.
● The member has demonstrated improved mobility, function and physiologic symptoms or has maintained ambulation status with the use of the requested gait trainer (when other alternatives have failed) and is able to follow a home ambulation program incorporating the use of the gait trainer (as documented by clinical ambulation program or home trial with the requested gait trainer).
● There is a home therapy plan outlining the use of the requested gait trainer.
● The member does not utilize, or require, a home standing device in addition to a walker or gait trainer. Provision of both a standing system and walker/gait trainer is typically considered a duplication of service, as both address weight bearing.

Documentation Requirements:
● A prescription including the gait trainer and any modifications/accessories requested
● A detailed letter of medical necessity (LMN) that includes:
  1. A comprehensive history and physical exam by a licensed physician, physical therapist or occupational therapist.
  2. A summary of the existing medical condition, age at diagnosis, prognosis and co-morbid conditions.
  3. The member’s functional and physical assessment including
strength, range of motion, tone, sensation, balance, ADL’s, and functional status.

4. Documentation of failure of less costly alternatives (include make and model of alternatives tried as well as the length of the trial with each alternative).

5. A home therapy plan outlining the planned use of the requested gait trainer

- Documentation that the member does not have sufficient access to equipment in an alternative setting, e.g. clinic, outpatient therapy, etc.
- Documentation regarding the level of caregiver assistance available/needed on daily basis.
- Documentation that the member’s home can accommodate the requested gait trainer and that the family/caregiver has been trained in the use and maintenance of the requested gait trainer.
WHEELED MOBILITY EQUIPMENT (WME), SEATING AND POSITIONING COMPONENTS (SPC)

I. GENERAL CLINICAL AND COVERAGE CRITERIA FOR WHEELED MOBILITY EQUIPMENT

- The term wheeled mobility equipment (WME) describes manual wheelchairs (MWC), power mobility devices (PMD) including power wheelchairs (PWC), power operated vehicles (POV) and push rim activated power assist devices (PAD). Seating and positioning components (SPC) describe seat, back and positioning equipment used to optimize the individual's positioning and level of function in their wheeled mobility equipment.
- Wheeled mobility equipment is covered if the member's medical condition(s) and mobility limitation(s) are such that without the use of the WME, the member's ability to perform mobility related activities of daily living (MRADL) in the home and/or community is significantly impaired and the member is not ambulatory or functionally ambulatory.
- In order for these criteria to be met, the member must have an evaluation that was performed by a qualified practitioner who has specific training and/or experience in wheelchair evaluation and ordering.
- The practitioner must document, to the extent required by the coverage criteria for the specific WME, how the member's medical condition supports Medicaid reimbursement.
- The practitioner must have no financial relationship with the supplier.
- If coverage criteria for the WME that is requested or provided are not met and if there is another device that meets the member's medical needs, payment will be based on the allowance for the least costly medically appropriate alternative.
- Determination of least costly alternatives will take into account the member's weight, seating needs, amount and type of use and needs for other medically necessary features.
- Reimbursement for the wheelchair codes includes all labor charges involved in the assembly of the wheelchair. Reimbursement also includes support services, such as delivery, set-up, and education about the use of the WME. No separate or additional payments will be made for shipping, handling, delivery or necessary fittings and adjustments.
- Maintaining documentation of least costly alternatives reviewed and attempted is the responsibility of the ordering practitioner and DMEPOS provider.
- Documentation must be submitted or provided at the time of manual review of a prior approval request, claim, or audit.
- When a member presents for a medical evaluation for WME and SPC (Seating and Positioning Components), the sequential consideration of the questions, listed below, by ordering and treating practitioners provides clinical guidance for the ordering of an appropriate device to meet the
medical need of treating and restoring the member's ability to perform MRADLs. MRADLs include dining, personal hygiene tasks and activities specified in a medical treatment plan completed in customary locations in the home and community.

1. Does the member have a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs? A mobility limitation is one that:
   (a) Prevents the member from accomplishing the MRADLs entirely, or,
   (b) Places the member at a reasonably determined heightened risk of morbidity or mortality secondary to attempts to participate in MRADLs, or
   (c) Prevents the member from completing the MRADLs within a reasonable time frame.

2. Are there other conditions that limit the member’s ability to participate in MRADLs?
   (a) Some examples are significant impairment of cognition or judgment and/or vision.
   (b) For these beneficiaries, the provision of WME and SPC might not enable them to participate in MRADLs if the co-morbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with WME and SPC.

3. If these other limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of WME and SPC will be reasonably expected to significantly improve the member’s ability to perform or obtain assistance to participate in MRADLs?
   (a) A caregiver, for example a family member, may be compensatory, if consistently available and willing and able to safely operate and transfer the member to and from the wheelchair and to transport the member using the wheelchair. The caregiver’s need to use a wheelchair to assist the member in the MRADLs is to be considered in this determination.
   (b) If the amelioration or compensation requires the member's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of WME and SPC coverage if it results in the member continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of WME and SPC.

4. Does the member or caregiver demonstrate the capability and the willingness to consistently operate the WME and SPC safely and independently?
   (a) Safety considerations include personal risk to the member as well as risk to others. The determination of safety may need to
occur several times during the process as the consideration focuses on a specific device.
(b) A history of unsafe behavior may be considered.

5. Can the functional mobility deficit be sufficiently resolved by the prescription of a cane or walker?
(a) The cane or walker should be appropriately fitted to the member for this evaluation.
(b) Assess the member’s ability to safely use a cane or walker.

6. Does the member’s typical environment support the use of WME and SPC?
(a) Determine whether the member’s environment will support the use of these types of WME and SPC.
(b) Keep in mind such factors as physical layout, surfaces, and obstacles, which may render WME and SPC unusable.

7. Does the member have sufficient upper and/or lower extremity function to propel a manual wheelchair to participate in MRADLs during a typical day? The manual wheelchair should be optimally configured (seating and positioning components, wheelbase, device weight, and other appropriate accessories) for this determination.
(a) Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.
(b) A member with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, i.e. light weight, etc., should be determined based on the member’s physical characteristics and anticipated intensity of use.
(c) The member’s home should provide adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.
(d) Assess the member’s ability to safely use a manual wheelchair.

8. Does the member have sufficient strength and postural stability to operate a POW/scooter?
(a) A covered POW is a 4-wheeled device with tiller steering and limited seat modification capabilities. The member must be able to maintain stability and position for adequate operation without additional SPC (a 3-wheeled device is not covered).
(b) The member’s home should provide adequate access, maneuvering space and surfaces for the operation of a POW.
(c) Assess the member’s ability to safely use a POW/scooter.
(d) Consider the potential for progression of some diagnoses.

9. Are the additional features provided by a power wheelchair or powered SPC needed to allow the member to participate in one or more MRADLs?
(a) The pertinent features of a power wheelchair compared to a POW are typically control by a joystick or alternative input
device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.

(b) The type of wheelchair and options provided should be appropriate for the degree of the member's functional impairments.

(c) The member's home should provide adequate access, maneuvering space and surfaces for the operation of a power wheelchair.

(d) Assess the member's ability to safely and independently use a power wheelchair and powered SPC.

**NOTE:** If the member is unable to use a power wheelchair or power SPC and if there is a caregiver who is available, willing and able to provide assistance, a manual wheelchair and manual SPC is appropriate.

Go to [http://www.cms.hhs.gov/determinationprocess/downloads/id143c.pdf](http://www.cms.hhs.gov/determinationprocess/downloads/id143c.pdf) for a flow chart developed by the Medicare program that visually describes the clinical criteria for the evaluation and ordering of WME.

II. WHEELED MOBILITY EQUIPMENT DOCUMENTATION REQUIREMENTS

- All services must be supported by the original signed written order from a qualified licensed practitioner. In the event an order has been telephoned or faxed to the vendor, it is the vendor's responsibility to obtain the signed fiscal order from the ordering practitioner within 30 calendar days. A written, faxed or telephoned order must be received prior to delivery of the service.

- The fiscal order must be specific to the item being requested. Generic orders such as “wheelchair” or “wheelchair repairs” are not acceptable. The order must clearly and specifically state the type of repairs being requested (e.g., “replace seat covering”) or the presenting problem (e.g., “joystick malfunctioning”).

- In addition to the fiscal order, the supplier must maintain the following written documentation of medical necessity for WME/SPC in the member’s file and/or submit to the Department for review:
  1. A description of, and cost quote for all the equipment and components as ordered (e.g., HCPCS code, make, model, size, seat and back dimensions) and how they accommodate relevant member measurements (e.g., height, weight, chest, shoulders, thighs, legs).
  2. A statement of the alternatives considered or attempted (e.g., manual versus power, single versus multiple power option) and why these alternatives do not meet the member’s medical needs.
  3. A description of the customary environment and caregiver supports (e.g., skilled nursing facility, OMRDD-certified residence, private home,
home health or waiver services); please give details of the results of trial of equipment in this environment (e.g., fitting through doorways, access to home, transportable, ability to safely operate, secure storage space).

4. The practitioner must document medical necessity, to the extent required by the coverage criteria for the specific WME/SPC; how the member’s medical condition supports Medicaid reimbursement. The documentation must be summarized and forwarded to the supplier in the form of a qualified practitioner’s letter of medical justification, an evaluation template and/or, physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. The practitioner must maintain appropriate and complete medical records even if a letter of medical justification or evaluation template is provided to the supplier. Examples of medical documentation which is applicable include but are not limited to:

**History:**
- Symptoms
- Explain history of decubitus/skin breakdown, if applicable
- How long the condition has been present.
- Clinical progression
- Interventions that have been tried and the results
- Past use of walker, manual wheelchair, POV, or power wheelchair and the results
- A list of all current WME and SPC (e.g., make, model, serial number, age) and an explanation of why it no longer meets the member’s medical needs (suppliers must obtain cost estimates of repair of equipment).
- Reports of pertinent laboratory tests, x-rays, and/or other diagnostic tests (e.g., pulmonary function tests, cardiac stress test, electromyogram, etc.) performed in the course of management of the member.
- Describe other physical limitations or concerns (e.g., respiratory)
- Describe any recent or expected changes in medical, physical, or functional status

**Physical exam:**
- Related diagnoses
- Impairment of strength, range of motion, sensation, or coordination of arms and legs
- Presence of abnormal tone or deformity of arms, legs, or trunk
- Neck, trunk, and pelvic posture and flexibility
- Sitting and standing balance
- Measurements of height, weight, chest, shoulders, hips, legs
- Absent or impaired sensation in the area of contact with the seating surface
Physicians shall document the examination in a detailed narrative note in their charts in the format that they use for other entries. The note must clearly indicate that a major reason for the visit was a mobility examination.

**Functional assessment:**
- Describe MRADL capabilities and any problems with performing MRADLs, including the need to use a cane, walker, or the assistance of another person
- Describe activities, other than MRADLs, performed while in wheelchair
- Transferring between a bed, chair, commode, toilet and WME
- Walking around customary environment – provide information on distance walked, speed, and balance.
- Ability to carry out a functional weight shift
- Describe in detail any significant postural asymmetries with applicable quantitative measurements (e.g., scoliosis leg length discrepancy).
- Describe feeding capabilities and seating modifications required to facilitate feeding capabilities
- Specifics why less costly alternatives are not medically appropriate based on the member’s medical needs.

**Plan of Care:**
- Intended use and amount of time daily the equipment is used and, degree of ambulation in customary environment
- What MRADLs will the member participate in with the new WME and SPC
- A narration of medical necessity for the WME and SPC, describing what medical needs specific to the member will be met if the equipment is provided.
- An estimate of how long the equipment will be needed
- If surgery is anticipated, indicate the CPT Procedure code(s) and ICD Diagnosis code(s) and expected surgery date.
- Describe anticipated modifications or changes to the equipment within the next three years
- Describe the growth potential of the requested equipment in number of years
- For SPC, describe whether it can be integrated into a new or existing wheelchair

5. For beneficiaries who receive a Group 2 Single Power Option or Multiple Power Options PWC, any Group 3 or Group 4 PWC, or a push-rim activated power assist device, the evaluation must provide detailed information explaining why each specific option or accessory is needed to address the member’s mobility limitation.
6. Prior to or at the time of delivery of a POV or PWC, the supplier, practitioner, or case manager must perform an on-site evaluation of the member’s home to verify that the member can adequately maneuver the device that is provided considering physical layout, doorway width, doorway thresholds, and surfaces. There must be a written report of this evaluation available on request.

- See the following link for an example of an evaluation form template [Wheelchair and Seating Assessment Guide](#). This form is not a required element of the medical record or prior approval submission. Although a practitioner-completed form is considered part of the medical record, it is not a substitute for the comprehensive medical record as noted above. If only a form is provided to the supplier, the documentation, to the extent required by the coverage criteria for the specific WME/SPC, present on the form must describe how the member’s medical condition supports Medicaid reimbursement.

- If the evaluation form, letter of medical justification or medical records of a licensed/certified medical professional (LCMP) (e.g., physical or occupational therapist) is to be considered as part of the medical record, there must be a signed and dated attestation by the supplier that the LCMP has no financial relationship with the supplier. Documentation without such an attestation will not be considered part of the medical record for prior approval or audit purposes. Documentation must contain the therapist’s name and licensure, evaluation date, phone number, address and employer.
III. MANUAL WHEELCHAIRS

Manual Wheelchairs are covered when:
- Criterion 1, 2, 3, 4, and 5 are met; and
- Criterion 6 or 7 is met, and
- Criterion is met for specific devices listed below
  1. The member has a mobility limitation that significantly impairs his/her ability to participate in one or more MRADL, and
  2. The member’s mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker, and
  3. The manual wheelchair supplied to the member for use in the home and community settings provides adequate access to these settings (e.g., between rooms, in and out of the home, transportation, over surfaces and a secure storage space), and
  4. Use of a manual wheelchair will significantly improve the member’s ability to participate in MRADLs and the member will use it on a regular basis, and
  5. The member has not expressed an unwillingness to use the manual wheelchair that is provided, and
  6. The member has sufficient upper extremity and/or lower extremity function and other physical and mental abilities needed to safely self-propel the manual wheelchair during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function, or
  7. The member has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

Reimbursement price for all manual wheelchairs includes:
  1. any type arm style or armrest, arm pad
  2. seat (a medically indicated non-standard seat, back cushion or seating system that is not included by the manufacturer may be billed separately)
  3. standard leg rest
  4. standard footrest
  5. safety belt/pelvic strap (2-point)
  6. solid tires and casters, metal hand rims
  7. brakes
  8. side guards (any type)
  9. push/attendant handles (any type)
(The above parts may not be billed separately with a new wheelchair.)

Codes and descriptions:
**E1161**

#Manual adult size wheelchair, includes tilt-in-space

**E1229**

Wheelchair, pediatric size, not otherwise specified

**E1233**

#Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system, (E2231 solid seat included)

**E1234**

#Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system

- Manual tilt-in-space wheelchairs (E1161, E1233, and E1234) are covered when
  (a) The member is not independent with transfers, and
  (b) The member has a plan of care that addresses the medical need for frequent positioning changes (e.g., for pressure reduction or poor/absent trunk control) that do not always include a tilt position.

- Pediatric tilt-in-space wheelchairs satisfy future growth capability, attendant or user controlled tilt, multi position tilt, transit system, attendant handles, 10-18" width, 13-18" depth and standard back heights.

- Adult tilt-in-space wheelchairs feature attendant or user controlled tilt, multi position tilt, transit system, attendant handles, 10-19" width and standard depth and back height.

- A combination of manual tilt-in-space along with manual recline option is covered when the member meets the coverage criteria for both components and when provided alone, one function will not meet their seating and positioning needs.

**E1236**

Wheelchair, pediatric size, folding, adjustable, with seating System (Limited to stroller-style mobility devices only)

- Code includes all accessories, parts and seating. Wheelchair accessory codes are not to be used at initial issue or for replacement parts.

- All requested repairs and replacement parts should be submitted for prior approval review using code E1236 RB.

- Strollers (E1236) are covered when supporting documentation:
  (a) illustrates why a manual wheelchair (E1161, E1233, E1234, K0001-K0009) would not meet the member’s medical needs in their customary environments;
  (b) selection is not based solely on caregiver convenience but on medical need of the member.
  (c) confirms there is no presence of severe, fixed postural deviations or contractures.

**K0001**

#Standard wheelchair

‘-RR’

A standard wheelchair is covered when

(a). The member is able to self-propel the wheelchair, or

(b). Propell with assistance.

- This wheelchair features heavy steel cross adult frame and fixed rear axle position, 16/18" width, 16" depth, and 16/18/20" back.
K0002 F4
‘-RR’

#Standard hemi (low-seat) wheelchair
A standard hemi-wheelchair is covered
(a). For disarticulation of one or both lower extremities, or
(b). Requires a lower seat height because of short stature, or
(c). To enable the member to place his/her feet on the ground for propulsion.

● This wheelchair features heavy steel cross frame and fixed rear axle position, 16/18" width, 16" depth, and 16-18" back.

K0003 F3
‘-RR’

#Lightweight wheelchair
A lightweight wheelchair is covered
(a). When a member's medical condition and the weight of the wheelchair affects the member's ability to self-propel, or
(b). For a member with marginal propulsion skills.

● This wheelchair features an adult, hemi or pediatric folding frame, aluminum or steel cross frame, fixed rear axle position, 14/16/18" width, 16/18" depth, and 16-18" back.

K0004 F3
‘-RR’

#High strength, lightweight wheelchair
A high strength lightweight wheelchair is covered when
(a). The member's medical condition and the weight of the wheelchair affects the member's ability to self-propel while engaging in frequent MRADLs that cannot be performed in a standard or lightweight wheelchair, or
(b). The member requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair.

● This wheelchair features an adult, hemi, or pediatric folding frame, limited rear axle adjustment, lightweight tires and casters, 12-20" width, 16-19" depth and 16-19" back.

K0005 F3

#Ultra lightweight wheelchair
An ultra lightweight multi-adjustable wheelchair is covered when:
(a). The member's medical condition and the weight of the wheelchair affects the member's ability to self-propel while engaging in frequent MRADLs that cannot be performed in a standard, lightweight or high strength lightweight wheelchair, and
(b). The member's medical condition and the position of the push rim in relation to the member's arms and hands is integral to the ability to self-propel the wheelchair effectively, and
(c). The member has demonstrated the cognitive and physical ability to independently and functionally self-propel the wheelchair, or
(d). The member's medical condition requires multi-adjustable features or dimensions that are not available in a less costly
wheelchair (e.g., pediatric size and growth options).

- A high-strength multi-adjustable (e.g.: depth adjustable back, adjustable seat to floor angle, adjustable seat to back angle) wheelchair features low rolling resistance, a fully adjusting rear axle, any type push handles, transport option, quick release axles, and folding or rigid pediatric or adult frame. Additionally, the weight distribution may be changed, adjusting the ease or difficulty of self-propulsion. This wheelchair features 11-19” width, 12-19” depth, and 17-20” back.

- Ultra lightweight wheelchairs should not be dispensed as back up manual wheelchairs unless due to the required dimensions not being available in less costly alternatives (e.g., pediatric size and growth options).

**K0006**

**F3**

#Heavy-duty wheelchair

A heavy duty wheelchair is covered when:
1. The member weighs more than 250 pounds, or
2. The member has severe spasticity, or
3. Body measurements cannot be accommodated by standard sized wheelchairs.

- This wheelchair features a reinforced folding cross frame, 300 lb weight capacity, reinforced seat and back, fixed rear axle position, calf pads, 20-22” width, 16-19” depth, and 18-20” back.

**K0007**

**F3**

#Extra heavy-duty wheelchair

An extra heavy duty (K0007) wheelchair is covered when
1. the member weighs more than 300 pounds, or
2. body measurements cannot be accommodated by a heavy duty wheelchair.

- In addition to the features provided in a heavy-duty wheelchair, a double cross brace and dual or triple axle positioning, 19-24” width, 16-20” depth and low/medium/tall backs are featured.

**K0009**

**F5**

Other manual wheelchair/base

- This code is to be used for beneficiaries with medical needs for features in addition to those indicated for the wheelchair and/or accessory codes listed. Custom-made wheelchairs feature a wheelchair frame that is uniquely constructed or substantially modified for a specific member and is covered if the feature needed is not available in an already manufactured wheelchair or accessory. The assembly of a wheelchair from modular components and the use of customized options do not meet the requirements for a custom-made wheelchair.

**Other:**

- Back-up manual wheelchairs are covered when:

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(a). the member meets the criteria for a power mobility device, and 
(b). the member meets the criteria for the rented or purchased back-up 
manual wheelchair, and 
(c). the member is unable to complete MRADLs without a back-up manual 
wheelchair, and 
(d.) the backup wheelchair accommodates the SPC on the primary 
wheelchair.

**NOTE:** Ultra lightweight wheelchairs should not be dispensed as back up 
manual wheelchairs unless due to the required dimensions not being available in 
less costly alternatives (e.g., pediatric size and growth options).

- Pediatric sized folding adjustable wheelchairs with seating systems are 
covered as primary or back-up wheeled mobility when: 
  (a) the member meets the criteria for wheeled mobility, and 
  (b) the wheelchair is an appropriate size for the member, and 
  (c) the member meets the criteria for recline and positioning options, and 
  (d) the wheelchair provides growth capability in width and length.

**IV. POWERED MOBILITY DEVICES (PMD)**

Are covered when: 
- Criterion 1, 2 and 3 are met, and 
- Criterion is met for specific devices listed below. 
  1. The member has a mobility limitation that impairs his or her ability to 
participate in one or more MRADL, and 
  2. The member’s mobility limitation cannot be sufficiently and safely resolved by 
the use of an appropriately fitted cane or walker, and 
  3. The member does not have sufficient upper extremity function to self-propel 
an optimally-configured manual wheelchair to perform MRADLs during a 
typical day. Limitations of strength, endurance, range of motion, or 
coordination, presence of pain, or deformity or absence of one or both upper 
extremities are relevant to the assessment of upper extremity function. An 
optimally-configured manual wheelchair is one with an appropriate 
wheelbase, device weight, seating options, and other appropriate non- 
powered accessories.

**NOTE:** A PMD will be denied as not medically necessary if the underlying 
condition is reversible and the length of need is less than 3 months (e.g., 
following lower extremity surgery which limits ambulation).

**Power Operated Vehicles (POV)**
Four-wheeled, are covered if all of the basic coverage criteria (1-3) for PMDs have been met and if criteria (4-9) are also met.

4. The member is able to:
   (a) Safely transfer to and from a POV, and
   (b) Operate the tiller steering system, and
   (c) Maintain postural stability and position in standard POV seating while operating the POV without the use of any additional positioning aids

5. The member’s mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home, and

6. The member’s home provides adequate access between rooms, in and out of the home, maneuvering space, over surfaces and a secure storage space for the operation of the POV that is provided, and

7. The member’s weight is less than or equal to the weight capacity of the POV that is provided, and

8. Use of a POV will significantly improve the member’s ability to participate in MADLs, and

9. The member has not expressed an unwillingness to use a POV.

NOTE: Group 2 POVs have added capabilities that must be medically justified; otherwise payment will be based on the allowance for the least costly medically appropriate alternative, the comparable Group 1 POV. If coverage criteria 1-9 are met and if a member’s weight can be accommodated by a POV with a lower weight capacity than the POV that is provided, payment will be based on the allowance for the least costly medically appropriate alternative.

Reimbursement price for all POV includes:
1. Battery or batteries required for operation
2. Battery charger single mode
3. Weight appropriate upholstery and seating system
4. Tiller steering
5. Non-expandable controller with proportional response
6. Complete set of tires
7. All accessories needed for safe operation
(The above parts may not be billed separately with a new POV.)

Codes and Descriptions:

Group 1 (POVs)
Features: Width less than or equal to 28 inches, length less than or equal to 48 inches, minimum top end speed-flat 3mph, minimum range 5 miles, minimum obstacle climb 20 mm, radius pivot turn less than or equal to 54 inches, dynamic stability incline 6 degrees, fatigue cycle test 200,000 cycles, and drop test 6,666 cycles.
K0800 F3  Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds

K0801 F3  Power operated vehicle, group 1 heavy duty, patient weight capacity 301 to 450 pounds

K0802 F3  Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds

**Group 2 (POVs)**
Features: Width less than or equal to 28 inches, length less than or equal to 48 inches, minimum top end speed-flat 4 mph, minimum range 10 miles, minimum obstacle climb 50 mm, radius pivot turn less than or equal to 54 inches, dynamic stability incline 7.5 degrees, fatigue cycle test 200,000 cycles, and drop test 6,666 cycles.

K0806 F3  Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds

K0807 F3  Power operated vehicle, group 2 heavy duty, patient weight capacity 301 to 450 pounds

K0808 F3  Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds

K0812 F3  Power operated vehicle, not otherwise classified

**Power Wheelchairs (PWC)**
Covered if all of the basic coverage criteria (1-3) for PMDs have been met and
● The member does not meet coverage criterion 4, 5, or 6 for a POV; and
● Criterion 10-13 (below) are met; and
● Any coverage criteria pertaining to the specific wheelchair grouping (see below) are met.
10. The member has the mental and physical ability to safely and independently operate the power wheelchair that is provided, and
11. The member’s weight is less than or equal to the weight capacity of the power wheelchair that is provided, and
12. The member’s home and community environments provide adequate access between rooms, in and out of the home, maneuvering space, over surfaces and a secure storage space for the operation of the power wheelchair that is provided, and
13. The member has not expressed an unwillingness to use a power wheelchair.

**Reimbursement price for all power wheelchairs (PWCs) includes the following accessories:**
1. Lap belt or safety belt
2. Battery or batteries required for operation
3. Battery charger single mode
4. Complete set of tires and casters, any type
5. Fixed, swing away or detachable non-elevating leg rests with or without calf pad
   • Elevating leg rests may be billed separately.
6. Fixed, swing away or detachable footrests or a foot platform without angle adjustment with or without calf pad
   • There is no separate billing for angle adjustable footplates with Group 1 or 2. Angle adjustable footplates may be billed separately with Group 3, 4 and 5
7. Fixed, swing away, or detachable non-adjustable height armrests with arm pad
   • Adjustable height armrests may be billed separately
8. Joystick standard proportional (integrated or remote)
   • A non-proportional or mini, compact or short throw proportional joystick or other alternative control device may be billed separately with a Group 2 or Group 3 wheelchair.
9. Joystick hardware, fixed, swing away and/or retractable
10. Controller and Input Device – Non-expandable controller and a standard proportional joystick (integrated or remote)
11. Any weight specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient weight capacity
12. Any seat width and depth. Exception: for Group 3 and 4 PWCs with a sling/solid seat/back the following may be billed separately:
    • For Standard Duty, seat width and/or depth greater than 20 inches;
    • For Heavy Duty, back width greater than 22 inches;
    • For Very Heavy Duty, back width greater than 24 inches;
    • For Extra Heavy Duty, no separate billing
13. Any back width. Exception: for Group 3 and 4 PWCs with a sling/solid seat/back, the following may be billed separately:
    • For Standard Duty, back width greater than 20 inches;
    • For Heavy Duty, seat width and/or depth greater than 22 inches;
    • For Very Heavy Duty, seat width and/or greater than 24 inches;
    • For Extra Heavy Duty, no separate billing
14. Transit option/Transport brackets
15. Push/attendant handles (any type)
16. Attendant control joystick/controller: When an alternate drive control (e.g.: head array, min proportional joystick, etc.) is provided on a new power wheelchair, an attendant control would not be separately payable. The MRA for a new power wheelchair includes a joystick.

