NEW YORK STATE
MEDICAID PROGRAM

DURABLE MEDICAL EQUIPMENT, ORTHOTICS, PROSTHETICS, AND SUPPLIES

PROCEDURE CODES
AND
COVERAGE GUIDELINES

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WHAT'S NEW FOR THE 2013 MANUAL?

Please note the following changes to the Procedure Codes and Coverage Guidelines section of the Durable Medical Equipment, Orthotics, Prosthetics and Supplies (DMEOPS) manual, **Version 2013-2.**

- Procedure codes new to the manual are **bolded**. See below for any discontinued codes, new codes, or changes to a code's authorization type.
- The benefit limit coverage criteria for enteral formula have been updated.
- The authorization type and/or frequencies allowed have changed for many of the Orthotic and Prosthetic codes listed in sections 4.5 and 4.7. Due to the volume of codes changed, these are not individually listed below under the "authorization type changes" section. Please note the additional requirement concerning the use of "K" modifiers for lower extremity prosthetics. Additional details can be found in the provider communication posted on eMedNY March 7, 2013.
- Updated coverage guidelines for HCPCS code A4221 (Supplies for maintenance of drug infusion catheter) have been added.
- Documentation requirements for repair requests submitted via paper prior approval have been added.
- Updated criteria concerning the use of K0005 manual wheelchairs as a backup manual wheelchair have been added.
- The coverage criteria for standers and gait trainers have been updated.
- The updated coverage guidelines and documentation requirements for Speech Generating Devices posted on eMedNY October 8, 2013 have been added.
- Minimum breast pump specifications have been added.
- Reminder: The ICD-9 diagnosis code submitted on a claim must match the diagnosis code listed on the valid fiscal order, and must be specific to the need for the item or service being billed for (e.g.: incontinence related diagnosis when providing incontinence products).

New Codes: (Access a code's hyper link for provider communication updates related to changes)

A4375	**#Ostomy pouch, drainable, with faceplate attached, plastic, each**
A4384	**#Ostomy faceplate equivalent, silicone ring, each**
A4422	**#Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each**
A4428	**#Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (1 piece), each**
A4429	**#Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each**

A4430	**#Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece)**
A4431	**#Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (1 piece), each**
A4432	**#Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (2 piece), each**
A4433	**#Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each**
A4434	**#Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each**
A4435	**#Ostomy pouch, drainable, high output, with extended wear barrier (one-piece system), with or without filter, each** (used after surgery)
E0950	**#Wheelchair accessory, tray, each (for positioning only)**
E2378	**Power wheelchair component, actuator, replacement only**
E2511	**Speech generating software program, for personal computer or personal digital assistant**

Authorization type changes: (Access a code's hyper link for provider communication updates related to changes)

Code	Description
A4253	**Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips (for use with E2100 monitor only)**
E0240 F3	**#Bath/shower chair, with or without wheels, any size**
E0247 F3	**#Transfer bench for tub or toilet with or without commode opening**
E0274 F3	**#Over-bed table**
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**
E0910 F3 *'-RR'*	**#Trapeze bars, also known as Patient Helper, attached to bed, 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)**
E2100 F3	**#Blood glucose monitor with voice synthesizer**
E2510 F2	**Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access**

4.0 GENERAL INFORMATION AND INSTRUCTIONS

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

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

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

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

5. Where brand names and model numbers appear in the DME manual, they are intended to identify the type and quality of equipment expected, and are not exclusive of any comparable product by the same or another manufacturer.

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

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

   '-K0' through **'-K4'** modifiers, used to describe **functional classification levels of ambulation**, must be used for all lower extremity prosthetic procedure codes. The modifier relates to the specific functional classification level of the beneficiary. 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' <u>Replacement and Repair</u>:

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

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

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

'-RR' <u>Rental</u> - 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 $\mathbf{F_{26}}$ in the Procedure Code section).

- The **Length of Need** must be specified by the ordering practitioner on the fiscal order. If the order specifies a *Length of Need of less than 10 months,* the equipment must be rented initially. If *Length of Need is 10 months or greater,* the equipment may be initially rented or purchased.
- Equipment must be initially rented if a **trial period** is required per the DME Procedure Code section.
- All rental payments must be deducted from the purchase price, with the exception of continuous rentals. Utilization Review (UR) claims editing limits the sum of all rental payments to the code's purchase price.

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

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

8. **Frequency:** Durable Medical Equipment, Orthotics, Prosthetics, and Supplies have limits on the frequency that items can be dispensed to an eligible beneficiary. If a beneficiary 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/5 years	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/3 years	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		

CODE	DESCRIPTION	QUANTITY

4.1 MEDICAL/SURGICAL SUPPLIES

ADHESIVE TAPE/REMOVER

A4450	**Tape, non-waterproof, per 18 square inches**	(up to 300)
A4452	**Tape, waterproof, per 18 square inches**	(up to 100)
A4455	**Adhesive remover or solvent (for tape, cement or other adhesive), per ounce**	(up to 40)

ANTISEPTICS

A4244	**Alcohol or peroxide, per pint**	(up to 5)
A4245	**Alcohol wipes, per box** (100's)	(up to 5)
A4246	**Betadine or pHisoHex solution, per pint**	(up to 3)

BREAST PUMPS

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

E0602[F3] **Breast pump, manual, any type**

The manual pump must:

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

CODE	DESCRIPTION	QUANTITY

dishwasher cleaning which are scratch resistant and non-breakable.

