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DME Procedure Codes & Coverage Guidelines

New York State Medicaid, Durable Medical Equipment, Prosthetics, and Orthotics

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New York State Medicaid

Office of Health Insurance Programs
Department of Health

CONTACTS:

eMedNY URL
https://www.emedny.org/

ePACES Reference Guide

https://www.emedny.org/selfhelp/ePACES/PDFS/5010_ePACES_Professional_Real_Time_Claim_Reference_Guide.pdf

GDIT
(800) 343-9000
Billing Questions, Remittance Clarification, Request for Claim Forms, ePACES Enrollment, Electronic Claim Submission Support (eXchange, FTP), Provider Enrollment

Bureau of Medical Review
(800) 342-3005
OHIPMEDPA@health.ny.gov
Prior Approval; Policies and Procedures concerning Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies

All eMedNY Contact Information
eMedNY Contacts PDF

NYRx Medicaid Helpline
(800) 541-2831

Pharmacy Benefits and Coverage website
https://member.emedny.org/pharmacy/benefits

Coverage Guidelines

Durable Medical Equipment, Prosthetics, and Orthotics

NEW YORK STATE OF OPPORTUNITY. Department of Health

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Document Control Properties

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DMEPOS Policy Manual

The DMEPOS policy manual can be found on eMedNY.org which includes definitions, requirements for participation in Medicaid, and basis of payment for services provided.

https://www.emedny.org/ProviderManuals/DME/PDFS/DME_Policy_Section.pdf

3.0 NEW FOR OCTOBER 2025

Procedure Codes

Please note the following changes to the Procedure Codes section of the Durable Medical Equipment, Prosthetics, Orthotics and Supplies manual.

New Code	Description	Fee
A6519[F7]	Gradient compression garment, not otherwise specified, for nighttime use, each (e.g. TributeNight, CircAid Night)	Cost+51%
E0766[F9]	Electrical stimulation device used for cancer treatment, includes all accessories, any type	$10,980.88
E1032[F6]	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware used with joystick or other drive control interface	Cost+51%
E1033[F5]	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for headrest, cushioned, any type	Cost+51%
E1034[F5]	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for lateral trunk or hip support, any type	Cost+51%
L0720[F4]	#Cervical-thoracic-lumbar-sacral-orthoses (ctlso), anterior-posterior-lateral control, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise	$1,763.94
L6028[F3]	Partial hand including fingers, flexible or non-flexible interface, endoskeletal system, molded to patient model, for use without external power, not including inserts described by l6692	Cost+51%
L6029[F3]	Upper extremity addition, test socket/interface, partial hand including fingers	Cost+51%

L6030[F3]	Upper extremity addition, external frame, partial hand including fingers	Cost+51%
L6031[F3]	Replacement socket/interface, partial hand including fingers, molded to patient model, for use with or without external power	Cost+51%
L6032[F3]	Addition to upper extremity prosthesis, partial hand including fingers, ultralight material (titanium, carbon fiber or equal)	Cost+51%
L6033[F3]	Addition to upper extremity prosthesis, partial hand including fingers, acrylic material	Cost+51%
L6700[F3]	Upper extremity addition, external powered feature, myoelectronic control module, additional emg inputs, pattern-recognition decoding intent movement	$23,145.25
L7406[F4]	#Addition to upper extremity, user adjustable, mechanical, residual limb volume management system	$2,470.64

Deleted Code	Description	Reason
L8010	#Breast prosthesis, mastectomy sleeve	CMS discontinued code on 4/1/2025

Description Change

A6549	Gradient compression garment, not otherwise specified, for daytime use, each
A6583	Gradient compression wrap with adjustable straps, below knee, each
A6585	Gradient compression wrap with adjustable straps, above knee, each
A6586	Gradient compression wrap with adjustable straps, full leg, each
A6587	Gradient compression wrap with adjustable straps, foot, each
A6588	Gradient compression wrap with adjustable straps, arm, each
E1028	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware, other

Criteria/Guidelines

Please note the following changes to the Criteria/Guidelines section of the Durable Medical Equipment, Prosthetics, Orthotics and Supplies manual.

Code or Category	Description
Compression Supports	Change to criteria for Compression Support codes A6519-A6610
A6584	Addition of (e.g. custom fabricated wraps) to end of description
E0955	Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each
E1028	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware, other
E0784	External ambulatory infusion pump, insulin Change in coverage guideline language regarding Omnipod

Frequency/Quantity

Please note the following changes to the frequency listed on the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule.

Code	Previous Frequency/Quantity	New Frequency/Quantity
L2820	1 unit	2 units
L1920, L2230, L2240, L2250, L2260, L2265, L2795, L2800, L2810, L2820, L2830, L2999, L3908, L3925, L3927,	once/year (F6)	twice/year (F7)

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L4070, L4080, L4090, L4100, L4110, L4396, L4398		
L1902	four/yr (F22)/Qty 1	once/5yrs (F3)/Qty 2
L1951	once/3 years (F4)	once/year (F6)
L2035	once/3 years (F4)	once/2 years (F5)
L1904, L2387, L2768, L2780, L2785, L3806, L3808, L3891, L3913, L3915, L3919, L3921, L3933	All once/3 years (F4) except L1904 twice/lifetime (F2)	twice/3 years (F19)
L3807, L3809, L3923	once/6 months (F16)	two/6 months (F21)
L5683	once/year (F6)	once/3 years (F4)
L7367	twice/year (F7)	once/year (F6)

Change of Service Area

Code/Description	Previous Service Area	New Service Area
A9999 Miscellaneous DME supply or accessory, not otherwise specified	C-Orthotics and Prosthetics	E-DME

Change in Authorization Type

Code	Previous Auth Type	New Auth Type
A4632	Prior Approval	Direct Bill (By Report, BR)
A9282, E0651, E0784, E1002, E2313, E2326, E2374, E2375 E2377, E2621, K0056, L3671, L3674, L3961, L3971, L3973, L3975, L3976, L3977, L3978, L6621, L6624, L6638, L6711, L6712, L6713, L6714, L6715, L6721, L6722, L6883, L6884 L6885	Prior Approval	DVS
E0958, E1029, E1225, E1298, E2341, E2342, E2343, L1001, L3677, L6693	Prior Approval	DVS, BR (BR=By Report, Claims will pend for pricing)

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4.0 General Information and Instructions

Fees

Fees are published in the Fee Schedule section of the DME Manual located at https://www.emedny.org/ProviderManuals/DME/

Standards

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.

Federal Law

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

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 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.

Brand Names

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.

Modifiers

The following modifiers should be added to the five-character Healthcare Common Procedure Coding System (HCPCS) code when appropriate.

'-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 twice 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.

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	- '-RB' is not to be billed in combination with A9900, L4210 or L7510 for repair or replacement of the same device. - 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 25% of the price listed on the code for the device. ➢ For charges $35.00 and under use L4210 or L7510. - 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 25% of the price listed on the code for the device. ➢ If the charge is greater than 25% 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

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	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 of Patient Owned Equipment	- Is required when billing for repairs to patient owned equipment when the member is in a hospital or skilled nursing facility.

Quantity
The max units listed on the DME Fee Schedule is the maximum allowed according to the frequency limitations set for that code (see below). If the fiscal order exceeds this amount, the provider must obtain prior approval.

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:

F1=once/lifetime	F2-twice/lifetime	F3=once/5years	F4=once/3 years
F5=once/2 years	F6=once/year	F7=twice/year	F8=three/2 months
F9=once/month	F10=twice/month	F11=four/month	F12=once/day
F13=once/3 months	F14=four/lifetime	F15=six/lifetime	F16=once/6 months
F17=twelve/lifetime	F18=three/lifetime	F19=twice/3years	F20=two/2 years
F21=two/6 months	F22=four/year	F23=six/2 years	F24=eight/year
F25=eight/lifetime	F26=continuous monthly rental	F27=once/week	

Dispensing
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, 4.2, 4.3 Medical Supplies, Enteral Therapy, Hearing Aid Battery

Please see separate Medical Supply Procedure Code manual:
https://www.emedny.org/ProviderManuals/DME/PDFS/MedicalSupply_Procedure_Codes.pdf

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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 can accommodate/support 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.
- Requests for special needs beds that do not meet the hospital bed code descriptions (below), should be submitted for prior approval using miscellaneous code E1399. Please see criteria for Special Needs Bed under code E1399.

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 can accommodate/support 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

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	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 affect 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** 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)** Coverage Criteria: A heavy duty extra wide (E0301) hospital bed is covered if the member meets one of the criteria 1-4 above and: 8. 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** Coverage Criteria: An extra heavy-duty hospital bed (E0302) is covered if the member meets one of the criteria 1-4 above and:

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	9. The member's weight exceeds 600 pounds.
E0328[F3] '-RR'	**#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 twin-size 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.
E0271[F5] '-RR'	**#Mattress, inner spring**
E0272[F5] '-RR'	**#Mattress, foam rubber**
E0274[F3]	**#Over-bed table**
E0305[F5]	**#Bedside rails, half-length (telescoping per pair, replacement only)**
E0310[F5]	**#Bedside rails, full-length (telescoping per pair, replacement only)**

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E0316[F3] '-RR'	**Safety enclosure frame/canopy for use with hospital bed, any type** (includes top) Coverage Criteria: A hospital bed safety enclosure frame/canopy is covered when criteria 10-13 are met, and 14-16 below: 14. The member should be evaluated by a qualified practitioner (PT/OT/MD) who has specific training and/or experience in the ordering of complex durable medical equipment and/or enclosed bed evaluation and ordering. The evaluation and/or letter of medical necessity should include at minimum: • height and weight; • medical history; • current functional status; • upper and lower extremity range of motion and strength; • cognitive status; • skin integrity; • transfer status; • ambulation; • bed mobility, including specifically how it results in risk for safety in bed that cannot be accommodated by an enclosed pediatric manual hospital bed (E0328); • Any additional information that supports the medical need for the bed; and 15. A written monitoring plan approved by the ordering and all treating practitioners has been completed which at minimum describes: • when the bed will be used; • how the member will be monitored at specified time intervals; • how 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 • a statement confirming that the requested bed system will not be used as a restraint 16. For members residing in an OMRDD certified residence, approval as a restraint with the agency's Human Rights Committee (if applicable).

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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
  4. Compromised circulatory status

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[F6]	#Replacement pad for use with medically necessary alternating pressure pad owned by patient
E0181[F3]	#Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty
E0182[F3]	#Pump for alternating pressure pad, for replacement only
E0184[F6] '-RR'	#Dry pressure mattress
E0185[F6]	#Gel or gel-like pressure pad for mattress, standard mattress length and width
E0186[F6] '-RR'	#Air pressure mattress
E0187[F6] '-RR'	#Water pressure mattress
E0190[F5]	#Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories

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E0193[F2] '-RR-'	#Powered air flotation bed (low air loss therapy)
E0196[F6] '-RR'	#Gel pressure mattress
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] '-RR-'	Power pressure reducing air mattress
E0371[F2] '-RR'	#Non-powered advance pressure reducing overlay for mattress, standard mattress length and width
E0372[F2] '-RR'	#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 members 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

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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. Members 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.

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- 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)
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
A7029[F7]	#Nasal pillows for combination oral/nasal mask, replacement only, pair
A7030[F6]	#Full face mask used with positive airway pressure device, each
A7031[F7]	#Face mask interface, replacement for full face mask, each
A7032[F7]	#Cushion for use on nasal mask interface, replacement only, each
A7033[F7]	#Pillow for use on nasal cannula type interface, replacement only, pair
A7034[F6]	#Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap
A7035[F7]	#Headgear used with positive airway pressure device
A7036[F7]	#Chinstrap used with positive airway pressure device
A7037[F7]	#Tubing used with positive airway pressure device
A7038[F9]	Filter, disposable, used with positive airway pressure device, each
A7039[F21]	Filter, non-disposable, used with positive airway pressure device, each
A7044[F6]	#Oral interface used with positive airway pressure device, each
A7045[F7]	#Exhalation port with or without swivel used with accessories for positive airway devices, replacement only

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E0445[F3] '-RR'	**Oximeter device for measuring blood oxygen levels non-invasively** 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.
A4606[F6]	**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[F26]	#Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
E0466[F26]	#Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)
E0467[F26]	#Home ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions
E0468[F26]	#Home ventilator, dual-function respiratory device, also performs additional function of cough stimulation, includes all accessories, components and supplies for all functions

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 back-up equipment as needed.