**PWC Seating**
- A sling/solid seat is a rigid metal or plastic material usually covered with cloth, vinyl, leather or equal material, with or without some padding material designed to serve as the support for the buttocks or back of the user respectively. They may or may not have thin padding but are not intended to provide cushioning or...
positioning for the user. PWC’s with an automatic back and a solid seat pan are considered as a solid seat/back system, not Captains Chair.

- A Captain’s Chair is a one or two-piece automotive-style seat with a rigid frame, cushioning material in both seat and back sections, covered in cloth, vinyl, leather or equal upholstery, and designed to serve as a complete seating, support, and cushioning system for the user. It may have armrests that can be fixed, swing away, or detachable. It will not have a headrest. Chairs with stadium style seats are billed using the captain’s chair codes. If medically necessary, refer to positioning/ skin protection seat/back codes and bill the PWC using a sling/solid seat code.

**PWC Power Options**

- Power Options are defined as tilt, recline, elevating seat, and power standing. These may be added to a PWC to accommodate a patient’s specific medical need for seating and positioning assistance.

- No power options- A category of PWCs that is incapable of accommodating any power options.

- Single power option- A category of PWCs with the capability to accept and operate only one power option at a time on the base. A PMD does not have to be able to accommodate all features to qualify for this code. For example, a power wheelchair that can only accommodate a power tilt could qualify for this code.

- Multiple Power Option- A category of PWC with the capability to accept and operate more than one power option at a time on the base. A PWC does not have to accommodate all features from the defined list of power options to qualify for this code, but must be capable of having more than one power feature present and operational on the PWC at the same time.

- Proportional control input device is a device that transforms a user’s drive command (a physical action initiated by the user) into a corresponding and comparative movement, both in direction and in speed, of the wheelchair. The input device shall be considered proportional if it allows for both a non-discrete directional command and a non-discrete speed command for a single drive command movement.

**Codes and Descriptions:**

**Group 1 Power Wheelchairs**

Features: Standard duty, 300 pounds or less, length less than or equal to 40 inches, width less than or equal to 24 inches, minimum top end speed-flat 3 mph, minimum range 5 miles, minimum obstacle climb 20 mm, and fatigue cycle test 6 degrees, fatigue cycle test 200,000 cycles, drop test 6,666 cycles, standard integrated or remote proportional control input device, non-expandable controller, largest single component not to exceed 55 pounds (portable only), incapable of upgrade to expandable controllers, incapable of upgrade to alternative control devices, may have cross brace construction, accommodates non-powered
options and seating systems (e.g., recline only backs, manually elevating leg rests).

**K0813**
**F3**
Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds

**K0814**
**F3**
Power wheelchair, group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds

**K0815**
**F3**
Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds

**K0816**
**F3**
Power wheelchair, group 1 standard, captains chair, patient weight capacity up to and including 300 pounds

**Group 2 Power wheelchairs**
Features: Length less than or equal to 48 inches, width less than or equal to 34 inches, minimum top end speed-flat 3 mph, minimum range 7 miles, minimum obstacle climb 40 mm, dynamic stability incline 6 degrees, fatigue cycle test 200,000 cycles, drop test 6,666 cycles, standard integrated or remote proportional control input device, may have cross brace construction, accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports) (except captains chairs).

**No Power Options**
Features: In addition to standard Group 2 features, has non-expandable controller, incapable of upgrade to expandable controllers, incapable of upgrade to alternative control devices, largest single component not to exceed 55 pounds (portable only), accommodates non-powered options and seating systems (e.g., recline only backs, manually elevating leg rests).

**K0820**
**F3**
Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds

**K0821**
**F3**
Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds

**K0822**
**F3**
Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds

**K0823**
**F3**
Power wheelchair, group 2 standard, captains chair, patient weight capacity up to and including 300 pounds

**K0824**
**F3**
Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds

**K0825**
**F3**
Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pounds

**K0826**
**F3**
Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds

Version 2019-1 (08/1/2019)
Power wheelchair, group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds

Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more

Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds

K0826

Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more

K0829

Power wheelchair, group 2 extra heavy duty, captains chair, patient weight 601 pounds or more

K0835

Single Power Option

Covered if all of the coverage criteria (1-3, 10-13) for a PWC are met and if:

1. The member meets coverage criteria for a power tilt, power recline, or power elevating seating system and the system is being used on the wheelchair.

Features: In addition to Group 2 standard features, non-expandable controller, capable of upgrade to expandable controllers, capable of upgrade to alternative control devices, accommodates only one powered seating system at a time on the base.

K0836

Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds

K0837

Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds

K0838

Power wheelchair, group 2 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds

K0839

Power wheelchair, group 2 very heavy duty, single power option sling/solid seat/back, patient weight capacity 451 to 600 pounds

K0840

Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more

K0841

Multiple Power Options

Covered if all of the coverage criteria (1-3, 10-13) for a PWC are met and if criterion 1 or 2 below is met:

1. The member meets coverage criteria for a power tilt and recline seating system and the system is being used on the wheelchair, or

2. The member uses a ventilator which is mounted on the wheelchair

Features: In addition to Group 2 standard features, expandable controller at initial use, capable of upgrade to alternative control devices, accommodates more than one powered seating system at a time on the base, and accommodates ventilators.

K0841

Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0842 F3  Power wheelchair, group 2 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds

K0843 F3  Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds

**Group 3 Power wheelchairs**
Features: Length less than or equal to 48 inches, width less than or equal to 34 inches, minimum top end speed-flat 4.5 mph, minimum range 12 miles, minimum obstacle climb 60 mm, dynamic stability incline 7.5 degrees, fatigue cycle test 200,000, drop test 6,666 cycles, standard integrated or remote proportional control, drive wheel suspension to reduce vibration, may not have cross brace construction, accommodates seating and positioning items (e.g. seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports) (except captains chairs).

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**No Power Options**
Covered if all of the coverage criteria (1-3, 10-13) for a PWC are met and if the member's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity.
Features: In addition to Group 3 standard features, non-expandable controller, capable of upgrade to expandable controllers, capable of upgrade to alternative control devices, accommodates non-powered options and seating systems (e.g., recline only backs, manually elevating leg rests).

K0848 F3  Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds

K0849 F3  Power wheelchair, group 3 standard, captains chair, patient weight capacity up to and including 300 pounds

K0850 F3  Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds

K0851 F3  Power wheelchair, group 3 heavy duty, captains chair, patient weight capacity 301 to 450 pounds

K0852 F3  Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds

K0853 F3  Power wheelchair, group 3 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds

K0854 F3  Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more

K0855 F3  Power wheelchair, group 3 extra heavy duty, captains chair, patient weight capacity 601 pounds or more

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**Single Power Options**
Covered if all of the coverage criteria (1-3, 10-13) for a PWC are met and if:
1. The Group 3 no power option criteria are met, and
2. The Group 2 Single Power Option criteria are met. Features: In addition to Group 3 standard features, non-expandable controller, capable of upgrade to expandable controllers, capable of upgrade to alternative control devices, accommodates only one powered seating system at a time on the base.

K0856\textsuperscript{F3} Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0857\textsuperscript{F3} Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds
K0858\textsuperscript{F3} Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds
K0859\textsuperscript{F3} Power wheelchair, group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds
K0860\textsuperscript{F3} Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds

**Multiple Power Options**

Covered if all of the coverage criteria (1-3, 10-13) for a PWC are met and if:
1. The Group 3 no power option criteria are met, and
2. The Group 2 Multiple Power Options are met.

Features: In addition to Group 3 standard features, expandable controller at initial use, capable of upgrade to alternative control devices, accommodates more than one powered seating system at a time on the base, and accommodates ventilators.

K0861\textsuperscript{F3} Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0862\textsuperscript{F3} Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0863\textsuperscript{F3} Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0864\textsuperscript{F3} Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more

**Group 4 Power wheelchairs**

Features: Length less than or equal to 48 inches, width less than or equal to 34 inches, minimum top end speed-flat 6 mph, minimum range 16 miles, minimum obstacle climb 75 mm, dynamic stability incline 9 degrees, fatigue cycle test 200,000 cycles, drop test 6,666 cycles, standard integrated or remote proportional control, may not have cross brace construction, and accommodates
seating and positioning items (e.g. seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports) (except captain’s chairs).

**No Power Options**

A Group 4 PWC with no power options (K0868-K0871) is covered if all of the coverage criteria (1-3, 10-13) for a PWC are met and if:

1. The Group 3 criteria are met, and
2. The minimum range, top end speed, obstacle climb or dynamic stability incline that is medically necessary for the patient engaging in frequent MRADL’s cannot be performed in a Group 3 PWC

Features: In addition to Group 4 standard features, non-expandable controller, capable of upgrade to expandable controllers, capable of upgrade to alternative control devices, accommodates non-powered options and seating systems (e.g. recline only backs, manually elevating leg rests).

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0868</td>
<td>Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0869</td>
<td>Power wheelchair, group 4 standard, captains chair, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0870</td>
<td>Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td>K0871</td>
<td>Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds</td>
</tr>
</tbody>
</table>

**Single Power Options**

Covered if all of the coverage criteria (1-3, 10-13) for a PWC are met and if

1. The Group 4 no power option criteria are met, and
2. The Group 2 Single Power Option criteria.

Features: In addition to Group 4 standard features, non-expandable controller, drive wheel suspension to reduce vibration, capable of upgrade to expandable controllers, capable of upgrade to alternative control devices, accommodates non-powered options and seating systems (e.g. recline-only backs, manually elevating leg rests), and accommodates only one powered seating system at a time on the base.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0877</td>
<td>Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0878</td>
<td>Power wheelchair, group 4 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td>K0879</td>
<td>Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td>K0880</td>
<td>Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds</td>
</tr>
</tbody>
</table>
Multiple Power Options
Covered if all of the coverage criteria (1-3, 10-13) for a PWC are met and if
1. The Group 4 no power option criteria are met, and
2. The Group 2 Multiple Power Options are met.
Features: In addition to Group 4 standard features, expandable controller at initial issue, capable of upgrade to alternative control devices, accommodates more than one powered seating system at a time on the base, and accommodates ventilators.

K0884 F3 Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0885 F3 Power wheelchair, group 4 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds
K0886 F3 Power wheelchair, group 4 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds

Group 5 Power wheelchairs
Features: Patient weight capacity pediatric (125 pounds or less), length less than or equal to 48 inches, width less than or equal to 28 inches, minimum top end speed-flat 4 mph, minimum range 4 mph, minimum range 12 miles, minimum obstacle climb 60 mm, dynamic stability incline 9 degrees, crash testing passed, fatigue cycle test 200,000 cycles, drop test 6,666 cycles, standard integrated or remote proportional control, seat width minimum of 5 one-inch options, seat depth minimum 3 one-inch options, seat height adjustment requirements greater than or equal to 3 inches, back height adjustment requirements minimum of 3 options, seat to back angle range of adjustment - minimum of 12 degrees, drive wheel suspension to reduce vibration, expandable controller at initial issue, capable of upgrade to alternative control devices, accommodates powered seating options, accommodates seating and positioning items (e.g. seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports), adjustability for growth (minimum of 3 inches for width, depth, and back height adjustment).

Single Power Option
Covered if the coverage criteria (1-3, 10-13) for a PWC are met; and
1. The member is expected to grow in height, and
2. The Group 2 Single Power Option criteria are met.
Features: In addition to Group 5 standard features, may accommodate non-powered options and seating systems, allows only one power option on the base at a time

K0890 F3 Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including
125 pounds

Multiple Power Options
Covered if the coverage criteria (1-3, 10-13) for a PWC are met; and
1. The member is expected to grow in height, and
2. The Group 2 Multiple Power Options are met.
Features: In addition to Group 5 standard features, allows more than one power option on the base at a time, and accommodates ventilators.

K0891F3 Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds

V. SEATING AND POSITIONING COMPONENTS (SPC) / WHEELED MOBILITY ACCESSORIES

SPC are covered when:
• Criterion 1, 2 and 3 (below) are met; and
• The coverage criteria listed under the specific SPC procedural code is met.
  1. The member has met the criteria for Wheeled Mobility Equipment (WME), and
  2. The SPC meets the quality standards and coding definitions specified in the Definitions Section. A Product Classification List with products which have received a Medicare coding verification can be found on the Medicare Pricing, Data Analysis and Coding (MPDAC) web site. If a coding assignment is not available from MPDAC, the vendor must exercise due diligence in assigning an appropriate code. The Medicaid program reserves the right to review any and all coding assignments by vendors and the MPDAC based on submitted and published product specifications and other relevant information.
  3. The primary and back-up WME bases accommodate the SPC.
  4. See code E0950 for Upper extremity support systems (UESS).
  5. If foam-in-place or other material is used to fit a substantially prefabricated cushion to an individual member, the cushion must be billed as a customized cushion, not custom fabricated.

General Guidelines
• The code for a seat or back cushion includes any rigid or semi-rigid base or posterior panel, respectively, which is an integral part of the cushion.
• Payment for all wheelchair seats, backs and accessory codes includes fixed, adjustable, removable and/or quick-release mounting hardware, if hardware is applicable to the item. If the code description includes any type of mounting or adjustable hardware, no additional payment for this hardware will be made.

• The swing away, retractable, or flip-down hardware upgrade code (E1028) may only be billed in addition to the codes for a headrest, lateral trunk supports, hip supports, medial thigh supports, calf supports, abductors/pommels, foot supports, and replacement joystick mounts when medically justified. It must not be billed in addition to the codes for shoulder harness/straps or chest straps, wheelchair seat cushions or back cushions, or new power wheelchair joystick mounts. If the swing away or flip-down hardware is being added to a new accessory (e.g. headrest, medial knee support or laterals), it will be reimbursed at invoice cost in addition to the MRA for the accessory component.

• May be included with new WME or billed separately under the following conditions:
  1. Refer to the SPC Coverage Criteria for information concerning coverage of the following: general use, skin protection, and positioning, powered and custom-made components.
  2. A POV or PWC with Captain's Chair seating is not appropriate for a member who needs a separate SPC
  3. If a member needs a seat and/or back cushion but does not meet coverage criteria for a skin protection and/or positioning cushion, it is appropriate to provide a Captain's Chair seat (if the code exists) rather than a sling/solid seat/back and a separate general use seat and/or back cushion.
  4. A general use seat and/or back cushion provided with a PWC with a sling/solid seat/back will be considered equivalent to a power wheelchair with Captain's Chair and will be coded and priced accordingly, if that code exists.
  5. If a member’s weight combined with the weight of seating and positioning accessories can be accommodated by WME with a lower weight capacity than the wheelchair that is requested or provided, approval or payment will be based on the appropriate HCPCS code that meets the medical need.

• Wheeled mobility accessories that are included in new equipment (as indicated in the Manual and Powered Mobility sections) are reimbursable ONLY as replacement parts outside of warranty and are not to be billed with a new wheelchair. For new wheeled mobility devices, use accessory codes ONLY when included accessories do not meet a specific medical need.

• Coverage of flat free, zero pressure and foam filled tires is limited to beneficiaries who are independent in mobility or whose medical conditions indicate such tires.
### Codes, descriptions, and code-specific criteria:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0944</td>
<td><strong>Pelvic belt/harness/boot</strong> (limited to wheelchair 4-point padded belt)</td>
</tr>
<tr>
<td>E0950</td>
<td><strong>Wheelchair accessory, tray, each</strong> (upper extremity support surface for positioning only)</td>
</tr>
<tr>
<td>E0951</td>
<td><strong>Heel loop/holder, any type, with or without ankle strap, each</strong></td>
</tr>
<tr>
<td>E0952</td>
<td><strong>Toe loop/holder, any type, each</strong></td>
</tr>
<tr>
<td>E0953</td>
<td><strong>Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware, each</strong></td>
</tr>
<tr>
<td>E0954</td>
<td><strong>Wheelchair accessory, foot box, any type, includes attachment and mounting hardware, each foot</strong> (Includes padding. If dispensing a double-leg or full size footbox, obtain an authorization for quantity of 2.)</td>
</tr>
<tr>
<td>E0955</td>
<td><strong>Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each</strong></td>
</tr>
<tr>
<td>E0956</td>
<td><strong>Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each</strong> (up to 4 supports/prompts)</td>
</tr>
<tr>
<td>E0957</td>
<td><strong>Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each</strong></td>
</tr>
<tr>
<td>E0958</td>
<td><strong>Manual wheelchair accessory, one-arm drive attachment, each</strong></td>
</tr>
<tr>
<td>E0959</td>
<td><strong>Manual wheelchair accessory, adapter for amputee, each</strong></td>
</tr>
<tr>
<td>E0960</td>
<td><strong>Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware</strong> (includes padding and strap guides)</td>
</tr>
<tr>
<td>E0961</td>
<td><strong>Manual wheelchair accessory, wheel lock brake extension</strong></td>
</tr>
</tbody>
</table>

- Covered when the medical need for positioning in a wheelchair cannot be met with less costly alternatives such as any combination of a safety belt, pelvic strap, harness, prompts, armrest modifications, recline, tilt in space or other existing or potential seating or wheelchair features.
- The MRA for trays/upper extremity supports includes any size/dimension, all mounting hardware/accessories, cut outs, and rims.
- UESS dimensions should not exceed the positioning length of the forearms (e.g., 12-15”)
- UESS and related accessories are not covered when used solely for activities of daily living.
- Padding and positioning blocks are separately billable using HCPCS code K0108.

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Procedure Codes and Coverage Guidelines

**E0966**

#Manual wheelchair accessory, headrest extension, each

- Covered when the member has a covered manual tilt-in space, manual semi or fully reclining back, or power tilt and/or recline power seating system or needs additional head support. The code for a headrest includes any type of cushioned headrest, fixed, removable or non-removable hardware.

**E0967**

#Manual wheelchair accessory, hand rim with projections, any type, replacement only, each

**E0971**

#Manual wheelchair accessory, anti-tipping device, each

**E0973**

#Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each

**E0974**

#Manual wheelchair accessory, anti-rollback device, each

**E0978**

#Wheelchair accessory, positioning belt/safety belt/pelvic strap, each (includes padding)

**E0986**

Manual wheelchair accessory, push rim activated power assist system

- A push-rim activated power assist device (E0986) for a manual wheelchair is covered if the coverage criteria (1-3, 10-13) for a PWC are met; and documentation includes:
  1. A thorough upper extremity assessment including but not limited to ROM, strength testing, tone assessment, and evaluation of gross and fine motor skills and hand strength.
  2. Description of a detailed, successful trial in a variety of situations in all customary environments (or simulations of customary environments) showing a clear regard for safety as well as awareness of others, the environment, and objects/barriers. Include ability to navigate indoor/outdoor, up/down ramps, tight spaces, backing up, etc.
  3. A well-defined medical necessity justification for this item versus a power wheelchair.
  4. Confirmation that the member has no excessive non-purposeful spasticity/extraneous movements.
  5. Confirmation that the member has no history of seizures or there is confirmed successful medical management of seizures.

**Please note:** An additional back-up manual wheelchair, when primary mobility is a manual wheelchair with a power assist system, is not considered a medical necessity. In addition, when primary mobility is a power wheelchair, there is no medical necessity for a back-up manual wheelchair to include power assisted propulsion.

**E0990**

#Wheelchair accessory, elevating leg rest, complete assembly, each

**E0992**

#Manual wheelchair accessory, solid seat insert

**E0995**

#Wheelchair accessory, calf rest/pad, replacement only, each
**E1002**

**Wheelchair accessory, power seating system, tilt only**

Covered when:
- The member meets criterion 1-3 of the Seating and Positioning Components coverage criteria, and
- The member meets the coverage criteria for manual tilt, and
- The member has the mental and physical ability to safely and independently operate the power tilt-in-space that is provided.

**Note:** A combination power tilt-in-space and recline option is covered when the member meets the coverage criteria for both components and, when provided alone, one function will not meet their seating and positioning needs.

**E1003**

**Wheelchair accessory, power seating system, recline only, without shear reduction**

Covered when:
- The member meets criteria 1-3 of the Seating and Positioning component coverage criteria, and
- The member meets the above criteria for manual recline, and
- The member has the mental and physical ability to safely and independently operate the power recline feature that is provided.

**E1004**

**Wheelchair accessory, power seating system, recline only, with mechanical shear reduction**

Covered when:
- The member meets criteria 1-3 of the Seating and Positioning component coverage criteria, and
- The member meets the above criteria for manual recline, and
- The member has the mental and physical ability to safely and independently operate the power recline feature that is provided.

**E1005**

**Wheelchair accessory, power seating system, recline only, with power shear reduction**

Covered when:
- The member meets criteria 1-3 of the Seating and Positioning component coverage criteria, and
- The member meets the above criteria for manual recline, and
- The member has the mental and physical ability to safely and independently operate the power recline feature that is provided.

**E1006**

**Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction**

- A combination of power tilt-in-space along with power recline option is covered when the member meets the coverage criteria for both components and when provided alone, one function will not meet their seating and positioning needs.

**E1007**

**Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction**

- A combination of power tilt-in-space along with power recline option is covered when the member meets the coverage criteria for both components and when provided alone, one function will not meet their seating and positioning needs.
**E1008**

**Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction**
- A combination of power tilt-in-space along with power recline option is covered when the member meets the coverage criteria for both components and when provided alone, one function will not meet their seating and positioning needs.

**E1009**

**Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including push rod and leg rest, each**

**E1010**

**Wheelchair Accessory, addition to power seating system, power leg elevation system, including leg rest, pair**

**E1011**

**Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair)**

**E1012**

**Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each**

**E1014**

#Reclining back, addition to pediatric size wheelchair

**E1020**

#Residual limb support system for wheelchair, any type
(with adjustable drop hooks)

**E1028**

**Wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory**

**E1225**

**Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each**

Covered when:
- The member meets criteria [1-3 of the Seating and Positioning component coverage criteria](#), and
- The member has a plan of care that requires a recline position to complete Mobility Related Activities of Daily Living (MRADL’s), and
- The member has positioning needs that cannot be met by upright or fixed angle chair, or
- The member's postural control requires a recline feature, or
- The member utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed.

**E1226**

#Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each

Covered when:
- The member meets criteria [1-3 of the Seating and Positioning component coverage criteria](#), and
- The member has a plan of care that requires a recline position to complete Mobility Related Activities of Daily Living (MRADL’s), and
- The member has positioning needs that cannot be met by upright or fixed angle chair, or
6. The member's postural control requires a recline feature, or
7. The member utilizes intermittent catheterization for bladder
management and is unable to independently transfer from the
wheelchair to the bed.

E1228[^F6] Special back height for wheelchair
E1298[^F3] Special wheelchair seat depth and/or width, by construction
E2201[^F3] #Manual wheelchair accessory, nonstandard seat frame, width
greater than or equal to 20 inches and less than 24 inches
E2202[^F3] #Manual wheelchair accessory, nonstandard seat frame width, 24-
27 inches
E2203[^F3] #Manual wheelchair accessory, nonstandard seat frame depth, 20
to less than 22 inches
E2204[^F3] #Manual wheelchair accessory, nonstandard seat frame depth, 22
to 25 inches
E2205[^F3] # Manual wheelchair accessory, hand rim without projections
(includes ergonomic or contoured), any type, replacement only, each
E2206[^F7] #Manual wheelchair accessory, wheel lock assembly, complete,
replacement only, each (any type of brakes)
E2207[^F6] #Wheelchair accessory, crutch and cane holder, each
E2209[^F6] #Arm trough, with or without hand support, each (includes non-
gle adjustable/articulating hardware and straps)
E2210[^F6] Wheelchair accessory, bearings, any type, replacement only, each
E2211[^F7] #Manual wheelchair accessory, pneumatic propulsion tire, any
size, each
E2212[^F7] #Manual wheelchair accessory, tube for pneumatic propulsion tire,
any size, each
E2213[^F6] #Manual wheelchair accessory, insert for pneumatic propulsion
tire (removable), any type, any size, each
E2214[^F7] #Manual wheelchair accessory, pneumatic caster tire, any size,
each
E2215[^F7] #Manual wheelchair accessory, tube for pneumatic caster tire, any
size, each
E2218[^F6] #Manual wheelchair accessory, foam propulsion tire, any size,
each
E2219[^F6] #Manual wheelchair accessory, semi pneumatic foam caster tire,
any size, each
E2220[^F7] #Manual wheelchair accessory, solid (rubber/plastic) propulsion
tire, any size, replacement only, each
E2221[^F7] #Manual wheelchair accessory, solid (rubber/plastic) caster tire
(removable), any size, replacement only, each
E2222[^F6] #Manual wheelchair accessory, solid (rubber/plastic) caster tire
with integrated wheel, any size, replacement only, each
E2224[^F6] #Manual wheelchair accessory, propulsion wheel excludes tire,
any size, replacement only, each
E2225[^F6] #Manual wheelchair accessory, caster wheel excludes tire, any
size, replacement only, each
# Manual wheelchair accessory, caster fork, any size, replacement only, each

# Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware
- A solid seat support base/insert with mounting hardware may be billed separately when added to a folding manual wheelchair or when replacement is needed (When replacing a solid seat support base on a rigid manual wheelchair or power wheelchair use the chair's base code and the RB modifier)

**NOTE:** Because payment for power wheelchairs, rigid manual wheelchairs, and pediatric seating for any wheelchair includes a solid seat support base/insert, it may not be billed separately.