The manual petal pump must:

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

E0603[F2] **#Breast pump, electric (AC and/or DC), any type**

The electric personal use/single-user pump must:

- Be lightweight and portable. The total weight of furnished assembly should not exceed 10 pounds.
- Be packaged pre-assembled with all parts necessary for pumping. Assembly includes but not limited to pump motor unit, minimum 5 feet-long electric cord, and double pumping collection kit.
- Operate on a 110-volt household current and be UL listed.
- Have an adjustable suction pressure between 50 mm Hg and 250 mm Hg at the breast shield during use; a suction range just at the low or high end of the range is not acceptable.
- Have an automatic mechanism to prevent suction greater than 250 mm Hg when used according to manufacturer's instructions to prevent nipple trauma.
- Have a mechanism for automatic release of suction for safety.
- Have variable/adjustable cycling not less than 30 cycles per minute; one fixed cycling time is not acceptable.
- Have single and double pumping capacity and capable of maintaining a consistent vacuum (no pressure change) as the collection container fills regardless of the container size and whether single or double pumping.
- Have double pumping capacity which is simultaneous, not alternating.
- Have a visible breast milk pathway and no milk is able to contact the internal pump-motor unit parts at any time when the product is used per manufacturer instructions.
- Include breast flanges that are either adjustable/flexible or if rigid, come in at least two (2) sizes to accommodate

different breast sizes with no sharp edges.

- Include a collection bottle of four to six ounces with a spill-proof cap and standard-size opening, and be bisphenol-A (BPA) and DHEP-free.
- Include a durable soft-sided carrying case with a storage compartment to hold pumping accessories and an insulated cooling compartment including freezer packs for storing expressed breast milk; this is recommended especially for women returning to work or school.
- Include a battery option and adapter that can be used as an alternate power source other than electric; this is recommended for flexibility of pumping.

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

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

CANES/CRUTCHES/ACCESSORIES

A4635	**Underarm pad, crutch, replacement, each**	(up to 2)
A4636	**Replacement, handgrip, cane, crutch or walker, each**	(up to 2)
A4637	**Replacement, tip, cane, crutch, or walker, each**	(up to 5)
E0100 [F4]	**#Cane, includes canes of all materials, adjustable or fixed, with tip**	

CODE	DESCRIPTION	QUANTITY
E0105 [F4]	**#Cane, quad or three-prong, includes canes of all materials, adjustable or fixed, with tips** (over 31" height, no rotation option)	
E0110 [F3]	**Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and hand grips** (over 23" height, no rotation option)	
E0111 [F3]	**Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrip** (over 23" height, no rotation option)	
E0112 [F3]	**Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and hand grips**	
E0113 [F3]	**Crutch, underarm, wood, adjustable or fixed, each, with pad, tip and handgrip**	
E0114 [F3]	**Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and hand grips**	
E0116 [F3]	**Crutch, underarm, other than wood, adjustable or fixed, with pad, tip, handgrip, with or without shock absorber, each**	

INCONTINENCE APPLIANCES AND CARE SUPPLIES

A4310	**Insertion tray without drainage bag and without catheter (accessories only)**	each (up to 10)
A4311	**Insertion tray without drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.)**	each (up to10)
A4314	**Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.)**	each (up to10)
A4320	**Irrigation tray with bulb or piston syringe, any purpose**	each (up to 30)
A4322	**Irrigation syringe, bulb or piston, each**	(up to 50)
A4326	**Male external catheter with integral collection chamber, any type, each**	(up to 2)
A4331	**Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each**	(up to 5)
A4333	**Urinary catheter anchoring device, adhesive skin attachment, each**	(up to 5)
A4334	**Urinary catheter anchoring device, leg strap, each**	(up to12)
A4335	**Incontinence supply; miscellaneous**	up to 1 per 30 days
A4338	**Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each**	(up to10)
A4344	**Indwelling catheter, Foley type, two-way, all silicone**	each (up to10)
A4346	**Indwelling catheter, Foley type, three-way for continuous irrigation, each**	(up to10)

CODE	DESCRIPTION	QUANTITY
A4349	**Male external catheter, with or without adhesive, disposable, each**	(up to 60)
A4351	**Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each**	(up to 250)
A4352	**Intermittent urinary catheter; coude (curved) tip, with or without coating (Teflon, sil-icone, silicone elastomeric, or hydrophilic, etc.), each** ● Covered for self catheterization when the ordering practitioner documents treatment failure with straight tip (A4351) intermittent catheters.	(up to 250)
A4353	**Intermittent urinary catheter, with insertion supplies**	each (up to 60)
A4354	**Insertion tray with drainage bag but without catheter**	each (up to 30)

EXTERNAL URINARY SUPPLIES

A4356 [F5]	**External urethral clamp or compression device (not to be used for catheter clamp), each**	
A4357	**Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each**	(up to 10)
A4358	**Urinary drainage bag; leg or abdomen, vinyl, with or without tube, with straps, each**	(up to 30)

OSTOMY SUPPLIES
These codes must be billed for ostomy care only.