Guidelines:

1. Ventilators (E0465, E0466, E0467, and E0468) are covered for the following conditions as supported by documentation in the member's medical record:
    - Neuromuscular disorder/disease
    - Thoracic restrictive disorder/disease
    - Chronic respiratory failure
2. The following information must be in the member's medical record and available on request:
    - The underlying medical condition requiring ventilator support.
    - The need for the ventilator must be documented by the ordering medical professional. Frequency of use and ventilator settings must be on the fiscal order.
3. Home ventilators are:
    - Not covered when used to function as a CPAP (E0601) or bi-level PAP (E0470, E0471).

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- If the ventilator is only intended for use in CPAP or BiPAP mode, the ordering provider is responsible to order the appropriate equipment and the equipment provider is responsible to dispense the appropriate equipment.
- E0465, E0466, and BiPAP ST devices (E0471 and E0472) are not to be billed in combination,

4. Only one ventilator code will be reimbursable per rental month.
5. Billing providers are responsible to maintain documentation that the member meets coverage criteria.
6. The following therapies/supplies/equipment are included in the functionality of code E0467 and will not be separately reimbursable:
   - Ventilators (HCPCS codes E0465, E0466, E0468)
   - Oxygen and oxygen equipment
   - Nebulizers and related accessories
   - Aspirator and related accessories
   - Cough Stimulator and related accessories
   - Mechanical Insufflation-Exsufflation devices and related accessories
   - High Frequency Chest Wall Oscillation devices and related accessories
   - Oscillatory positive expiratory pressure device and related accessories

Coverage Criteria for E0467:

Members must meet the following criteria:

- Member must require ventilator and one of the following covered therapies: cough stimulator, oxygen, suction pump, nebulizer.

7. The following therapies/supplies/equipment are included in the functionality of code E0468 and will not be separately reimbursable:
   - Ventilators (HCPCS codes E0465, E0466, E0467)
   - Cough Stimulator and related accessories
   - Oxygen and oxygen equipment
   - Mechanical Insufflation-Exsufflation devices and related accessories
   - High Frequency Chest Wall Oscillation devices and related accessories
   - Oscillatory positive expiratory pressure device and related accessories

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Coverage Criteria for E0468:

Members must meet the following criteria:

- Member must require a ventilator and a cough stimulator.

Positive Airway Pressure Devices (PAP)

Positive Airway Pressure (PAP) Devices are for the treatment of Obstructive Sleep Apnea. The term PAP (positive airway pressure) devices refers to both a single-level continuous positive airway pressure device (E0601) and a bi-level respiratory assist device without back-up rate (E0470) when it is used in the treatment of obstructive sleep apnea.

E0601[F3] '-RR'	#Continuous positive airway pressure (CPAP) device
E0470[F3] '-RR'	#Respiratory assist device, bi-level pressure capability without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)

Coverage Guidelines:

CPAP (E0601) is covered for treatment of Obstructive Sleep Apnea (OSA) if the following criteria are met:

- The member must have a diagnosis of OSA documented by an attended, facility-based, as defined by Medicare polysomnogram OR a home sleep apnea test (HSAT) for members who meet the coverage criteria for HSAT (see the August 2024 Medicaid Update for HSAT criteria) AND meet the following additional 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:

  a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia or,

  b. Hypertension, ischemic heart disease, or history of stroke.

CPAP Replacement (E0601)

If a CPAP device is replaced prior to or following the 5-year useful life, there must be an in-person evaluation by the treating practitioner that documents that the member continues to use and benefit from the CPAP device.
The following documentation must be submitted with the prior approval request:

- Face-to-face clinical reevaluation by the treating practitioner with documentation that symptoms of obstructive sleep apnea have improved or stabilized; and

- Objective evidence of member compliance with use of the CPAP device, including but not limited to, compliance graph printouts. Adherence to therapy is defined as use of CPAP four (4) or more hours per night on at least 70% of nights during a consecutive thirty (30) day period anytime within the last 6 months of usage prior to submitting for a replacement E0601 or E0470.

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BIPAP (E0470) will be covered for members with a diagnosis of OSA who have failed a facility-based therapeutic trial of a single level positive airway pressure device (CPAP).

Positive Airway Pressure (PAP) devices can either be purchased or rented as a 10-month capped rental. If the member has a primary payor, the provider must submit an EOB from the primary payor according to Medicaid billing guidelines.

RESPIRATORY ASSIST DEVICES

- BiPAP: E0470
- BiPAP ST: E0471 and E0472

A Respiratory Assist Device (RAD) is covered for those members with one of the following clinical disorders: restrictive thoracic disorders (i.e., neuromuscular diseases or severe thoracic cage abnormalities), severe chronic obstructive pulmonary disease (COPD), CSA or CompSA (Complex sleep apnea), or hypoventilation syndrome.

E0471[F26]	#Respiratory assist device, bi-level pressure capability, with backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) (BiPAP ST)
E0472[F26]	#Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device) (BiPAP ST)

Airway Clearance Devices

E0480, E0481, E0482, E0483
Requests for Airway Clearance Devices must have the following information documented in the member's medical record and be available upon request:

- The underlying medical condition(s) causing the accumulation of pulmonary secretions and the specific diagnosis supporting such equipment (e.g., neuromuscular disease(s); chronic pulmonary disease, bronchiectasis, cystic fibrosis).
- The need for the requested equipment and the treatment plan, with frequency of use and settings included on the fiscal order.
- The training given to the member or caregiver on the use of the equipment.

E0480[F3] '-RR'	#Percussor, electric or pneumatic, home model
E0481[F9]	#Intrapulmonary percussive ventilation system and related accessories Purchase price reached at 720 days (24 months)
E0482[F9]	#Cough stimulating device, alternating positive and negative airway pressure (manual or automatic) Purchase price reached at 720 days (24 months)

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E0483[F9]	#High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each Purchase price reached at 720 days (24 months)
E0484[F6]	#Oscillatory positive expiratory pressure device, non-electric, any type, each (one per year)
A7020[F9]	Interface for cough stimulating device, includes all components, replacement only
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
A7046[F7]	Water chamber for humidifier, used with positive airway pressure device, replacement, 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
E0562[F3] '-RR'	#Humidifier, heated, used with positive airway pressure device
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
E0890[F3]	Traction frame, attached to footboard, pelvic traction

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E0900[F3]	Traction stand, free standing, pelvic traction (e.g., Buck's)
E0910[F3] *'-RR'*	#Trapeze bars, also known as Patient Helper, attached to bed, with grab bar
E0911[F3] *'-RR'*	#Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar
E0912[F3] *'-RR'*	#Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar
E0940[F3] *'-RR'*	#Trapeze bar, free standing, complete with grab bar
E0946[F3] *'-RR'*	#Fracture, frame, dual with cross bars, attached to bed (e.g. Balken, Four Poster)

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 is 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 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.

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	- 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, ADLs, 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.
E0141[F2]	#Walker, rigid, wheeled, adjustable or fixed height
E0143[F4]	#Walker, folding, wheeled, adjustable or fixed height
E0144[F3]	#Walker, enclosed, four sided framed, rigid or folding, wheeled with posterior seat - Provides safety and promotes unassisted walking. - May include brake and/or variable resistance wheels. - For an adult or child who requires enclosure and seat due to motor and balance dysfunction.
E0147[F3]	#Walker, heavy duty, multiple braking system, variable wheel resistance
E0148[F3]	#Walker, heavy duty, without wheels, rigid or folding, any type, each
E0149[F3]	#Walker, heavy duty, wheeled, rigid or folding, any type
E0153[F7]	#Platform attachment, forearm crutch, each (supports arm)

E0154[F7]	#Platform attachment, walker, each (supports arm)
E0155[F7]	#Wheel attachment, rigid pick-up walker, per pair
E0156[F4]	#Seat attachment, walker
E0157[F7]	#Crutch attachment, walker, each
E0159[F7]	#Brake attachment for wheeled walker, replacement, each

Pediatric Gait Trainers

- 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 is 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.

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3. The member's functional and physical assessment including strength, range of motion, tone, sensation, balance, ADLs, 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.

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

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.
- 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.

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- 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 one 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/or community.

Note: Medicaid funds and maintains one medically necessary manual mobility device to meet the member's medical needs whether primarily used in the home, community, or as a back-up to the primary PWC.

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 members, 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.

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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 POV/scooter?
   a) A covered POV 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 POV.
   c) Assess the member's ability to safely use a POV/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 POV are typically controlled 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 for a **flow chart developed by the Medicare program** that visually describes the clinical criteria for the evaluation and ordering of WME.

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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).

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- 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 of 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.

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- 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 members 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 MWC, 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. The evaluation should also include a description of the secure storage space in the member's home for the wheeled mobility device. Whether the WME is approved for the home and/or community, the WME provided must have an accessible secure storage space in the home. A written report of this evaluation should be 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 1-5 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 using an appropriately fitted cane or walker, and
3. The manual wheelchair supplied to the member for use in the home and/or community settings provides adequate access to these settings (e.g., between rooms, in and out of the home, transportation and over surfaces), 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,

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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[F3]	#Manual adult size wheelchair, includes tilt-in-space
E1229[F3]	Wheelchair, pediatric size, not otherwise specified
E1233[F3]	#Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system (E2231 solid seat included)
E1234[F3]	#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, 14-19" 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.

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E1236[F3]	**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 environment. 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[F4] '-RR'	**#Standard wheelchair** A standard wheelchair is covered when: (a) The member can self-propel the wheelchair, or (b) Propel 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

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	(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 self-propel the wheelchair independently and functionally, 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. **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).
K0006[F3] '-RR'	#Heavy-duty wheelchair A heavy-duty wheelchair is covered when: (a) The member weighs more than 250 pounds, or (b) The member has severe spasticity, or (c) 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: (a) The member weighs more than 300 pounds, or (b) 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[F3]	Other manual wheelchair/base This code is to be used for members 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.

Back-up Manual Wheelchair

Back-up manual wheelchairs are covered when:

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

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If the SPC is integrated into the primary power wheelchair and cannot be removed or transferred with appropriate hardware, Medicaid would consider secondary seating for the back-up manual wheelchair. Documentation for the secondary seating must include:

- the make/model of the power wheelchair; AND
- make/model of the seating system that cannot be transferred; AND
- documentation from the power wheelchair manufacturer that the seating cannot be removed.

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:

- the member meets the criteria for wheeled mobility, and
- the wheelchair is an appropriate size for the member, and
- the member meets the criteria for recline and positioning options, and
- the wheelchair provides growth capability in width and length.

IV. Powered Mobility Devices (PMD)

Are covered when:

- Criterion 1-3 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 using 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 the basic coverage criteria (1-3) for PMDs have been met and if criteria (4-9) are also met.

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4. The member can:
   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, adequate maneuvering space, 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 MRADLs, 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.)

Repairs to a POV:

- Base codes for POVs includes all accessories, parts and seating. Power 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 K0800 RB unless the repair is less than 25% of the base code's MRA. Less than 25% of the base code can be directly billed twice per year.

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

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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 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/or community environments provide adequate access between rooms, in and out of the home, maneuvering space and over surfaces 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

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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:
    a. For Standard Duty, seat width and/or depth greater than 20 inches,
    b. For Heavy Duty, back width greater than 22 inches,
    c. For Very Heavy Duty, back width greater than 24 inches,
    d. 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:
    a. For Standard Duty, back width greater than 20 inches,
    b. For Heavy Duty, seat width and/or depth greater than 22 inches,
    c. For Very Heavy Duty, seat width and/or greater than 24 inches,
    d. 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.