# Back, planar, for pediatric size wheelchair including fixed attaching hardware
- Pediatric sized chairs have seat depths and widths less than 16 inches

# Seat, planar, for pediatric size wheelchair including fixed attaching hardware
- Pediatric sized chairs have seat depths and widths less than 16 inches

Wheelchair accessory, power seat elevator system, any type
1. The member meets criterion 1-3 of the Powered Mobility Device coverage criteria, and
2. The member has demonstrated the mental and physical abilities to safely and independently operate the power seat function that is requested; AND
3. All less costly options have been considered including reasonable adaptation/modification of the member’s environment. Examples of reasonable adaptation/modification include, but are not limited to, adjustable height bed/table, dresser/closet re-organization, refrigerator re-organization, or installation of a grab bar for transfer assistance; AND (one of the following)
   - the member is not able to transfer independently without power height adjustment; OR
   - power seat elevation allows the member to independently perform MRADLs that cannot be performed independently without the addition of power seat elevation

Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware

Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2312</td>
<td>Power wheelchair accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including fixed mounting hardware</td>
</tr>
<tr>
<td>E2313</td>
<td>Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each</td>
</tr>
<tr>
<td>E2323</td>
<td>Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated</td>
</tr>
<tr>
<td>E2324</td>
<td>Power wheelchair accessory, chin cup for chin control interface</td>
</tr>
<tr>
<td>E2325</td>
<td>Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swing away mounting hardware (includes enhanced visual display)</td>
</tr>
<tr>
<td>E2326</td>
<td>Power wheelchair accessory, breath tube kit for sip and puff interface</td>
</tr>
<tr>
<td>E2327</td>
<td>Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware (includes enhanced visual display)</td>
</tr>
<tr>
<td>E2328</td>
<td>Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware (includes enhanced visual display)</td>
</tr>
<tr>
<td>E2329</td>
<td>Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware (includes enhanced visual display)</td>
</tr>
<tr>
<td>E2330</td>
<td>Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware (includes enhanced visual display)</td>
</tr>
<tr>
<td>E2340</td>
<td>Power wheelchair accessory, nonstandard seat frame width, 20-23 inches (for 21&quot;-23&quot; only, 20&quot; included in base)</td>
</tr>
<tr>
<td>E2341</td>
<td>Power wheelchair accessory, nonstandard seat frame width, 24-27 inches</td>
</tr>
<tr>
<td>E2342</td>
<td>Power wheelchair accessory, nonstandard seat frame depth, 20-21 inches</td>
</tr>
<tr>
<td>E2343</td>
<td>Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches</td>
</tr>
<tr>
<td>E2358</td>
<td>Power Wheelchair accessory, Group 34 non-sealed lead acid battery, each (replacement only)</td>
</tr>
<tr>
<td>E2359</td>
<td>Power Wheelchair accessory, Group 34 sealed lead acid battery, each (e.g. Gel Cell, Absorbed glassmat) (replacement only)</td>
</tr>
<tr>
<td>E2360</td>
<td>Power wheelchair accessory, 22 NF non-sealed lead acid battery, each (replacement only)</td>
</tr>
<tr>
<td>E2361</td>
<td>Power wheelchair accessory, 22 NF sealed lead acid battery, each,</td>
</tr>
</tbody>
</table>
(e.g. gel cell, absorbed glass mat) replacement only

E2362 F6
Power wheelchair accessory, group 24 non-sealed lead acid battery, each (replacement only)

E2363 F6
Power wheelchair accessory, group 24 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat) replacement only

E2364 F6
Power wheelchair accessory, U-1 non-sealed lead acid battery, each (replacement only)

E2365 F6
Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat) replacement only

E2366 F3
#Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each (replacement only)

E2367 F3
#Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each (replacement only)

E2368 F3
#Power wheelchair component, drive wheel motor, replacement only

E2369 F3
#Power wheelchair component, drive wheel gear box, replacement only

E2370 F3
#Power wheelchair component, drive wheel motor and gear box combination, replacement only

E2371 F7
#Power wheelchair accessory, group 27 sealed lead acid battery, (e.g. gel cell, absorbed glassmat), each (replacement only)

E2373 F6
Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware

E2374 F6
Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only

E2375 F6
Power wheelchair accessory, non-expandable controller, including all related electronics and mounting hardware, replacement only

E2376 F6
Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only (includes harness)

E2377 F2
Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue

E2378 F6
Power wheelchair component, actuator, replacement only

E2381 F6
#Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each

E2382 F6
#Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each

E2383 F6
#Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each

E2384 F6
#Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each
#Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each

#Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each

#Power wheelchair accessory, foam filled caster tire, any size, replacement only, each

#Power wheelchair accessory, foam drive wheel tire, any size, replacement only, each

#Power wheelchair accessory, foam caster tire, any size, replacement only, each

#Power wheelchair accessory, solid (rubber/plastic) drive wheel tire, any size, replacement only, each

#Power wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each

#Power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each

#Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each

#Power wheelchair accessory, caster wheel excludes tire, any size, replacement only, each

#Power wheelchair accessory, caster fork, any size, replacement only, each

##General use wheelchair seat cushion, width less than 22 inches, any depth

- A general use seat cushion (E2601) is covered when 1, 2 and 3 of the SPC guidelines are met.

##General use wheelchair seat cushion, width 22 inches or greater, any depth

- See coverage criteria for E2601

##Skin protection wheelchair seat cushion, width less than 22 inches, any depth

- A skin protection seat cushion (E2603) is covered when 1, 2 and 3 of the SPC guidelines are met and that member has one of the following diagnoses/conditions:
  
  (a). A current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface (See Appendix A); or
  
  (b). Absent or impaired sensation in the area of contact with the seating surface due to but not limited to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis, post-polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer’s disease, Parkinson’s disease (See Appendix A); or
  
  (c). Inability to carry out a functional weight shift due to one of, but not limited to, the following diagnoses: spinal cord injury resulting in
quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis, post-polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer’s disease, Parkinson’s disease (See Appendix A); or

(d). Confined to their wheelchair for more than four (4) continuous hours on a daily basis.

(e). Documentation of malnutrition (past and present)

E2604

#Skin protection wheelchair seat cushion, width 22 inches or greater, any depth

- See coverage criteria for E2603

E2605

#Positioning wheelchair seat cushion, width less than 22 inches, any depth

- A positioning seat cushion (E2605) is covered when 1, 2 and 3 of the SPC guidelines are met and the member has one of the following:
  (a). Significant postural asymmetries that are due to, but not limited to, one of the diagnoses listed above under E2603 (b); or
  (b). One of the following diagnoses: monoplegia of the lower limb, hemiplegia due to stroke, traumatic brain injury, or other etiology, muscular dystrophy, torsion dystonias, spinocerebellar disease. (See Appendix A)

E2606

#Positioning wheelchair seat cushion, width 22 inches or greater, any depth

- See coverage criteria for E2605

E2607

#Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth

- A combination skin protection and positioning seat cushion (E2607) is covered when criterion 1, 2, 3 of the SPC guidelines are met and the criteria for both a skin protection seat cushion and a positioning seat cushion are met.

E2608

#Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth

- See coverage criteria for E2607

E2609

Custom fabricated wheelchair seat cushion, any size (pediatric or adult)

- A custom fabricated seat cushion (E2609) is covered if the criteria for a skin protection and positioning seat cushion are met and there is a comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a vendor or manufacturer) which clearly explains why a standard seating system is not sufficient to meet the member’s seating and positioning needs. (If a custom fabricated seat and back are integrated into a one-piece cushion, code using the custom seat plus the custom back codes.)

E2611

#General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware

- A general use back cushion (E2611) is covered when 1, 2 and 3 of the
**SPC guidelines** are met.

**E2612**

**#General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware**
- See coverage criteria for E2611

**E2613**

**#Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware**
- A positioning back cushion (E2613) is covered when 1, 2 and 3 of the **SPC guidelines** are met and the member has one of the following:
  1. Significant postural asymmetries that are due to, but not limited to, one of the diagnoses listed under E2603 (b); or
  2. One of the following diagnoses: monoplegia of the lower limb, hemiplegia due to stroke, traumatic brain injury, or other etiology, muscular dystrophy, torsion dystonias, spinocerebellar disease. *(See Appendix A)*

**E2614**

**#Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware**
- See coverage criteria for E2613

**E2615**

**#Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware**
- A positioning back cushion (E2615) is covered when 1, 2 and 3 of the **SPC guidelines** are met and the member has one of the following:
  1. Significant postural asymmetries that are due to, but not limited to, one of the diagnoses listed under E2603 (b); or
  2. One of the following diagnoses: monoplegia of the lower limb, hemiplegia due to stroke, traumatic brain injury, or other etiology, muscular dystrophy, torsion dystonias, spinocerebellar disease. *(See Appendix A)*

**E2616**

**#Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware**
- See coverage criteria for E2615

**E2617**

**Custom fabricated** wheelchair back cushion, any size, including any type mounting hardware *(pediatric or adult)*
- A custom fabricated back cushion (E2617) is covered if the criteria for a positioning back cushion are met and there is a comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a vendor or manufacturer) which clearly explains why a standard seating system is not sufficient to meet the member’s seating and positioning needs. *(If a custom fabricated seat and back are integrated into a one-piece cushion, code using the custom seat plus the custom back codes.)*

**E2619**

**#Replacement cover for wheelchair seat cushion or back cushion, each**

**E2620**

**#Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware**
Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware

#Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth
● See coverage criteria for E2603

#Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth
● See coverage criteria for E2603

#Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth
● See coverage criteria for E2607

#Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth
● See coverage criteria for E2607

#Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable
#Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable rancho type
#Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, reclining
#Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints)
#Wheelchair accessory, shoulder elbow, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support
#Wheelchair accessory, addition to mobile arm support, elevating proximal arm
#Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control
#Wheelchair accessory, addition to mobile arm support, supinator
#Detachable, nonadjustable height armrest, each
#Detachable, adjustable height armrest, base, replacement only, each
#Detachable, adjustable height armrest, upper portion, replacement only, each
#Arm pad, replacement only, each
#High mount flip-up footrest, each
#Leg strap, each
#Leg strap, H style, each
#Adjustable angle footplate, each
#Large size footplate, each
#Standard size footplate, replacement only, each
#Footrest, lower extension tube, replacement only, each
#Footrest, upper hanger bracket, replacement only, each
#Footrest, complete assembly, replacement only
K0046 F4  #Elevating leg rest, lower extension tube, replacement only, each
K0047 F4  #Elevating leg rest, upper hanger bracket, replacement only, each
K0052 F4  #Swing away, detachable footrests, replacement only, each
K0053 F4  #Elevating footrests, articulating (telescoping), each
K0056 F3  Seat height less than 17” or equal to or greater than 21” for a high strength, lightweight, or ultra-lightweight wheelchair
K0065 F5  #Spoke protectors, each
K0071 F6  #Front caster assembly, complete, with pneumatic tire, replacement only, each
K0072 F6  #Front caster assembly, complete, with semi pneumatic tire, replacement only, each
K0073 F6  #Caster pin lock, each
K0077 F6  #Front caster assembly, complete, with solid tire, replacement only, each
K0098 F6  #Drive belt for power wheelchair, replacement only
K0105 F4  #IV hanger, each (for wheelchair)
K0108 F6  Other accessories (limited to wheeled mobility parts not listed)

Examples:
UESS padding and positioning blocks:
- Padding is covered in addition to a UESS when there is documented evidence of skin breakdown as a result of weight bearing and that a care plan without padding, including times when the UESS was removed, proved unsuccessful.
- Positioning blocks are covered when there is a medical need, due to strong spasticity or exaggerated muscle activity, to stabilize the upper extremities on the UESS to allow for weight bearing.
- Positioning blocks may also be considered for mounting directly to a wheeled mobility device when the member does not meet the coverage criteria for a UESS.

Foot-Ankle Padded Positioning Straps (e.g., ankle huggers):
- Covered when there is a medical need for stabilization of the foot and ankle due to strong spasticity or exaggerated muscle activity, and positioning in the wheelchair cannot be met with less costly alternatives, such as any combination of heel loop/holders and or toe/loop/holders, with or without ankle straps.

Dynamic Backrest Support System:
- Covered when the member has moderate to severe hypertonicity, and has a documented history of rocking or shaking or other movements related to behavior and/or increased muscle tone, and there is documented evidence of frequent backrest, back canes or wheelchair frame repairs as a result of the member’s behaviors and tone.

Dynamic Foot Support Systems (i.e.: Dynamic Footrest Coil; Dynamic Footrest Gas Spring; Dynamic Footrest Hanger):
- Covered when the member has moderate to severe hypertonicity
and less costly alternatives have been tried and have not withstood the member’s tone, and there is documented evidence of frequent footrest, footplate or wheelchair frame repairs and/or replacement.

**Shock absorbers** (non-standard caster forks, i.e.: Frog Legs or any other brands):
- Covered when the member has increased muscle tone that is triggered when driving the wheelchair over bumps and cracks, or has documented low back pain that increases when driving the wheelchair over rough terrain, or demonstrates fatigue with decreased proficiency in propelling the wheelchair, and the member has shown a decrease in any of the above symptoms during a trial with the shock absorbers.

### MISCELLANEOUS DURABLE MEDICAL EQUIPMENT

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4265</td>
<td>Paraffin, per pound (for medically necessary paraffin bath unit)</td>
<td>(for medically necessary paraffin bath unit)</td>
</tr>
<tr>
<td>A4556</td>
<td>Electrodes (e.g., Apnea monitor), per pair (up to 2 pair, any type)</td>
<td>TENs Replacement electrodes are covered for beneficiaries with a diagnosis of knee pain due to osteoarthritis. Please refer to the coverage criteria listed under code E0730.</td>
</tr>
<tr>
<td>A4557</td>
<td>Lead wires (e.g., Apnea monitor), per pair (up to 2 pair, any type)</td>
<td>TENs Replacement lead wires are covered for beneficiaries with a diagnosis of knee pain due to osteoarthritis. Please refer to the coverage criteria listed under code E0730.</td>
</tr>
<tr>
<td>A4602</td>
<td>Replacement battery for external infusion pump owned by patient, lithium, 1.5 volt, each</td>
<td>(also see A4632, K0601 – K0605)</td>
</tr>
<tr>
<td>A4630</td>
<td>#Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient</td>
<td>TENs Replacement batteries are covered for beneficiaries with a diagnosis of knee pain due to osteoarthritis. Please refer to the coverage criteria listed under code E0730.</td>
</tr>
<tr>
<td>A4632</td>
<td>Replacement battery for external infusion pump, any type, each</td>
<td>(also see K0601-K0605)</td>
</tr>
<tr>
<td>A7520</td>
<td>Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each</td>
<td></td>
</tr>
<tr>
<td>A7521</td>
<td>Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each</td>
<td></td>
</tr>
<tr>
<td>A7522</td>
<td>Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each</td>
<td></td>
</tr>
<tr>
<td>A7524</td>
<td>Tracheostoma stent/stud/button, each</td>
<td></td>
</tr>
<tr>
<td>E0235</td>
<td>Paraffin bath unit, portable</td>
<td>● Covered for rheumatoid arthritis only with documented treatment failure with medication and when ordered by a rheumatologist.</td>
</tr>
<tr>
<td>B9002</td>
<td>#Enteral nutrition infusion pump, any type</td>
<td></td>
</tr>
</tbody>
</table>
B9004 F3 #Parenteral nutrition infusion pump, portable
‘-RR’
B9006 F3 #Parenteral nutrition infusion pump, stationary
‘-RR’

**Note:** The maximum monthly rental amount for infusion pumps (codes B9002, B9004, B9006, E0781, and E0791) is $60.00. The maximum daily rental amount for a parenteral infusion pump for short-term use is $5.00 per day up to a total of $60.00 per month. The maximum monthly rental amount is applicable if a pump is left in the home for a monthly medication dose. Medicaid rents with option to purchase. All rental fees must be deducted from purchase price.

E0163 F3 #Commode chair, mobile or stationary, with fixed arms
E0165 F3 #Commode chair, mobile or stationary, with detachable arms (removable, drop down or swing away)
E0168 F5 #Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each
E0175 F3 #Foot rest, for use with commode chair, each (one or two piece)
E0202 F2 #Phototherapy (bilirubin) light with photometer (rental only, blanket or overhead light) (treatment plan greater than 10 days requires prior approval)
E0240 F3 #Bath/shower chair, with or without wheels, any size
E0241 F2 Bathtub wall rail, each
E0243 F2 Toilet rail, each
E0244 F3 #Raised toilet seat (with or without arms)
E0245 F3 #Tub stool or bench
E0246 F2 Transfer tub rail attachment
E0247 F3 #Transfer bench for tub or toilet with or without commode opening
E0248 F3 #Transfer bench, heavy duty, for tub or toilet with or without commode opening
E0604 F7 #Breast pump, hospital grade, electric (AC and/or DC), any type (rental only)

- Hospital or professional grade breast pump coverage is limited to cases of prematurity (including multiple gestation), neurologic disorders, genetic abnormalities (e.g., Down’s Syndrome), anatomic and mechanical malformations (e.g., cleft lip and palate), congenital malformations requiring surgery (e.g., respiratory, cardiac, gastrointestinal, CNS), prolonged infant hospitalization, or other conditions that prevent normal breast feeding (e.g. respiratory compromise).
- A Dispensing Validation System (DVS) authorization is available for up to 2 months. Prior approval is required for cases requiring more than 2 months rental (e.g. extreme prematurity, less than 28 weeks gestation).

**The hospital grade electric (multi-user) pump must:**
- Must not exceed 12 pounds including carrying case.
- Operate on a 110-volt household current and be UL listed.
• Have a visible breast milk pathway and no milk is able to contact the internal pump-motor unit parts at any time when the product is used per manufacturer instructions.
• Have an adjustable suction pressure between 30 mm Hg and 250 mm Hg at the breast shield during use; a suction range just at the low or high end of the range is not acceptable.
• Have an automatic mechanism to prevent suction greater than 250 mm Hg when used according to manufacturer’s instructions to prevent nipple trauma.
• Have a mechanism for automatic release of suction for safety.
• Have variable/adjustable cycling not less than 30 cycles per minute; one fixed cycling time is not acceptable.
• Have double pumping capacity which is simultaneous, not alternating.
• Include a pumping kit for each personal user including durable tubing to connect to the pump and flanges, and have single and double pumping capacities.
• Include a carrying case made of durable, washable materials for the pump-motor assembly and pump kit accessories; this is recommended if the pump needs to be portable.

**Minimum Breast Pump Specifications for Single-User/Multi-User**
**Double Pumping Kits**
*Use with hospital grade rentals.*

- **The kit must:** Include breast flanges that are either adjustable/flexible or if rigid, come in at least two (2) sizes to accommodate different breast sizes with no sharp edges.
- Be packaged pre-assembled with all accessories necessary for pumping two breasts simultaneously or only one breast manually.
- Include at least two collection bottles of four (4) to six (6) ounces with a spill-proof cap and standard-sized opening, and be bisphenol-A (BPA) and DHEP-free.
- Contain collection bottle(s) and flanges made of medical grade quality to allow for repeated boiling and/or dishwasher cleaning which are scratch resistant and non-breakable.
- Have durable tubing designed for long-term pumping use.
- Design and materials of the furnished assembly shall allow viewing the breast milk pathway.
- Include an adapter that can be used as an alternate power source other than electric; this is recommended and may come as part of pump assembly or pumping kit.

**Apnea monitor, with recording feature**

- Apnea monitors will only be rented. As with all rentals, the monthly fee
includes all necessary features and equipment, delivery, maintenance and repair costs, parts, supplies and services for equipment set-up, maintenance and replacement of worn essential accessories or parts, loading or downloading software, and backup equipment as needed.

● For children under 1 year of age, an electronic DVS prior authorization number must be obtained prior to providing an apnea monitor. Board certified pulmonologists or neonatologists only are qualified to order apnea monitors.

● Prior approval is still required for members over 1 (one) year of age.

Related Links:
Infant Apnea Monitor billing

E0621^F6  Sling or seat, patient lift, canvas or nylon

E0627^F2  #Seat lift mechanism, electric, any type (see criteria below)
E0629^F2  #Seat lift mechanism, non-electric, any type:

Only separate seat lift mechanisms for use with patient owned furniture are covered. These codes are not to be used to bill seat lift mechanisms incorporated into furniture.

● A separate seat lift mechanism is covered if all of the following criteria are met:

1. The member must have severe arthritis of the hip or knee or have a severe neuromuscular disease.

2. The seat lift mechanism must be a part of the physician's course of treatment and be prescribed to effect improvement, or arrest or retard deterioration in the member's condition. (The physician ordering the seat lift mechanism must be the treating physician or a consulting physician for the disease or condition resulting in the need for a seat lift. The physician's record must document that all appropriate therapeutic modalities (e.g. medication, physical therapy) have been tried and failed to enable the member to transfer from a chair to a standing position.)

3. The member must be completely incapable of standing up from a regular armchair or any chair in their home. (The fact that a member has difficulty, or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all beneficiaries who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.)

4. Once standing, the member must have the ability to ambulate.

● Coverage is limited to those types which operate smoothly, can be controlled by the member, and effectively assist a member in standing up and sitting down without other assistance.

● Excluded from coverage is the type of lift which operates by spring release mechanism with a sudden, catapult-like motion and jolts the
member from a seated to a standing position.
● Patient (member) and seat lift equipment (E0628, E0629 & E0630) are not to be billed in combination.

E0630

#Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s)
● Covered if the severity of the medical condition is such that periodic movement is necessary to effect improvement or to retard deterioration of that condition, and the alternative to use of this device is wheelchair or bed confinement.
Durable medical equipment, miscellaneous

Examples:

Positioning bath chair, tub or shower stand:
- A positioning bath chair is covered when the documented medical and hygiene needs of the member require proper positioning and alignment while providing a stable and safe means of support during bathing. The positioning bath chair’s maximum reimbursement amount (MRA) includes all accessories required for positioning of the member such as but not limited to a head support, trunk laterals, hip laterals, pelvic belt or chest belt.
- A tub stand addition is covered when the documented medical and safety needs of the member require a tub stand and when the dimension of the member’s tub will accommodate the requested stand.
- A shower stand addition is covered when the documented medical and safety needs of the member require the use of a shower stand.

Reclining shower/commode chair:
- Reclining shower-commode chair: is covered when recline is necessary to complete hygiene needs, and the member either has positioning needs that cannot be met by upright and a fixed angle chair or the member’s postural control requires recline.

Rehab (self-propelling) shower/commode chair:
- Rehab (self-propelling) shower/commode chairs are defined as chairs that have large rear wheelchair style wheels, typically 18 inches or greater, to allow for self-propulsion.
- Rehab style chairs are covered when the member has access to a roll in shower and is capable of independently propelling the chair into the shower and independently completing all aspects of the shower routine.

Toilet systems:
Covered with:
- Documentation from a Urologist or Neurologist establishing the member is physiologically capable of being toilet trained.
- Evidence of success with an established toilet training program.
- Evidence the member is unable to use a standard toilet due to physical limitations requiring additional support.

Standing frame systems:
- Use E1399 for member’s requiring a single (E0638) or multi-position (E0641) standing frame that accommodates an individual over 60 inches tall. See Home Standing Systems guidelines above.
Relat Related Links:
For information on how to obtain a prior approval number for a positioning bath chair, stand, or reclining shower-commode chair, or for information on these products’ maximum reimbursable amounts, see the following links;
Positioning bath chair and/or stand Reclining shower-commode chair

HOME STANDING SYSTEMS

General Guidelines:
- Standers are durable medical equipment (DME) designed to assist a child or adult in attaining and maintaining an upright position.
- Standers may provide medical and functional benefits to otherwise bed or chair-bound individuals.
- DMEPOS providers must provide documentation that the member has tried more cost-effective alternatives and still requires a stander.
- A glider component does not qualify as DME, as it is non-medical in nature and is primarily used for exercise purposes.

Clinical Coverage:
- The member is unable to stand or ambulate independently due to conditions such as, but not limited to, neuromuscular or congenital disorders, including acquired skeletal abnormalities.
- The member is at high risk for lower extremity contractures that cannot be appropriately managed by other treatment modalities (i.e. stretching, active therapy, home programs, etc.).
- The alignment of the member’s lower extremities are such that they can tolerate a standing or upright position.
- The member does not have orthostatic hypotension, postural tachycardia syndrome, osteogenesis imperfecta, osteoporosis and other brittle bone diseases, or hip and knee flexion contractures of more than 20°.
- The member has demonstrated improved mobility, function and physiologic symptoms or has maintained status with the use of the requested stander (when other alternatives have failed) and is able to follow a home standing program incorporating the use of the stander (as documented by clinical standing program or home trial with the requested stander).
- The member is unable to stand or ambulate with caregiver assistance or ambulatory assistive device a sufficient duration/distance to achieve a medical benefit.
- The member does not have, and it is not anticipated they will require, a walker or gait trainer. Provision of both a walker/gait trainer and standing device is typically considered a duplication of service, as both type devices address the medical need for weight bearing.
- There is a home therapy plan outlining the use of the requested stander.
- The member is able to self-propel the mobile stander (code E0642 only), the documentation establishes the specific medical need(s) that will be met while
using the mobile stander, and why these medical needs must be met while utilizing the mobile stander.

Documentation Requirements:
- A prescription including the stander and any modifications/accessories requested.
- A detailed letter of medical necessity (LMN) that includes:
  1. A comprehensive history and physical exam by a licensed physician, physical therapist or occupational therapist.
  2. A summary of the existing medical condition, age at diagnosis, prognosis and co-morbid conditions.
  3. The member’s functional and physical assessment including strength, range of motion, tone, sensation, balance, ADL’s, and functional status.
  4. Documentation of failure of less costly alternatives (include make and model of alternatives tried as well as the length of the trial with each alternative).
  5. A home therapy plan outlining the planned use of the requested stander.
- Documentation that the member does not have sufficient access to equipment in an alternative setting, e.g. clinic, outpatient therapy, etc.
- Documentation regarding the level of caregiver assistance available/needed on daily basis
- Documentation that the member’s home can accommodate the requested stander and that the family/caregiver has been trained in the use and maintenance of the requested stander.
- Documentation the member does not have, and it is not anticipated they will require, a walker or gait trainer. Provision of both a walker/gait trainer and standing device is typically considered a duplication of service, as both type devices address the medical need for weight bearing.
- Documentation that the member is able to self-propel the mobile stander (code E0642 only), the specific medical need(s) that will be met while using the mobile stander, and why these medical needs must be met while utilizing the mobile stander.
- The fees listed for home standing systems include all necessary prompts and supports.

E0637\textsuperscript{F2} 'RR'
combination sit to stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels

E0638\textsuperscript{F2} 'RR'
#Standing frame/table system, one position (e.g. upright, supine or prone stander), any size including pediatric, with or without wheels
- Prior approval is required for ages 21 and over and uses other than bone density or trunk strength development.

E0641\textsuperscript{F2} 'RR'
#Standing frame/table system, multi-position (e.g. three-way stander), any size including pediatric, with or without wheels
- Prior approval is required for ages 21 and over and uses other than bone density or trunk strength development.
E0642 F2  **Standing frame/table system, mobile (dynamic stander), any size including pediatric** (self-propelled, multi-positioning, no lift feature, for use when gait trainer does not meet medical need)

E0650 F2  **Pneumatic compressor, non-segmental home model, (Lymphedema pump)**

- Pneumatic compression devices are covered for the treatment of generalized or refractory lymphedema or refractory edema from venous insufficiency only when all less invasive treatments have been attempted and are unsuccessful.
- The following documentation is required as an attachment to all claims for pneumatic compression devices:
  1. Member history
  2. Diagnosis
  3. Underlying causes and prognosis
  4. Symptoms and objective findings (including measurements, the pressures to be used and expected duration of use of device)
  5. Full description of attempts to use less invasive treatments and outcomes of such treatments
  6. Responsible party for monitoring member compliance and response to treatment
  7. Plan of care for post-compression pump treatment
  8. Rental or purchase
  9. A copy of the fiscal order

E0655 F3  **Non-segmental pneumatic appliance for use with pneumatic compressor, half arm**

E0660 F3  **Non-segmental pneumatic appliance for use with pneumatic compressor, full leg**

E0665 F3  **Non-segmental pneumatic appliance for use with pneumatic compressor, full arm**

E0666 F3  **Non-segmental pneumatic appliance for use with pneumatic compressor, half leg**

E0700 F5  #Safety equipment, device or accessory, any type (limited to gait belt)

E0705 F6  **Transfer device, any type, each**

E0730 F5  #Transcutaneous electrical nerve stimulation (tens) device, four or more leads, for multiple nerve stimulation (dual channel)

Covered for:

- Beneficiaries with a diagnosis of knee pain due to osteoarthritis.
- Reimbursable ICD codes are limited to: M17.0, M17.11, M17.12, M17.2, M17.31, M17.32, M17.4, and M17.5.
- The following codes may be billed in conjunction with E0730: A4556, A4557 and A4630.

E0747 F2  #Osteogenesis stimulator electrical, noninvasive, other than spinal applications

Covered when ordered by a board-certified or board-eligible orthopedic surgeon for:

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1. Nonunion of long bone fractures confirmed by a minimum 2 sets of radiographs:
   - including multiple views of the fracture site,
   - obtained prior to starting treatment with the osteogenic stimulator,
   - separated by a minimum of 90 days, and
   - accompanied by written physician interpretation stating there has been no clinically significant evidence of fracture healing between the 2 sets of radiographs; OR 
2. Failed fusion of a joint other than the spine, where a minimum of 9 months has elapsed since the last surgery; OR 
3. Congenital pseudarthrosis.

Not covered for:
1. Nonunion fractures of the skull.
2. Tumor-related fractures.

Related Links:
The osteogenesis stimulator worksheet is available at: https://www.emedny.org/ProviderManuals/DME/PDFS/Osteogenesis_Stimulator_Worksheet__2019.pdf

E0748F2 #Osteogenesis stimulator electrical, noninvasive, spinal applications
Covered when ordered by a board-certified or board-eligible orthopedic surgeon or neurosurgeon for:
1. Failed spinal fusion where a minimum of 9 months has elapsed since the last surgery; OR 
2. Following multilevel spinal fusion surgery; OR 
3. Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site.