A4361	**#Ostomy faceplate, each**	(up to15)
A4362	**#Skin barrier; solid 4x4 or equivalent, each**	(up to 25)
A4363	**#Ostomy clamp, any type, replacement only, each**	(up to 5)
A4364	**#Adhesive, liquid, or equal, any type, per ounce**	(up to 20)
A4366	**#Ostomy vent, any type, each**	(up to 10)
A4367	**#Ostomy belt, each**	(up to 5)
A4368	**#Ostomy filter, any type, each**	(up to 40)
A4369	**#Ostomy skin barrier, liquid (spray, brush, etc.), per ounce**	(up to 22)
A4371	**#Ostomy skin barrier, powder, per ounce**	(up to 21)
A4372	**#Ostomy skin barrier, solid 4x4 or equivalent, standard wear, with built-in convexity, each**	(up to15)
A4373	**#Ostomy skin barrier, with flange (solid, flexible or accordion), with built-in convexity, any size, each**	(up to15)
A4375	**#Ostomy pouch, drainable, with faceplate attached, plastic, each**	(up to 2)
A4376	**#Ostomy pouch, drainable, with faceplate attached, rubber, each**	(up to 2)

CODE	DESCRIPTION	QUANTITY
A4377	**#Ostomy pouch, drainable, for use on faceplate, plastic, each**	(up to 15)
A4378	**#Ostomy pouch, drainable, for use on faceplate, rubber, each**	(up to 2)
A4379	**#Ostomy pouch, urinary, with faceplate attached, plastic, each**	(up to 15)
A4380	**#Ostomy pouch, urinary, with faceplate attached, rubber, each**	(up to 2)
A4381	**#Ostomy pouch, urinary, for use on faceplate, plastic, each**	(up to 10)
A4382	**#Ostomy pouch, urinary, for use on faceplate, heavy plastic, each**	(up to 15)
A4383	**#Ostomy pouch, urinary, for use on faceplate, rubber. each**	(up to 2)
A4384	**#Ostomy faceplate equivalent, silicone ring, each**	(up to 10)
A4385	**#Ostomy skin barrier, solid 4x4 or equivalent, extended wear, without built-in convexity, each**	(up to 15)
A4387	**#Ostomy pouch closed, with barrier attached, with built-in convexity (1 piece), each**	(up to 15)
A4388	**#Ostomy pouch, drainable, with extended wear barrier attached, without built-in convexity (1 piece) each**	(up to 15)
A4389	**#Ostomy pouch, drainable, with barrier attached, with built-in convexity (1 piece), each**	(up to 15)
A4390	**#Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each**	(up to 15)
A4391	**#Ostomy pouch, urinary, with extended wear barrier attached, (1 piece), each**	(up to 15)
A4392	**#Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each**	(up to 15)
A4393	**#Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each**	(up to 15)
A4394	**#Ostomy deodorant for use in ostomy pouch, liquid, per fluid ounce**	(up to 8)
A4395	**#Ostomy deodorant for use in ostomy pouch, solid, per tablet**	(up to 60)
A4396	**#Ostomy belt with peristomal hernia support**	(up to 2)
A4397	**#Ostomy irrigation supply; sleeve, each**	(up to 125)
A4398	**#Ostomy irrigation supply; bag, each**	(up to 125)
A4399 F10	**#Ostomy irrigation supply; cone/catheter, including brush**	
A4400	**#Ostomy irrigation set**	(up to 30)
A4402	**#Lubricant, per ounce**	(up to 20)
A4404	**#Ostomy ring, each**	(up to 15)

CODE	DESCRIPTION	QUANTITY
A4405	**#Ostomy skin barrier, non-pectin based, paste, per ounce**	(up to 18)
A4406	**#Ostomy skin barrier, pectin-based, paste, per ounce**	(up to 18)
A4407	**#Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 inches or smaller, each**	(up to 10)
A4408	**#Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each**	(up to 10)
A4409	**#Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each**	(up to 10)
A4410	**#Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each**	(up to 10)
A4411	**#Ostomy skin barrier, solid 4x4 or equivalent, extended wear, with built-in convexity, each**	(up to 10)
A4412	**#Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), without filter, each** (used after ostomy surgery)	(up to 15)
A4413	**#Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), with filter, each** (used after ostomy surgery)	(up to 15)
A4414	**#Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 x 4 inches or smaller, each**	(up to 20)
A4415	**#Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4 x4 inches, each**	(up to 20)
A4416	**#Ostomy pouch, closed, with barrier attached, with filter (one piece), each**	(up to 60)
A4417	**#Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (one piece), each**	(up to 60)
A4418	**#Ostomy pouch, closed; without barrier attached, with filter (one piece), each**	(up to 60)
A4419	**#Ostomy pouch, closed; for use on barrier with non-locking flange, with filter (two piece), each**	(up to 60)
A4420	**#Ostomy pouch, closed; for use on barrier with locking flange (two piece), each**	(up to 60)
A4421	**Ostomy supply; miscellaneous**	(up to 30)
A4422	**#Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each**	(up to 60)
A4423	**#Ostomy pouch, closed; for use on barrier with locking flange, with filter (two piece), each**	(up to 60)