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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 captain's 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

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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
K0827[F3]	Power wheelchair, group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds
K0828[F3]	Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more
K0829[F3]	Power wheelchair, group 2 extra heavy duty, captains chair, patient weight 601 pounds or more

Single Power Option

Covered if all 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.

K0835[F3]	Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0836[F3]	Power wheelchair, group 2 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds
K0837[F3]	Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0838[F3]	Power wheelchair, group 2 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds
K0839[F3]	Power wheelchair, group 2 very heavy duty, single power option sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0840[F3]	Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more

Multiple Power Options

Covered if all 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.

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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[F3]	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 captain's chairs).

No Power Options

Covered if all 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

Single Power Options

Covered if all 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.

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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[F3]	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0857[F3]	Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds
K0858[F3]	Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds
K0859[F3]	Power wheelchair, group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds
K0860[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 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[F3]	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0862[F3]	Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0863[F3]	Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0864[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

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2. The minimum range, top end speed, obstacle climb or dynamic stability incline that is medically necessary for the patient engaging in frequent MRADLs 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).

K0868[F3]	Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0869[F3]	Power wheelchair, group 4 standard, captains chair, patient weight capacity up to and including 300 pounds
K0870[F3]	Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0871[F3]	Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds

Single Power Options

Covered if all 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.

K0877[F3]	Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0878[F3]	Power wheelchair, group 4 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds
K0879[F3]	Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0880[F3]	Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds

Multiple Power Options

Covered if all 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.

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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, captains 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.

K0891[F3]	Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds

Group 6 PWC Miscellaneous Code

K0898[F3]	Power wheelchair, not otherwise classified

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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.
- 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.

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- Coverage of flat free, zero pressure and foam filled tires is limited to members who are independent in mobility or whose medical conditions indicate such tires.

Codes, Descriptions, and Code Specific Criteria

E0944[F7]	#Pelvic belt/harness/boot (limited to wheelchair 4-point padded belt)
E0950[F3]	#Wheelchair accessory, tray, each (upper extremity support surface for positioning only) - 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.
E0951[F6]	#Heel loop/holder, any type, with or without ankle strap, each
E0952[F6]	#Toe loop/holder, any type, each
E0953[F5]	#Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware, each
E0954[F5]	#Wheelchair accessory, foot box, any type, includes attachment and mounting hardware, each foot (Includes padding. If dispensing a double-leg or full size footbox, obtain an authorization for quantity of 2.)
E0955[F5]	#Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, 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.
E0956[F5]	#Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each (up to 4 supports/prompts)
E0957[F5]	#Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each
E0958[F5]	#Manual wheelchair accessory, one-arm drive attachment, each
E0959[F5]	#Manual wheelchair accessory, adapter for amputee, each
E0960[F7]	#Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware (includes padding and strap guides)
E0961[F5]	#Manual wheelchair accessory, wheel lock brake extension (handle), each
E0966[F5]	#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.

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E0967[F3]	#Manual wheelchair accessory, hand rim with projections, any type, replacement only, each
E0971[F7]	#Manual wheelchair accessory, anti-tipping device, each
E0973[F5]	#Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each
E0974[F5]	#Manual wheelchair accessory, anti-rollback device, each
E0978[F7]	#Wheelchair accessory, positioning belt/safety belt/pelvic strap, each (includes padding)
E0986[F3]	Manual wheelchair accessory, push rim activated power assist system

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[F5] '-RR'	#Wheelchair accessory, elevating leg rest, complete assembly, each
E0992[F6]	#Manual wheelchair accessory, solid seat insert
E0995[F6]	#Wheelchair accessory, calf rest/pad, replacement only, each
E1002[F3]	#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.

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E1003[F3]	**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 operate the provided power recline feature safely and independently.
E1004[F3]	**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 operate the provided power recline feature safely and independently.
E1005[F3]	**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[F3]	**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[F3]	**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[F3]	**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[F3]	**Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including push rod and leg rest, each**
E1010[F3]	**Wheelchair Accessory, addition to power seating system, power leg elevation system, including leg rest, pair**
E1011[F3]	**Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair)**
E1012[F3]	**Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each**

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E1014[F3] '-RR'	#Reclining back, addition to pediatric size wheelchair
E1020[F3]	#Residual limb support system for wheelchair, any type (with adjustable drop hooks)
E1028[F3]	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware, other If swing away or flip-down hardware is being added to a new accessory and is found to be medically necessary, it will be reimbursed at invoice cost in addition to the reimbursement for the accessory. Swing away and/or flip-down hardware for wheelchair positioning supports is considered medically necessary when: - It is the least costly option that allows the member to manage the hardware themselves (without caregiver assistance) to facilitate independent transfers and; - Less costly mounting hardware (i.e. fixed, removeable, and/or quick release hardware) for positioning supports does not meet the member's positioning and/or transfer needs. Note: Swing away and/or flip-down hardware is not considered a medical necessity if it is intended for caregiver convenience or to prevent loss of positioning devices.
E1029[F3]	#Wheelchair accessory, ventilator tray, fixed
E1032[F6]	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware used with joystick or other drive control interface (replacement only) If manual swingaway, retractable or removable mounting hardware is being added to a new joystick and is found to be medically necessary, it will be reimbursed at invoice cost in addition to the reimbursement for the joystick
E1033[F5]	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for headrest, cushioned, any type If manual swingaway, retractable or removable mounting hardware is being added to a new headrest and is found to be medically necessary, it will be reimbursed at invoice cost in addition to the reimbursement for the headrest
E1034[F5]	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for lateral trunk or hip support, any type If manual swingaway, retractable or removable mounting hardware is being added to a new lateral trunk or hip support and is found to be medically necessary, it will be reimbursed at invoice cost in addition to the reimbursement for the lateral trunk or hip support
E1225[F3]	#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 4. The member has a plan of care that requires a recline position to complete Mobility Related Activities of Daily Living (MRADLs), and 5. 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.

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E1226[F3] '-RR'	#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 4. The member has a plan of care that requires a recline position to complete Mobility Related Activities of Daily Living (MRADLs), and 5. 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 to 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- angle 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[F6]	#Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, replacement only, each
E2221[F6]	#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
E2226[F6]	#Manual wheelchair accessory, caster fork, any size, replacement only, each

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E2231[F3]	#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 chairs 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.
E2291[F3]	#Back, planar, for pediatric size wheelchair including fixed attaching hardware Pediatric sized chairs have seat depths and widths less than 16 inches
E2292[F3]	#Seat, planar, for pediatric size wheelchair including fixed attaching hardware Pediatric sized chairs have seat depths and widths less than 16 inches
E2298[F3]	Complex rehabilitative power wheelchair accessory, power seat elevation system, any type Coverage Criteria: - E2298 can only be used on K0835- K0898 complex power wheelchair bases. - In rare circumstances, if power seat elevation needs to be added to a non-complex rehabilitative power wheelchair K0822-K0829 (no power option), K0108 should be used. Invoice is required for cost+51% pricing, however, cost+51% pricing will not exceed the fee listed on the DMEPOS Fee Schedule for E2298. - The member meets criterion 1-3 of the Powered Mobility Device coverage criteria, and - The member has demonstrated the mental and physical abilities to safely and independently operate the power seat function that is requested; AND - Selection of the power seat elevator system is not based solely on caregiver convenience but on medical need of the member. - 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.
E2301[F3]	Wheelchair accessory, power standing system, any type (includes all medically necessary supports and accessories)

Power Standing System

General Criteria (must meet all the following):

1. Wheelchair evaluation, written LOMN, and recommendations are made by a physician, physical or occupational therapist that has experience in complex rehab wheelchair prescription.

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2. Member has a set, recommended standing program prescribed by a physician.
3. Member does not have a caregiver available for all waking hours.
4. Member must have adequate cognition to know when to use the power standing feature, how to operate it, and good safety awareness.
5. Member cannot access a static home standing system, when necessary, with or without assistance. Documentation must include that the member has tried more cost-effective alternatives, and still requires a power wheelchair with power standing feature.
6. The member does not have orthostatic hypotension, postural tachycardia syndrome, osteogenesis imperfecta (or similar diagnoses), or hip or knee flexion contractures of more than 45°.
7. Provision of the requested power standing feature would decrease the necessity for caregivers.

Guidelines

When requesting a standing power wheelchair, the following guidelines should be considered:

- Member does not have ROM limitations, tonal abnormalities, or strength limitations that would make ADLs unsafe to complete in customary locations in the home and/or community (ADLs include dining, personal hygiene tasks and activities specified in a medical treatment plan).
- Member meets all established criteria for power seat elevation (E2300) and static home standing systems (E0637-E0641).
- Member is independent with managing associated chest and knee supports.
- Documented history of bone loss (limited to adults).
- The alignment of the member's lower extremities is such that they can tolerate a standing or upright position and the member has recently trialed and effectively utilized a static stander with no history of adverse physiological responses.
- The member has evidence-based reasons and documented clinical justification for why a power assisted standing component will meet the member's medical needs and why a
- static stander, tilt table, or other therapeutic interventions cannot meet those medical needs.
- Member is at high risk for lower extremity contractures with thorough explanation of why they cannot be appropriately managed by other treatment modalities (i.e. stretching, active therapy, orthotics, home programs, etc.) or use of a static stander.
- The member does not have, and it is not anticipated they will require, a walker or gait trainer.

Documentation requirements:

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1. Fiscal order from a qualified provider (physician, nurse practitioner, physician's assistant) for a power standing component on a power wheelchair.

2. Letter of medical necessity (LOMN) that includes:
   a) Comprehensive history and physical exam by a qualified provider.
   b) Summary of the existing medical condition, age at diagnosis, prognosis, and co-morbid conditions.
   c) Wheelchair evaluation, performed by a physiatrist, physical or occupational therapist that has experience in complex rehab wheelchair prescription.
   d) Thorough description of the member's functional and physical assessment including strength, range of motion (ROM), tone, sensation, balance, ADLs, and functional status.
   e) Documentation of trial of less costly alternatives (include make and model of alternatives tried as well as the length of the trial and results with each alternative) and why they do not meet the members current needs.
   f) Home therapy plan outlining the planned use of the requested standing feature.
   g) Documentation regarding the level of caregiver assistance available/needed on a daily basis, including a tentative schedule.
   h) Itemized list of all current DME (including, but not limited to, standers, wheelchairs, any transfer devices, etc.) owned, rented, or borrowed.

E2310[F3]	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
E2311[F3]	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
E2312[F6]	Power wheelchair accessory, hand or chin control interface, mini proportional remote joystick, proportional, including fixed mounting hardware
E2313[F6]	#Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each
E2323[F5]	#Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated
E2324[F6]	#Power wheelchair accessory, chin cup for chin control interface
E2325[F3]	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)
E2326[F3]	#Power wheelchair accessory, breath tube kit for sip and puff interface
E2327[F3]	Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware (includes enhanced visual display)

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E2328[F3]	Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware (includes enhanced visual display)
E2329[F3]	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)
E2330[F3]	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)
E2340[F3]	#Power wheelchair accessory, nonstandard seat frame width, 20-23 inches (for 21"-23" only, 20" included in base)
E2341[F3]	#Power wheelchair accessory, nonstandard seat frame width, 24-27 inches
E2342[F3]	#Power wheelchair accessory, nonstandard seat frame depth, 20-21 inches
E2343[F3]	#Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches
E2358[F6]	Power Wheelchair accessory, Group 34 non-sealed lead acid battery, each (replacement only)
E2359[F6]	Power Wheelchair accessory, Group 34 sealed lead acid battery, each (e.g. Gel Cell, Absorbed glassmat) (replacement only)
E2360[F6]	Power wheelchair accessory, 22 NF non-sealed lead acid battery, each (replacement only)
E2361[F6]	Power wheelchair accessory, 22 NF sealed lead acid battery, each, (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

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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
E2385[F6]	#Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each
E2386[F6]	#Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each
E2387[F6]	#Power wheelchair accessory, foam filled caster tire, any size, replacement only, each
E2388[F6]	#Power wheelchair accessory, foam drive wheel tire, any size, replacement only, each
E2389[F6]	#Power wheelchair accessory, foam caster tire, any size, replacement only, each
E2390[F6]	#Power wheelchair accessory, solid (rubber/plastic) drive wheel tire, any size, replacement only, each
E2391[F6]	#Power wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each
E2392[F6]	#Power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each
E2394[F6]	#Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each
E2395[F6]	#Power wheelchair accessory, caster wheel excludes tire, any size, replacement only, each
E2396[F6]	#Power wheelchair accessory, caster fork, any size, replacement only, each
E2398[F3]	Wheelchair accessory, dynamic positioning hardware for back Covered when: 1. the member has moderate to severe hypertonicity, or 2. has a documented history of rocking, shaking or other movements related to behavior and/or increased muscle tone, and 3. there is documented evidence of frequent backrest, back canes, or wheelchair frame repairs as a result of the member's behaviors and tone.
E2601[F5]	#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.