Not covered for:
1. Nonunion fractures of vertebral fractures.

Related Links:
The osteogenesis stimulator worksheet is available at: https://www.emedny.org/ProviderManuals/DME/PDFS/Osteogenesis_Stimulator_Worksheet__2019.pdf

E0760F2 #Osteogenesis stimulator, low intensity ultrasound, non-invasive
Covered when ordered by a board-certified or board-eligible orthopedic surgeon for:
- Nonunion of long bone fractures confirmed by a minimum 2 sets of radiographs:
  1. including multiple views of the fracture site,
  2. obtained prior to starting treatment with the osteogenic stimulator,
  3. separated by a minimum of 90 days, and...
4. accompanied by written physician interpretation stating there has been no clinically significant evidence of fracture healing between the 2 sets of radiographs.

Not covered for:
1. Nonunion fractures of the skull or vertebrae.
2. Tumor-related fractures.
3. Fresh fracture or delayed union.
4. When used concurrently with other non-invasive osteogenic devices.

Related Links:
The osteogenesis stimulator worksheet is available at:

**E0776**
‘-RR’
#I.V. pole

**E0781**
‘-RR’
#Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient

**E0784**
#External ambulatory infusion pump, insulin

- An external insulin infusion pump will be covered for Diabetes Mellitus as medically necessary when ordered by an endocrinologist if the following criteria are demonstrated and documented in the clinical and DMEPOS providers’ records:
  1. Failure to achieve acceptable control of blood sugars on 3-4 injections that is not explained by poor motivation or compliance, and
  2. Documented frequency of glucose testing of at least 4 times/day during 2 months prior to initiation of pump therapy, and
  3. Must have one or more of the following criteria while receiving multiple daily injections:
     (a) HbA1c >7%
     (b) History of recurring hypoglycemia (<60mg/dl)
     (c) Wide fluctuations in blood glucose before mealtime (>140mg/dl)
     (d) Dawn phenomenon in a fasting state (>200mg/dl)
     (e) History of severe glycemic excursions, and
  4. Member has completed a comprehensive diabetes education program, and has been on multiple injections with frequent self-adjustments for at least 6 months, or
  5. Diagnosis of gestational diabetes.

**Preferred Diabetic Supply Program**

Disposable insulin pump supplies and meters (i.e. Omnipod) are
covered under the Preferred Diabetic Supply Program. Please see the pharmacy preferred diabetic supply program link below for additional information.

https://newyork fhsc.com/providers/diabeticsupplies.asp

Parenteral infusion pump, stationary, single or multichannel
● Covered if both the therapy and the prescribed pump are appropriate for home use and adequate supervision by the physician is specified on the prescription.

CONTINUOUS GLUCOSE MONITORING

Preferred Diabetic Supply Program

Certain CGM and related diabetic supply products (disposable insulin delivery systems) have been added to the Preferred Diabetic Supply Program. Please see the pharmacy preferred diabetic supply program for additional information.

https://newyork fhsc.com/providers/diabeticsupplies.asp

For CGM and related diabetic supply products that are not covered by the Preferred Diabetic Supply Program, please see the link below to the December 17, 2018 DME Provider Communication.

Approval of Continuous Glucose Monitoring and Insulin Pumps for Individuals with Type 1 Diabetes

K0554 F4 Receiver (monitor), dedicated, for use with therapeutic continuous glucose monitor system
K0555 F9 Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service
A9276 F9 Sensor; invasive (e.g. subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day (non-therapeutic device)
A9277 F13 Transmitter, external, for use with interstitial continuous glucose monitoring system (non-therapeutic device)
A9278 F4 Receiver (monitor); external, for use with interstitial continuous glucose monitoring system (non-therapeutic device)

CGM Coverage Guidelines:
Members who meet each of the following criteria may be eligible for a CGM device. The member must:

- Have a diagnosis of Type 1 diabetes; and
- Be under the care of the endocrinologist who orders the device; and
- Currently be performing at least four finger stick glucose tests daily; and
- Be on an insulin treatment plan that requires frequent adjustment of insulin dosing; and
- Be able, or have a caregiver who is able, to hear and view CGM alerts and respond appropriately.

Additional CGM Guidelines:

- In addition to the above coverage criteria, ordering providers should verify that their patients meet manufacturer’s recommendations for appropriate age range, testing and calibration requirements, etc., prior to prescribing the CGM device.
- Members must comply with the manufacturer’s specified finger stick testing recommendations for the CGM device prescribed.
- Only one type of monitor will be covered: either therapeutic (such as but not limited to DexCom5) or non-therapeutic (such as but not limited to Metronics Minimed).
- Ancillary devices (such as but not limited: smart phones, tablets, personal computers) are not covered
- Replacement will be considered when medically necessary and outside of manufacturer’s warranty and not for recent technology upgrades.
- Repairs will be funded if outside of manufacturer’s warranty and cost effective (< 50% of Fee).
- Claims submitted for all supplies and receiver (monitor) without a diagnosis of Type 1 diabetes will be denied.

#Topical hyperbaric oxygen chamber, disposable

General Definitions:

- Topical oxygen wound therapy (TOWT) is the controlled application of 100% oxygen directly to an open moist wound at slightly higher than atmospheric pressure. An oxygen concentrator is connected to a FDA approved O2 boot and/or O2 sacral device that are for onetime use and disposable, therefore reducing the risk of cross contamination.

- Staging: The staging of pressure ulcers used in this policy is as follows:
  1. Stage I: nonblanchable erythema of intact light toned skin or darker or violet hue in darkly pigmented skin.
  2. Stage II: partial thickness skin loss involving epidermis and/or dermis.
  3. Stage III: full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia.
4. Stage IV: full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures.

- Wound healing: Defined as improvement occurring in either the surface area or depth of the wound. Lack of improvement of a wound is defined as a lack of progress in these quantitative measurements.

Coverage Criteria:

- TOWT (A4575 with E1390) is covered when criteria 1 and any of criteria 2-6 are met:
  1. A complete wound therapy program as applicable, depending on the type of wound, has been attempted prior to the application of TOWT, including:
     (a). Documentation in the member's medical record of evaluation, care, compliance and wound measurements by the treating physician, and
     (b). Application of dressings to maintain a moist wound environment, and
     (c). Debridement of necrotic tissue if present, and
     (d). Evaluation of and provision for adequate nutritional status, and
  2. Stage IV pressure ulcers:
     (a). The member has been appropriately turned and positioned, and
     (b). The member has used a support surface for pressure ulcers on the posterior trunk or pelvis (not required if the ulcer is not on the trunk or pelvis), and
     (c). The member's moisture and incontinence have been appropriately managed, or
  3. Neuropathic (for example, diabetic) ulcers:
     (a). The member has been on a comprehensive diabetic management program, and
     (b). Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities, or
  4. Venous insufficiency ulcers:
     (a). Compression bandages and/or garments have been consistently applied, and
     (b). Leg elevation and ambulation have been encouraged, or
  5. For non-healing surgically created or traumatic wounds, documentation of medical necessity for accelerated formation of granulation tissue that cannot be achieved by other topical wound treatments, or
  6. A chronic (being present for at least 30 days) ulcer of mixed etiology.

Non-Covered Indications:

- TOWT is considered investigational, not medically necessary, medically contraindicated and not covered for all other indications, including but not limited to, the following:
  1. The presence in the wound of necrotic tissue with eschar, if debridement is not attempted;
2. Untreated osteomyelitis within the vicinity of the wound;
3. Cancer present in the wound;
4. The presence of a fistula to an organ or body cavity within the vicinity of the wound;
5. Stage I, II or III pressure ulcers.

General Guidelines:
• The procedure codes for billing TOWT are A4575 Topical oxygen chamber, disposable and E1390 Oxygen concentrator, single delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate.
• Payment for E1390 includes all necessary equipment, delivery, maintenance and repair costs, parts, supplies and services for equipment set-up, maintenance and replacement of worn essential accessories and parts.
• Payment for A4575 includes the dressing set and canister set used in conjunction with E1390 and contains all necessary components, including but not limited to an occlusive dressing which creates a seal around the wound site for maintaining the desired concentration of oxygen at the wound.
• Payment for E1390 and A4575 are considered payment in full for TOWT.
• An initial electronic prior authorization (DVS) will be granted for A4575 for a maximum of 16 days in a 28-day period, as treatment is 4 days on, 3 days off. The DMEPOS provider should request authorization once for the number of days (units) based on the written order. Prior approval is required for treatment exceeding 4 weeks. E1390 is prior authorized (DVS) and is billed monthly.
• TOWT should be attempted first in a hospital or another health care facility prior to discharge to the home setting. In these continuing cases, documentation should reflect member compliance and pain management during application of TOWT. If TOWT has not been attempted, DMEPOS providers must obtain an initial electronic prior authorization of two weeks (8 days or units) only. Prior approval may then be requested for an extension of the treatment.
• Documentation of previous treatment regimens and how the member meets the coverage criteria above must be maintained in the member’s medical record and available upon request. This documentation must include dressing types and frequency of change, changes in wound conditions (including precise length, width and surface area measurements), quantity of exudates, presence of granulation and necrotic tissue, concurrent measures being addressed relevant to wound therapy (debridement, nutritional concerns, support surfaces in use, positioning, incontinence control, etc.) and training received by the member/family in the application of the occlusive dressing to the wound site and proper hook up of the oxygen to the dressing set.
• When an extension of treatment is requested, the following documentation must be submitted: how the member meets the coverage
criteria, status of wound healing, weekly quantitative measurements of
wound characteristics, wound length, width and depth (surface area) and
amount of wound exudate (drainage) and member compliance with the
treatment plan. If detailed documentation is insufficient or if any
measurable degree of wound healing has failed to occur, prior approval
beyond the initial approved period of service will not be granted.

● Upon completion of treatment, documentation regarding the outcome of
treatment with TOWT must be submitted to the prior approval office.

E2402

#Negative pressure wound therapy electrical pump, stationary or
portable (daily rate includes all necessary supplies, up to 30 days allowed
without Prior Approval)
The Bureau of Medical Review approves DME providers, to offer NPWT, in
a separate process that includes a review of the associated supplies, cost
analysis, technical support/training, documentation format and
demonstration of the equipment.

● Negative pressure wound therapy (NPWT) is the controlled application of
sub atmospheric pressure to a wound using an electrical pump
(described in the definition of HCPCS coded E2402) to intermittently or
continuously convey sub atmospheric pressure through connecting
tubing to a specialized wound dressing which includes a resilient, open-
cell foam surface dressing, sealed with an occlusive dressing that is
meant to contain the sub atmospheric pressure at the wound site and
thereby promote wound healing. Drainage from the wound is collected in
a canister.

● A stationary or portable NPWT electrical pump provides controlled sub
atmospheric pressure that is designed for use with NPWT dressings to
promote wound healing. Such a NPWT pump is capable of being
selectively switched between continuous and intermittent modes of
operation and is controllable to adjust the degree of sub atmospheric
pressure conveyed to the wound in a range from 23 to greater than 200
mm Hg sub atmospheric pressure. The pump is capable of sounding an
audible alarm when desired pressures are not being achieved (that is,
where there is a leak in the dressing seal) and when the wound drainage
canister is full. The pump is designed to fill the canister to full capacity.

The staging of pressure ulcers in this policy is as follows:

Stage I: non-blanchable erythema of intact light toned skin or darker or
violet hue in darkly pigmented skin.
Stage II: partial thickness skin loss involving epidermis and or dermis.
Stage III: full thickness skin loss involving damage or necrosis of
subcutaneous tissue that may extend down to, but not
through, underlying fascia.
Stage IV: full thickness skin loss with extensive destruction, tissue
necrosis or damage to muscle, bone, or supporting
structures.
General Coverage criteria (for all wound types):
● Documentation of the history and previous treatment regimens must be maintained in the member’s medical record and available upon request. This documentation must include such elements as dressing types and frequency of change, changes in wound conditions (including precise measurements) quantity of exudates, presence of granulation and necrotic tissue and concurrent measures being addressed relevant to wound therapy (debridement, nutritional concerns, support surfaces in use, positioning, incontinence control, etc.)
● Coverage will be considered when the member has a chronic Stage IV pressure ulcer, neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, a non-healing surgically created or traumatic wound, or a chronic (being present for at least 30 days) ulcer of mixed etiology. See below for diagnosis specific coverage criteria.
● A complete wound therapy program described below, as applicable depending on the type of wound, should have been tried prior to application of NPWT. NPWT should be attempted first in a hospital or another health care facility prior to discharge to the home setting. In these continuing cases, documentation should reflect member compliance and pain management during application of NPWT.
● If NPWT has not been attempted, DMEPOS providers must obtain an initial authorization of two weeks only. Prior approval may then be requested for an extension of the treatment. In addition, documentation of the availability of licensed medical professionals to perform dressing changes and cleaning of the devices should be maintained and/or submitted for all cases.

Diagnosis Specific Coverage Criteria:
● All ulcers or wounds:
  1. Documentation in the member’s medical record of evaluation, care, and wound measurements by the treating physician, and
  2. Application of dressings to maintain a moist wound environment, and
  3. Debridement of necrotic tissue if present, and
  4. Evaluation of and provision for adequate nutritional status
● Stage IV pressure ulcers:
  1. The member has been appropriately turned and positioned, and
  2. The member has used a support surface for pressure ulcers and the posterior trunk or pelvis (not required if the ulcer is not on the trunk or pelvis) and
  3. The member’s moisture and incontinence have been appropriately managed.
● Neuropathic (for example, diabetic) ulcers:
  1. The member has been on a comprehensive diabetic management program, and
  2. Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
Venous insufficiency ulcers:
1. Compression bandages and/or garments have been consistently applied, and
2. Leg elevation and ambulation have been encouraged.

Non-healing surgically created or traumatic wounds:
1. Documentation of medical necessity for accelerated formation of granulated tissue which cannot be achieved by other topical wound treatments.

Non-covered conditions:
• The presence in the wound of necrotic tissue with eschar, if debridement is not attempted;
• Untreated osteomyelitis within the vicinity of the wound;
• Cancer present in the wound,
• The presence of a fistula to an organ or body cavity within the vicinity of the wound.

Documentation requirements (for continuation of services):
• Documentation of wound evaluation and treatment, recorded in the member’s medical record, must indicate regular evaluation and treatment of the member’s wounds and must be available upon request.
• Documentation of quantitative measurements of wound characteristics including wound length and width (surface area), and depth and amount of wound exudate (drainage), indicating progress of healing must be entered at least weekly.
• If treatment beyond the initial approved period of service is indicated by the treating physician upon review of the clinical progress, this documentation must be submitted with the new prior approval request. Lack of improvement of a wound is defined as a lack of progress in quantitative measurements of wound characteristics including wound length and width (surface area), or depth measured serially and documented, over the approved period of service.
• Wound healing is defined as improvement occurring in either surface area or depth of the wound. If detailed documentation is insufficient or if any measurable degree of wound healing has failed to occur, prior approval beyond the initial approved period of service will not be granted.
• Upon completion of treatment, documentation regarding the outcome of treatment with NPWT must be submitted to the prior approval office.

SPEECH GENERATING DEVICES

Prior approval (PA) is the process of evaluating the request for Durable Medical Equipment (DME) in order to determine the medical necessity and appropriateness of the DME according to policies and regulations. Requests for PA are submitted through DME providers enrolled in New York State Medicaid. The DME provider is responsible for submitting all necessary documentation.
required for the PA request in accordance with 18 New York State Codes, Rules and Regulations ("NYCRR") Part 513. Please refer to Title: Section 513.0 Policy, purpose and scope at https://regs.health.ny.gov/content/section-5130-policy-purpose-and-scope for further information.

The following guidelines were developed to assist DME providers, ordering practitioners, Medicaid members, caregivers, and evaluating clinicians with the PA process for Speech Generating Devices (SGD). The purpose of these guidelines is to provide detailed coverage criteria for SGDs and accessories so that medically necessary equipment is provided to Medicaid beneficiaries in a timely manner in compliance with applicable Federal, Laws, policies and New York State Codes, Rules and Regulations. These guidelines are the product of collaboration with practitioners, therapists, medical equipment providers, advocates and New York State Medicaid medical review staff, utilizing state and national standards and are the basis for compliance with applicable Medicaid policies.

As outlined in 18 NYCRR Section 513.0(b)(2), the Department retains the authority and responsibility to exercise administrative discretion in the supervision of the program and make decisions with respect to the application of the rules, regulations and policies of the Medicaid program.

SGDs are one strategy used for augmentative alternative communication (AAC). AAC employs strategies to assist individuals who are unable to effectively use their own speech to communicate. Successful use of a device requires the ability to functionally communicate using the device’s output in addition to physical ability to activate and manipulate the device. A detailed and individualized assessment of a person’s communication, cognitive, language, motor, and visual abilities is required to determine which device will meet the person’s medical needs and abilities.

New York State Medicaid coverage includes only dedicated devices. Dedicated AAC devices are limited to primarily serve a medical need (e.g., solely for the purpose of expressive communication) such that they are generally NOT useful in the absence of disability, illness, or injury. Non-dedicated devices are non-medical devices designed for a non-medical purpose and are generally useful in the absence of disability, illness, or injury; however, they may also include functionality for use as a communication tool.

Coverage Guidelines

1) Speech Generating Devices (SGDs) and Related Accessories

An SGD will be considered medically necessary when documentation demonstrates all of the following:
a) The member has a severe expressive communication impairment related to a medical condition or developmental disability that interferes with the member’s ability to meet daily functional communication, AND;
b) The member’s ability to communicate using speech and/or writing is insufficient to meet daily functional communication needs, AND;
c) The member cannot meet daily functional communication needs with any unaided means of communication, AND;
d) The recommended device can be used to communicate with multiple individuals in multiple settings within the trial location while conveying varying message types without being fully dependent on prompting or assistance in producing the communication, AND;
e) The member has the cognitive, auditory, visual, language, and physical abilities to use the recommended SGD for functional communication, AND;
f) A licensed Speech Language Pathologist (SLP) experienced in AAC service delivery has made the recommendation for the device and a licensed physician, nurse practitioner, or physician’s assistant enrolled as a NY State Medicaid provider has prescribed the device or software, AND;
g) The member has demonstrated the ability to use the recommended device and accessories or software for functional communication as evidenced by a data-driven device trial showing that skills can be demonstrated repeatedly over time, beyond a single instance or evaluation session, AND;
h) The SGD and related accessories are the adequate, less expensive alternative to enable the member to meet daily functional communication needs. There must be clear explanation of why other alternatives were ruled out. (See 18 NYCRR 513.4(d)), AND
i) The SGD and related accessories must allow members to improve their communication to a functional level not achievable without a SGD or less costly device.

2) Eye Control/Eye Gaze Accessory

An eye gaze accessory should be considered only after all other methods of accessing the SGD have been evaluated and ruled out. The recommendation for an eye gaze accessory must be based on an assessment by the SLP and either a PT or OT. Other professionals also may be needed for members who present additional issues, such as vision impairment that interferes with the ability to use eye gaze to access a SGD. An eye gaze accessory will be considered medically necessary when objective documentation demonstrates the following:

a) Scanning and head pointing systems have been tried repeatedly over time (within a single evaluation session or in several sessions) were ruled out as not appropriate.
b) The member demonstrates abilities to use eye gaze technology beyond cause and effect activation, simple eye tracking activities, and learning tools. A recent vision assessment may be required.
c) The member has the physical ability to activate the system and demonstrate meaningful/functional use of the device without being fully dependent on prompting or assistance in producing the communication

d) A data driven objective trial with the requested eye gaze access device has occurred.

e) Documentation shows that other eye gaze access devices from multiple manufacturers have been considered.

f) The member can use the eye gaze technology to communicate significantly beyond the capabilities of a light technology eye gaze system such as an eye gaze board or E-Tran system with less partner assistance.

g) A PT and/or OT with assistive technology (AT) experience has explored the member’s positioning needs and head control abilities and all potential less costly access methods, including non-voice output eye gaze boards.

3) Mounts
Mounts are used to secure SGDs for access and safety. Reimbursement is for one mount that meets the member’s needs in all customary environments. Selection should be based on medical necessity and 18 NYCRR Section 513.4(d)

Indication for Non-Coverage
1) The member fails to demonstrate during the trial period or at any subsequent time the ability to learn to use the device or software functionally for communication.

2) The requested device does not meet the member’s current and reasonably foreseeable communication abilities and needs.

3) The intention is to unlock the device for uses other than communication or for use by other individuals.

4) The request includes reimbursement for the installation of the software/program or technical support of a non-dedicated device. (Communication software/program is a covered benefit when all other coverage criteria are met.)

5) The request is for reimbursement for a device or maintenance of a device (e.g. laptop, tablet) for which Medicaid-funded communication software has been installed.

6) The request is for reimbursement for repairs of a device and the minimum coverage requirements for the SGD are not met.

7) The request is for repairs, cleaning or other services for non-dedicated communication devices.

8) The request is for an upgrade to new technology that is not medically necessary.

9) The request is for replacement of a device due to new technology or replacement based on a manufacturer’s recommended replacement schedule when the beneficiary’s current SGD meets his/her medical and functional communication needs.
10) The request is for multiple devices, back up or duplicate accessories.
11) The request is for environmental control devices such as switches and control boxes.

Documentation Requirements
Each SGD request is reviewed on an individual basis. Please refer to 18NYCRR Section 513.0(b)(2). Medicaid reserves the right to request an evaluation of a member from another licensed medical professional, other than the SLP, for supporting the appropriateness of the device being recommended. In addition to the specific requirements stated below, the documentation submitted in support of a funding request for a SGD, mount or related accessories must establish that all the standards stated in the Coverage Guidelines are met. Documentation submitted should include the following:

1) Detailed Fiscal Order including the make and model of equipment requested (see “Filling Orders for DMEPOS at https://www.emedny.org/ProviderManuals/DME/PDFS/DME_Policy_Section.pdf)
2) A cost quote from the manufacturer of all the equipment and components as ordered (e.g., make, model). Include the usual and customary price charged to the general public and all dealer discounts.
3) Individualized Education Plan (IEP) for school aged members
4) Formal face to face evaluation and assessment written by a SLP within 6 months prior to the date of PA submission that includes:
   a) Background information
      i. Medical diagnosis; course and prognosis
      ii. Significant history and medications
      iii. Communication disorder(s)/diagnosis and severity; course and prognosis
      iv. Past speech/ spoken language treatment
      v. Member’s history, school, vocational status
      vi. Member's living environment
      vii. Members’ attitude and motivation to communicate
   b) Current communication abilities
      i. Speech/articulation and intelligibility
      ii. Expressive language skills
      iii. Receptive language skills
      iv. Current mode of communication including nonverbal communication methods
      v. Current method of communicating pain, discomfort or other medical emergencies
      vi. Previous use of AAC including devices, dates utilized, and explanation why the currently used device does not meet the member’s current and reasonably foreseeable daily functional communication needs
      vii. Currently used functions of communication (e.g. requesting, protesting, commenting, describing, etc.),
viii. Reading, writing, and spelling abilities

c) Sensory functioning
   i. visual abilities (e.g. tracking ability, acuity for symbol size, etc.)
   ii. auditory abilities as they relate to a SGD system

d) Psychometric or developmental assessment characterizing cognitive and
   learning abilities and levels of function (include results of most recent
   evaluation, name of test, IQ or developmental levels, and date
   performed). NOTE: Members who do not exhibit cognitive deficits may
   not need to participate in assessments, however Medicaid reserves the
   right to request additional documentation regarding cognitive functioning
   after initial review of PA submission.

e) Behavioral and Learning abilities
   i. Executive-functioning skills, including attention span
   ii. Memory
   iii. Problem solving skills
   iv. Understanding of cause and effect

f) Motor abilities
   i. Gross motor abilities: ambulatory, uses walker or wheelchair, head
   control and trunk mobility
   ii. Positioning and Seating: current DME used, positioning needs as
   related to SGD use including eye gaze access if necessary (including
   primary positions in which the member spends a typical day and
   percentage of time in each position)
   iii. Fine Motor and upper extremity abilities and functional use (including
   strength and endurance for carrying SGD)
   iv. Alternative access (except for access via gaze), e.g., head mouse,
   single switch or multiple switch scanning, or other alternative access
   method) should be evaluated by a PT, OT or other health professional
   when necessary.

g) Formal evaluation of AAC by evaluating SLP
   i. Description of need, short and long-term goals for device use; primary
   communication partners; current and reasonably foreseeable
   communication environments
   ii. Treatment options considered including past use of communication
   supports and why each does not meet the member’s communication
   needs
   iii. Description of consideration of more than one device by multiple
   manufacturers within the same HCPCS category that includes
   explanation of why devices were selected or ruled out.
   iv. Data driven AAC device trial of the recommended device. The
   following items should be addressed:
      1) Length and dates of trial, amount of time device was accessed
         during the trial
      2) Time framed measurable goals for functional communication set
         for trial and criteria for measurement
      3) Empirical data including baseline performance and results of
         trial period goals
4) Description of environments in which device was trialed such as, but not limited to, home, school, and community
5) Whether communication occurred in both structured and unstructured settings
6) Manner in which the device was accessed (e.g. eye gaze, direct selection, scanning-type)
7) Description of the member’s ability to use the SGD for functional communication (ability to use training software, including but not limited to cause and effect games does not demonstrate functional communication)
8) Sampling of multiple messages communicated including the frequency, type (e.g. verbal, physical, gesture), and level of cueing required
9) Number of messages expressed in a time period including the type and level of cueing required
10) Communicative intents and functions expressed
11) If recommending eye gaze access: the member’s endurance to maintain gaze, ability to calibrate or obstacles to calibration

v. Description and rationale for the software or language system recommended including specific page sets/layout/symbols per page/vocabulary organization.
vi. Description of recommended device; the rationale for the selection including a cost comparison among devices considered from more than one manufacturer; and how the recommendation meets the current communication needs of member.
vii. Description of environmental supports for SGD use: capacity of family/caregivers/friends to assist in care and maintenance of SGD; need for their training.
viii. Documentation that device is configured to limit use to the purpose of communication.
ix. Explanation of how the device is the adequate, less expensive alternative to meet the member’s medical need.

h) Outline of a training and implementation plan that will be used to ensure the most appropriate use of the device over time, including plans for maintaining the system, implementing programming updates and modifications due to changing language, environmental, or motoric needs.
i) A signed and dated attestation by the SLP that the licensed/certified medical professional (LCMP) has no financial relationship with the Medicaid provider or SGD manufacturer
j) Dated signature of SLP, license number and pertinent contact information.
k) All other professionals directly involved in the evaluation should sign, date, and provide their license numbers.

Documentation for Consideration for Coverage of:
1) Upgrade

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The Medicaid-funded or member-owned device is no longer clinically effective at meeting functional communication needs. Documentation must include

a) Statement addressing why the device is no longer clinically effective in meeting member’s functional communication needs
b) Statement of significant changes that have occurred in the member’s physical or linguistic abilities, or social environment, and how these changes impact the member’s ability to functionally communicate with the currently owned device.
c) Establish why the replacement device is required (not solely due to advances in technology or other factors that are not medical in nature).

2) Repairs

a) The minimum coverage criteria for SGDs are met.
b) The request includes a quote from the manufacturer of the initially covered device for the cost of the repairs (The decision whether to repair or replace a device will be based on a determination of which will be most cost effective.)
c) When repair is required due to accidental or non-accidental trauma to the device, the SLP or ordering Physician must provide a statement indicating the cause of damage and what reasonable measures will be taken to prevent a recurrence.