CODE	DESCRIPTION	QUANTITY
A4424	**#Ostomy pouch, drainable, with barrier attached, with filter (one piece), each**	(up to 20)
A4425	**#Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (two piece system), each**	(up to 20)
A4426	**#Ostomy pouch, drainable; for use on barrier with locking flange (two piece system), each**	(up to 20)
A4427	**#Ostomy pouch, drainable; for use on barrier with locking flange, with filter (two piece system), each**	(up to 20)
A4428	**#Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (1 piece), each**	(up to 15)
A4429	**#Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each**	(up to 15)
A4430	**#Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece)**	(up to 15)
A4431	**#Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (1 piece), each**	(up to 15)
A4432	**#Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (2 piece), each**	(up to 15)
A4433	**#Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each**	(up to 15)
A4434	**#Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each**	(up to 15)
A4435	**#Ostomy pouch, drainable, high output, with extended wear barrier (one-piece system), with or without filter, each** (used after ostomy surgery)	(up to 15)
A4456	**#Adhesive remover, wipes, any type, each**	(up to 50)
A5051	**#Pouch, closed; with barrier attached (1 piece), each**	(up to 60)
A5052	**#Pouch, closed; without barrier attached (1 piece), each**	(up to 60)
A5053	**#Pouch, closed; for use on faceplate, each**	(up to 60)
A5054	**#Pouch, closed; for use on barrier with flange (2 piece), each**	(up to 60)
A5055	**#Stoma cap**	each (up to 5)
A5056	**#Ostomy pouch, drainable, with extended wear barrier Attached, with filter, (1 piece), each**	(up to 20)
A5057	**#Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (1 piece), each**	(up to 20)
A5061	**#Pouch, drainable; with barrier attached (1 piece), each**	(up to 150)

CODE	DESCRIPTION	QUANTITY
A5062	**#Pouch, drainable; without barrier attached (1 piece), each**	(up to 150)
A5063	**#Pouch, drainable, for use on barrier with flange (2 piece system), each**	(up to 50)
A5071	**#Pouch, urinary; with barrier attached (1 piece), each**	(up to 50)
A5072	**#Pouch, urinary; without barrier attached (1 piece), each**	(up to 50)
A5073	**#Pouch, urinary; for use on barrier with flange (2 piece), each**	(up to 50)
A5081	**#Continent device; plug for continent stoma**	each (up to 31)
A5082 F10	**#Continent device; catheter for continent stoma**	
A5083	**#Continent device, stoma absorptive cover for continent stoma**	each (up to 120)
A5093	**#Ostomy accessory; convex insert**	each (up to 5)

ADDITIONAL INCONTINENCE APPLIANCES/SUPPLIES

A4458 F7	**#Enema bag with tubing, reusable**	
A5105	**# Urinary suspensory with leg bag, with or without tube, each**	(up to 5)
A5112	**Urinary leg bag; latex**	each (up to 5)
A5113	**Leg strap; latex, replacement only, per set**	(up to 2 pair)
A5114	**Leg strap; foam or fabric, replacement only, per set**	(up to 2 pair)
A5120	**Skin barrier, wipes or swabs, each** **● Billed for ostomy care only**	(up to 100)
A5121	**Skin barrier; solid, 6x6 or equivalent, each**	(up to 25)
A5122	**Skin barrier; solid, 8x8 or equivalent, each**	(up to 25)
A5126	**Adhesive or non-adhesive; disc or foam pad**	each (up to 30)
A5131 F10	**Appliance cleaner, incontinence and ostomy appliances, per 16 oz.**	
A5200	**Percutaneous catheter/tube anchoring device, adhesive skin attachment**	each (up to 30)

COMMODE ACCESSORIES

E0160 F3	**#Sitz type bath, or equipment, portable, used with or without commode**
E0167 F3	**#Pail or pan for use with commode chair, replacement only**
E0275 F7	**Bed pan, standard, metal or plastic**
E0276 F4	**#Bed pan, fracture, metal or plastic**
E0325 F3	**#Urinal; male, jug-type, any material**
E0326 F3	**#Urinal; female, jug-type, any material**

CODE	DESCRIPTION	QUANTITY

DIABETIC DIAGNOSTICS

A4233	**#Replacement battery, alkaline (other than j cell), for use with medically necessary home blood glucose monitor owned by patient, each**	(up to 2)
A4234 [F10]	**#Replacement battery, alkaline, j cell, for use with medically necessary home blood glucose monitor owned by patient, each**	
A4235 [F10]	**#Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each**	
A4250	**Urine test or reagent strips or tablets, (100 tablets or strips)**	each (up to 2)
A4252	**#Blood ketone test or reagent strip, each**	(up to 100)
A4253	**Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips (for use with E2100 monitor only)**	(up to 4)
A4256 [F10]	**#Normal, low and high calibrator solution/chips**	
E2100 [F3]	**#Blood glucose monitor with integrated voice synthesizer**	
A9275	**#Home glucose disposable monitor, includes test strips**	each (up to 2)

Coverage Criteria:

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

Non-Covered Indications:

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

DIABETIC DAILY CARE

A4230	**#Infusion set for external insulin pump, non needle cannula type**	each (up to 30) (60 day supply)
A4231	**#Infusion set for external insulin pump, needle type**	each (up to 24) (60 day supply)
A4244	**Alcohol or peroxide, per pint**	(up to 5)
A4245	**Alcohol wipes, per box** (100's)	(up to 5)
A4258	**Spring-powered device for lancet, each**	(up to 2)
A4259	**Lancets, per box of 100**	(up to 2)

CODE	DESCRIPTION	QUANTITY
FAMILY PLANNING PRODUCTS		
A4267	**Contraceptive supply, condom, male, each**	(up to 108)
A4268	**Contraceptive supply, condom, female, each**	(up to 108)
GLOVES		
A4927	**#Gloves, non-sterile, per 100**	(up to 1)
A4930	**#Gloves, sterile, per pair**	(up to 30)

Coverage Criteria:
- Gloves are reimbursable only when medically necessary for use by the beneficiary.
- Sterile gloves are only reimbursable when medically necessary to perform a sterile procedure.