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E2602[F5]	#General use wheelchair seat cushion, width 22 inches or greater, any depth See coverage criteria for E2601
E2603[F5]	#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 daily. e) Documentation of malnutrition (past and present).
E2604[F5]	#Skin protection wheelchair seat cushion, width 22 inches or greater, any depth See coverage criteria for E2603
E2605[F5]	#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[F5]	#Positioning wheelchair seat cushion, width 22 inches or greater, any depth See coverage criteria for E2605
E2607[F5]	#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[F5]	#Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth See coverage criteria for E2607
E2609[F5]	Custom fabricated wheelchair seat cushion, any size (pediatric or adult)

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	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[F5]	#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[F5]	#General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware See coverage criteria for E2611
E2613[F5]	#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: a) Significant postural asymmetries that are due to, but not limited to, one of the diagnoses listed 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)
E2614[F5]	#Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware See coverage criteria for E2613
E2615[F5]	#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: a) Significant postural asymmetries that are due to, but not limited to, one of the diagnoses listed 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)
E2616[F5]	#Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware See coverage criteria for E2615

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E2617[F5]	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[F20]	#Replacement cover for wheelchair seat cushion or back cushion, each
E2620[F5]	#Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware
E2621[F5]	#Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware
E2622[F5]	#Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth See coverage criteria for E2603
E2623[F5]	#Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth See coverage criteria for E2603
E2624[F5]	#Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth See coverage criteria for E2607
E2625[F5]	#Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth See coverage criteria for E2607
E2626[F3]	#Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable
E2627[F3]	#Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable rancho type
E2628[F3]	#Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, reclining
E2629[F3]	#Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints)
E2630[F3]	#Wheelchair accessory, shoulder elbow, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support
E2631[F3]	#Wheelchair accessory, addition to mobile arm support, elevating proximal arm
E2632[F3]	#Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control
E2633[F3]	#Wheelchair accessory, addition to mobile arm support, supinator
K0015[F4]	#Detachable, nonadjustable height armrest, each
K0017[F3]	#Detachable, adjustable height armrest, base, replacement only, each
K0018[F3]	#Detachable, adjustable height armrest, upper portion, replacement only, each
K0019[F7]	#Arm pad, replacement only, each
K0037[F3]	#High mount flip-up footrest, each
K0038[F6]	#Leg strap, each

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K0039[F6]	#Leg strap, H style, each
K0040[F4]	#Adjustable angle footplate, each
K0041[F4]	#Large size footplate, each
K0042[F4]	#Standard size footplate, replacement only, each
K0043[F4]	#Footrest, lower extension tube, replacement only, each
K0044[F4]	#Footrest, upper hanger bracket, replacement only, each
K0045[F4]	#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]	Wheelchair component or accessory, not otherwise specified (limited to wheeled mobility parts not listed)

K0108 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 Foot Support Systems (i.e.: Dynamic Footrest Coil; Dynamic Footrest Gas Spring; Dynamic Footrest Hanger):

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- 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

A4265[F9]	**Paraffin, per pound** (for medically necessary paraffin bath unit)
A4556[F9]	**Electrodes (e.g., Apnea monitor), per pair** (up to 2 pair, any type) TENs Replacement electrodes are covered for members with a diagnosis of knee pain due to osteoarthritis. Please refer to the coverage criteria listed under code E0730
A4557[F6]	**Lead wires (e.g., Apnea monitor), per pair** (up to 2 pair, any type) TENs Replacement lead wires are covered for members with a diagnosis of knee pain due to osteoarthritis. Please refer to the coverage criteria listed under code E0730
A4602	**Replacement battery for external infusion pump owned by patient, lithium, 1.5 volt, each** (also see A4632, K0601-K0605)
A4630[F7]	**#Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient** TENs Replacement batteries are covered for members with a diagnosis of knee pain due to osteoarthritis. Please refer to the coverage criteria listed under code E0730.
A4632[F7]	**Replacement battery for external infusion pump, any type, each** (also see K0601-K0605)
A7520[F9]	**Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each**
A7521[F9]	**Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each**
A7522[F7]	**Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each**
A7524[F7]	**Tracheostoma stent/stud/button, each**
E0235[F2]	**Paraffin bath unit, portable** Covered for rheumatoid arthritis only with documented treatment failure with medication and when ordered by a rheumatologist.
B9002[F3] '-RR'	**#Enteral nutrition infusion pump, any type**
B9004[F3] '-RR'	**#Parenteral nutrition infusion pump, portable**
B9006[F3] '-RR'	**#Parenteral nutrition infusion pump, stationary**

Note: The maximum monthly rental amount for infusion pumps (codes B9004, B9006, E0781, and E0791) is $60.60. The maximum daily rental amount for a parenteral infusion pump for short-term use is $5.00 per day up to a total of $60.60 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**

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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 Grade Breast Pump

- 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 breastfeeding (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:

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- 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.

E0619[F9]	#Apnea monitor, with recording feature

Apnea Monitor

- 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 back-up 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

Seat Lift Mechanism

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 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

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not sufficient justification for a seat lift mechanism. Almost all members 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 lift (E0630) and seat lift equipment (E0627 and E0629) are not to be billed in combination.

E0630[F2]	#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.

E1399[F9]	Durable medical equipment, miscellaneous

E1399 Examples with Criteria/Guidelines:

Special Needs Bed

Use the miscellaneous code for a special needs bed with one or more of the following features:

- a fixed foundation
- foundations with electric adjustability (articulation or height)
- side rails greater than 24 inches above the mattress
- integrated full enclosure (360-degree enclosure with a top)

Coverage criteria:
A fully enclosed special needs bed is covered when hospital bed criteria 10-15 are met, 16 if applicable, and:

- There is evidence of mobility that puts the patient at risk for injury while in a hospital bed with high-sides (E0328) and a full enclosure (E0316).

Supporting documentation should include:

- a list of comparable, less costly beds that have been explored (from multiple manufacturers) and why they would not meet the member's needs; and
- medical justification for each accessory requested that is an additional cost.

Only twin-size beds will be considered. Exceptions for a large sized bed will be reviewed if the manufacturer does not offer a twin-size bed and the cost of the larger bed is comparable to other twin-size beds.

PLEASE NOTE: Electronic components that do not adjust the position of the bed (camera/video monitoring systems, speaker/mic, sound/light machines, etc.) are considered assistive technology and are not within the scope of the NYS Medicaid DME program. However, these electronics MAY fall under the scope of state or local Waiver programs.

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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.

To obtain a prior approval number for a positioning bath chair and stand additions, the item(s) must be coded E1399 (Durable Medical Equipment, Miscellaneous) and submitted using the following procedure:

a) DME provider obtains valid order and medical documentation (to maintain in their records for audit purposes) from the ordering practitioner;

b) DME provider submits a prior approval request containing a copy of valid order and either a manufacturer's price quote or the item's make and model;

c) These items must be submitted singularly on one line on a separate prior approval from all other prior approval items;

d) The DME Provider will be issued a prior approval priced up to the established MRA and may bill Medicaid upon dispensing.

Reimbursement for positioning bath chairs and stand additions can be found on the DMEPOS Fee Schedule under E1399 https://www.emedny.org/ProviderManuals/DME/

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.

Reimbursement for reclining shower/commode chair can be found on the DMEPOS Fee Schedule under E1399 https://www.emedny.org/ProviderManuals/DME/

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.

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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.

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 is 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 or knee flexion contractures of more than 45°.
- 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.

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- 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 can 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, ADLs, 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.
- Reimbursement amount includes the following features/accessories (any type/size):
  - Base and configuration
  - Tray (any type)
  - Head support (any type)
  - Trunk and hip straps/supports with or without padding (any type)

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- Knee straps or supports with or without padding (any type)
- Standard leg supports
- Foot straps, supports, or sandals with or without padding (any type)
- Hygienic covers or coating

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

E0637[F2] '-RR'	Combination sit to stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels
E0638[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
E0641[F2] '-RR'	Standing frame/table system, multi-position (e.g. three-way stander), any size including pediatric, with or without wheels
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)

Pneumatic Compression Device (PCD)

Pneumatic compression devices (lymphedema pumps) are covered for the treatment of generalized or refractory lymphedema, or refractory edema from chronic venous insufficiency, only when all less invasive treatments have been attempted and are unsuccessful.

Coverage Criteria for E0650 and E0651

I. Lymphedema

- The member has a diagnosis of lymphedema, and
- Persistence of chronic and severe lymphedema as documented by presence of at least one of the following:
  - Marked hyperkeratosis with hyperplasia and hyperpigmentation
  - Papillomatosis cutis lymphostatica
  - Deformity of limb or involved area - i.e., elephantiasis (measurements to support compared to contralateral limb)
  - Skin breakdown with persisting lymphorrhea
  - Detailed measurements over time confirming the persistence of lymphedema with a history evidencing a likely etiology, and
- A documented 4-week trial of conservative therapy demonstrating failed response to the treatment is required. The trial must include **ALL** the following:
  - Regular compliance with an appropriate compression bandage system or compression garment to provide adequate compression. (Adequate compression is defined as having sufficient pressure at lowest pressure point to cause fluid movement, and sufficient pressure across the gradient (from highest to lowest pressure point) to move fluid from distal to proximal.) The compression should not create a tourniquet effect at any point.
  - The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression with a minimum of 30mmHg distally.
  - Regular exercise program
  - Elevation of limb

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- Evidence of participation in a manual lymph drainage (MLD) program and results.
- Evidence of appropriate medication treatment for co-morbidities, i.e., congestive heart failure (CHF) and results.