The reimbursement for a new SGD includes all necessary screen protectors, batteries, power source components, software, stands (not including mounts: e.g. wheelchair or desk mounts) and any type of carrying case.

E2500F2 ‘-RR’  #Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time
E2502F2 ‘-RR’  #Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time
E2504F2 ‘-RR’  #Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time
E2506F2 ‘-RR’  #Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time
E2508F2 ‘-RR’  #Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device
E2510F2  Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access
E2511F2  Speech generating software program, for personal computer or personal digital assistant
E2512 F3 Accessory for speech generating device, mounting system
E2599 F3 Accessory for speech generating device, not otherwise classified

References

K0601 F8 #Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each
K0602 F8 #Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each
K0603 F8 #Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each
K0604 F8 #Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each
K0605 F8 #Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each
K0606 F9 Automatic external defibrillator, with integrated electrocardiogram analysis, garment type
See following link: K0606 General Coverage Guidelines

L7900 F2 Vacuum erection system
- Limited to diagnosis of impotence, with an order from a urologist or neurologist.
L8500 F2 #Artificial larynx, any type
L8501\textsuperscript{F7}  
\textit{#Tracheostomy speaking valve}

L8505\textsuperscript{F7}  
\textit{#Artificial larynx replacement battery/accessory, any type}

L8507\textsuperscript{F10}  
\textit{Tracheo-esophageal voice prosthesis, patient inserted, any type, each}

L8510\textsuperscript{F3}  
\textit{#Voice amplifier}

L8511\textsuperscript{F7}  
\textit{#Insert for indwelling tracheoesophageal prosthesis, with or without valve, replacement only, each}

L8514\textsuperscript{F7}  
\textit{#Tracheoesophageal puncture dilator, replacement only, each}

L8515\textsuperscript{F5}  
\textit{#Gelatin capsule, application device for use with tracheoesophageal voice prosthesis, each}

S8270\textsuperscript{F1}  
\textit{#Enuresis alarm, using auditory buzzer and/or vibration device (Prior approval required over age 20)}

T5001\textsuperscript{F2}  
\textit{#Positioning seat for persons with special orthopedic needs, (adjustable, for use in vehicles, able to accommodate users up to 60 inches, prior approval required for ages less than 2 or over 10)}

\textbf{Covered when the:}

\begin{itemize}
  \item Member's postural needs cannot be safely met by less costly alternatives such as the vehicle's restraint system or other restraint systems such as an EZ on vest.
  \item Member's size or postural support needs restricts the use of a standard/commercially available car seat.
  \item Car seat is used in the primary caregiver's personal vehicle.
\end{itemize}

Reimbursement price includes the following features/accessories (any type/size):

\begin{itemize}
  \item Head support
  \item Trunk positioning pads/supports
  \item Harness or safety belts (with or without safety cover)
  \item Abductor pommel
  \item Any positioning wedges, cushions or padding
  \item Tilt and/or recline (fixed or adjustable)
  \item All LATCH/tether straps
\end{itemize}

Additional, medically necessary accessories will require prior approval under miscellaneous code E1399.

\section*{SERVICING, PARTS, REPAIRS}

- Repair requests submitted on a paper prior approval (for frequency or quantity override) must include, at minimum; the specific part(s) being requested with associated cost quote(s) or invoice(s), list of other repairs being provided not requiring prior approval and anticipated useful life of the device with the requested repairs. If NYS Medicaid did not fund the device originally and this is the first repair request submitted for paper prior approval, the device's serial number, date provided, funding source, and original supporting documentation must be provided.

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K0739, A9900, RB modifier
- For replacement parts that have a specific HCPCS code:
  1. Report the replacement part code, and
  2. Report K0739 for labor component.
- For replacement parts to base equipment with a specific HCPCS code:
  1. Report the base equipment code with the -RB modifier (e.g., wheelchair base code with -RB, hospital bed code with -RB), for the replacement part(s) and
  2. Report K0739 for the labor component.
- For miscellaneous DME with no specific or base code to report:
  1. Report the appropriate miscellaneous code, E1399 or K0108 or A9900 with the –RB modifier for the replacement part(s), and
  2. Report K0739 for labor component.
- A9900 miscellaneous DME supply, accessory, and/or service component of another HCPCS code will now require prior approval and will be priced manually.
- The fee for K0739 Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes (more than 2 hours requires prior approval) is $18.00.
- Payment for pick-up and delivery of DME for repair is included in the payment for replacement equipment and parts.
- Repairs (labor, replacement equipment and parts) covered under the manufacturer’s warranty are not to be billed to Medicaid.
- When labor is performed by a manufacturer; Medicaid pays the Medicaid DMEPOS provider the line item labor cost on the manufacturer's invoice and the applicable Medicaid fee for the parts. If labor and parts charges are not separately itemized on the manufacturer invoice as required by 18NYCRR505.5, the DMEPOS provider will be paid the invoice cost of parts and labor.

A9900
Miscellaneous DME supply, accessory, and/or service component of another HCPCS code

K0739
Repair or non routine service for Durable Medical Equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes
(more than 2 hours requires prior approval)
4.5 ORTHOTICS

GENERAL COVERAGE CRITERIA:

1. This schedule is applicable to both children and adults.
2. Base codes are covered when the physician’s order and supporting documentation clearly establish the medical and functional need being met by the prescribed device. Where applicable, code specific coverage criteria must be met.
3. L Code “additions” are covered only when both the base codes coverage criteria has been met and specific documentation exists establishing the medical necessity of the addition code.
4. When providing a custom fabricated device, the documentation should establish specific reason(s) why a prefabricated alternative was not medically indicated. This should include, where applicable, the documented failure of prefabricated alternatives. A prefabricated orthosis is one which is manufactured in quantity without a specific member in mind. It is pre-formed with a shape that generally conforms to the body part. A prefabricated orthosis may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific member (i.e.: custom fitted). A custom fabricated orthosis is one which is individually made for a specific member (no other patient would be able to use this orthosis) starting with basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc.
5. The providers shall be responsible for any needed repairs or replacements due to defects in quality or workmanship that appear within three months of delivery. This does not include adjustments or replacements necessitated by anatomical changes.
6. Replacements and repairs: used to indicate replacement and repair of orthotic and prosthetic devices which have been in use for some time. Prior approval is not required when the charge is over $35.00 and is less than 10% of the price listed on the code for the device. When specific replacement and repair codes are available, they should be used instead of the code for the device with ‘-RB’. For charges $35.00 and under, use L4210.
7. The fees contained in this schedule will be paid under State-administered programs, and are to be considered full payment for the services rendered. The provider shall make no additional charge to the member.
8. Unless otherwise specified all fees are for the unilateral, single unit or “each.”
9. All normal necessary pads, straps and stops are included in the prices quoted.

10. Consideration for coverage of Functional Electrical Stimulation devices (e.g.: foot drop systems) is limited to qualifying conditions. Please refer to the September 2013 Medicaid Update for specific coverage guidance. Qualifying devices submitted for prior approval should be billed using HCPCS code E1399. Please note: replacement accessories (e.g.: A4556 electrodes, A4557 lead wires) are only to be billed for covered FES devices.

**ORTHOTIC DEVICES – SPINAL**

**CERVICAL**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A8000</td>
<td>Helmet, protective, soft, prefabricated, includes all components and accessories</td>
</tr>
<tr>
<td>A8001</td>
<td>Helmet, protective, hard, prefabricated, includes all components and accessories</td>
</tr>
<tr>
<td>A8002</td>
<td>Helmet, protective, soft, custom fabricated, includes all components and accessories</td>
</tr>
<tr>
<td>A8003</td>
<td>Helmet, protective, hard, custom fabricated, includes all components and accessories</td>
</tr>
<tr>
<td>A8004</td>
<td>Soft interface for helmet, replacement only</td>
</tr>
<tr>
<td>L0112</td>
<td>Cranial cervical orthosis, congenital torticollis type, with or without soft interface material, adjustable range of motion joint, custom fabricated</td>
</tr>
<tr>
<td>L0113</td>
<td>Cranial cervical orthosis, torticollis type, with or without joint, with or without soft interface material, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>L0130</td>
<td>Cervical, flexible, thermoplastic collar, molded to patient</td>
</tr>
<tr>
<td>L0140</td>
<td>Cervical, semi-rigid, adjustable (plastic collar)</td>
</tr>
<tr>
<td>L0150</td>
<td>Cervical, semi-rigid, adjustable molded chin cup (plastic collar with mandibular/occipital piece)</td>
</tr>
<tr>
<td>L0160</td>
<td>Cervical, semi-rigid, wire frame occipital/mandibular support, prefabricated, off-the-shelf</td>
</tr>
<tr>
<td>L0170</td>
<td>Cervical, collar, molded to patient model</td>
</tr>
<tr>
<td>L0172</td>
<td>Cervical, collar, semi-rigid thermoplastic foam, two-piece, prefabricated, off-the-shelf</td>
</tr>
<tr>
<td>L0174</td>
<td>Cervical, collar, semi-rigid, thermoplastic foam, two piece with thoracic extension, prefabricated, off-the-shelf</td>
</tr>
<tr>
<td>S1040</td>
<td>Cranial remodeling orthosis, rigid, with soft interface material, custom fabricated, includes fitting and adjustment(s)</td>
</tr>
</tbody>
</table>

**Covered when:**
- The member has moderate to severe positional head deformities associated with premature birth, restrictive intrauterine positioning, cervical abnormalities, birth trauma, torticollis and/or sleeping
positions in children.

- Anthropometric measurements verify that a moderate to severe plagiocephaly is documented by a physician experienced in such measurements.
- The member is between the ages of 3-18 months old and is considered to have a reasonable likelihood of continued skull growth.
- There is documentation of, at minimum, a 2 month trial of repositioning and stretching exercises as follows:
  1. Alternating back and side sleeping
  2. Supervised tummy time
  3. Rearranging the crib relative to the primary light source
  4. Limiting time spent in a supine position
  5. Limiting time in strollers, carriers and swings
  6. Rotating chair activity
  7. Neck motion exercises

Not covered for:

- Beneficiaries over the age of 24 months.
- Unmanaged hydrocephalus
- Craniosynostosis

Documentation requirements:

- A valid fiscal order signed by a pediatrician, a general surgeon with specialty in pediatrics, and/or a craniofacial surgeon.
- Anthropometric measurements.
- Documentation of medical necessity from a pediatric neurosurgeon or a craniofacial surgeon.
- Documented trial of repositioning and stretching exercises as outlined above.

MULTIPLE POST COLLAR

L0180 F3 #Cervical, multiple post collar, occipital/mandibular supports, adjustable
L0190 F3 #Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars (Somi, Guilford, Taylor types)
L0200 F3 #Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars, and thoracic extension

THORACIC

L0220 F6 #Thoracic, rib belt, custom fabricated
Thoracic-lumbar-sacral orthosis (TLSO)

- Covered when ordered for the following indications:
  1. To reduce pain by restricting mobility of the trunk; or
  2. To facilitate healing following an injury, or surgical procedure, to the spine or related soft tissues; or
  3. To support weak spinal muscles and/or a spinal deformity

L0450 F4  #TLSO, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, off-the-shelf

L0452 F4  #TLSO, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, custom fabricated

L0454 F4  #TLSO, flexible, provides trunk support, extends from sacrococcygeal junction to above T-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, off-the-shelf

L0455 F4  #TLSO, flexible, provides trunk support, extends from sacrococcygeal junction to above T-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, custom fabricated

L0457 F4  #TLSO, flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated, off-the-shelf

L0458 F4  #TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine,
anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment

L0460 F4
#TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment

L0462 F4
#TLSO, triplanar control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment

L0464 F4
#TLSO, triplanar control, modular segmented spinal system, four rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, prefabricated, includes fitting and adjustment

L0466 F4
#TLSO, sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, includes fitting and shaping the frame, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L0467 F4
#TLSO, sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated, off-the-shelf

L0468 F4
#TLSO, sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts
gross trunk motion in sagittal, and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, includes fitting and shaping the frame, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L0469 F4 #TLSO, sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated, off-the-shelf

L0470 F4 #TLSO, triplanar control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction to scapula, lateral strength provided by pelvic, thoracic, and lateral frame pieces, rotational strength provided by subclavicular extensions, restricts gross trunk motion in sagittal, coronal, and transverse planes, produces intracavitary pressure to reduce load on intervertebral disks, includes filling and shaping the frame, prefabricated, includes fitting and adjustment

L0472 F4 #TLSO, triplanar control, hyperextension, rigid anterior and lateral frame extends from symphysis pubis to sternal notch with two anterior components (one pubic and one sternal), posterior and lateral pads with straps and closures, limits spinal flexion, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment

L0480 F6 #TLSO, triplanar control, one piece rigid plastic shell without interface liner, with multiple straps and closures posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated

L0482 F6 #TLSO, triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated

L0484 F6 #TLSO, triplanar control, two piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping
plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated

L0486 F6  #TLSO, triplanar control, two piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacroccocygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated

L0488 F6  #TLSO, triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacroccocygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, prefabricated, includes fitting and adjustment

L0490 F6  #TLSO, sagittal-coronal control, one piece rigid plastic shell, with overlapping reinforced anterior, with multiple straps and closures, posterior extends from symphysis pubis to xiphoid, anterior opening, restricts gross trunk motion in sagittal and coronal planes, prefabricated, includes fitting and adjustment

L0491 F4  #TLSO, sagittal-coronal control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacroccocygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment

L0492 F4  #TLSO, sagittal-coronal control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacroccocygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment

CERVICAL-THORACIC-LUMBAR-SACRAL ORTHOSIS (CTLSO)

L0621 F4  #Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, off-the-shelf

L0622 F4  #Sacroiliac orthosis, flexible, provides pelvic-sacral support,
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reduces motion about the sacroiliac joint includes straps, closures, may include pendulous abdomen design, custom fabricated

L0623 F4  #Sacroiliac orthosis provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, off-the-shelf

L0624 F4  #Sacroiliac orthosis provides pelvic-sacral support, with rigid or semi-rigid panels placed over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated

Lumbar Orthosis

- Covered when ordered for the following indications:
  1. To reduce pain by restricting mobility of the trunk; or
  2. To facilitate healing following an injury, or surgical procedure, to the spine or related soft tissues; or
  3. To support weak spinal muscles and/or a spinal deformity

L0625 F4  #Lumbar Orthosis, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, off-the-shelf

L0626 F4  #Lumbar Orthosis, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L0627 F4  #Lumbar Orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L0641 F4  #Lumbar orthosis, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf
L0642\textsuperscript{F4} #Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf

Lumbar-sacral orthosis

- Covered when ordered for the following indications:
  1. To reduce pain by restricting mobility of the trunk; or
  2. To facilitate healing following an injury, or surgical procedure, to the spine or related soft tissues; or
  3. To support weak spinal muscles and/or a spinal deformity

L0628\textsuperscript{F4} #Lumbar sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf

L0629\textsuperscript{F4} #Lumbar sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes stays, shoulder straps, pendulous abdomen design, custom fabricated

L0630\textsuperscript{F4} #Lumbar sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L0631\textsuperscript{F4} #Lumbar sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L0632\textsuperscript{F4} #Lumbar sacral orthosis, sagittal-coronal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated
#Lumbar sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

#Lumbar sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated

#Lumbar sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, prefabricated, includes fitting and adjustment

#Lumbar sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, custom fabricated

#Lumbar sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

#Lumbar sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to
reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated

L0639 F4
#Lumbar sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s) posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xiphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated

L0640 F4
#Lumbar sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xiphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated

L0643 F4
#Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf

L0648 F4
#Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf

L0649 F4
#Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf

L0650 F4
#Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures,
may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf

L0651 F4  #Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacroccocygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated, off-the-shelf

ANTERIOR-POSTERIOR-LATERAL CONTROL

L0700 F2  #Cervical-thoracic-lumbar-sacral orthosis (CTLSO), anterior-posterior-lateral control, molded to patient model, (Minerva type)
L0710 F2  #Cervical-thoracic-lumbar-sacral orthosis (CTLSO), anterior-posterior-lateral-control, molded to patient model, with interface material (Minerva type)

HALO PROCEDURE

L0810 F2  #Halo procedure cervical halo incorporated into jacket vest
L0820 F2  #Halo procedure, cervical halo incorporated into plaster body jacket
L0830 F2  #Halo procedure, cervical halo incorporated into Milwaukee type orthosis
L0861 F14 #Addition to halo procedure, replacement liner/interface material

ADDITIONS TO SPINAL ORTHOSES

L0970 F6  #TLSO, corset front
L0972 F6  #LSO, corset front
L0974 F6  #TLSO, full corset
L0976 F6  #LSO, full corset
L0978 F6  #Axillary crutch extension
L0980 F6  #Peritoneal straps, prefabricated, off-the-shelf, pair
L0982 F6  #Stocking supporter grips, prefabricated, off-the-shelf, set of four (4)
L0984 F16 #Protective body sock, prefabricated, off-the-shelf, each
L0999 F6  Addition to spinal orthosis, not otherwise specified

ORTHOTIC DEVICES – SCOLIOSIS PROCEDURES
NOTE: The orthotic care of scoliosis differs from other orthotic care in that the treatment is more dynamic in nature and utilizes ongoing, continual modification of the orthosis to the member's changing condition. This coding structure uses the proper names, or eponyms, of the procedures because they have historic and universal acceptance in the profession. It should be recognized that variations to the basic procedures described by the founders/developers are accepted in various medical and orthotic practices throughout the country.

CERVICAL-THORACIC-LUMBAR-SACRAL ORTHOSIS (CTLSO)

L1000 F2  #Cervical-thoracic-lumbar-sacral orthosis (CTLSO) (Milwaukee), inclusive of furnishing initial orthosis, including model
L1001 F2  Cervical-thoracic-lumbar-sacral orthosis (CTLSO), immobilizer, infant size, prefabricated, includes fitting and adjustment
L1005 F3  Tension based scoliosis orthosis and accessory pads, includes fitting and adjustment
L1010 F6  #Addition to Cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, axilla sling
L1020 F6  #Addition to CTLSO or scoliosis orthosis, kyphosis pad, each
L1025 F6  #Addition to CTLSO or scoliosis orthosis, kyphosis pad, floating
L1030 F6  #Addition to CTLSO or scoliosis orthosis, lumbar bolster pad
L1040 F6  #Addition to CTLSO or scoliosis orthosis, lumbar or lumbar rib pad
L1050 F6  #Addition to CTLSO or scoliosis orthosis, sternal pad
L1060 F6  #Addition to CTLSO or scoliosis orthosis, thoracic pad
L1070 F6  #Addition to CTLSO or scoliosis orthosis, trapeze sling
L1080 F6  #Addition to CTLSO or scoliosis orthosis, outrigger
L1085 F6  #Addition to CTLSO or scoliosis orthosis, outrigger, bilateral with vertical extensions
L1090 F6  #Addition to CTLSO or scoliosis orthosis, lumbar sling
L1100 F6  #Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather
L1110 F6  #Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather, molded to patient model
L1120 F6  #Addition to CTLSO, scoliosis orthosis, cover for upright, each

THORACIC-LUMBAR-SACRAL ORTHOSIS (TLSO) (LOW-PROFILE)

L1200 F4  #Thoracic-lumbar-sacral orthosis (TLSO), inclusive of furnishing initial orthosis only
L1210 F4  #Addition to TLSO, (low profile), lateral thoracic extension
L1220 F4  #Addition to TLSO, (low profile), anterior thoracic extension
L1230 F4  #Addition to TLSO, (low profile), Milwaukee type superstructure
L1240 F16 #Addition to TLSO, (low profile), lumbar derotation pad
L1250 F16 #Addition to TLSO, (low profile), anterior ASIS pad
L1260 F16 #Addition to TLSO, (low profile), anterior thoracic derotation pad
Addition to TLSO, (low profile), abdominal pad
Addition to TLSO, (low profile), rib gusset (elastic), each
Addition to TLSO, (low profile), lateral trochanteric pad

OTHER SCOLIOSIS PROCEDURES

Other scoliosis procedure, body jacket molded to patient model
Other scoliosis procedure, postoperative body jacket
Spinal orthosis, not otherwise specified

ORTHOTIC DEVICES – LOWER LIMB

NOTE: Lower Limb: The procedures in L1600-L2999 are considered as “Base” or “Basic Procedures” and may be modified by listing procedure from the “Additions Sections” and adding them to the base procedure.

HIP ORTHOSIS (HO) – FLEXIBLE

Hip Orthosis, abduction control of hip joints, flexible, Frejka type with cover, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
Hip Orthosis, abduction control of hip joints, flexible, (Frejka cover only), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
Hip Orthosis, abduction control of hip joints, flexible, (Pavlik harness), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
Hip Orthosis, abduction control of hip joints, semi-flexible (Von Rosen type), custom fabricated
Hip Orthosis, abduction control of hip joints, static, pelvic band or spreader bar, thigh cuffs custom fabricated
Hip Orthosis, abduction control of hip joints, static, adjustable (Ilfled type), prefabricated, includes fitting and adjustment
Hip orthosis, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, includes fitting and adjustment, any type
Hip Orthosis, abduction control of hip joints, static, plastic, prefabricated, includes fitting and adjustment
HO, abduction control of hip joints, dynamic pelvic control, adjustable hip motion control, thigh cuffs (Rancho hip action type) custom fabricated
Hip Orthosis, abduction control of hip joint, post-operative hip abduction type, custom fabricated
Hip Orthosis, abduction control of hip joint, post-operative hip
abduction type, prefabricated, includes fitting and adjustments

LEGG PERTHES

L1700 F2 #Legg-Perthes orthosis, (Toronto type), custom fabricated
L1710 F2 #Legg-Perthes orthosis, (Newington type), custom fabricated
L1720 F2 #Legg-Perthes orthosis, trilateral, (Tachdijan type), custom fabricated
L1730 F2 #Legg-Perthes orthosis, (Scottish Rite type), custom fabricated
L1755 F2 #Legg-Perthes orthosis, (Patten Bottom type), custom fabricated

KNEE ORTHOSIS (KO)

• A custom fabricated knee orthosis is covered when there is a documented physical characteristic which requires the use of a custom fabricated orthosis instead of a prefabricated orthosis. Examples of situations which meet the criterion for a custom fabricated orthosis include, but are not limited to:

1. Deformity of the leg or knee;
2. Size of thigh and calf;
3. Minimal muscle mass upon which to suspend an orthosis.

• Although these are examples of potential situations where a custom fabricated orthosis may be appropriate, suppliers must consider prefabricated alternatives such as pediatric knee orthoses in patients with small limbs, straps with additional length for large limbs, etc.

Knee Orthosis (KO); L1810, L1820

• Covered for:
  1. Beneficiaries who have weakness or deformity of the knee and require stabilization.

L1810 F16 #Knee orthosis, elastic with joints, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L1812 F16 #Knee orthosis, elastic with joints, prefabricated, off-the-shelf
L1820 F16 #Knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment
L1830 F2 #Knee orthosis, immobilizer, canvas longitudinal, prefabricated, off-the-shelf
L1831 F3 #Knee orthosis, locking knee joint(s), positional orthosis, prefabricated, includes fitting and adjustment
  • Covered for member’s with flexion or extension contractures of the knee.
L1832 F3 # Knee orthosis, adjustable knee joints (unicentric or polycentric),
positional orthosis, rigid support, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L1833 F3  #Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the-shelf

L1834 F3  #Knee orthosis, without knee joint, rigid, custom fabricated
• Covered when:
  1. The coverage criteria for L1830 are met; and
  2. The general criterion for a custom fabricated orthosis is met.

L1836 F3  #Knee orthosis, rigid, without joint(s), includes soft interface material, prefabricated, off-the-shelf

L1840 F3  #Knee orthosis, derotation, medial-lateral, anterior cruciate ligament, custom fabricated
• Covered for:
  1. Member’s with instability due to internal ligamentous disruption of the knee.

L1843 F3  #Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L1844 F3  #Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated
• Covered when:
  1. The coverage criteria for L1843 is met; and
  2. The general criterion for a custom fabricated orthosis is met.

L1845 F3  #Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L1846 F3  #Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated
• Covered when:
  1. The coverage criteria for L1845 is met; and
  2. The general criterion for a custom fabricated orthosis is met.
Knee orthosis, double upright with adjustable joint, with inflatable air support chamber(s), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise.

Knee orthosis, double upright with adjustable joint, with inflatable air support chamber(s), prefabricated, off-the-shelf.

Knee orthosis, Swedish type, prefabricated, off-the-shelf.
- Covered for:
  1. Member’s with knee instability due to genu recurvatum.

Knee orthosis, modification of supracondylar prosthetic socket, custom fabricated (SK).
- Covered for:
  1. Beneficiaries with knee instability due to genu recurvatum.

ANKLE–FOOT ORTHOSIS (AFO)

AFOs that are molded-to-patient-model, or custom-fabricated, are covered for beneficiaries when the basic coverage criteria listed above and one of the following criteria are met:
1. The patient could not be fit with a prefabricated AFO, or
2. The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months), or
3. There is a need to control the knee, ankle or foot in more than one plane, or
4. The patient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury, or
5. The patient has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

Static or dynamic ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise.

Static or dynamic ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated, off-the-shelf.

Foot drop splint, recumbent positioning device, prefabricated, off-the-shelf.

Charcot Restraint Orthotic Walker
- No other codes may be billed for a CROW boot.
- There is no separate billing for any modifications, fitting, or adjustments.
L4631^F6  #Ankle foot orthosis, walking boot type, varus/valgus correction, rocker bottom, anterior tibial shell, soft interface, custom arch support, plastic or other material, includes straps and closures, custom fabricated (CROW boot)

- Ankle-foot orthoses (AFO) described by codes L1900-L1990 are covered for beneficiaries with weakness or deformity of the foot and ankle who have the potential to benefit functionally, and/or who require stabilization for medical reasons. For non-ambulatory beneficiaries requiring stabilization, the supporting documentation from the prescriber or evaluating medical provider (e.g. Physical Therapist) must clearly describe the location and degree of joint instability, in addition to medical necessity to utilize AFO’s.
- The allowed frequency of "F7" for procedural codes L1907, L1960, and L1970 is intended for pediatric beneficiaries where growth and development may require more frequent replacement. The supporting documentation on file must include evidence of growth or anatomical change warranting the replacement.