Non-Covered Indications:
- Gloves are not reimbursable as personal protective equipment for employees/caregivers or when included in a kit or tray (e.g., catheter or tracheostomy).

HEAT/COLD APPLICATION		
E0210[F4]	**#Electric heat pad, standard**	
E0215[F4]	**#Electric heat pad, moist**	
A9273[F6]	**Hot water bottle, ice cap or collar, heat and/or cold wrap, any (ice cap/or collar not reimbursable)**	1 per 365 days
SYNTHETIC SHEEP SKIN AND DECUBITUS CARE		
E0188[F13]	**Synthetic sheepskin pad**	
E0191	**Heel or elbow protector, each**	(up to 5)
MASTECTOMY CARE		
L8000	**Breast prosthesis, mastectomy bra, without integrated breast prosthesis form**	each (up to 5)
L8001	**Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral, any size, any type**	each (up to 5)
L8002	**Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral, any size, any type**	each (up to 5)
L8020	**Breast prosthesis, mastectomy form**	each (up to 2)
L8030	**Breast prosthesis, silicone or equal, without integral adhesive**	each (up to 2)
L8031	**Breast prosthesis, silicone or equal, with integral adhesive**	each (up to 2)
S8460	**Camisole, post-mastectomy**	each (up to 5)

CODE	DESCRIPTION	QUANTITY
	RESPIRATORY/TRACHEOSTOMY CARE SUPPLIES	
	NOTE: Supplies/parts are for patient-owned equipment only	
A4605	**Tracheal suction catheter, closed system, each** (for mechanical ventilation patient)	(up to 15)
A4481	**#Tracheostoma filter, any type, any size, each** (i.e., "artificial nose," heat and moisture exchanger, Thermavent, Humid-vent, Povox stomafilter, Bruce-Foam stomafilter). ● If ventilator-dependent, included in the 30 day ventilator rental fee. ● Not to be billed in conjunction with E0450, E0461, E0463, or E0464	(up to 30)
A4614[F8]	**Peak expiratory flow meter, hand held**	
A4615	**Cannula, nasal**	each (up to 4)
A4616	**Tubing, (oxygen), per foot** ● For patient owned respiratory equipment	(up to 30)
A4619	**Face tent**	each (up to 4)
A4620	**Variable concentration mask**	each (up to 4)
A4623	**Tracheostomy, inner cannula**	each (up to 5)
A4624	**Tracheal suction catheter, any type, other than closed system, each** (tray)	(up to 250)
A4625	**Tracheostomy care kit for new tracheostomy** ● Consists of all necessary supplies for tracheostomy care. Includes but not limited to: tray, gloves, brush, gauze sponges, gauze tracheostomy dressing, pipe cleaners, cotton tip applicators, 30" twill tape, gauze roll and tracheostomy tube holder.	each (up to 90)
A4626	**Tracheostomy cleaning brush**	each (up to 2)
A4628	**Oropharyngeal suction catheter, each** (e.g., Yankauer)	each (up to 5)
A4629	**Tracheostomy care kit for established tracheostomy** ● Consists of all necessary supplies for tracheostomy care. Includes but not limited to: tray, gloves, brush, gauze sponges, gauze tracheostomy dressing, pipe cleaners, cotton tip applicators, 30" twill tape and tracheostomy tube holder.	each (up to 90)
A7000	**Canister, disposable, used with suction pump, each**	(up to 5)
A7002	**Tubing, used with suction pump, each** (suction connection tubes)	(up to 30)
A7003	**Administration kit, with small volume nonfiltered pneumatic nebulizer, disposable**	each (up to 2)
A7004	**Small volume nonfiltered pneumatic nebulizer, disposable**	each (up to 5)
A7005[F7]	**#Administration set, with small volume non filtered pneumatic nebulizer, non-disposable**	
A7007	**Large volume nebulizer, disposable, unfilled, used with aerosol compressor**	each (up to 5)