- Symptoms and objective findings, including measurements which establish the severity of the condition
- Reason the device is required, including treatments which have been tried and failed

II. Chronic Venous Insufficiency (CVI)

PCDs coded E0650 or E0651 are covered for treatment of CVI of the lower extremities **ONLY** if the member has **ALL** the following:

- Edema in the affected lower extremity
- One or more venous stasis ulcer(s)
- Non-healing ulcers after a six-month trial of conservative therapy directed by the treating practitioner. The six-month trial includes:
  - The 4-week lymphedema trial criteria outlined above; **AND**
  - Appropriate wound care for the ulcer(s) (including sharp debridement where appropriate)

Coverage Criteria for E0652

E0652 is only covered when the individual has unique characteristics which prevent them from receiving adequate satisfactory pneumatic compression treatment using a non-segmented device along with a segmented appliance or compression device without manual control of the pressure in each chamber.
A PCD coded as E0652 is covered for the treatment of lymphedema extending onto the chest, trunk and/or abdomen when **ALL** the following are met:

- Diagnosis of lymphedema of an extremity
- Coverage criteria for E0650 and E0651 are met
- The member has lymphedema extending onto the chest, trunk and/or abdomen that extends past the limits of a standard compression sleeve, and the chest, trunk and/or abdominal lymphedema has failed to improve with a four-week trial. 4-week trial includes all the requirements for the 4-week trial outlined above under Lymphedema, **AND**:
  - Manual lymph drainage (MLD) (where available) and self MLD for at least 30 minutes/day
  - Evaluation of diet and implementation of necessary changes
  - Medications as appropriate (i.e., diuretics and/or treatment of CHF, etc.)
  - correction (where possible) of anemia and/or hyponatremia

E0650[F2]	#Pneumatic compressor, non-segmental home model, (Lymphedema pump) Appliances (garments) appropriate for use are E0655, E0660, E0665, E0666, E0671, E0672 and E0673
E0651[F2]	#Pneumatic compressor, segmental home model without calibrated gradient pressure Appliances (garments) appropriate for use are E0667, E0668, E0669
E0652[F2]	Pneumatic compressor, segmental home model with calibrated gradient pressure Appliances (garments) appropriate for use are E0656, E0657, E0667, E0668, E0669 and E0670
E0655[F3]	#Non-segmental pneumatic appliance for use with pneumatic compressor, half arm
E0656[F3]	#Segmental pneumatic appliance for use with pneumatic compressor, trunk
E0657[F3]	#Segmental pneumatic appliance for use with pneumatic compressor, chest
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

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E0666[F3]	#Non-segmental pneumatic appliance for use with pneumatic compressor, half leg
E0667[F3]	#Segmental pneumatic appliance for use with pneumatic compressor, full leg
E0668[F3]	#Segmental pneumatic appliance for use with pneumatic compressor, full arm
E0669[F3]	#Segmental pneumatic appliance for use with pneumatic compressor, half leg
E0670[F3]	#Segmental pneumatic appliance for use with pneumatic compressor, integrated, two full legs and trunk
E0671[F3]	#Segmental gradient pressure pneumatic appliance, full leg
E0672[F3]	#Segmental gradient pressure pneumatic appliance, full arm
E0673[F3]	#Segmental gradient pressure pneumatic appliance, half leg

Safety Equipment

E0700[F5]	#Safety equipment, device or accessory, any type (limited to gait belt)
E0705[F6]	Transfer device, any type, each

Electric Stimulation Devices and Osteogenesis Stimulator

E0730[F5]	#Transcutaneous electrical nerve stimulation (tens) device, four or more leads, for multiple nerve stimulation (dual channel) Covered for: - Members 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: 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_Worksheet2019.pdf

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E0748[F2]	#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_Worksheet2019.pdf
E0760[F2]	#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: https://www.emedny.org/ProviderManuals/DME/PDFS/Osteogenesis_Stimulator_Worksheet2019.pdf

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E0766[F9]	**Electrical stimulation device used for cancer treatment, includes all accessories, any type** Coverage Criteria: Tumor Treatment Field Therapy (TTFT), E0766, are alternating electric fields, produced by a pulse generator, and transmitted by ceramic transducers placed on a patient's head. Tumor Treatment Field Therapy (TTFT) uses alternating electric fields to target cancer cells and disrupt cancer cell division. TTFT is covered when **all** the following criteria are met: 1. The member has histologically confirmed (World Health Organization (WHO) grade IV astrocytoma), newly diagnosed, Glioblastoma Multiforme (GBM); *and* 2. The member has received initial treatment with maximal debulking surgery, followed by chemotherapy and radiotherapy; *and* 3. Tumor treatment field therapy is initiated within 7 weeks from the last dose of concomitant chemotherapy or radiotherapy, whichever is later; *and* 4. The member has no evidence of progression by Response Assessment in Neuro-Oncology (RANO) criteria; *and* 5. The member has a Karnofsky Performance Score (KPS) of at least 70; *and* 6. The member will use tumor treatment field therapy (TTFT) for an average of 18 hours per day; *and* 7. The member is 22 years of age or older; *and* a. Confirmation of non-pregnant status for women of child-bearing age. 8. Absence of intracranial shunt or other implanted intracranial device. **Tumor treatment field therapy will be denied as not reasonable and necessary for the treatment of recurrent GBM** Reimbursement for E0766 includes treatment with the device and all supplies for the duration of therapy. If criteria is met, initial prior approval will be given for 3 months. **CONTINUED COVERAGE FOR NEWLY DIAGNOSED GBM BEYOND THE FIRST THREE MONTHS OF THERAPY:** Continued coverage of TTFT (E0766) beyond the first three months of therapy requires that no sooner than the 60th day but no later than the 91st day after initiating therapy, the treating practitioner must conduct a clinical re-evaluation and document that the beneficiary is continuing to use and is benefiting from TTFT. Documentation of clinical benefit is demonstrated by: 1. Re-evaluation by the treating practitioner; and, 2. Objective evidence of adherence to therapy, reviewed by the treating practitioner. Adherence to therapy is defined as the use of TTFT for an average of 18 hours per day (excluding days the treating practitioner has documented a medical need to limit or interrupt treatment).

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Infusion Pumps

E0776[F2] '-RR'	#I.V. pole
E0781[F3] '-RR'	#Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient
E0784[F3]	#External ambulatory infusion pump, insulin An external ambulatory insulin infusion pump will be covered for the diagnosis of diabetes mellitus when ordered by an endocrinologist or a medical practitioner who has experience managing patients on continuous subcutaneous insulin infusion therapy if the following criteria are demonstrated and documented in the clinical and DMEPOS provider's records: 1. The member has been on a program of multiple daily injections of insulin (i.e., at least 3 injections per day) with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump and has failed to achieve acceptable control of blood sugars that are not explained by poor motivation or compliance AND i. has one or more of the following criteria while receiving multiple daily injections: a) HbA1c >7% b) History of recurring hypoglycemia 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 ii. has completed a comprehensive diabetes education program. 2. The member has a diagnosis of gestational diabetes. <u>Preferred Diabetic Supply Program</u> Omnipod supplies and meters are covered under the Preferred Diabetic Supply Program. For coverage of disposable insulin pump supplies and meters (i.e. Omnipod) see the pharmacy Preferred Diabetic Supply Program link below for additional information. https://newyork.fhsc.com/providers/diabeticsupplies.asp
E0791[F3] '-RR'	Parenteral infusion pump, stationary, single or multichannel

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	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.

Topical Hyperbaric Oxygen Chamber

A4575[F2]	#Topical hyperbaric oxygen chamber, disposable

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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 an 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.

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- 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.

Negative Pressure Wound Therapy

E2402[F2]	#Negative pressure wound therapy electrical pump, stationary or portable (Bill as a monthly recurring rental rate with modifier "RR". Initial 30 days allowed without prior approval)

- Supplies are billed separately:

  - A6550: Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories, and

  - A7000: Canister, disposable, used with suction pump, each.

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- 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 (A6550) 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 (A7000).

- 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.

Staging of Pressure Ulcers

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.

- Prior approval will be required after the initial 30 days if an extension of the treatment is justified. 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.

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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

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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.

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 members 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.

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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 an 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 of SGD

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 member'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.

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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 an 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.

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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).

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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.

<u>Documentation for Consideration for Coverage of:</u>

1) Upgrade

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.

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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.

E2500[F2] *'-RR'*	#Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time
E2502[F2] *'-RR'*	#Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time
E2504[F2] *'-RR'*	#Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time
E2506[F2] *'-RR'*	#Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time
E2508[F2] *'-RR'*	#Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device
E2510[F2]	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access
E2511[F2]	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

- American Speech-Language Hearing Association (ASHA) Practice Portal: Augmentative and Alternative Communication available at http://www.asha.org/PRPSpecificTopic.aspx?folderid=8589942773&section=Key_Issues.
- ASHA Position Statement on Access to Communication Services and Supports: Concerns Regarding the Application of Restrictive "Eligibility" Policies available at http://www.asha.org/policy/PS2003-00227/.
- ASHA Medical Necessity for Speech-Language Pathology and Audiology Services available at https://www.asha.org/practice/reimbursement/medical-necessity-for-audiology-and-SLP-services/
- MassHealth Guidelines for Medical Necessity Determination for Augmentative and Alternative Communication Devices and Speech Generation Devices. https://www.mass.gov/doc/guidelines-for-medical-necessity-determination-for-augmentative-and-alternative-communication-devices-including-speech-generating-devices-1/

External Infusion Pump Batteries

K0601[F8]	#Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each

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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

Automatic External Defibrillator

K0606[F9]	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type See following link: K0606 General Coverage Guidelines *Reimbursement is prorated based on daily use of 20 hours or more

Vacuum Erection Device

L7900[F2]	Vacuum erection system Limited to diagnosis of impotence, with an order from a urologist or neurologist

Larynx and Trachea Prosthetics and Accessories

L8500[F2]	#Artificial larynx, any type
L8501[F7]	#Tracheostomy speaking valve
L8505[F7]	#Artificial larynx replacement battery/accessory, any type
L8507[F10]	Tracheo-esophageal voice prosthesis, patient inserted, any type, each
L8510[F3]	#Voice amplifier
L8511[F7]	#Insert for indwelling tracheoesophageal prosthesis, with or without valve, replacement only, each
L8514[F7]	#Tracheoesophageal puncture dilator, replacement only, each
L8515[F5]	#Gelatin capsule, application device for use with tracheoesophageal voice prosthesis, each

Enuresis Alarm

S8270[F1]	#Enuresis alarm, using auditory buzzer and/or vibration device (Prior approval required over age 20)

Positioning Car Seat

T5001[F2]	#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)

Coverage Criteria

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

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

- Head support

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- Trunk positioning pads/supports
- Harness or safety belts (with or without safety cover)
- Abductor pommel
- Any positioning wedges, cushions, or padding
- Tilt and/or recline (fixed or adjustable)
- All LATCH/tether straps

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

SERVICING, PARTS, REPAIRS

- Repair requests 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.

HCPCS Codes, RB modifier, K0739

a) For replacement parts that have a specific HCPCS code:

   1. Report the replacement part code, and
   2. Report K0739 for labor component.

b) 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.

c) 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.

d) 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.

e) Payment for pick-up and delivery of DME for repair is included in the payment for replacement equipment and parts.

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f) Repairs (labor, replacement equipment and parts) covered under the manufacturer's warranty are not to be billed to Medicaid.

g) 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[F7]	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code
A9999	Miscellaneous DME supply or accessory, not otherwise specified
K0739[F9]	#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 have 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 25% 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.

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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

A8000[F6]	#Helmet, protective, soft, prefabricated, includes all components and accessories
A8001[F6]	#Helmet, protective, hard, prefabricated, includes all components and accessories
A8002[F6]	#Helmet, protective, soft, custom fabricated, includes all components and accessories
A8003[F6]	#Helmet, protective, hard, custom fabricated, includes all components and accessories
A8004[F6]	Soft interface for helmet, replacement only
L0112[F3]	#Cranial cervical orthosis, congenital torticollis type, with or without soft interface material, adjustable range of motion joint, custom fabricated
L0113[F3]	#Cranial cervical orthosis, torticollis type, with or without joint, with or without soft interface material, prefabricated, includes fitting and adjustment
L0130[F3]	#Cervical, flexible, thermoplastic collar, molded to patient
L0140[F3]	#Cervical, semi-rigid, adjustable (plastic collar)
L0150[F3]	#Cervical, semi-rigid, adjustable molded chin cup (plastic collar with mandibular/occipital piece)
L0160[F3]	#Cervical, semi-rigid, wire frame occipital/mandibular support, prefabricated, off-the-shelf
L0170[F3]	#Cervical, collar, molded to patient model
L0172[F3]	#Cervical, collar, semi-rigid thermoplastic foam, two-piece, prefabricated, off-the-shelf
L0174[F3]	#Cervical, collar, semi-rigid, thermoplastic foam, two piece with thoracic extension, prefabricated, off-the-shelf

Cranial Remolding Orthosis

S1040[F1]	#Cranial remolding orthosis, rigid, with soft interface material, custom fabricated, includes fitting and adjustment(s)

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:

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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

- The member has a diagnosis of craniosynostosis and has had surgical intervention of either calvarial vault reconstruction or minimally invasive, endoscopic-assisted craniectomy.

Not covered for:

- Members over the age of 24 months.
- Unmanaged hydrocephalus.
- Craniosynostosis (without surgical intervention).

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.

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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 item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
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, off-the-shelf
L0456[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 item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
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 item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
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

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	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 the 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

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	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 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
L0488[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, 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 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 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 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 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, 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.