L1900^F6  #Ankle foot orthosis, spring wire, dorsiflexion assist calf band, custom fabricated
L1902^F2  #Ankle foot orthosis, ankle gauntlet, prefabricated, off-the-shelf
L1904^F2  #Ankle orthosis, ankle gauntlet, custom fabricated
L1906^F2  #Ankle foot orthosis, multiligamentous ankle support, prefabricated, off-the-shelf
L1907^F7  #Ankle orthosis, supramalleolar with straps, with or without interface/pads, custom fabricated
L1910^F6  #Ankle foot orthosis, posterior, single bar, clasp attachment to shoe counter, prefabricated, includes fitting and adjustment
L1920^F6  #Ankle foot orthosis, single upright with static or adjustable stop (Phelps or Perlstein type), custom fabricated
L1930^F6  #Ankle foot orthosis, plastic or other material, prefabricated, includes fitting and adjustment
L1932^F6  #Ankle foot orthosis, rigid anterior tibial section, total carbon fiber or equal material, prefabricated, includes fitting and adjustment
L1940^F6  #Ankle foot orthosis, plastic or other material, custom fabricated
L1945^F6  #Ankle foot orthosis, molded to patient model, plastic, rigid anterior tibial section (floor reaction), custom fabricated
L1950^F4  #Ankle foot orthosis, spiral (IRM type), plastic, custom fabricated
L1951^F4  #Ankle foot orthosis, spiral, (Institute of Rehabilitative Medicine type), plastic or other material, prefabricated, includes fitting and adjustment
L1960^F7  #Ankle foot orthosis, posterior solid ankle, plastic, custom fabricated
L1970^F7  #Ankle foot orthosis, plastic, with ankle joint, custom fabricated
L1971^F6  #Ankle foot orthosis, plastic or other material with ankle joint, prefabricated, includes fitting and adjustment
L1980^F6  #Ankle foot orthosis, single upright free plantar dorsiflexion,
solid stirrup, calf band/cuff (single bar “BK” orthosis), custom fabricated

L1990 F6  #Ankle foot orthosis, double upright free plantar dorsiflexion, solid stirrup, calf band/cuff (double bar “BK” orthosis), custom fabricated

KNEE-ANKLE-FOOT-ORTHOSIS (KAFO) (OR ANY COMBINATION)

- KAFOs that are molded-to-patient-model, or custom-fabricated, are covered for beneficiaries when the basic coverage criteria listed above and one of the following criteria are met:
  1. The patient could not be fit with a prefabricated KAFO, or
  2. The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months), or
  3. There is a need to control the knee, ankle or foot in more than one plane, or
  4. The patient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury, or
  5. The patient has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

- Knee-ankle-foot orthoses (KAFO) described by codes L2000-L2038 are covered for beneficiaries for whom an ankle-foot orthosis is covered and for whom additional knee stability is required.

L2000 F4  #Knee ankle foot orthosis, single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar “AK” orthosis), custom fabricated

L2005 F4  #Knee ankle foot orthosis, any material, single or double upright, stance control, automatic lock and swing phase release, mechanical activation, includes ankle joint, any type, custom fabricated

L2010 F4  #Knee ankle foot orthosis, single upright, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar “AK” orthosis), without knee joint, custom fabricated

L2020 F4  #Knee ankle foot orthosis, double upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar “AK” orthosis), custom fabricated

L2030 F4  #Knee ankle foot orthosis, double upright, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar “AK” orthosis), without knee joint, custom fabricated

L2034 F4  #Knee ankle foot orthosis, full plastic, single upright, with or without free motion knee, medial lateral rotation control, with or without free motion ankle, custom fabricated

L2035 F4  #Knee ankle foot orthosis, full plastic, static (pediatric size), without free motion ankle, prefabricated, includes fitting and adjustment

L2036 F4  #Knee ankle foot orthosis, full plastic, double upright, with or without free motion knee, with or without free motion ankle,
custom fabricated

**L2037 F4**  
Knee ankle foot orthosis, full plastic, single upright, with or without free motion knee, with or without free motion ankle, custom fabricated

**L2038 F4**  
Knee ankle foot orthosis, full plastic, with or without free motion knee, multi-axis ankle, custom fabricated

**TORSION CONTROL – HIP-KNEE-ANKLE-FOOT ORTHOSIS (HKAFO)**

**L2040 F4**  
Hip knee ankle foot orthosis, torsion control, bilateral rotation straps, pelvic band/belt, custom fabricated

**L2050 F4**  
Hip knee ankle foot orthosis, torsion control, bilateral torsion cables, hip joint, pelvic band/belt, custom fabricated

**L2060 F4**  
Hip knee ankle foot orthosis, torsion control, bilateral torsion cables, ball bearing hip joint, pelvic band/belt, custom fabricated

**L2070 F4**  
Hip knee ankle foot orthosis, torsion control, unilateral rotation straps, pelvic band/belt, custom fabricated

**L2080 F4**  
Hip knee ankle foot orthosis, torsion control, unilateral torsion cable, hip joint, pelvic band/belt, custom fabricated

**L2090 F4**  
Hip knee ankle foot orthosis, torsion control, unilateral torsion cable, ball bearing hip joint, pelvic band/belt, custom fabricated

**FRACTURE ORTHOSES**

- Ankle-foot orthoses (AFO) described by codes L2106–L2116 are covered for ambulatory patients with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.

- Knee-ankle-foot orthoses (KAFO) described by codes L2126-L2136 are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required.

**L2106 F2**  
Ankle foot orthosis, fracture orthosis, tibial fracture cast orthosis, thermoplastic type casting material, custom fabricated

**L2108 F2**  
Ankle foot orthosis, fracture orthosis, tibial fracture cast orthosis, custom fabricated

**L2112 F2**  
Ankle foot orthosis, fracture orthosis, tibial fracture orthosis, soft, prefabricated, includes fitting and adjustment

**L2114 F2**  
Ankle foot orthosis, fracture orthosis, tibial fracture orthosis, semi-rigid, prefabricated, includes fitting and adjustment

**L2116 F2**  
Ankle foot orthosis, fracture orthosis, tibial fracture orthosis, rigid, prefabricated, includes fitting and adjustment

**L2126 F2**  
Knee ankle foot orthosis, fracture orthosis, femoral fracture cast orthosis, thermoplastic type casting material, custom fabricated

**L2128 F2**  
Knee ankle foot orthosis, fracture orthosis, femoral fracture cast orthosis, custom fabricated

**L2132 F2**  
KAFO, fracture orthosis, femoral fracture cast orthosis, soft, prefabricated, includes fitting and adjustment
L2134 F2  #KAFO, fracture orthosis, femoral fracture cast orthosis, semi-rigid, prefabricated, includes fitting and adjustment
L2136 F2  #KAFO, fracture orthosis, femoral fracture cast orthosis, rigid, prefabricated, includes fitting and adjustment

ADDITIONS TO FRACTURE ORTHOSIS

L2180 F2  #Addition to lower extremity fracture orthosis, plastic shoe insert with ankle joints
L2182 F2  #Addition to lower extremity fracture orthosis, drop lock knee joint
L2184 F2  #Addition to lower extremity fracture orthosis, limited motion knee joint
L2186 F2  #Addition to lower extremity fracture orthosis, adjustable motion knee joint, Lerman type
L2188 F2  #Addition to lower extremity fracture orthosis, quadrilateral brim
L2190 F2  #Addition to lower extremity fracture orthosis, waist belt
L2192 F2  #Addition to lower extremity fracture orthosis, hip joint, pelvic band, thigh flange, and pelvic belt

ADDITIONS TO LOWER EXTREMITY ORTHOSES: SHOE–ANKLE–SHIN–KNEE

- The allowed frequency of "F7" for procedural codes L2210, L2220, L2270, L2275, and L2280 is intended for pediatric beneficiaries where growth and development may require more frequent replacement. The supporting documentation on file must include evidence of growth or anatomical change warranting the replacement.
   L2210 F7  #Addition to lower extremity, dorsiflexion assist (plantar flexion resist), each joint
   L2220 F7  #Addition to lower extremity, dorsiflexion and plantar flexion assist/resist, each joint
   L2230 F6  #Addition to lower extremity, split flat caliper stirrups and plate attachment
   L2232 F6  #Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only
   L2250 F6  #Addition to lower extremity, foot plate, molded to patient model, stirrup attachment
   L2260 F6  #Addition to lower extremity, reinforced solid stirrup (Scott-Craig type)
   L2265 F6  #Addition to lower extremity, long tongue stirrup
   L2270 F7  #Addition to lower extremity, varus/valgus correction ("T") strap, padded/lined or malleolus pad
   L2275 F7  #Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined
   L2280 F7  #Addition to lower extremity, molded inner boot
   L2300 F2  #Addition to lower extremity, abduction bar (bilateral hip involvement), jointed, adjustable
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L2310</td>
<td>Addition to lower extremity, abduction bar-straight</td>
</tr>
<tr>
<td>L2320</td>
<td>Addition to lower extremity, non-molded lacer, for custom fabricated orthosis only</td>
</tr>
<tr>
<td>L2330</td>
<td>Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only</td>
</tr>
<tr>
<td>L2335</td>
<td>Addition to lower extremity, anterior swing band</td>
</tr>
<tr>
<td>L2340</td>
<td>Addition to lower extremity, pre-tibial shell, molded to patient model</td>
</tr>
<tr>
<td>L2350</td>
<td>Addition to lower extremity, prosthetic type, (BK) socket, molded to patient model, (used for ‘PTB’ ‘AFO’ orthosis)</td>
</tr>
<tr>
<td>L2360</td>
<td>Addition to lower extremity, extended steel shank</td>
</tr>
<tr>
<td>L2370</td>
<td>Addition to lower extremity, Patten bottom</td>
</tr>
<tr>
<td>L2375</td>
<td>Addition to lower extremity, torsion control ankle joint and half solid stirrup</td>
</tr>
<tr>
<td>L2380</td>
<td>Addition to lower extremity, torsion control straight knee joint, each joint</td>
</tr>
<tr>
<td>L2385</td>
<td>Addition to lower extremity, straight knee joint, heavy duty, each joint</td>
</tr>
<tr>
<td></td>
<td>• Covered for member’s with documented weight of more than 300 pounds.</td>
</tr>
<tr>
<td>L2387</td>
<td>Addition to lower extremity, polycentric knee joint, for custom fabricated knee ankle foot orthosis, each joint</td>
</tr>
<tr>
<td>L2390</td>
<td>Addition to lower extremity, offset knee joint, each joint</td>
</tr>
<tr>
<td>L2395</td>
<td>Addition to lower extremity, offset knee joint, heavy duty, each joint</td>
</tr>
<tr>
<td></td>
<td>• Covered for member’s with documented weight of more than 300 pounds.</td>
</tr>
<tr>
<td>L2397</td>
<td>Addition to lower extremity orthosis, suspension sleeve</td>
</tr>
<tr>
<td>L2861</td>
<td>Addition to lower extremity joint, knee or ankle, concentric adjustable torsion</td>
</tr>
</tbody>
</table>

**ADDITIONS TO STRAIGHT KNEE OR OFFSET KNEE JOINTS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L2405</td>
<td>Addition to knee joint, drop lock, each</td>
</tr>
<tr>
<td>L2415</td>
<td>Addition to knee lock with integrated release mechanism (bail, cable, or equal), any material, each joint</td>
</tr>
<tr>
<td>L2425</td>
<td>Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint</td>
</tr>
<tr>
<td>L2430</td>
<td>Addition to knee joint, ratchet lock for active and progressive knee extension, each joint</td>
</tr>
<tr>
<td>L2492</td>
<td>Addition to knee joint, lift loop for drop lock ring</td>
</tr>
</tbody>
</table>

**ADDITIONS: THIGH/WEIGHT BEARING- GLUTEAL/ISCHIAL WEIGHT BEARING**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L2500</td>
<td>Addition to lower extremity, thigh/weight bearing, gluteal/ischial</td>
</tr>
</tbody>
</table>
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**ADDITIONS – PELVIC AND THORACIC CONTROL**

L2570 F4  #Addition to lower extremity, pelvic control, hip joint, clevis type
L2580 F4  #Addition to lower extremity, pelvic control, pelvic sling
L2600 F4  #Addition to lower extremity, pelvic control, hip joint, Clevis type,
or thrust bearing, free, each
L2610 F4  #Addition to lower extremity, pelvic control, hip joint, clevis or
L2620 F4  #Addition to lower extremity, pelvic control, hip joint, heavy duty,
each
L2622 F4  #Addition to lower extremity, pelvic control, hip joint, adjustable
L2624 F4  #Addition to lower extremity, pelvic control, hip joint, adjustable
L2627 F4  #Addition to lower extremity, pelvic control, plastic, molded to
L2628 F4  #Addition to lower extremity, pelvic control, metal frame,
L2630 F4  #Addition to lower extremity, pelvic control, band and belt,
L2640 F4  #Addition to lower extremity, pelvic control, band and belt,
bilateral
L2650 F4  #Addition to lower extremity, pelvic and thoracic control, gluteal
L2660 F4  #Addition to lower extremity, thoracic control, thoracic band
L2670 F4  #Addition to lower extremity, thoracic control, paraspinal
uprights
L2680 F4  #Addition to lower extremity, thoracic control, lateral support

weight bearing, ring

L2510 F4  #Addition to lower extremity, thigh/weight bearing, quadrilateral
brim, molded to patient model
L2520 F4  #Addition to lower extremity, thigh/weight bearing, quadrilateral
brim, custom fitted
L2525 F4  #Addition to lower extremity, thigh/weight bearing, ischial
containment/narrow M-L brim molded to patient model
L2526 F4  #Addition to lower extremity, thigh/weight bearing, ischial
containment/narrow M-L brim, custom fitted
L2530 F4  #Addition to lower extremity, thigh/weight bearing, lacer, non-
molded
L2540 F4  #Addition to lower extremity, thigh/weight bearing, lacer, molded
to patient model
L2550 F4  #Addition to lower extremity, thigh/weight bearing, high roll cuff
uprights

**ADDITIONS – GENERAL**

<table>
<thead>
<tr>
<th>Code</th>
<th>Freq</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L2750</td>
<td>F4</td>
<td>Addition to lower extremity orthosis, plating chrome or nickel, per bar</td>
</tr>
<tr>
<td>L2755</td>
<td>F4</td>
<td>Addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, per segment, for custom fabricated orthosis only</td>
</tr>
<tr>
<td>L2760</td>
<td>F20</td>
<td>Addition to lower extremity orthosis, extension, per extension, per bar (for lineal adjustment for growth)</td>
</tr>
<tr>
<td>L2768</td>
<td>F4</td>
<td>Orthotic side bar disconnect device, per bar</td>
</tr>
<tr>
<td>L2780</td>
<td>F4</td>
<td>Addition to lower extremity orthosis, non-corrosive finish, per bar</td>
</tr>
<tr>
<td>L2785</td>
<td>F4</td>
<td>Addition to lower extremity orthosis, drop lock retainer, each</td>
</tr>
<tr>
<td>L2795</td>
<td>F6</td>
<td>Addition to lower extremity orthosis, knee control, full kneecap</td>
</tr>
<tr>
<td>L2800</td>
<td>F6</td>
<td>Addition to lower extremity orthosis, knee control, knee cap, medial or lateral pull, for use with custom fabricated orthosis only</td>
</tr>
<tr>
<td>L2810</td>
<td>F6</td>
<td>Addition to lower extremity orthosis, knee control, condylar pad</td>
</tr>
<tr>
<td>L2820</td>
<td>F6</td>
<td>Addition to lower extremity orthosis, soft interface for molded plastic, below knee section</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Covered for a documented history of skin breakdown.</td>
</tr>
<tr>
<td>L2830</td>
<td>F6</td>
<td>Addition to lower extremity orthosis, soft interface for molded plastic, above knee section</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Covered for a documented history of skin breakdown.</td>
</tr>
<tr>
<td>L2840</td>
<td>F7</td>
<td>Addition to lower extremity orthosis, tibial length sock, fracture or equal, each</td>
</tr>
<tr>
<td>L2850</td>
<td>F7</td>
<td>Addition to lower extremity orthosis, femoral length sock, fracture or equal, each</td>
</tr>
<tr>
<td>L2999</td>
<td>F10</td>
<td>Lower extremity orthoses, not otherwise specified</td>
</tr>
</tbody>
</table>

Refer to “2010 Orthotics and Prosthetics Procedure Code Changes” update dated December 28, 2009 for specific items that are billable using L2999. Billing code L2999 is not limited to only those items.

**ORTHOTIC DEVICES – UPPER LIMB**

**NOTE:** Upper Limb: the procedures in this section are considered as “Base” or “Basic Procedures” and may be modified by listing procedures from the “Additions Section” and adding them to the base procedure.

**SHOULDER ORTHOSIS (SO)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Freq</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L3650</td>
<td>F2</td>
<td>Shoulder orthosis, figure of “8” design abduction restrainer, prefabricated, off-the-shelf</td>
</tr>
</tbody>
</table>
#Shoulder orthosis, figure of “8” design abduction restrainer, canvas and webbing, prefabricated, off-the-shelf

#Shoulder orthosis, acromio/clavicular (canvas and webbing type), prefabricated, off-the-shelf

Shoulder orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment

Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, with or without non torsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment

#Shoulder orthosis, vest type abduction restrainer, canvas webbing type, or equal, prefabricated, off-the-shelf

Shoulder orthosis, shoulder joint design, without joints, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

##ELBOW ORTHOSIS (EO)

#Elbow orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment

#Elbow orthosis, elastic with metal joints, prefabricated, off-the-shelf

#Elbow orthosis, double upright with forearm/arm cuffs, free motion, custom fabricated

#Elbow orthosis, double upright with forearm/arm cuffs, extension/flexion assist, custom fabricated

#Elbow orthosis, double upright with forearm/arm cuffs, adjustable position lock with active control, custom fabricated

#Elbow orthosis (EO), with adjustable position locking joint(s), prefabricated, item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

#Elbow orthosis, rigid, without joints, includes soft interface material, prefabricated, off-the-shelf

#EWHO, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment

#EWHO, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment

#EWHFO, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment

#EWHFO, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
WRIST–HAND–FINGER ORTHOSIS (WHFO)

L3806 F4  Wrist hand finger orthosis, includes one or more nontorsion joint(s),
turnbuckles, elastic bands/springs, may include soft interface material, straps, custom fabricated, includes fitting and adjustment

L3807 F16  Wrist hand finger orthosis, without joint(s), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L3808 F4  Wrist hand finger orthosis, rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment

L3809 F16  Wrist hand finger orthosis, without joint(s), prefabricated, off-the-shelf, any type

ADDITIONS TO UPPER EXTREMITY ORTHOSIS

L3891 F4  Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion

DYNAMIC FLEXOR HINGE, RECIPROCAL WRIST EXTENSION/FLEXION, FINGER FLEXION/EXTENSION

L3900 F4  Wrist hand finger orthosis, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven, custom fabricated

L3901 F4  Wrist hand finger orthosis, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, cable driven, custom fabricated

EXTERNAL POWER

L3904 F3  Wrist hand finger orthosis, external powered, electric, custom fabricated

OTHER WHFO’S – CUSTOM-FITTED

L3905 F4  Wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3906 F6  Wrist hand orthosis, wrist hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment

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#Wrist hand orthosis, wrist extension control cock-up, non-molded, prefabricated, off-the-shelf

#Hand finger orthosis, flexion glove with elastic finger control, prefabricated, off-the-shelf

#Hand finger orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment

#Wrist hand orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

#Wrist hand orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, off-the-shelf

#Hand orthosis, metacarpal fracture orthosis, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

#Hand orthosis, metacarpal fracture orthosis, prefabricated, off-the-shelf

#Hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment

#Hand finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment

#Hand finger orthosis, without joints, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

#Hand finger orthosis, without joints, may include soft interface, straps, prefabricated, off-the-shelf

#Finger orthosis, proximal interphalangeal (pip)/distal interphalangeal (dip), nontorsion joint/spring, extension/flexion, may include soft interface material, prefabricated, off-the-shelf

#Finger orthosis, proximal interphalangeal (pip)/distal interphalangeal (dip), without joint/spring, extension/flexion (e.g. static or ring type), may include soft interface material, prefabricated, off-the-shelf

#Hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

#Hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, off-the-shelf

#Wrist hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft
interface material, straps, prefabricated, includes fitting and adjustment
L3933 F4 #FO, without joints, may include soft interface, custom fabricated, includes fitting and adjustment
L3935 F4 #FO, nontorsion joint, may include soft interface, custom fabricated, includes fitting and adjustment

SHOULDER-ELBOW–WRIST–HAND ORTHOSIS (SEWHO) ABDUCTION POSITION-CUSTOM FITTED

ABDUCTION POSITION-CUSTOM FITTED

L3960 F2 #Shoulder elbow wrist hand finger orthosis, abduction positioning, airplane design, prefabricated, includes fitting and adjustment
L3961 F2 Shoulder elbow wrist hand finger orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3962 F2 #Shoulder elbow wrist hand finger orthosis, abduction positioning, Erbs Palsy design, prefabricated, includes fitting and adjustment
L3967 F3 Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3971 F3 Shoulder elbow wrist hand finger orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3973 F3 Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3975 F3 Shoulder elbow wrist hand finger orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3976 F3 Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3977 F3 Shoulder elbow wrist hand finger orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3978 F3  Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment

FRACTURE ORTHOSES

L3980 F2  #Upper extremity fracture orthosis, humeral, prefabricated, includes fitting and adjustment
L3982 F2  #Upper extremity fracture orthosis, radius/ulnar, prefabricated, includes fitting and adjustment
L3984 F2  #Upper extremity fracture orthosis, wrist, prefabricated, includes fitting and adjustment
L3995 F7  #Addition to upper extremity orthosis, sock, fracture or equal, each
L3999 F10 Upper limb orthosis, not otherwise specified

Refer to “2010 Orthotics and Prosthetics Procedure Code Changes” update dated December 28, 2009 for specific items that are billable using L3999. Billing code L3999 is not limited to only those items.

REPAIRS, REPLACEMENTS AND MAINTENANCE TO EXISTING ORTHOSES

NOTE: The following codes are to be used only in billing for repair, maintenance and/or replacements to existing orthoses. These codes are not to be billed in conjunction with codes for newly fitted orthoses.

SPECIFIC REPAIR

L4000 F6  #Replace girdle for spinal orthosis (CTLSO or SO) (e.g. Milwaukee)
L4002 F22 #Replacement strap, any orthosis, includes all components, any length, any type
L4010 F6  #Replace trilateral socket brim
L4020 F6  #Replace quadrilateral socket brim, molded to patient model
L4030 F6  #Replace quadrilateral socket brim, custom fitted
L4040 F6  #Replace molded thigh lacer, for custom fabricated orthosis only
L4045 F6  #Replace non-molded thigh lacer, for custom fabricated orthosis only
L4050 F6  #Replace molded calf lacer, for custom fabricated orthosis only
L4055 F6  #Replace non-molded calf lacer, for custom fabricated orthosis only
L4060 F6  #Replace high roll cuff
L4070 F6  #Replace proximal and distal upright for KAFO
L4080 F6  #Replace metal bands KAFO, proximal thigh
L4090 F6  #Replace metal bands KAFO-AFO, calf or distal thigh
L4100 F6  #Replace leather cuff KAFO, proximal thigh
L4110 F6  #Replace leather cuff KAFO-AFO, calf or distal thigh
L4130 F6  #Replace pre Tibial shell
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REPAIRS
L4205 F9 #Repair of orthotic device, labor component, per 15 minutes
(more than 2 hours requires prior approval)
L4210 F7 #Repair of orthotic device, repair or replace minor parts
(not to be billed in conjunction with L4205)

4.6 PRESCRIPTION FOOTWEAR

Orthopedic Footwear
● Orthopedic footwear are shoes, shoe modifications or shoe additions that are
covered when used to correct, accommodate or prevent a physical deformity or
range of motion malfunction in a diseased or injured part of the ankle or foot; to
support a weak or deformed structure of the ankle or foot or to form an integral
part of a brace.
● Minimum orthopedic shoe specifications consist of Blucher or Bal construction,
leather construction or synthetic material of equal quality, welt construction with
a cement attached outsole or sewn on outsole, upper portion properly fitted as
to length and width, no unit sole, bottom sized to the last, closure appropriate to
foot condition (Velcro strap or lace closure preferred), full range of width; not just
narrow, medium, wide; extended medial counter and firm heel counter.
● The additional charge for split size (mismating) orthopedic footwear may be
billed using code L3257 (MEVS dispensing validation required).

Non-Covered Indications:
● Sneakers and athletic shoes are not considered orthopedic shoes by the
  Medicaid Program and therefore are not Medicaid reimbursable.

INSERT, REMOVABLE, MOLDED TO PATIENT MODEL

L3000 F7 #Foot, insert, removable, molded to patient model, “UCB” type,
Berkeley shell, each
L3001 F7 #Foot, insert, removable, molded to patient model, Spenco, each
L3002 F6 #Foot, insert, removable, molded to patient model, plastazote or
equal, each
L3003 F7 #Foot, insert, removable, molded to patient model, silicone gel,
each
L3010 F6 #Foot, insert, removable, molded to patient model, longitudinal
arch support, each
L3020 F6 #Foot, insert, removable, molded to patient model,
longitudinal/metatarsal support, each
L3030 F7 #Foot, insert, removable, formed to patient foot, each

ARCH SUPPORT, REMOVABLE, PREMOLDED, EACH

L3040 F6 #Foot, arch support, removable, premolded, longitudinal, each
L3050 F7 #Foot, arch support, removable, premolded, metatarsal, each
L3060 F6  #Foot, arch support, removable, premolded, longitudinal/metatarsal, each

ARCH SUPPORT, NON-REMOVABLE, ATTACHED TO SHOE

L3070 F7  #Foot, arch support, non-removable attached to shoe, longitudinal, each
L3080 F7  #Foot, arch support, non-removable attached to shoe, metatarsal, each
L3090 F7  #Foot, arch support, non-removable attached to shoe, longitudinal/metatarsal, each
L3100 F7  #Hallus-valgus night dynamic splint

ABDUCTION AND ROTATION BARS

L3140 F7  #Foot, abduction rotation bars, including shoes (Dennis Browne type)
L3150 F7  Foot, abduction rotation bars, without shoe(s) (Dennis Browne type)
L3160 F7  Foot, adjustable shoe-styled positioning device
L3170 F7  #Foot, plastic, silicone or equal, heel stabilizer, each

ORTHOPEDIC FOOTWEAR

L3201 F7  #Orthopedic shoe, oxford with supinator or pronator, infant (each)
L3202 F7  #Orthopedic shoe, oxford with supinator or pronator, child (each)
L3203 F7  #Orthopedic shoe, oxford with supinator or pronator, junior (each)
L3204 F7  #Orthopedic shoe, hightop with supinator or pronator, infant (each)
L3206 F7  #Orthopedic shoe, hightop with supinator or pronator, child (each)
L3207 F7  #Orthopedic shoe, hightop with supinator or pronator, junior (each)
L3208 F7  #Surgical boot, each, infant
L3209 F7  #Surgical boot, each, child
L3211 F7  #Surgical boot, each, junior
L3212 F7  #Benesch boot, pair, infant
L3213 F7  #Benesch boot, pair, child
L3214 F7  #Benesch boot, pair, junior
L3215 F7  #Orthopedic footwear, ladies shoe, oxford, each
L3216 F7  #Orthopedic footwear, ladies shoe, depth inlay, each
L3217 F7  #Orthopedic footwear, ladies shoe, hightop, depth inlay, each
L3219 F7  #Orthopedic footwear, mens shoe, oxford, each
L3221 F7  #Orthopedic footwear, mens shoe, depth inlay, each
L3222 F7  #Orthopedic footwear, mens shoe, hightop, depth inlay, each
L3224 F7  #Orthopedic footwear, woman’s shoe, oxford, used as an integral
part of a brace (orthosis) (each)

L3225 F7  #Orthopedic footwear, man’s shoe, oxford, used as an integral part of a brace (orthosis) (each)
L3230 F7  #Orthopedic footwear, custom (molded to patient) shoe, depth inlay, each
L3250 F7  #Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each
L3252 F7  #Foot, shoe molded to patient model, plastazote (or similar), custom fabricated, each
L3253 F7  #Foot, molded shoe, plastazote (or similar), custom fitted, each
L3254 F7  #Non-standard size or width
L3255 F7  #Non-standard size or length
L3257 F7  #Orthopedic footwear, additional charge for split size
L3260 F7  #Surgical boot/shoe, each
L3265 F7  #Plastazote sandal, each

SHOE MODIFICATION – LIFTS

L3300 F7  #Lift, elevation, heel, tapered to metatarsals, per inch
L3310 F7  #Lift, elevation, heel and sole, neoprene, per inch
L3320 F7  #Lift, elevation, heel and sole, cork, per inch
L3330 F7  #Lift, elevation, metal extension (skate)
L3332 F7  #Lift, elevation, inside shoe, tapered, up to one-half inch
L3334 F7  #Lift, elevation, heel, per inch

SHOE MODIFICATION – WEDGES

L3340 F7  #Heel wedge, SACH
L3350 F7  #Heel wedge
L3360 F7  #Sole wedge, outside sole
L3370 F7  #Sole wedge, between sole
L3380 F7  #Clubfoot wedge
L3390 F7  #Outflare wedge
L3400 F7  #Metatarsal bar wedge, rocker
L3410 F7  #Metatarsal bar wedge, between sole
L3420 F7  #Full sole and heel wedge, between sole

SHOE MODIFICATION – HEELS

L3430 F7  #Heel, counter, plastic reinforced
L3440 F7  #Heel, counter, leather reinforced
L3450 F7  #Heel, SACH cushion type
L3455 F7  #Heel, new leather, standard
L3460 F7  #Heel, new rubber, standard
L3465 F7  #Heel, Thomas with wedge
L3470 F7  #Heel, Thomas extended to ball
L3480 F7  #Heel, pad and depression for spur
L3485 F7  #Heel, pad, removable for spur

MISCELLANEOUS SHOE ADDITIONS

L3540 F7  #Orthopedic shoe addition, sole, full (each)
L3570 F7  Orthopedic shoe addition, special extension to instep (leather with eyelets)
L3580 F7  Orthopedic shoe addition, convert instep to velcro closure

TRANSFERS OR REPLACEMENT

L3600 F7  Transfer of an orthosis from one shoe to another, calliper plate, existing
L3610 F7  Transfer of an orthosis from one shoe to another, caliper plate, new

SHOE CORRECTIONS AND MODIFICATIONS

L3620 F7  Transfer of an orthosis from one shoe to another, solid stirrup, existing
L3630 F7  Transfer of an orthosis from one shoe to another, solid stirrup, new
L3640 F7  Transfer of an orthosis from one shoe to another, Dennis Browne splint (Riveton), both shoes
L3649 F7  #Orthopedic shoe, modification, addition or transfer, not otherwise specified (more than two procedures require prior approval)

DIABETIC SHOES, FITTING, and MODIFICATIONS

Covered as a component of a comprehensive diabetic treatment plan to treat amputation, or pre-ulcerative calluses, or peripheral neuropathy with evidence of callus formation of either foot, or a foot deformity or poor circulation. Limited to shoe codes, inserts, and/or modifications designated for diabetics only.