CODE	DESCRIPTION	QUANTITY
A7013	**Filter, disposable, used with aerosol compressor**	each (up to 5)
A7014[F8]	**Filter, non-disposable, used with aerosol compressor or ultrasonic generator**	
A7015[F8]	**Aerosol mask, used with DME nebulizer**	
A7038	**Filter, disposable, used with positive airway pressure device** (for replacement only)	each (up to 2)
A7039[F21]	**Filter, nondisposable, used with positive airway pressure device** (for replacement only)	each (up to 1)
A7523[F5]	**Tracheostomy shower protector, each**	
A7525	**Tracheostomy mask, each**	(up to 4)
E0605[F4]	**#Vaporizer, room type** ● Covered for the treatment of respiratory illness; warm or cool mist.	
L8512	**Gelatin capsules or equivalent, for use with tracheoesophageal voice prosthesis, replacement only, per 10**	(up to 9)
L8513	**Cleaning device used with tracheoesophageal voice prosthesis, pipet, brush, or equal, replacement only, each**	(up to 6)
S8100	**#Holding chamber or spacer for use with an inhaler or nebulizer; without mask**	each (up to 2)
S8101	**#Holding chamber or spacer for use with an inhaler or nebulizer; with mask**	each (up to 2)
S8189	**Tracheostomy supply, not otherwise classified**	1 per 30 days

SUPPORT GOODS

A4463	**Surgical dressing holder, reusable, each**	(up to 5)
A4510[F7]	**#Surgical stockings full length, each** (only for treatment of severe varicosities and edema during pregnancy , any compression gradient)	each (up to 2)
A4565[F10]	**Slings**	
A4570	**Splint**	each (up to 5)
L0120[F13]	**Cervical, flexible, non-adjustable (foam collar)**	

THERMOMETERS

A4931	**Oral thermometer, reusable, any type, each**	one
A4932	**Rectal thermometer, reusable, any type, each**	one

CODE	DESCRIPTION	QUANTITY

UNDERPADS/DIAPERS/LINERS

Coverage Criteria:

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

Non-Covered Indications:

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

General Guidelines:

- The dispenser must maintain documentation of measurements (e.g., waist/hip size, weight) which supports reimbursement for the specific size of diaper/liner dispensed.
- Up to a total of 250 disposable diapers and/or liners are allowed per 30 days, providing for up to 8 changes per day. Claims for any combination of diapers and/or liners over 250 per 30 days will be denied.
- The quantity limits reflect amounts required to meet the medical need for a beneficiary's incontinence treatment plan.

A4335	**Incontinence supply; miscellaneous**	each (up to 30)
A4554	**#Disposable underpads, all sizes, (e.g., Chux's)**	each (up to 300)
T4521	**#Adult sized disposable incontinence product, brief/diaper, small, each** (waist/hip 20"-34")	(up to 250)
T4522	**#Adult sized disposable incontinence product, brief/diaper, medium, each** (waist/hip 28"-47")	(up to 250)
T4523	**#Adult sized disposable incontinence product, brief/diaper, large, each** (waist/hip 40"-59")	(up to 250)
T4524	**#Adult sized disposable incontinence product, brief/diaper, extra large, each** (waist/hip 60"-62")	(up to 250)
T4529	**#Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each** (12-23 lbs)	(up to 250)
T4530	**#Pediatric sized disposable incontinence product, brief/diaper, large size, each** (24-35 lbs)	(up to 250)
T4533	**#Youth sized disposable incontinence product, brief/diaper, each** (>35 lbs)	(up to 250)

CODE	DESCRIPTION	QUANTITY
T4535	**#Disposable liner/shield/guard/pad/undergarment, for incontinence, each**	(up to 250)
T4537	**#Incontinence product, protective underpad, reusable, bed size, each**	(up to 3)
T4539	**#Incontinence product, diaper/brief, reusable, any size, each**	(up to 5)
T4540	**#Incontinence product, protective underpad, reusable, chair size, each**	(up to 3)
T4543	**Disposable incontinence product, brief/diaper, bariatric, each** (waist/hip >-62")	(up to 250)

WOUND DRESSINGS

A6010	**#Collagen based wound filler, dry form, sterile, per gram of collagen**	up to 30
A6011	**#Collagen based wound filler, gel/paste, sterile, per gram of collagen**	up to 30
A6021	**#Collagen dressing, sterile, size 16 sq. in. or less, each**	up to 5
A6022	**#Collagen dressing, sterile, size more than 16 sq. in. but less than or equal to 48 sq. in., each**	up to 5
A6023	**#Collagen dressing, sterile, size more than 48 sq. in., each**	up to 5
A6024	**#Collagen dressing wound filler, sterile, per 6 inches**	up to 3
A6196	**Alginate or other fiber gelling dressing, wound cover, sterile, pad size 16 sq. in. or less, each dressing**	up to 30
A6197	**Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 sq. in., each dressing**	up to 30
A6198	**Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 48 sq. in., each dressing**	up to 15
A6199	**Alginate or other fiber gelling dressing, wound filler, sterile, per 6 inches**	up to 60
A6203	**Composite dressing, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing**	up to 30
A6204	**Composite dressing, sterile, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing**	up to 30
A6205	**Composite dressing, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing**	up to 15
A6206	**Contact layer, sterile, 16 sq. in., or less, each dressing**	up to 30
A6207	**Contact layer, sterile, more than 16 but less than or equal to 48 sq. in., each dressing**	up to 30
A6208	**Contact layer, sterile, more than 48 sq. in., each dressing**	up to 15