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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, 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
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, stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf
L0642[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[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[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, custom fabricated
L0630[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[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,

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	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[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
L0633[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 item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L0634[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, custom fabricated
L0635[F4]	#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
L0636[F4]	#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
L0637[F4]	#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
L0638[F4]	#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 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 item that has been trimmed,

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	bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
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-9vertebra, 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 sacrococcygeal 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)
L0720[F4]	#Cervical-thoracic-lumbar-sacral-orthoses (ctlso), anterior-posterior-lateral control, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

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

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L0859[F14]	#Addition to HALO procedure, magnetic resonance image compatible systems, rings and pins, any material
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
L1006[F4]	#Scoliosis orthosis, sagittal-coronal control provided by a rigid lateral frame, extends from axilla to trochanter, includes all accessory pads, straps and interface, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
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

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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
L1270[F16]	#Addition to TLSO, (low profile), abdominal pad
L1280[F16]	#Addition to TLSO, (low profile), rib gusset (elastic), each
L1290[F16]	#Addition to TLSO, (low profile), lateral trochanteric pad

Other Scoliosis Procedures

L1300[F4]	#Other scoliosis procedure, body jacket molded to patient model
L1310[F2]	#Other scoliosis procedure, postoperative body jacket
L1320[F4]	Thoracic, pectus carinatum orthosis, sternal compression, rigid circumferential frame with anterior and posterior rigid pads, custom fabricated
L1499[F10]	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 procedures from the "Additions" sections and adding them to the base procedure.

Hip Orthosis (HO)-Flexible

L1600[F2]	#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
L1610[F2]	#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
L1620[F2]	#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
L1630[F2]	#Hip Orthosis, abduction control of hip joints, semi-flexible (Von Rosen type), custom fabricated
L1640[F2]	#Hip Orthosis, abduction control of hip joints, static, pelvic band or spreader bar, thigh cuffs custom fabricated
L1650[F2]	#Hip Orthosis, abduction control of hip joints, static, adjustable (Ilfled type), prefabricated, includes fitting and adjustment
L1652[F2]	#Hip orthosis, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, includes fitting and adjustment, prefabricated item that has been trimmed, bent,

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	molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L1660[F2]	#Hip Orthosis, abduction control of hip joints, static, plastic, prefabricated, includes fitting and adjustment
L1680[F2]	#HO, abduction control of hip joints, dynamic pelvic control, adjustable hip motion control, thigh cuffs (Rancho hip action type) custom fabricated
L1685[F2]	#Hip Orthosis, abduction control of hip joint, post-operative hip abduction type, custom fabricated
L1686[F2]	#Hip Orthosis, abduction control of hip joint, post-operative hip abduction type, prefabricated, includes fitting and adjustments
L1690[F2]	#Combination, bilateral, lumbo-sacral, hip, femur orthosis providing adduction and internal rotation control, prefabricated, includes fitting and adjustment

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, (Tachdjian 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. Members 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 item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
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

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	Covered for members 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: Members 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.
L1847 [F3]	#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
L1848[F3]	#Knee orthosis, double upright with adjustable joint, with inflatable air support chamber(s), prefabricated, off-the-shelf
L1850 [F3]	#Knee orthosis, Swedish type, prefabricated, off-the-shelf Covered for: Members with knee instability due to genu recurvatum.

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L1851[F3]	#Knee Orthosis (KO), 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, off-the-shelf
L1852[F3]	#Knee Orthosis (KO), 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, off-the-shelf
L1860 [F3]	#Knee orthosis, modification of supracondylar prosthetic socket, custom fabricated (SK) Covered for: Members with knee instability due to genu recurvatum.

Ankle-Foot Orthosis (AFO)

AFOs that are molded-to-patient-model, or custom-fabricated, are covered for members 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.

L4392[F16]	#Replacement, soft interface material, static AFO
L4394[F16]	#Replacement, soft interface material, foot drop splint
L4396[F7]	#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
L4397[F6]	#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
L4398[F7]	#Foot drop splint, recumbent positioning device, prefabricated, off-the-shelf
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 (Charcot Restraint Orthotic Walker- CROW boot) - No other codes may be billed for a CROW boot. - There is no separate billing for any modifications, fitting, or adjustments.

- Ankle-foot orthoses (AFO) described by codes L1900-L1990 are covered for members 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 members 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.

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- The allowed frequency of "F7" for procedural codes L1907, L1960, and L1970 is intended for pediatric members 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[F3]	#Ankle foot orthosis, ankle gauntlet, prefabricated, off-the-shelf
L1904[F19]	#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[F7]	#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[F6]	#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 members 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 members for whom an ankle-foot orthosis is covered and for whom additional knee stability is required.

APPROVED

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[F5]	#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

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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 members 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.

L2200[F7]	#Addition to lower extremity, limited ankle motion, each joint
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[F7]	#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
L2240[F7]	#Addition to lower extremity, round caliper and plate attachment
L2250[F7]	#Addition to lower extremity, foot plate, molded to patient model, stirrup attachment
L2260[F7]	#Addition to lower extremity, reinforced solid stirrup (Scott-Craig type)
L2265[F7]	#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

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L2280[F7]	#Addition to lower extremity, molded inner boot
L2300[F2]	#Addition to lower extremity, abduction bar (bilateral hip involvement), jointed, adjustable
L2310[F2]	#Addition to lower extremity, abduction bar-straight
L2320[F6]	#Addition to lower extremity, non-molded lacer, for custom fabricated orthosis only
L2330[F6]	#Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only
L2335[F4]	#Addition to lower extremity, anterior swing band
L2340[F4]	#Addition to lower extremity, pre-tibial shell, molded to patient model
L2350[F6]	#Addition to lower extremity, prosthetic type, (BK) socket, molded to patient model, (used for 'PTB' 'AFO' orthosis)
L2360[F5]	#Addition to lower extremity, extended steel shank
L2370[F3]	#Addition to lower extremity, Patten bottom
L2375[F6]	#Addition to lower extremity, torsion control ankle joint and half solid stirrup
L2380[F6]	#Addition to lower extremity, torsion control straight knee joint, each joint
L2385[F6]	#Addition to lower extremity, straight knee joint, heavy duty, each joint Covered for members with documented weight of more than 300 pounds.
L2387[F19]	#Addition to lower extremity, polycentric knee joint, for custom fabricated knee ankle foot orthosis, each joint
L2390[F6]	#Addition to lower extremity, offset knee joint, each joint
L2395[F6]	#Addition to lower extremity, offset knee joint, heavy duty, each joint Covered for members with documented weight of more than 300 pounds.
L2397[F7]	#Addition to lower extremity orthosis, suspension sleeve

Additions to Straight Knee or Offset Knee Joints

L2405[F4]	#Addition to knee joint, drop lock, each
L2415[F4]	#Addition to knee lock with integrated release mechanism (bail, cable, or equal), any material, each joint
L2425[F4]	#Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint
L2430[F4]	#Addition to knee joint, ratchet lock for active and progressive knee extension, each joint
L2492[F4]	#Addition to knee joint, lift loop for drop lock ring

Additions: Thigh/Weightbearing- Gluteal/Ischial Weightbearing

L2500[F4]	#Addition to lower extremity, thigh/weight bearing, gluteal/ischial 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

Additions: Pelvic and Thoracic Control

L2570[F4]	#Addition to lower extremity, pelvic control, hip joint, clevis type two position hip joint, each

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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 thrust bearing, lock, each
L2620[F4]	#Addition to lower extremity, pelvic control, hip joint, heavy duty, each Covered for members with documented weight of more than 300 pounds.
L2622[F4]	#Addition to lower extremity, pelvic control, hip joint, adjustable flexion, each
L2624[F4]	#Addition to lower extremity, pelvic control, hip joint, adjustable flexion, extension, abduction control, each
L2627[F4]	#Addition to lower extremity, pelvic control, plastic, molded to patient model, reciprocating hip joint and cables
L2628[F4]	#Addition to lower extremity, pelvic control, metal frame, reciprocating hip joint and cables
L2630[F4]	#Addition to lower extremity, pelvic control, band and belt, unilateral
L2640[F4]	#Addition to lower extremity, pelvic control, band and belt, bilateral
L2650[F4]	#Addition to lower extremity, pelvic and thoracic control, gluteal pad, each
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 uprights

Additions: General

L2750[F4]	#Addition to lower extremity orthosis, plating chrome or nickel, per bar
L2755[F4]	#Addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, per segment, for custom fabricated orthosis only
L2760[F20]	#Addition to lower extremity orthosis, extension, per extension, per bar (for lineal adjustment for growth)
L2768[F19]	#Orthotic side bar disconnect device, per bar
L2780[F19]	#Addition to lower extremity orthosis, non-corrosive finish, per bar
L2785[F19]	#Addition to lower extremity orthosis, drop lock retainer, each
L2795[F7]	#Addition to lower extremity orthosis, knee control, full kneecap
L2800[F7]	#Addition to lower extremity orthosis, knee control, knee cap, medial or lateral pull, for use with custom fabricated orthosis only
L2810[F7]	#Addition to lower extremity orthosis, knee control, condylar pad
L2820[F7]	#Addition to lower extremity orthosis, soft interface for molded plastic, below knee section Covered for a documented history of skin breakdown.
L2830[F7]	#Addition to lower extremity orthosis, soft interface for molded plastic, above knee section Covered for a documented history of skin breakdown.
L2840[F7]	#Addition to lower extremity orthosis, tibial length sock, fracture or equal, each
L2850[F7]	#Addition to lower extremity orthosis, femoral length sock, fracture or equal, each
L2861[F3]	Addition to lower extremity joint, knee or ankle, concentric adjustable torsion
L2999[F7]	Lower extremity orthoses, not otherwise specified

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)

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L3650[F2]	#Shoulder orthosis, figure of "8" design abduction restrainer, prefabricated, off-the-shelf
L3660[F2]	#Shoulder orthosis, figure of "8" design abduction restrainer, canvas and webbing, prefabricated, off-the-shelf
L3670[F2]	#Shoulder orthosis, acromio/clavicular (canvas and webbing type), prefabricated, off-the-shelf
L3671[F2]	#Shoulder orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3674[F2]	#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
L3675[F2]	#Shoulder orthosis, vest type abduction restrainer, canvas webbing type, or equal, prefabricated, off-the-shelf
L3677[F2]	#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)

L3702[F4]	#Elbow orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3710[F4]	#Elbow orthosis, elastic with metal joints, prefabricated, off-the-shelf
L3720[F4]	#Elbow orthosis, double upright with forearm/arm cuffs, free motion, custom fabricated
L3730[F4]	#Elbow orthosis, double upright with forearm/arm cuffs, extension/flexion assist, custom fabricated
L3740[F4]	#Elbow orthosis, double upright with forearm/arm cuffs, adjustable position lock with active control, custom fabricated
L3760[F4]	#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
L3761[F4]	#Elbow orthosis (EO), with adjustable position locking joint(s), prefabricated, off-the-shelf
L3762[F4]	#Elbow orthosis, rigid, without joints, includes soft interface material, prefabricated, off-the-shelf
L3763[F4]	#EWHO, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3764[F4]	#EWHO, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3765[F4]	#EWHFO, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3766[F4]	#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[F19]	#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[F21]	#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

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L3808[F19]	#Wrist hand finger orthosis, rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment
L3809[F21]	#Wrist hand finger orthosis, without joint(s), prefabricated, off-the-shelf, any type

Additions to Upper Extremity Orthosis

L3891[F19]	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
L3908[F7]	#Wrist hand orthosis, wrist extension control cock-up, non-molded, prefabricated, off-the-shelf
L3912[F2]	#Hand finger orthosis, flexion glove with elastic finger control, prefabricated, off-the-shelf
L3913[F19]	#Hand finger orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3915[F19]	#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
L3916[F4]	#Wrist hand orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, off-the-shelf
L3917[F2]	#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
L3918[F2]	#Hand orthosis, metacarpal fracture orthosis, prefabricated, off-the-shelf
L3919[F19]	#Hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3921[F19]	#Hand finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3923[F21]	#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
L3924[F16]	#Hand finger orthosis, without joints, may include soft interface, straps, prefabricated, off-the-shelf