Billing in conjunction with other orthopedic footwear codes may be considered a duplication of service and result in a claim denial.

A5500 F7  # For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe
A5501 F7  # For diabetics only, fitting (including follow-up), custom preparation and supply of shoe molded from cast(s) of patient’s foot (custom-molded shoe), per shoe
A5503
# For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with roller or rigid rocker bottom, per shoe

A5504
# For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with wedge(s), per shoe

A5505
# For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with metatarsal bar, per shoe

A5506
# For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with off-set heel(s), per shoe

A5507
# For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe

A5512
# For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient’s foot, including arch, base layer minimum of ¼ inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each

A5513
# For diabetics only, multiple density insert, custom molded from model of patient’s foot, total contact with patient’s foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each

A5514
# For diabetics only, multiple density insert, made by direct carving with CAM technology from a rectified CAD model created from a digitized scan of the patient, total contact with patient’s foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each
4.7 PROSTHETICS

1. This schedule is applicable to both children and adults.
2. Base codes are covered when the physician's order and supporting documentation clearly establish the medical and functional need being met by the prescribed device. Where applicable, code specific coverage criteria must be met.
3. L Code “additions” are covered only when both the base codes coverage criteria has been met and specific documentation exists establishing the medical necessity of the addition code.
4. The providers shall be responsible for any needed repairs or replacements due to defects in quality or workmanship that appear within three months of delivery. This does not include adjustments or replacements necessitated by anatomical changes.
5. Replacements and repairs: used to indicate replacement and repair of orthotic and prosthetic devices which have been in use for some time. Prior approval is not required when the charge is over $35.00 and is less than 10% of the price listed on the code for the device. When specific replacement and repair codes are available, they should be used instead of the code for the device with ‘-RB’. For charges $35.00 and under, use L7510.
6. The fees contained in this schedule will be paid under State-administered programs, and are to be considered full payment for the services rendered. The provider shall make no additional charge to the member.
7. Unless otherwise indicated all fees are for the unilateral, single unit or “each”.
8. All normal necessary pads and straps are included in the prices quoted.
9. Polypropylene (ultra-light) should be used only when judged a medical necessity because of bilateral or multiple disabilities, frailty, cardiac disability, etc.
10. For home visit, see code L9900

LOWER LIMB

NOTE: The procedures in this section are considered as “Base” or “Basic Procedures”, and may be modified by listing items/procedures or special materials from the “Additions Section”, adding them to the “Base” Procedure.

A lower limb prosthesis is covered when the patient:
1. Will reach or maintain a defined functional state within a reasonable period of time; and
2. Is motivated to ambulate.

FUNCTIONAL LEVELS:
• A determination of the medical necessity for certain components/additions to the prosthesis is based on the patient's potential functional abilities. Potential
functional ability is based on the reasonable expectations of the prosthetist, and treating physician, considering factors including, but not limited to:
a. The patient's past history (including prior prosthetic use if applicable); and
b. The patient's current condition including the status of the residual limb and the nature of other medical problems; and
c. The patient's desire to ambulate.

• Clinical assessments of patient rehabilitation potential must be based on the following classification levels:
  Level 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.
  Level 1: 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.
  Level 2: 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.
  Level 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.
  Level 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.

• The records must document the patient's current functional capabilities and his/her expected functional potential, including an explanation for the difference, if that is the case. It is recognized, within the functional classification hierarchy, that bilateral amputees often cannot be strictly bound by functional level classifications.

• The determination of coverage for selected prostheses and components with respect to potential functional levels represents the usual case. Exceptions will be considered in an individual case if additional documentation is included which justifies the medical necessity. Prostheses will be denied as not reasonable and necessary if the patient's potential functional level is 0.

• A determination of the type of foot, or knee for the prosthesis will be made by the treating physician and the prosthetist based upon the functional needs of the patient. Basic lower extremity prostheses include a SACH foot. Basic lower extremity prostheses include a single axis, constant friction knee. Other prosthetic feet or and/or knees are considered for coverage based upon functional classification.

PARTIAL FOOT

L5000 F4  #Partial foot, shoe insert with longitudinal arch, toe filler
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L5010 F4  #Partial foot, molded socket, ankle height, with toe filler
L5020 F4  #Partial foot, molded socket, tibial tubercle height, with toe filler

ANKLE
L5050 F4  #Ankle, Symes, molded socket, SACH foot

BELOW KNEE
L5100 F4  #Below knee, molded socket, shin, SACH foot
L5105 F4  #Below knee, plastic socket, joints and thigh lacer, SACH foot

KNEE DISARTICLUATION
L5150 F4  #Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot
L5160 F4  #Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin, SACH foot

ABOVE KNEE
L5200 F4  #Above knee, molded socket, single axis constant friction knee, shin, SACH foot
L5210 F4  #Above knee, short prosthesis, no knee joint (“stubbies”), with foot blocks, no ankle joints, each
L5220 F4  #Above knee, short prosthesis, no knee joint (“stubbies”), with articulated ankle/foot, dynamically aligned, each
L5230 F4  #Above knee, for proximal femoral focal deficiency, constant friction knee, shin, SACH foot

HIP DISARTICLUATION
L5250 F4  #Hip disarticulation, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot
L5270 F4  #Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin, SACH foot

HEMIPLEVECTOMY
L5280 F4  #Hemipelvectomy, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot

ENDOSKELETAL – BELOW KNEE
For prosthetic covers, see codes L5704-L5707
L5301 F4  #Below knee, molded socket, shin, SACH foot, endoskeletal system

ENDOSKELETAL – KNEE DISARTICULATION

L5312 F4  #Knee disarticulation (or through knee), molded socket, single axis knee, pylon, SACH foot, endoskeletal system

ENDOSKELETAL – ABOVE KNEE

L5321 F4  #Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee

ENDOSKELETAL – HIP DISARTICULATION

L5331 F4  #Hip disarticulation, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot

ENDOSKELETAL – HEMIPELVECTOMY

L5341 F4  #Hemipelvectomy, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot

IMMEDIATE POST SURGICAL OR EARLY FITTING PROCEDURES

NOTE: The immediate post-surgical procedure components will at all times remain the property of the prosthetic facility and will be used only on a loan basis. It is estimated that the period of use by the amputee in each case will not exceed one month.

L5400 F2  #Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, and one cast change, below knee

L5410 F2  #Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, below knee, each additional cast change and realignment

L5420 F2  #Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension and one cast change “AK” or knee disarticulation

L5430 F2  #Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, “AK” or knee disarticulation, each additional cast change and realignment

L5450 F18 #Immediate post surgical or early fitting, application of non-weight bearing rigid dressing, below knee

L5460 F18 #Immediate post surgical or early fitting, application of non-weight bearing rigid dressing, above knee

INITIAL PROSTHESIS
L5500 F2  #Initial, below knee “PTB” type socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, direct formed
L5505 F2  #Initial, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, direct formed

PREPARATORY AND DIAGNOSTIC PROSTHESES
● The preparatory prosthesis components will at all times remain the property of the prosthetic facility and will be used only on a loan basis.
● Diagnosis AK and BK prostheses are prostheses that allow various suspension, socket, knee, ankle systems to be utilized by the member to determine optimal prescription; same qualifications exist as with preparatory prostheses.

PREPARATORY PROSTHESIS
L5510 F2  #Preparatory, below knee “PTB” type socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, molded to model
L5520 F2  #Preparatory, below knee “PTB” type socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed
L5530 F2  #Preparatory, below knee “PTB” type socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model
L5535 F2  #Preparatory, below knee “PTB” type socket, non-alignable system, pylon, no cover, SACH foot, prefabricated, adjustable open end socket
L5540 F2  #Preparatory, below knee “PTB” type socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model
L5560 F2  #Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, molded to model
L5570 F2  #Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed
L5580 F2  #Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model
L5585 F2  #Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, prefabricated adjustable open end socket
L5590 F2  #Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model
L5595 F2  #Preparatory, hip disarticulation – hemipelvectomy, pylon, no
cover, SACH foot, thermoplastic or equal, molded to patient model
L5600 F2
Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, laminated socket, molded to patient model

ADDITIONS TO LOWER EXTREMITY

- A fluid or pneumatic knee (L5610, L5613, L5614) is covered for member’s whose functional level is 3 or above.

L5610 F4
Addition to lower extremity, endoskeletal system, above knee, hydracadence system
L5611 F4
Addition to lower extremity, endoskeletal system, above knee–knee disarticulation, 4-bar linkage, with friction swing phase control
L5613 F4
Addition to lower extremity, endoskeletal system, above knee–knee disarticulation, 4-bar linkage, with hydraulic swing phase control
L5614 F4
Addition to lower extremity, endoskeletal system, above knee–knee disarticulation, 4-bar linkage, with pneumatic swing phase control

ADDITIONS - TEST SOCKETS

L5618 F4
Addition to lower extremity, test socket, Symes
L5620 F4
Addition to lower extremity, test socket, below knee
L5622 F4
Addition to lower extremity, test socket, knee disarticulation
L5624 F4
Addition to lower extremity, test socket, above knee
L5626 F4
Addition to lower extremity, test socket, hip disarticulation
L5628 F4
Addition to lower extremity, test socket, hemipelvectomy

ADDITIONS - SOCKET VARIATIONS

L5629 F4
Addition to lower extremity, below knee, acrylic socket
L5631 F4
Addition to lower extremity, above knee or knee disarticulation, acrylic socket
L5632 F4
Addition to lower extremity, Symes type, “PTB” Brim design socket
L5634 F4
Addition to lower extremity, Symes type, posterior opening (Canadian) socket
L5636 F4
Addition to lower extremity, Symes type, medial opening socket
L5637 F4
Addition to lower extremity, below knee, total contact
L5638 F4
Addition to lower extremity, below knee, leather socket
L5639 F4
Addition to lower extremity, below knee, wood socket
L5640 F4
Addition to lower extremity, knee disarticulation, leather socket
L5642 F4
Addition to lower extremity, above knee, leather socket
L5643 F4
Addition to lower extremity, hip disarticulation, flexible inner socket, external frame
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L5644 F4  #Addition to lower extremity, above knee, wood socket
L5645 F4  #Addition to lower extremity, below knee, flexible inner socket, external frame
L5646 F4  #Addition to lower extremity, below knee, air, fluid, gel, or equal, cushion socket
L5647 F4  #Addition to lower extremity, below knee, suction socket
L5648 F4  #Addition to lower extremity, above knee, air, fluid, gel or equal, cushion socket
L5649 F4  #Addition to lower extremity, ischial containment/narrow M-L socket
L5650 F4  #Addition to lower extremity, total contact, above knee or knee disarticulation socket
L5651 F4  #Addition to lower extremity, above knee, flexible inner socket, external frame
L5652 F4  #Addition to lower extremity, suction suspension, above knee or knee disarticulation socket
L5653 F4  #Addition to lower extremity, knee disarticulation, expandable wall socket

ADDITIONS - SOCKET INSERT AND SUSPENSION

L5654 F6  #Addition to lower extremity, socket insert, Symes, (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5655 F6  #Addition to lower extremity, socket insert, below knee (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5656 F6  #Addition to lower extremity, socket insert, knee disarticulation (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5658 F6  #Addition to lower extremity, socket insert, above knee (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5661 F6  #Addition to lower extremity, socket insert, multi-durometer Symes
L5665 F6  #Addition to lower extremity, socket insert, multi-durometer, below knee
L5666 F6  #Addition to lower extremity, below knee, cuff suspension
L5668 F6  #Addition to lower extremity, below knee, molded distal cushion
L5670 F6  #Addition to lower extremity, below knee, molded supracondylar suspension ("PTS" or similar)
L5671 F6  #Addition to lower extremity, below knee/above knee suspension locking mechanism (shuttle, lanyard or equal), excludes socket insert
L5672 F6  #Addition to lower extremity, below knee, removable medial brim suspension
L5673 F6  #Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism
L5676 F4  #Additions to lower extremity, below knee, knee joints, single
axis, pair

L5677 F4 #Additions to lower extremity, below knee, knee joints, polycentric, pair

L5678 F6 #Additions to lower extremity, below knee, joint covers, pair

L5679 F6 #Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism

L5680 F6 #Addition to lower extremity, below knee, thigh lacer, non-molded

L5681 F6 #Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism; initial only (for use other than initial, use code L5673 or L5679)

L5682 F6 #Addition to lower extremity, below knee, thigh lacer, gluteal/ischial, molded

L5683 F6 #Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L5673 or L5679)

L5684 F6 #Addition to lower extremity, below knee, fork strap

L5685 F6 #Addition to lower extremity prosthesis, below knee, suspension/sealing sleeve, with or without valve, any material, each

L5686 F6 #Addition to lower extremity, below knee, back check (extension control)

L5688 F7 #Addition to lower extremity, below knee, waist belt, webbing

L5690 F7 #Addition to lower extremity, below knee, waist belt, padded and lined

L5692 F7 #Addition to lower extremity, above knee, pelvic control belt, light

L5694 F7 #Addition to lower extremity, above knee, pelvic control belt, padded and lined

L5695 F7 #Addition to lower extremity, above knee, pelvic control, sleeve suspension, neoprene or equal, each

L5696 F4 #Addition to lower extremity, above knee or knee disarticulation, pelvic joint

L5697 F7 #Addition to lower extremity, above knee or knee disarticulation, pelvic band

L5698 F7 #Addition to lower extremity, above knee or knee disarticulation, Silesian bandage

L5699 F7 #All lower extremity prostheses, shoulder harness

ADDITIONS - FEET ANKLE UNITS

L5700 F4 #Replacement, socket, below knee, molded to patient model

L5701 F4 #Replacement, socket, above knee/knee disarticulation, including
attachment plate, molded to patient model

L5702 F4  #Replacement, socket, hip disarticulation, including hip joint, molded to patient model
L5703 F4  #Ankle, symes, molded to patient model, socket without solid ankle cushion heel (SACH) foot, replacement only
L5704 F6  #Custom shaped protective cover, below knee
L5705 F6  #Custom shaped protective cover, above knee
L5706 F6  #Custom shaped protective cover, knee disarticulation
L5707 F6  #Custom shaped protective cover, hip disarticulation
L5710 F6  #Addition, exoskeletal knee-shin system, single axis, manual lock
L5711 F6  #Additions exoskeletal knee-shin system, single axis, manual lock, ultra-light material
L5712 F6  #Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)
L5714 F6  #Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control

ADDITIONS – KNEE – SHIN SYSTEM

L5716 F6  #Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock

• A fluid or pneumatic knee (L5722-L5780) is covered for member's whose functional level is 3 or above.
L5722 F4  #Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control
L5724 F4  #Addition, exoskeletal knee-shin system, single axis, fluid swing phase control
L5726 F4  #Addition, exoskeletal knee-shin system, single axis, external joints, fluid swing phase control
L5728 F4  #Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control
L5780 F4  #Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control
L5781 F4  Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system

COMPONENT MODIFICATION

L5785 F4  #Addition, exoskeletal system, below knee, ultra light material (titanium, carbon fiber or equal)
L5790 F4  #Addition, exoskeletal system, above knee, ultra light material (titanium, carbon fiber or equal)
L5795 F4  #Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)

**ENDOSKELETAL**

L5810 F4  #Addition, endoskeletal knee-shin system, single axis, manual lock
L5811 F4  #Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material
L5812 F4  #Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)
L5814 F4  #Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock
  • Covered for member’s whose functional level is 3 or above.
L5816 F4  #Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock
L5818 F4  #Addition, endoskeletal knee-shin system, polycentric, friction swing and stance phase control
  • A fluid or pneumatic knee (L5822-L5840) is covered for member’s whose functional level is 3 or above.
L5822 F4  #Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control
L5824 F4  #Addition, endoskeletal knee-shin system, single axis, fluid swing phase control
L5826 F4  #Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame
L5828 F4  #Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control
L5830 F4  #Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control
L5840 F4  #Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, pneumatic swing phase control
L5845 F4  #Addition, endoskeletal, knee-shin system, stance flexion feature, adjustable
L5850 F4  #Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist
L5855 F4  #Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist
  • Electric knees (L5856-L5858) are covered for member’s whose functional level is 3 or above, and when the clinical documentation establishes why a non electric knee fails to meet the member’s medical needs and the member’s maximum functional level can not be achieved through the use of a non electric knee. Documentation should include, at minimum, a detailed specialist (Physiatrist, Therapist, etc.) evaluation and specific objective measures taken during the trial of both the electric knee and non electric knee.

L5856 F3  **Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase,**
includes electronic sensor(s), any type

- **L5857** F3 Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing phase only, includes electronic sensor(s), any type
- **L5858** F3 Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type
- **L5910** F4 #Addition, endoskeletal system, below knee, alignable system
- **L5920** F4 #Addition, endoskeletal system, above knee or hip disarticulation, alignable system
- **L5925** F4 #Addition, endoskeletal system, above knee, knee disarticulation or hip disarticulation, manual lock
- **L5930** F4 #Addition, endoskeletal system, high activity knee control frame
  - A high activity knee control frame (L5930) is covered for patients whose functional level is 4.
- **L5940** F4 #Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)
- **L5950** F4 #Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)
- **L5960** F4 #Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)
- **L5962** F4 #Addition, endoskeletal system, below knee, flexible protective outer surface covering system
- **L5964** F4 #Addition, endoskeletal system, above knee, flexible protective outer surface covering system
- **L5966** F4 #Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system
- **L5968** F3 #Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature
  - An external keel SACH foot (L5970) or single axis ankle/foot (L5974) is covered for patients whose functional level is 1 or above.
  - A flexible-keel foot (e) or multiaxial ankle/foot (L5978) is covered for patients whose functional level is 2 or above.
  - A microprocessor-controlled ankle foot system (L5973), energy storing foot (L5976), dynamic response foot with multiaxial ankle (L5979), flex foot system (L5980), flex-walk system or equal (L5981), or shank foot system with vertical loading pylon (L5987) is covered for patients whose functional level is 3 or above.
  - Coverage is extended only if there is sufficient clinical documentation of functional need for the technologic or design feature of a given type of foot. This information must be retained in the physician's and prosthetist's files and be available upon request.
- **L5970** F4 #All lower extremity prostheses, foot, external keel, SACH foot
- **L5971** F4 #All lower extremity prostheses, solid ankle cushion heel (SACH) foot, replacement only
- **L5972** F4 #All lower extremity prostheses, foot, flexible keel
L5973^F3  Endoskeletal ankle foot system, microprocessor controlled feature, dorsiflexion
L5974^F4  #All lower extremity prostheses, foot, single axis ankle/foot
L5975^F4  #All lower extremity prostheses, combination single axis ankle and flexible keel foot
L5976^F4  #All lower extremity prostheses, energy storing foot (Seattle Carbon Copy II or equal)
L5978^F4  #All lower extremity prostheses, foot, multi-axial ankle/foot (Gressinger or equal)
L5979^F4  #All lower extremity prostheses, multi-axial ankle, dynamic response foot, one piece system
L5980^F3  All lower extremity prostheses, flex foot system
L5981^F3  All lower extremity prostheses, flex-walk system or equal
L5982^F4  #All exoskeletal lower extremity prostheses, axial rotation unit
L5984^F4  #All endoskeletal lower extremity prostheses, axial rotation unit, with or without adjustability
L5985^F3  #All endoskeletal lower extremity prostheses, dynamic prosthetic pylon
L5986^F4  #All lower extremity prostheses, multi-axial rotation unit (“MCP” or equal)
L5987^F3  All lower extremity prosthesis, shank foot system with vertical loading pylon
L5988^F4  #Addition to lower limb prosthesis, vertical shock reducing pylon feature
L5990^F4  #Addition to lower extremity prosthesis, user adjustable heel height
L5999^F10  Lower extremity prosthesis, not otherwise specified

**UPPER LIMB**
• The procedures in this section are considered as base or basic procedures and may be modified by listing procedures from the “Additions” sections. The base procedures include only standard friction wrist and control cable system unless otherwise specified.

**PARTIAL HAND**
L6000^F3  #Partial hand, Robin-Aids, thumb remaining (or equal)
L6010^F3  #Partial hand, Robin-Aids, little and/or ring finger remaining (or equal)
L6020^F3  #Partial hand, Robin-Aids, no finger remaining (or equal)
L6026^F3  "Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device, excludes terminal device(s)"
WRIST DISARTICULATION

L6050 F3  #Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad
L6055 F3  #Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad

BELOW ELBOW

L6100 F3  #Below elbow, molded socket, flexible elbow hinge, triceps pad
L6110 F3  #Below elbow, molded socket, (Muenster or Northwestern suspension types)
L6120 F3  #Below elbow, molded double wall split socket, step-up hinges, half cuff
L6130 F3  #Below elbow, molded double wall split socket, stump activated locking hinge, half cuff

ELBOW DISARTICULATION

L6200 F3  #Elbow disarticulation, molded socket, outside locking hinge, forearm
L6205 F3  #Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm

ABOVE ELBOW

L6250 F3  #Above elbow, molded double wall socket, internal locking elbow, forearm

SHOULDER DISARTICULATION

L6300 F3  #Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm
L6310 F3  #Shoulder disarticulation, passive restoration (complete prosthesis)
L6320 F3  #Shoulder disarticulation, passive restoration (shoulder cap only)

INTERSCAPULAR THORACIC

L6350 F3  #Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm
L6360 F3  #Interscapular thoracic, passive restoration (complete prosthesis)
L6370 F3  #Interscapular thoracic, passive restoration (shoulder cap only)

IMMEDIATE AND EARLY POST SURGICAL PROCEDURES
L6380 F2  #Immediate post surgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, wrist disarticulation or below elbow

L6382 F2  #Immediate post surgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, elbow disarticulation or above elbow

L6384 F2  #Immediate post surgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, shoulder disarticulation or interscapular thoracic

L6386 F2  #Immediate post surgical or early fitting, each additional cast change and realignment

L6388 F2  #Immediate post surgical or early fitting, application of rigid dressing only

ENDOSKELETAL – BELOW ELBOW

L6400 F2  #Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping

L6883 F3  Replacement socket, below elbow/wrist disarticulation, molded to patient model, for use with or without external power

ENDOSKELETAL – ELBOW DISARTICULATION

L6450 F2  #Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping

ENDOSKELETAL – ABOVE ELBOW

L6500 F2  #Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping

L6884 F3  Replacement socket, above elbow/elbow disarticulation, molded to patient model, for use with or without external power

ENDOSKELETAL – SHOULDER DISARTICULATION

L6550 F2  #Shoulder disarticulation, molded socket endoskeletal system, including soft prosthetic tissue shaping

L6885 F3  Replacement socket, shoulder disarticulation/interscapular thoracic, molded to patient model, for use with or without external power
ENDOSKELETAL – INTERSCAPULAR THORACIC

L6570 F2 #Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6580 F2 #Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, "USMC" or equal pylon, no cover, molded to patient model
L6582 F2 #Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, “USMC” or equal pylon, no cover, direct formed
L6584 F2 #Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, “USMC” or equal pylon, no cover, molded to patient model
L6586 F2 #Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, “USMC” or equal pylon, no cover, direct formed
L6588 F2 #Preparatory, shoulder disarticulation or interscapular thoracic, single wall, plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, “USMC” or equal pylon, no cover, molded to patient model
L6590 F2 #Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, “USMC” or equal pylon, no cover, direct formed

ADDITIONS – UPPER LIMB

NOTE: The following procedures/modifications/components may be added to other base procedures. The items in this section should reflect the additional complexity of each modification procedure. In addition to base procedure, at the time of the original order.