CODE	DESCRIPTION	QUANTITY
A6209	**Foam dressing, wound cover, sterile, pad size 16 sq. in, or less, without adhesive border, each dressing**	up to 30
A6210	**Foam dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing**	up to 30
A6211	**Foam dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing**	up to 30
A6212	**Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing**	up to 30
A6213	**Foam dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing**	up to 30
A6214	**Foam dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing**	up to 15
A6216	**Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing**	up to 120
A6217	**Gauze, non-impregnated, non-sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing**	up to 120
A6218	**Gauze, non-impregnated, non-sterile, pad size more than 48 sq. in., without adhesive border, each dressing**	up to 60
A6219	**Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing**	up to 120
A6220	**Gauze, non-impregnated, sterile, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing**	up to 30
A6221	**Gauze, non-impregnated, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing**	up to 15
A6222	**Gauze, impregnated, other than water, normal saline, or hydrogel, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing**	up to 30
A6223	**Gauze, impregnated, other than water, normal saline, or hydrogel, sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing**	up to 60
A6224	**Gauze, impregnated, other than water, normal saline, or hydrogel, sterile, pad size more than 48 sq. in., without adhesive border, each dressing**	up to 15
A6228	**Gauze, impregnated, water or normal saline, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing**	up to 30

CODE	DESCRIPTION	QUANTITY
A6229	**Gauze, impregnated, water or normal saline, sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing**	up to 30
A6230	**Gauze, impregnated, water or normal saline, sterile, pad size more than 48 sq. in., without adhesive border, each dressing**	up to 30
A6231	**Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size 16 sq. in. or less, each dressing**	up to 30
A6232	**Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size greater than 16 sq. in. but less than or equal to 48 sq. in., each dressing**	up to 30
A6233	**Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size more than 48 sq. in., each dressing**	up to 30
A6234	**Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing**	up to 30
A6235	**Hydrocolloid dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 sq. in. without adhesive border, each dressing**	up to 30
A6236	**Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing**	up to 30
A6237	**Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing**	up to 30
A6238	**Hydrocolloid dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 und coversq. in. with any size adhesive border, each dressing**	up to 30
A6239	**Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing**	up to 30
A6240	**Hydrocolloid dressing, wound filler, paste, sterile, per fluid ounce**	up to 20
A6241	**Hydrocolloid dressing, wound filler, dry form, sterile, per gram**	up to 25
A6242	**Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing**	up to 30
A6243	**Hydrogel dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing**	up to 30
A6244	**Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing**	up to 30

CODE	DESCRIPTION	QUANTITY
A6245	**Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing**	up to 30
A6246	**Hydrogel dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 sq. in., with any size adnesive border, each dressing**	up to 30
A6247	**Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing**	up to 30
A6248	**Hydrogel dressing, wound filler, gel, sterile, per fluid ounce**	up to 30
A6251	**Specialty absorptive dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing**	up to 30
A6252	**Specialty absorptive dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing**	up to 30
A6253	**Specialty absorptive dressing wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing**	up to 30
A6254	**Specialty absorptive dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing**	up to 30
A6255	**Specialty absorptive dressing, wound cover, sterile, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing**	up to 30
A6256	**Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing**	up to 30
A6257	**Transparent film, sterile, 16 sq. in. or less, each dressing**	up to 30
A6258	**Transparent film, sterile, more than 16 but less than or equal to 48 sq. in., each dressing**	up to 30
A6259	**Transparent film, sterile, more than 48 sq. in., each dressing**	up to 30
A6261	**Wound filler, gel/paste, sterile, per fluid ounce, not elsewhere classified**	up to 30
A6262	**Wound filler, dry form, sterile, per gram, not elsewhere classified**	up to 30
A6266	**Gauze, impregnated, other than water, normal saline, or zinc paste, sterile, any width, per linear yard**	up to 30
A6402	**Gauze, non-impregnated, sterile, pad size 16 sq. in. or less without adhesive border, each dressing**	up to 180
A6403	**Gauze, non-impregnated, sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing**	up to 120
A6404	**Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing**	up to 30

CODE	DESCRIPTION	QUANTITY
A6407	**Packing strips, non-impregnated, sterile, up to two inches in width, per linear yard**	up to 30
A6410	**Eye pad, sterile, each**	up to 50
A6411	**Eye pad, non-sterile, each**	up to 50
A6412	**Eye patch, occlusive, each**	up to 30
A6441	**Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard**	up to 30
A6442	**Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard**	up to 120
A6443	**Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard**	up to 120
A6444	**Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to five inches, per yard**	up to 120
A6445	**Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard**	up to 120
A6446	**Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard**	up to 120
A6447	**Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard**	up to 120
A6448	**Light compression bandage, elastic, knitted/ woven, width less than three inches, per yard**	up to 90
A6449	**Light compression bandage, elastic, knitted/woven, width greater than or equal to three iches and less than five inches, per yard**	up to 90
A6450	**Light compression bandage, elastic, knitted/ woven, width greater than or equal to five inches, per yard**	up to 90
A6451	**Moderate compression bandage, elastic, knitted/ woven, load resistance of 1.25 to 1.34 foot pounds at 50 percent maximum stretch, width greater than or equal to three inches and less than five inches, per yard**	up to 90
A6452	**High compression bandage, elastic, knitted/woven load resistance greater than or equal to 1.35 foot pounds at 50 percent maximum stretch, width greater than or equal to three inches and less than five inches, per yard**	up to 15
A6453	**Self-adherent bandage, elastic, non-knitted/non-woven, width less than three inches, per yard**	up to 30
A6454	**Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than five inches, per yard**	up to 30