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L3925[F7]	#Finger orthosis, proximal interphalangeal (pip)/distal interphalangeal (dip), nontorsion joint/spring, extension/flexion, may include soft interface material, prefabricated, off-the-shelf
L3927[F7]	#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
L3929[F6]	#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
L3930[F6]	#Hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, off-the-shelf
L3931[F6]	#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[F19]	#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

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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

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[F7]	#Replace proximal and distal upright for KAFO
L4080[F7]	#Replace metal bands KAFO, proximal thigh
L4090[F7]	#Replace metal bands KAFO-AFO, calf or distal thigh
L4100[F7]	#Replace leather cuff KAFO, proximal thigh
L4110[F7]	#Replace leather cuff KAFO-AFO, calf or distal thigh
L4130[F6]	#Replace pretibial shell

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

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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 (mis-mating) 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[F7]	#Foot, insert, removable, molded to patient model, plastazote or equal, each
L3003[F7]	#Foot, insert, removable, molded to patient model, silicone gel, each
L3010[F7]	#Foot, insert, removable, molded to patient model, longitudinal arch support, each
L3020[F7]	#Foot, insert, removable, molded to patient model, longitudinal/metatarsal support, each
L3030[F7]	#Foot, insert, removable, formed to patient foot, each
L3031[F7]	#Foot, insert/plate, removable, addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, each

Arch Support, Removable, Pre-molded

L3040[F7]	#Foot, arch support, removable, premolded, longitudinal, each
L3050[F7]	#Foot, arch support, removable, premolded, metatarsal, each
L3060[F7]	#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)

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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[F6]	#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

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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

L3500[F7]	#Orthopedic shoe addition, insole, leather
L3510[F7]	#Orthopedic shoe addition, insole, rubber
L3520[F7]	#Orthopedic shoe addition, insole, felt covered with leather
L3530[F7]	#Orthopedic shoe addition, sole, half
L3540 [F7]	#Orthopedic shoe addition, sole, full (each)
L3550[F7]	#Orthopedic shoe addition, toe tap standard
L3560[F7]	#Orthopedic shoe addition, toe tap, horseshoe
L3570[F7]	Orthopedic shoe addition, special extension to instep (leather with eyelets)
L3580[F7]	Orthopedic shoe addition, convert instep to Velcro closure
L3590[F7]	#Orthopedic shoe addition, convert firm shoe counter to soft counter
L3595[F7]	#Orthopedic shoe addition, March bar

Transfers or Replacement

L3600[F7]	Transfer of an orthosis from one shoe to another, caliper 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)

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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[F7]	#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[F7]	#For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with wedge(s), per shoe
A5505[F7]	#For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with metatarsal bar, per shoe
A5506[F7]	#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[F7]	#For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe
A5512[F22]	#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[F22]	#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[F22]	#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.

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3. L Code "additions" are covered only when both the base codes coverage criteria have 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 25% 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.
11. Only one prosthetic and its components can be obtained from the automated authorization system, the dispensing validation system (DVS). If bilateral prosthetics are necessary, prior approval must be obtained.

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 member:

1. Will reach or maintain a defined functional state within a reasonable amount 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.

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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 and/or knees are considered for coverage based upon functional classification.

Partial Foot

L5000[F4]	#Partial foot, shoe insert with longitudinal arch, toe filler
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 Disarticulation

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

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L5230[F4]	#Above knee, for proximal femoral focal deficiency, constant friction knee, shin, SACH foot

Hip Disarticulation

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

Hemipelvectomy

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

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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 Prosthesis

Lower limb prostheses, preparatory, may be considered medically necessary for a new or revised amputation when ALL the following criteria are met:

- The individual has had an above or below knee amputation; and
- The preparatory prosthesis is provided to an individual starting a rehabilitation program; and
- The preparatory prosthesis is provided after the surgical incision has healed; and
- The individual is motivated to ambulate using the prosthesis; and
- The preparatory prosthesis is prescribed by an eligible professional provider (i.e., physician with training and expertise in the functional evaluation of individuals with amputations) and fitted/made by an orthotist or prosthetist.

Lower limb prostheses, preparatory, are complete and all-inclusive; therefore, additional components, add-ons, upgrades, adjustments, modifications, or substitutions of components, etc., are not separately reimbursable.

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

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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, exoskeletal system, above knee–knee disarticulation, 4-bar linkage, with pneumatic swing phase control
L5615[F4]	Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control
L5616[F4]	#Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control
L5617[F4]	#Addition to lower extremity, quick change self-aligning unit, above knee or below knee, each

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
L5630[F4]	#Addition to lower extremity, Symes type, expandable wall 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
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

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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 supraconydlar 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[F4]	#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

ADOPTED

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
L5718[F4]	#Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control

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

Vacuum Pump

Vacuum pump suspension systems may be considered medically necessary when ALL of the following criteria are met:

Coverage Criteria

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a. There is a documented clinical condition of volume variation with objective measurements of the residual limb provided over a period of time (excluding weight gain, weight loss, the normal atrophy process, growth or systemic issues such as vascular or cardiac issues which would cause volume changes despite the use of vacuum technology).
b. The need to control residual limb volume is documented (see a. above) and there is a contraindication to or a failure of other socket suspension systems.
c. The member has adequate cognitive ability to safely and effectively use a vacuum pump and care for it as required.
d. The member has the physical ability, including adequate cardiovascular and pulmonary capacity for independent ambulation with a prosthesis in the community (use of the limb in the home or for basic community ambulation is not sufficient to justify a vacuum pump unless all other less costly alternatives have been adequately trialed and ruled out with the rationale clearly documented); and
e. There is excessive pistoning of the socket to the residual limb interface that cannot be resolved by adjustments in the current suspension system; or
f. Excessive residual limb hyperemia from prior socket use; or
g. Excessive skin hyperhidrosis from prior socket use; or
h. Safety issues such as multiple falls in below knee amputees (transtibial amputation).

L5781[F4]	Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system
L5782[F4]	Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy duty Covered for members with documented weight of more than 300 pounds.
L5783[F4]	#Addition to lower extremity, user adjustable, mechanical, residual limb volume management 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.

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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
L5848[F4]	#Addition to endoskeletal knee-shin system, fluid stance extension, dampening feature, with or without adjustability
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-L5859) 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 cannot 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
L5859[F3]	Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, includes any type motor(s)

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
L5926[F4]	#Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type
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)
L5961[F4]	#Addition, endoskeletal system, polycentric hip joint, pneumatic or hydraulic control, rotation control, with or without flexion and/or extension control

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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

Ankle-Foot Systems

- 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 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

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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)
L6028[F3]	Partial hand including fingers, flexible or non-flexible interface, endoskeletal system, molded to patient model, for use without external power, not including inserts described by I6692
L6029[F3]	Upper extremity addition, test socket/interface, partial hand including fingers
L6030[F3]	Upper extremity addition, external frame, partial hand including fingers
L6031[F3]	Replacement socket/interface, partial hand including fingers, molded to patient model, for use with or without external power
L6032[F3]	Addition to upper extremity prosthesis, partial hand including fingers, ultralight material (titanium, carbon fiber or equal)
L6033[F3]	Addition to upper extremity prosthesis, partial hand including fingers, acrylic material

Wrist Articulation

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)

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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

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L6582[F2]	#Preparatory, wrist disarticulation or below elbow, single wall 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 the 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

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L6646[F3]	Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable abduction friction control, for use with body powered or external powered system
L6647[F3]	Upper extremity addition, shoulder lock mechanism, body powered actuator
L6648[F3]	Upper extremity addition, shoulder lock mechanism, external powered actuator
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
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
L6700[F3]	Upper extremity addition, external powered feature, myoelectronic control module, additional emg inputs, pattern-recognition decoding intent movement

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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
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
L6715[F3]	#Terminal device, multiple articulating digit, includes motor(s), initial issue or replacement
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

L6880[F3]	Electric hand, switch or myoelectric controlled, independently articulating digits, any grasp pattern or combination of grasp patterns, includes motor(s)
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

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External Power

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, myoelectronic 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, myoelectronic 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, myoelectronic 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

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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
L7362[F4]	#Battery charger, six volt, each
L7364[F7]	#Twelve volt battery, each
L7366[F4]	#Battery charger, twelve volt, each
L7367[F6]	#Lithium ion battery, rechargeable, replacement
L7368[F4]	#Lithium ion battery charger (Replacement only)

Additions to Upper Extremity Prosthetics

L7400[F4]	#Addition to upper extremity prosthesis, below elbow/wrist disarticulation, ultralight material (titanium, carbon fiber or equal)
L7401[F4]	#Addition to upper extremity prosthesis, above elbow disarticulation, ultralight material (titanium, carbon fiber or equal)
L7402[F4]	#Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, ultralight material (titanium, carbon fiber or equal)
L7403[F4]	#Addition to upper extremity prosthesis, below elbow/wrist disarticulation, acrylic material
L7404[F4]	#Addition to upper extremity prosthesis, above elbow disarticulation, acrylic material
L7405[F4]	#Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, acrylic material
L7406[F4]	#Addition to upper extremity, user adjustable, mechanical, residual limb volume management system
L7499[F10]	Upper extremity prosthesis, not otherwise specified

Repairs

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

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	(includes evaluation) (more than 2 hours requires prior approval)

Prosthetic Supplies

L7700[F6]	#Gasket or seal, for use with prosthetic socket insert, any type, each

Prosthetic Socks

L8400[F21]	#Prosthetic sheath, below knee, each
L8410[F21]	#Prosthetic sheath, above knee, each
L8415[F21]	#Prosthetic sheath, upper limb, each
L8417[F21]	#Prosthetic sheath/sock, including a gel cushion layer, below knee or above
L8420[F21]	#Prosthetic sock, multiple ply, below knee, each
L8430[F21]	#Prosthetic sock, multiple ply, above knee, each
L8435[F21]	#Prosthetic sock, multiple ply, upper limb, each
L8440[F21]	#Prosthetic shrinker, below knee, each
L8460[F21]	#Prosthetic shrinker, above knee, each
L8465[F21]	#Prosthetic shrinker, upper limb, each
L8470[F21]	#Prosthetic sock, single ply, fitting, below knee, each
L8480[F21]	#Prosthetic sock, single ply, fitting, above knee, each
L8485[F21]	#Prosthetic sock, single ply, upper limb, each
L8499[F10]	Unlisted procedure for miscellaneous prosthetic services
L9900[F12]	#Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code (limited to home visit)

Breast And Hair Prosthesis

L8035[F6]	Custom breast prosthesis, post mastectomy, molded to patient model - L8035 describes a molded-to-patient-model custom breast prosthesis. - History of breast malignancy, post-mastectomy/partial mastectomy/lumpectomy, or acquired absence of breast(s) - Custom breast prosthetics will only be considered when all less costly prefabricated off-the-shelf options have been trialed and have been demonstrated to not meet the member's medical needs. - The medical necessity for the additional features of a custom fabricated prosthesis compared to prefabricated must be clearly documented by the ordering provider. - Custom breast prosthetics requested for cosmetic purposes only are not medically necessary and are non-covered.
A9282[F2]	#Wig, any type, each (Coverage limited to medically-induced or congenital hair loss.)

Compression Supports

Covered for venous or lymphatic impairment.

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Documentation Requirements

- A physician's fiscal order indicating the extremity/body part (i.e knee high, thigh high), specific level of compression in mm/Hg, specific style, type, hosiery knit, and any additional accessories/options.
- A letter of medical necessity including, but not limited to, pertinent medical history, related diagnoses, duration and extent of current symptoms, any neurological involvement of affected limbs, an objective description of the affected limb/area, ambulation status and degree of assistance required.
- Current and previous decompression treatment modalities utilized, and member's compliance and outcomes. (Clinical notes can be submitted)
- Detailed limb/body measurements and date measured. Contralateral limb measurements should be submitted for comparison to affected limb. Indicate the location and degree of edematous lobules, if present. Custom items require measurements documented by a certified fitter or LANA certified therapist.
- Plan of care for use of garments and goals.