L6600 F3 #Upper extremity additions, polycentric hinge, pair
L6605 F3 #Upper extremity additions, single pivot hinge, pair
L6610 F3 #Upper extremity additions, flexible metal hinge, pair
L6611 F3 #Addition to upper extremity prosthesis, external powered, additional switch, any type
L6615 F3 #Upper extremity addition, disconnect locking wrist unit
L6616 F3 #Upper extremity addition, additional disconnect insert for locking wrist unit, each
L6620 F3 #Upper extremity addition, flexion-friction wrist unit, with or without friction
L6621 F3 Upper extremity prosthesis addition, flexion/extension wrist with or without friction, for use with external powered terminal device
L6623 F3 #Upper extremity addition, spring assisted rotational wrist unit with latch release
L6624 F3 Upper extremity addition, flexion/extension and rotation wrist unit
L6625 F3 #Upper extremity addition, rotation wrist unit with cable lock
L6628 F3 #Upper extremity addition, quick disconnect hook adapter, Otto Bock or equal
L6629 F3 #Upper extremity addition, quick disconnect lamination collar with coupling piece, Otto Bock or equal
L6630 F3 #Upper extremity addition, stainless steel, any wrist
L6632 F3 #Upper extremity addition, latex suspension sleeve, each
L6635 F3 #Upper extremity addition, lift assist for elbow
L6637 F3 #Upper extremity addition, nudge control elbow lock
L6638 F3 Upper extremity addition to prosthesis, electric locking feature, only for use with manually powered elbow
L6640 F3 #Upper extremity additions, shoulder abduction joint, pair
L6641 F3 #Upper extremity addition, excursion amplifier, pulley type
L6642 F3 #Upper extremity addition, excursion amplifier, lever type
L6645 F3 #Upper extremity addition, shoulder flexion-abduction joint, each
L6646 F3 Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable abduction friction control, for use with body powered or external powered system
L6650 F4 #Upper extremity addition, shoulder universal joint, each
L6655 F4 #Upper extremity addition, standard control cable, extra
L6660 F4 #Upper extremity addition, heavy duty control cable
L6665 F6 #Upper extremity addition, Teflon, or equal, cable lining
L6670 F4 #Upper extremity addition, hook to hand, cable adapter
L6672 F4 #Upper extremity addition, harness, chest or shoulder, saddle type
L6675 F4 #Upper extremity addition, harness, (e.g. figure of eight type) single cable design
L6676 F4 #Upper extremity addition, harness, (e.g. figure of eight type) dual cable design
L6677 F4 #Upper extremity addition, harness, triple control, simultaneous operation of terminal device and elbow
L6680 F3 #Upper extremity addition, test socket, wrist disarticulation or below elbow
L6682 F3 #Upper extremity addition, test socket, elbow disarticulation or above elbow
L6684 F3 #Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic
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**L6686 F3**  #Upper extremity addition, suction socket
**L6687 F3**  #Upper extremity addition, frame type socket, below elbow or wrist disarticulation
**L6688 F3**  #Upper extremity addition, frame type socket, above elbow or elbow disarticulation
**L6689 F3**  #Upper extremity addition, frame type socket, shoulder disarticulation

**L6690 F3**  #Upper extremity addition, frame type socket, interscapular-thoracic
**L6691 F6**  #Upper extremity addition, removable insert, each
**L6692 F6**  #Upper extremity addition, silicone gel insert or equal, each
**L6693 F3**  Upper extremity addition, locking elbow, forearm counterbalance
**L6694 F6**  #Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism
**L6695 F6**  #Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism
**L6696 F6**  Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695)
**L6697 F6**  Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695)
**L6698 F6**  #Addition to upper extremity prosthesis, below elbow/above elbow, lock mechanism, excludes socket insert

**TERMINAL DEVICES**

**HOOKS**

**L6703 F3**  #Terminal device, passive hand/mitt, any material, any size
**L6706 F3**  #Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined
**L6707 F3**  #Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined

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L6708 F3  #Terminal device, hand, mechanical, voluntary opening, any material, any size
L6709 F3  #Terminal device, hand, mechanical, voluntary closing, any material, any size
L6711 F3  Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined, pediatric
L6712 F3  Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined, pediatric
L6713 F3  Terminal device, hand, mechanical, voluntary opening, any material, any size, pediatric
L6714 F3  Terminal device, hand, mechanical, voluntary closing, any material, any size, pediatric
L6721 F3  Terminal device, hook or hand, heavy duty, mechanical, voluntary opening, any material, any size, lined or unlined
L6722 F3  Terminal device, hook or hand, heavy duty, mechanical, voluntary closing, any material, any size, lined or unlined
L6805 F3  #Addition to terminal device, modifier wrist unit
L6810 F3  #Addition to terminal device, precision pinch device

HANDS

L6881 F3  Automatic grasp feature, addition to upper limb electric prosthetic terminal device
L6882 F3  Microprocessor control feature, addition to upper limb prosthetic terminal device

GLOVES FOR ABOVE HANDS

L6890 F6  #Addition to upper extremity prosthesis, glove for terminal device, any material, prefabricated, includes fitting and adjustment
L6895 F6  #Addition to upper extremity prosthesis, glove for terminal device, any material, custom fabricated

HAND RESTORATION

L6900 F3  #Hand restoration (casts, shading and measurements included), partial hand, with glove, thumb or one finger remaining
L6905 F3  #Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining
L6910 F3  #Hand restoration (casts, shading and measurements included), partial hand, with glove, no fingers remaining
L6915 F3  #Hand restoration (shading and measurements included), replacement glove for above

EXTERNAL POWER

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BASE DEVICES

L6920 F³ Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal, switch, cables, two batteries and one charger, myoelectric control of terminal device

L6925 F³ Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectric control of terminal device

L6930 F³ Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device

L6935 F³ Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectric control of terminal device

L6940 F³ Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device

L6945 F³ Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectric control of terminal device

L6950 F³ Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device

L6955 F³ Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectric control of terminal device

L6960 F³ Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device

L6965 F³ Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectric control of terminal device

L6970 F³ Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6975 F3  Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L7007 F3  Electric hand, switch or myoelectric controlled, adult
L7008 F3  Electric hand, switch or myoelectric controlled, pediatric
L7009 F3  Electric hook, switch or myoelectric controlled, adult
L7040 F3  Prehensile actuator, switch controlled
L7045 F3  Electric hook, switch or myoelectric controlled, pediatric

MYOELECTRIC
● To be used only when medically necessary as determined by an approved amputee clinic.

ELBOW
L7170 F3  Electronic elbow, Hosmer or equal, switch controlled
L7180 F3  Electronic elbow, microprocessor sequential control of elbow and terminal device
L7181 F3  Electronic elbow, microprocessor simultaneous control of elbow and terminal device
L7185 F3  Electronic elbow, adolescent, Variety Village or equal, switch controlled
L7186 F3  Electronic elbow, child, Variety Village or equal, switch controlled
L7190 F3  Electronic elbow, adolescent, Variety Village or equal, myoelectronically controlled
L7191 F3  Electronic elbow, child, Variety Village or equal, myoelectronically controlled
L7259 F3  Electronic wrist rotator, any type

BATTERY COMPONENTS
L7360 F7  #Six volt battery, each
L7364 F7  #Twelve volt battery, each
L7367 F7  #Lithium ion battery, rechargeable, replacement
L7362 F4  #Battery charger, six volt, each
L7368 F4  #Lithium ion battery charger (Replacement only)
L7499 F10 Upper extremity prosthesis, not otherwise specified
L7510 F7  #Repair of prosthetic device, repair or replace minor parts (not to be billed in conjunction with L7520)
L7520 F9  #Repair prosthetic device, labor component, per 15 minutes (includes evaluation) (more than 2 hours requires prior approval)
GENERAL

BREAST AND HAIR PROSTHESIS (Also see Section 4.1)

L8010 F21 #Breast prosthesis, mastectomy sleeve
L8035 F22 #Custom breast prosthesis, post mastectomy, molded to patient model
A9282 F2 Wig, any type, each
   • Coverage limited to medically-induced or congenital hair loss.

UPPER EXTREMITY ELASTIC SUPPORTS

S8421 F21 #Gradient pressure aid (sleeve and glove combination), ready made
S8424 F21 #Gradient pressure aid (sleeve), ready made
S8427 F21 #Gradient pressure aid (glove), ready made
S8428 F21 #Gradient pressure aid (gauntlet), ready made

LOWER EXTREMITY COMPRESSION SUPPORTS

• For custom-made gradient compression stockings, use code A6549
• For non-custom gradient compression stockings, refer to codes A6530-A6544
• For gradient compression/surgical stockings, refer to codes A4495-A4510

A6530 F7 #Gradient compression stocking, below knee, 18-30 mm Hg each
A6531 F7 #Gradient compression stocking, below knee, 30-40 mm Hg, each
A6532 F7 #Gradient compression stocking, below knee, 40-50 mmHg, each
A6533 F7 #Gradient compression stocking, thigh length, 18-30 mm Hg, each
A6534 F7 #Gradient compression stocking, thigh length, 30-40 mm Hg, each
A6535 F7 #Gradient compression stocking, thigh length, 40-50 mm Hg, each
A6536 F7 #Gradient compression stocking, full length/chap style, 18-30 mm Hg
A6537 F7 #Gradient compression stocking, elastic, full length/chap style 30-40 mm Hg, each
A6538 F7 #Gradient compression stocking, full length/chap style, 40-50 mm Hg, each
A6539 F7 #Gradient compression stocking, waist length, 18-30 mm Hg, each
   (panty hose style)
A6540 F7 #Gradient compression stocking, waist length, 30-40 mm Hg, each
   (panty hose style)
A6541 F7 #Gradient compression stocking, waist length, 40-50 mm Hg, each
   (panty hose style)
A6544 F7 #Gradient compression stocking, garter belt
A6549 F7 Gradient compression stocking, not otherwise specified
   • Custom-made gradient compression stockings/garments fabricated to the exact specifications of an individual whose
measurements fall outside the ranges of over-the-counter (OTC) ready-made garments.

- Covered for venous or lymphatic impairment

**Documentation Requirements**

- A physician’s fiscal order indicating the specific level of compression in mm/Hg, specific style, type, and hosiery knit, and any additional accessories/options.
- Ordering provider’s letter of medical necessity should include: medical history, related diagnoses, duration and extent of current symptoms, any neurological involvement of affected limbs, ambulation status and degree of assistance required.
- Current and previous decompression treatment modalities utilized and member’s compliance and medical outcomes.
- Detailed limb/body measurements obtained from a certified fitter or LANA certified therapist, and date measured. Indicate the location and degree of edematous lobules, if present.

**A9999**  
**Miscellaneous DME supply or accessory, not otherwise specified**  
Use for zippered gradient compression stockings.  
**Documentation Requirement:**

- Member meets the coverage criteria for code A6549.
- Indicate the presence of an open wound or inability to don /doff non-zippered stockings if caregivers are not available.
- Detailed description of member’s dexterity/ability to don /doff zippered stockings if caregivers are not available.

**TRUSSES**

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<tr>
<th>Code</th>
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<tbody>
<tr>
<td>L8300 F6</td>
<td>#Truss, single with standard pad</td>
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<tr>
<td>L8310 F6</td>
<td>#Truss, double with standard pads</td>
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<tr>
<td>L8320 F6</td>
<td>#Truss, addition to standard pad, water pad</td>
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<td>L8330 F6</td>
<td>#Truss, addition to standard pad, scrotal pad</td>
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**PROSTHETIC SOCKS**

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<td>#Prosthetic sheath, upper limb, each</td>
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<td>L8417 F21</td>
<td>#Prosthetic sheath/sock, including a gel cushion layer, below knee or above</td>
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<td>#Prosthetic sock, multiple ply, below knee, each</td>
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<td>#Prosthetic sock, multiple ply, upper limb, each</td>
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<td>#Prosthetic sock, single ply, fitting, below knee, each</td>
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**BURN GARMENTS**

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<td>Compression burn garment, glove to axilla, custom fabricated</td>
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<td>Compression burn garment, foot to thigh length, custom fabricated</td>
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<td>Compression burn garment, upper trunk to waist including arm openings (vest), custom fabricated</td>
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<td>Compression burn garment, trunk, including arms down to leg openings (leotard), custom fabricated</td>
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<td>Compression burn garment, lower trunk including leg openings (panty), custom fabricated</td>
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<td>Compression burn garment, not otherwise classified</td>
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4.8 Definitions

The presence of a definition does not constitute a coverage determination.

**Actuator** – A motor that operates a specific function of a power seating system – i.e., tilt, recline, power sliding back, elevating leg rest(s), seat elevation, or standing.

**Alternative Control Device** - A device that transforms a user’s drive commands by physical actions initiated by the user to input control directions to a power wheelchair that replaces a standard proportional joystick. Includes: mini-proportional, compact, or short throw joysticks, head arrays, sip and puff and other types of different input control devices.

**Augmentative Communication Systems** - A composite of communications components that may include, but are not limited to, communication devices, manual signs, and communication strategies.

**Captain’s Chair** - A one or two-piece automotive-style seat with rigid frame, cushioning material in both seat and back sections, covered in cloth, vinyl, leather or equal as upholstery, and designed to serve as a complete seating, support, and cushioning system for the user. It may have armrests that can be fixed, swing away, or detachable. It may or may not have a headrest, either integrated or separate.

**Combination skin protection and positioning seat cushion** – A standard or customized seat cushion which has the following features listed in (a) or (b), and (c), (d), and (e):

(a) Two or more of the following features which must be at least 25 mm in height in the pre-loaded state. Included in this definition are cushions which have a planar surface but have positioning features within the cushion which are made of a firmer material than the surface material:

- A pre-ischial bar or ridge which is placed anterior to the ischial tuberosities and prevents forward migration of the pelvis,
- Two lateral pelvic supports which are placed posterior to the trochanters and are intended to maintain the pelvis in a centered position in the seat and/or provide lateral stability to the pelvis,
- A medial thigh support which is placed in contact with the adductor region of the thigh and provides the prescribed amount of abduction and prevents adduction of the thighs,
- Two lateral thigh supports which are placed anterior to the trochanters and provide lateral stability to the lower extremities and prevent unwanted abduction of the thighs, or

(b) It has two or more air compartments located in areas which address postural asymmetries, each of which must have a cell height of at least 50 mm, must allow the user to add or remove air, and must have a valve which retains the desired air volume.
(c) It has a removable vapor permeable or waterproof cover or it has a waterproof surface; and
(d) It has a permanent label indicating the model and the manufacturer; and
(e) It has a warranty that provides for repair or full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 18 months.

**Communication Devices** - A general term used to describe a primary unit such as communication software/programs, speech generating device, manual board, or electro larynx, and accessories including but not limited to application programs, language symbols, interfaces, overlays, cables, and mounts.

**Crash Testing** - Successful completion of WC-19 testing.

**Cross Brace Chair** - A type of construction for a power wheelchair in which opposing rigid braces hinge on pivot points to allow the device to fold.

**Custom fabricated seat or back cushion** - Individually made for a specific patient starting with basic materials, may include certain prefabricated components (e.g., gel or multi-cellular air inserts) which may not be billed separately.
(a) liquid foam or a block of foam and
(b) sheets of fabric or liquid coating material.
(c) The cushion must be fabricated using molded-to-recipient-model technique, direct molded-to-recipient technique, CAD-CAM technology, or detailed measurements of the recipient used to create a configured cushion.
(d) The cushion must have structural features that significantly exceed the minimum requirements for a seat or back positioning cushion. The cushion must have a removable vapor permeable or waterproof cover or it must have a waterproof surface.

**Custom-fitted/customized** means componentry made or added to already existing model or device that is assembled, adjusted or modified in order to fit the member’s body.

**Custom-made** is fabricated solely for a particular patient from raw materials which cannot be readily changed to conform to another patient. These materials are used to create the item from patient measurements or patterns. Custom-made requires that the member be measured for the custom-made item so that it can be fabricated from these measurements.

**Dedicated Speech Generating Device (DSGD)** - Devices used as a medically necessary speech aid that is designed, manufactured, and utilized for the sole purpose of generating speech, primarily and customarily used for medical purposes, provides an individual who has a severe speech impairment with
the ability to meet functional speaking needs, and is used solely by the individual who has a severe speech impairment. The device is only intended to perform speech generating functions for the life of the device and cannot be altered by the average consumer to perform non-speech generating functions. DSGD’s may have digitized speech output using pre-recorded messages with defined recording times or may have synthesized speech output, which requires message formulation by spelling and device access by physical contact with the device-direct selection technique or multiple methods of device access.

**Durable medical equipment** are devices and equipment, other than prosthetic or orthotic appliances, which have been ordered by a practitioner in the treatment of a specific medical condition and which have all the following characteristics:
- Can withstand repeated use for a protracted period of time;
- Are primarily and customarily used for medical purposes;
- Are generally not useful in the absence of an illness or injury;
- Are not usually fitted, designed or fashioned for a particular individual’s use;
- Where equipment is intended for use by only one patient, it may be either custom-made or customized.

**Dynamic Stability Incline** - The minimum degree of slope at which the PMD in the most common seating and positioning configuration(s) remains stable at the required patient weight capacity. If the PMD is stable at only one configuration, the PMD may have protective mechanisms that prevent climbing inclines in configurations that may be unstable.

**Expandable Controller** - An electronic system that is capable of accommodating one or more of the following additional functions:
- Proportional input devices (e.g., mini, compact, or short throw joysticks, touch pads, chin control, head control, etc.) other than a standard proportional joystick.
- Non-proportional input devices (e.g., sip and puff, head array, etc.)
- Operate 3 or more powered seating actuators through the drive control. (Note: Control of the power seating actuators though the Control Input Device would require the use of an additional component, E2310 or E2311.)

An expandable controller may also be able to operate one or more of the following:
- A separate display (i.e., for alternate control devices)
- Other electronic devices (e.g., control of an augmentative speech device or computer through the chair’s drive control)
- An attendant control

**Foot-Ankle Padded Positioning Strap** – A padded foot positioning strap that wraps around the ankle and attaches to the wheelchair footplates. The purpose of a FAPPS is to prevent unwanted inversion, eversion, extension or
lifting of the foot, thereby reducing joint stress and increasing tolerance for positioning, creating a dynamic foot positioning system.

**General use back cushion** - A prefabricated cushion, which is planar or contoured; and has a removable vapor permeable or waterproof cover or it has a waterproof surface; and has a permanent label indicating the model and the manufacturer; and has a warranty that provides for repair or full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 12 months.

**General use seat cushion** - A prefabricated cushion with a removable vapor permeable or waterproof cover or has a waterproof surface; and has a permanent label indicating the model and the manufacturer; and has a warranty that provides for repair or full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 12 months.

**Highway Use** - Mobility devices that are powered and configured to operate legally on public streets.

**Integral Control System** - Non-expandable wheelchair control system where the joystick is housed in the same box as the controller. The entire unit is located and mounted near the hand of the user. A direct electrical connection is made from the Integral Control box to the motors and batteries through a high power wire harness.

**Multiple Power Options** - A category of PWCs with the capability to accept and operate a combination power tilt and recline seating system. It may also be able to accommodate power elevating leg rests. A PWC does not have to accommodate all features to qualify for this code.

**No Power Options** – A category of PWCs that is incapable of accommodating a power tilt, recline, seat elevation, or standing system. If a PWC can only accept power elevating leg rests, it is considered to be a No Power Option chair.

**Non-Dedicated Speech Generating Device (non-DSGD)** - Devices with one or more of the following characteristics;

a. The capability (locked or unlocked) of running software for purposes other than speech generation (e.g.: devices that can also run work processing package, an accounting program, or perform other non medical functions); or

b. Laptop computers, desktop computers, tablet computers, cell phones, or personal digital assistants, which may be programmed to perform the same function as a speech generating device, and are therefore not primarily medical in nature and do not meet the regulatory definition of **Durable Medical Equipment**; or

  c. A device that is useful to someone without severe speech impairment.
Non-Expandable Controller - An electronic system that controls the speed and direction of the power wheelchair drive mechanism. Only a standard proportional joystick (used for hand or chin control) can be used as the input device. This system may be in the form of an integral controller or a remotely placed controller. The non-expandable controller may have the ability to control up to 2 power seating actuators through the drive control (for example, seat elevator and single actuator power elevating legrests). (Note: Control of the power seating actuators though the Control Input Device would require the use of an additional component, E2310 or E2311.) May also allow for the incorporation of an attendant control.

Non-Proportional Control Input Device - A device that transforms a user's discrete drive command (a physical action initiated by the wheelchair user, such as activation of a switch) into perceptually discrete changes in the wheelchair's speed, direction, or both.

Obstacle Climb - Vertical height of a solid obstruction that can be climbed using the standing and/or 0.5 meter run-up RESNA test.

Patient Weight Capacity – The terms Standard Duty, Heavy Duty, etc., refer to weight capacity, not performance. For example, the term Group 3 heavy duty power wheelchair denotes that the PWC has Group 3 performance characteristics and patient weight handling capacity between 301 and 450 pounds. A device is not required to carry all the weight listed in the class of devices, but must have a patient weight capacity within the range to be included. For example, a PMD that has a weight capacity of 400 pounds is coded as a Heavy Duty device.

Performance Testing - Term used to denote the RESNA based test parameters used to test PMDs. The PMD is expected to meet or exceed the listed performance and durability figures for the category in which it is to be used when tested. There is no requirement to test the PMD with all possible accessories.

Portable - A category of devices with lightweight construction or ability to disassemble into lightweight components that allows easy placement into a vehicle for use in a distant location.

Positioning back cushion - a standard cushion customized to include materials or components that may be added, removed and or fabricated from commercially available components to help address orthopedic deformities or postural asymmetries. Included in this definition are cushions which have a planar surface but have positioning features within the cushion which are made of a firmer material than the surface material. In addition, the back cushion has the following characteristics:
(a) There is at least 25 mm of posterior contour in the pre-loaded state. A posterior contour is a backward curve measured from a vertical line in the midline of the cushion; and
(b) For posterior-lateral cushions and for planar cushions with lateral supports there is at least 75 mm of lateral contour in the pre-loaded state. A lateral contour is backward curve measured from a horizontal line connecting the lateral extensions of the cushion; and
(c) For posterior pelvic cushions there is mounting hardware that is adjustable for vertical position, depth, and angle, and
(d) It has a removable vapor permeable or waterproof cover or it has a waterproof surface; and
(e) The cushion and cover meet the minimum standards of the California Bulletin 117 or 133 for flame resistance; and
(f) It has a permanent label indicating the model and the manufacturer; and
(g) It has a warranty that provides for repair or full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 18 months.

**Positioning seat cushion** - May have materials or components that can be added or removed (customized) to help address orthopedic deformities or postural asymmetries and has the following characteristics listed in a or b and c and d:
(a) Two or more of the following features which must be at least 25 mm in height in the pre-loaded state. Included in this definition are cushions which have a planar surface but have positioning features within the cushion which are made of a firmer material than the surface material:
   • A pre-ischial bar or ridge (e.g., anti-thrust) which is placed anterior to the ischial tuberosities and prevents forward migration of the pelvis,
   • Two lateral pelvic supports which are placed posterior to the trochanters and are intended to maintain the pelvis in a centered position in the seat and/or provide lateral stability to the pelvis,
   • A medial thigh support (e.g., built-in pommel) which is placed in contact with the adductor region of the thigh and provides the prescribed amount of abduction and prevents adduction of the thighs,
   • Two lateral thigh supports which are placed anterior to the trochanters and provide lateral stability to the lower extremities and prevent unwanted abduction of the thighs; or
(b) Two or more air compartments located in areas which address postural asymmetries, each of which must have a cell height of at least 50 mm, must allow the user to add or remove air, and must have a valve which retains the desired air volume; and
(c) A permanent label indicating the model and the manufacturer; and
(d) A warranty that provides for repair or full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 18 months.
Power Mobility Device (PMD) - Base codes include both integral frame and modular construction type power wheelchairs (PWCs) and power operated vehicles (POVs).

Power Operated Vehicle - Chair-like battery powered mobility device for people with difficulty walking due to illness or disability, with integrated seating system, tiller steering, and four-wheel non-highway construction.

Power Options - Tilt, recline, elevating leg rests, seat elevators, or standing systems that may be added to a PWC to accommodate a patient's specific need for seating assistance.

Power Wheelchair - Chair-like battery powered mobility device for people with difficulty walking due to illness or disability, with integrated or modular seating system, electronic steering, and four or more wheel non-highway construction.

POV Basic Equipment Package - Each POV is to include all these items on initial issue (i.e., no separate billing/payment at the time of initial issue).

Proportional Control Input Device - A device that transforms a user's drive command (a physical action initiated by the wheelchair user) into a corresponding and comparative movement, both in direction and in speed, of the wheelchair. The input device shall be considered proportional if it allows for both a non-discrete directional command and a nondiscrete speed command from a single drive command movement.

Push-rim activated power assist – An option for a manual wheelchair in which sensors in specially designed wheels determine the force that is exerted by the patient on the wheel. Additional propulsive and/or braking force is then provided by motors in each wheel. Batteries are included.

PWC Basic Equipment Package - Each power wheelchair code is required to include all these items on initial issue (i.e., no separate billing/payment at the time of initial issue, unless otherwise noted).

Radius Pivot Turn – The distance required for the smallest turning radius of the PMD base. This measurement is equivalent to the “minimum turning radius” specified in the ANSI/RESNA bulletins.

Range - Minimum distance acceptable for a given category of devices on a single charge of the batteries. It is to be determined by the appropriate RESNA test for range.

Remotely Placed Controller - Non-expandable or expandable wheelchair control system where the joystick (or alternative control device) and the controller box are housed in separate locations. The joystick (or alternative
control device) is connected to the controller through a low power wire harness. The separate controller connects directly to the motors and batteries through a high power wire harness.

**Single Power Option** - A category of PWC with the capability to accept and operate a power tilt or power recline, but not a combination power tilt and recline seating system. It may be able to accommodate power elevating leg rests in combination with a power tilt or power recline. A PMD does not have to be able to accommodate all features to qualify for this code. For example, a power wheelchair that can only accommodate a power tilt could qualify for this code.

**Skin protection seat cushion** - a prefabricated cushion with a removable vapor permeable or waterproof cover or a waterproof surface; and a permanent label indicating the model and the manufacturer; and a warranty that provides for repair or full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 18 months.

**Sling Seat/Back** - Flexible cloth, vinyl, leather or equal material designed to serve as the support for buttocks or back of the user respectively. They may or may not have thin padding but are not intended to provide cushioning or positioning for the user.

**Solid seat insert** – used for a seat cushion, a separate rigid piece of plastic or other material which is inserted in the cover of a seat cushion to provide additional support. The seat cushion is then placed on top of a sling seat or mounted with hardware in place of a sling seat.

**Solid Seat/Back** - Rigid metal or plastic material usually covered with cloth, vinyl, leather or equal material, with or without some padding material designed to serve as the support for the buttocks or back of the user respectively. They may or may not have thin padding but are not intended to provide cushioning or positioning for the user. PWCs with an automotive-style back and a solid seat pan are considered as a solid seat/back system, not a Captains Chair.

**Solid seat support base** – Used to support a seat cushion, a rigid piece of plastic or other material which is included with a PWC base and pediatric seating or attached with hardware to the seat frame of a folding wheelchair in place of a sling seat. A seat cushion is placed on top of the solid support base.

**Speech Generating Device Software** - Programs used on a laptop computer, desktop computer, tablet, cell phone, or personal digital assistant (PDA) that enable the user to improve their communication to a functional level.

**Stadium Style Seat** - A one or two piece stadium-style seat with rigid frame and cushioning material in both seat and back sections, covered in cloth, vinyl,
leather or equal as upholstery, and designed to serve as a complete seating, support, and cushioning system for the user. It may have armrests that can be fixed, swingaway, or detachable. It will not have a headrest. Chairs with stadium style seats are billed using the Captains Chair codes.

**Standard** components are those components that are not made solely for one individual. They are prefabricated and readily available on the commercial market (off the shelf) and can be utilized by a variety of patients.

**Test Standards** - Performance and durability acceptance criteria defined by ANSI/RESNA standard testing protocols.

**Top End Speed** - Minimum speed acceptable for a given category of devices. It is to be determined by the RESNA test for maximum speed on a flat hard surface.

**Upper Extremity Support System/Wheelchair tray** – A flat surface across the abdominal area attached to a wheelchair at the armrests used to support proper positioning of upper extremities. Padded foam or foam like additions (i.e., protraction blocks, padding added to the flat surface) to a UESS are used to place the upper extremities in a protracted position to address strong spasticity or exaggerated muscle activity.
### Appendix A

**E2603FS #Skin protection wheelchair seat cushion, width less than 22 inches, any depth** (a)

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**E2603FS #Skin protection wheelchair seat cushion, width less than 22 inches, any depth** (b)

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**Durable Medical Equipment, Orthotics, Prosthetics and Supplies**  
**Procedure Codes and Coverage Guidelines**

**E2603**<sup>F5</sup> #Skin protection wheelchair seat cushion, width less than 22 inches, any depth (c)

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**E2605**<sup>F5</sup> #Positioning wheelchair seat cushion, width less than 22 inches, any depth (b)

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### E2613F5

**Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware (b)**

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### E2615F5

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