Non-Custom

- Prefabricated elastic support garment that applies varying pressure gradients to an area.
- Prefabricated garments are available in various sizes and different levels of compression.
- Prefabricated garments with appropriate level of compression (determined by the ordering provider) should be requested before custom is considered if the member's limb measurements fit within the size ranges specified by the manufacturers of the garment. Various manufacturers should be explored.

Custom

- Custom-made gradient compression stockings/garments/adjustable wraps are fabricated to the exact specifications of an individual.
- Custom-made are considered medically necessary when the degree of gradient pressure is one that cannot be provided in a prefabricated garment, or the measurements fall outside the ranges of prefabricated garments.
- Custom HCPCS codes and fees include zippered compression garments.

A6519[F7]	Gradient compression garment, not otherwise specified, for nighttime use, each (e.g. TributeNight, CircAid Night)
A6530[F7]	#Gradient compression stocking, below knee, 18-30 mm Hg 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, each
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)
A6549[F7]	Gradient compression garment, not otherwise specified, for daytime use, each
A6552[F7]	#Gradient compression stocking, below knee, 30-40 mmhg, each

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A6553[F7]	#Gradient compression stocking, below knee, 30-40 mmhg, custom, each
A6554[F7]	#Gradient compression stocking, below knee, 40 mmhg or greater, each
A6555[F7]	#Gradient compression stocking, below knee, 40 mmhg or greater, custom, each
A6556[F7]	#Gradient compression stocking, thigh length, 18-30 mmhg, custom, each
A6557[F7]	#Gradient compression stocking, thigh length, 30-40 mmhg, custom, each
A6558[F7]	#Gradient compression stocking, thigh length, 40 mmhg or greater, custom, each
A6559[F7]	Gradient compression stocking, full length/chap style, 18-30 mmhg, custom, each
A6560[F7]	Gradient compression stocking, full length/chap style, 30-40 mmhg, custom, each
A6561[F7]	Gradient compression stocking, full length/chap style, 40 mmhg or greater, custom, each
A6562[F7]	#Gradient compression stocking, waist length, 18-30 mmhg, custom, each
A6563[F7]	#Gradient compression stocking, waist length, 30-40 mmhg, custom, each
A6564[F7]	#Gradient compression stocking, waist length, 40 mmhg or greater, custom, each
A6565[F7]	#Gradient compression gauntlet, custom, each
A6568[F7]	#Gradient compression garment, torso and shoulder, each
A6569[F7]	#Gradient compression garment, torso/shoulder, custom, each
A6572[F7]	#Gradient compression garment, toe caps, each
A6573[F7]	#Gradient compression garment, toe caps, custom, each
A6574[F7]	#Gradient compression arm sleeve and glove combination, custom, each
A6575[F7]	#Gradient compression arm sleeve and glove combination, each
A6576[F7]	#Gradient compression arm sleeve, custom, medium weight, each
A6577[F7]	#Gradient compression arm sleeve, custom, heavy weight, each
A6578[F7]	#Gradient compression arm sleeve, each
A6579[F7]	#Gradient compression glove, custom, medium weight, each
A6580[F7]	#Gradient compression glove, custom, heavy weight, each
A6581[F7]	#Gradient compression glove, each
A6582[F7]	#Gradient compression gauntlet, each
A6583[F7]	#Gradient compression wrap with adjustable straps, below knee, each
A6584[F7]	Gradient compression wrap with adjustable straps, not otherwise specified (e.g. custom fabricated wraps)
A6585[F7]	#Gradient compression wrap with adjustable straps, above knee, each
A6586[F7]	#Gradient compression wrap with adjustable straps, full leg, each
A6587[F7]	#Gradient compression wrap with adjustable straps, foot, each
A6588[F7]	#Gradient compression wrap with adjustable straps, arm, each
A6610[F7]	#Gradient compression stocking, below knee, 18-30 mmhg, custom, each

Trusses

L8300[F6]	#Truss, single with standard pad
L8310[F6]	#Truss, double with standard pads
L8320[F6]	#Truss, addition to standard pad, water pad
L8330[F6]	#Truss, addition to standard pad, scrotal pad

Burn Garments

A6501[F7]	Compression burn garment, bodysuit (head to foot), custom fabricated
A6502[F7]	Compression burn garment, chin strap, custom fabricated

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A6503 [F7]	Compression burn garment, facial hood, custom fabricated
A6504 [F7]	Compression burn garment, glove to wrist, custom fabricated
A6505 [F7]	Compression burn garment, glove to elbow, custom fabricated
A6506 [F7]	Compression burn garment, glove to axilla, custom fabricated
A6507 [F7]	Compression burn garment, foot to knee length, custom fabricated
A6508 [F7]	Compression burn garment, foot to thigh length, custom fabricated
A6509 [F7]	Compression burn garment, upper trunk to waist including arm openings (vest), custom fabricated
A6510 [F7]	Compression burn garment, trunk, including arms down to leg openings (leotard), custom fabricated
A6511 [F7]	Compression burn garment, lower trunk including leg openings (panty), custom fabricated
A6512 [F7]	Compression burn garment, not otherwise classified

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Definitions

As used in Medicaid Durable Medical Equipment Guidelines:

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

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Custom-fitted/customized – means componentry made or added to already existing model or device that is assembled, adjusted, or modified 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 by 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.)

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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

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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 leg rests). (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

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(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 wheels 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)

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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 non-discrete 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 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

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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, swing away, or detachable. It will not have a headrest. Chairs with stadium style seats are billed using the Captain's 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

E2603[F5] #Skin protection wheelchair seat cushion, width less than 22 inches, any depth (a)

L89.130	L89.131	L89.132	L89.133	L89.134	L89.139	L89.140	L89.141	L89.142
L89.143	L89.144	L89.149	L89.150	L89.151	L89.152	L89.153	L89.154	L89.159
L89.40	L89.41	L89.42	L89.43	L89.44	L89.45	L89.200	L89.201	L89.202
L89.203	L89.204	L89.209	L89.210	L89.211	L89.212	L89.213	L89.214	L89.219
L89.220	L89.221	L89.222	L89.223	L89.224	L89.229	L89.300	L89.301	L89.302
L89.303	L89.304	L89.309	L89.310	L89.311	L89.312	L89.313	L89.314	L89.319
L89.320	L89.321	L89.322	L89.323	L89.324	L89.329			

E2603[F5] #Skin protection wheelchair seat cushion, width less than 22 inches, any depth (b)

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G82.50	G82.51	G82.52	G82.53	G82.54	G82.50	G04.1	G82.20	G82.21
G82.22	G95.0	G95.11	G95.19	G32.0	G99.2	G35	G36.0	G37.0
G37.5	G37.3	G36.1	G36.8	G37.1	G37.2	G37.4	G37.8	G36.9
G37.9	G80.1	G80.2	G80.0	G80.8	G80.4	G80.9	G12.0	G12.9
G12.1	G12.8	G12.21	G12.29	G12.20	G80.8	B91	G14	Q05.4
Q05.9	Q07.01	Q07.02	Q07.03	Q05.0	Q05.1	Q05.2	Q05.3	Q05.8
Q07.00	Q05.5	Q05.6	Q05.7	E75.23	E75.25	E75.29	E75.00	E75.01
E75.02	E75.09	E75.10	E75.11	E75.19	E75.4	G93.89	G93.9	F84.2
G31.81	G31.82	G31.9	G30.0	G30.1	G30.8	G30.9	G20	G21.4

E2603[F5] #Skin protection wheelchair seat cushion, width less than 22 inches, any depth (c)

G82.50	G82.51	G82.52	G82.53	G82.54	G82.50	G04.1	G82.20	G82.21
G82.22	G95.0	G95.11	G95.19	G32.0	G99.2	G35	G36.0	G37.0
G37.5	G37.3	G36.1	G36.8	G37.1	G37.2	G37.4	G37.8	G36.9
G37.9	G80.1	G80.2	G80.0	G80.8	G80.4	G80.9	G12.0	G12.9
G12.1	G12.8	G12.21	G12.29	G12.20	B91	G14	Q05.4	Q05.9
Q07.01	Q07.02	Q07.03	Q05.0	Q05.1	Q05.2	Q05.3	Q05.8	Q05.9
Q07.00	Q05.5	Q05.6	Q05.7	E75.23	E75.25	E75.29	E75.00	E75.01
E75.02	E75.09	E75.10	E75.11	E75.19	E75.4	G93.89	G93.9	F84.2
G31.8	G31.82	G31.9	G30.0	G30.1	G30.8	G30.9	G20	G21.4

E2605[F5] #Positioning wheelchair seat cushion, width less than 22 inches, any depth (b)

G83.10	G83.11	G83.12	G83.13	G83.14	I69.049	I69.149	I69.249	I69.349
I69.849	I69.949	I69.041	I69.042	I69.141	I69.142	I69.241	I69.242	I69.341
I69.342	I69.841	I69.842	I69.941	I69.942	I69.043	I69.044	I69.143	I69.144

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I69.243	I69.244	I69.343	I69.344	I69.843	I69.844	I69.943	I69.944	G81.00
G81.01	G81.02	G81.03	G81.04	G81.10	G81.11	G81.12	G81.13	G81.14
G81.90	G81.91	G81.92	G81.93	G81.94	I69.059	I69.159	I69.259	I69.359
I69.859	I69.959	I69.051	I69.052	I69.151	I69.152	I69.251	I69.252	I69.351
I69.352	I69.851	I69.852	I69.951	I69.952	I69.053	I69.054	I69.153	I69.154
I69.253	I69.254	I69.353	I69.354	I69.853	I69.854	I69.953	I69.954	G71.2
G71.0	G10	G24.1	G11.1	G11.4	G11.0	G11.2	G32.81	G11.3
G11.8	G11.9							

E2613[F5] **#Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware** **(b)**

G83.10	G83.11	G83.12	G83.13	G83.14	I69.049	I69.149	I69.249	I69.349
I69.849	I69.949	I69.041	I69.042	I69.141	I69.142	I69.241	I69.242	I69.341
I69.342	I69.841	I69.842	I69.941	I69.942	I69.043	I69.044	I69.143	I69.144
I69.243	I69.244	I69.343	I69.344	I69.843	I69.844	I69.943	I69.944	G81.00
G81.01	G81.02	G81.03	G81.04	G81.10	G81.11	G81.12	G81.13	G81.14
G81.90	G81.91	G81.92	G81.93	G81.94	I69.059	I69.159	I69.259	I69.359
I69.859	I69.959	I69.051	I69.052	I69.151	I69.152	I69.251	I69.252	I69.351
I69.352	I69.851	I69.852	I69.951	I69.952	I69.053	I69.054	I69.153	I69.154
I69.253	I69.254	I69.353	I69.354	I69.853	I69.854	I69.953	I69.954	G71.2
G71.0	G10	G24.1	G11.1	G11.4	G11.0	G11.2	G32.81	G11.3
G11.8	G11.9							

E2615[F5] **#Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware** **(b)**

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G83.10	G83.11	G83.12	G83.13	G83.14	I69.049	I69.149	I69.249	I69.349
I69.849	I69.949	I69.041	I69.042	I69.141	I69.142	I69.241	I69.242	I69.341
I69.342	I69.841	I69.842	I69.941	I69.942	I69.043	I69.044	I69.143	I69.144
I69.243	I69.244	I69.343	I69.344	I69.843	I69.844	I69.943	I69.944	G81.00
G81.01	G81.02	G81.03	G81.04	G81.10	G81.11	G81.12	G81.13	G81.14
G81.90	G81.91	G81.92	G81.93	G81.94	I69.059	I69.159	I69.259	I69.359
I69.859	I69.959	I69.051	I69.052	I69.151	I69.152	I69.251	I69.252	I69.351
I69.352	I69.851	I69.852	I69.951	I69.952	I69.053	I69.054	I69.153	I69.154
I69.253	I69.254	I69.353	I69.354	I69.853	I69.854	I69.953	I69.954	G71.2
G71.0	G10	G24.1	G11.1	G11.4	G11.0	G11.2	G32.81	G11.3
G11.8	G11.9							

ARCHIVED