CODE	DESCRIPTION	QUANTITY
A6455	**Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard**	up to 30
A6456	**Zinc impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard**	up to 24
A6457	**Tubular dressing with or without elastic, any width, per linear yard**	up to 25

VARIOUS MISCELLANEOUS

A4216	**Sterile water, saline, and/or dextrose (diluent), 10ml**	up to 120
A4217	**Sterile water/saline, 500ml**	up to 10
A4221	**#Supplies for maintenance of drug infusion catheter, per week (list drug separately)** (Bill 1 occurrence every 30 days) ● Not billable for supplies related to an implantable infusion pump for non-cancer pain. Implantable infusion pumps for non-cancer pain are not a covered benefit. ● Use for all supplies necessary for maintenance of drug infusion catheters and external pumps, and/or supplies necessary for the administration of drugs (except insulin) not otherwise listed in the fee schedule.	each unit (up to 200 units per 30 days)
A4649	**Surgical supply; miscellaneous**	up to 30
A4660[F5]	**#Sphygmomanometer/blood pressure apparatus with cuff and stethoscope, kit, any type**	
A4670[F5]	**Automatic blood pressure monitor (semi or fully automatic)** Semi-automatic monitors (hand cuff inflation) covered when: ● The device is ordered by a qualified practitioner as part of a comprehensive treatment plan for beneficiary monitoring and recording in the home. ● The beneficiary has a hearing or visual impairment, and/or ● The beneficiary could not be taught to use a manual monitor due to low literacy skills or a learning impairment. Fully-automatic monitors (push button operation) covered when: ● The beneficiary meets criteria for semi-automatic and ● The beneficiary has arthritis or other motor disorders involving the upper extremities.	
A9999	**Miscellaneous DME supply or accessory, not otherwise specified**	PA
E0710	**Restraints, any type (body, chest, wrist or ankle)**	each (up to 4)
T5999	**Supply, not otherwise specified** (limited to the following previously state-defined codes):	
• *Z2003*	**Plastic strips**	50's (up to 5)
• *Z2351*[F10]	**Basal thermometer**	
• *Z2156*	**Sterile 6" wood applicator w/cotton tips**	100's (up to 1)

CODE	DESCRIPTION	QUANTITY

- *Z2640*[F6] **Incentive spirometer**
- *Z2744*[F21] **Nasal aspirator**

CODE	DESCRIPTION	QUANTITY

4.2 ENTERAL THERAPY

ENTERAL FORMULAE AND ENTERAL SUPPLIES

B4034	**#Enteral feeding supply kit; syringe fed, per day**	up to 30/mo
B4035	**#Enteral feeding supply kit; pump fed, per day**	up to 30/mo
B4036	**#Enteral feeding supply kit; gravity fed, per day**	up to 30/mo

- Enteral feeding supply kits (B4034-B4036) include whatever supplies are necessary to administer the specific type of feeding, and maintain the feeding site. This includes, but is not limited to: syringes, measuring containers, tip adapters, anchoring device, gauze pads, protective-dressing wipes, tape, and tube cleaning brushes.

B4081	**#Nasogastric tubing with stylet**	one
B4082	**#Nasogastric tubing without stylet**	up to 2
B4083	**#Stomach tube - Levine type**	up to 2
B4087	**#Gastrostomy/jejunostomy tube, standard, any material, any type, each**	one
B4088	**#Gastrostomy/jejunostomy tube, low-profile, any material, any type, each**	1/3mo

- For beneficiaries who cannot tolerate the size of a standard gastrostomy tube or who have experienced failure of a standard gastrostomy tube. This code is for replacement in the patient's home and should not be billed when the tube is replaced in the physician's office, ER or facility with an all inclusive rate. This kit includes tube/ button/ port, syringes, all extensions and/or decompression tubing and obturator if indicated.

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

CODE	DESCRIPTION	QUANTITY
B4153	***Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit**	up to 600 caloric units
B4154	***Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit**	up to 600 caloric units
B4155	***Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g. glucose polymers), proteins/amino acids (e.g. glutamine, arginine), fat (e.g. medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories = 1 unit**	up to 300 caloric units
B4157	***Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit**	up to 600 caloric units
B4158	***Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit**	up to 600 caloric units
B4159	***Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit**	up to 600 caloric units
B4160	***Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit**	up to 600 caloric units

CODE	DESCRIPTION	QUANTITY
B4161	***Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through and enteral feeding tube, 100 calories = 1 unit**	up to 600 caloric units
B4162	***Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit**	up to 600 caloric units
B9998	**Not otherwise classified enteral supplies**	up to 90
S8265	**#Haberman feeder for cleft lip/palate**	up to 2 per 30 days

ENTERAL NUTRITIONAL FORMULA

Benefit Coverage Criteria is limited to:

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

Documentation Requirements:

- The therapy must be an integral component of a documented medical treatment plan and ordered in writing by an authorized practitioner. It is the responsibility of the practitioner to maintain documentation in the beneficiary's record regarding the medical necessity for enteral nutritional formula.
- The physician or other appropriate health care practitioner has documented the beneficiary's nutritional depletion.
- Medical necessity for enteral nutritional formula must be substantiated by documented physical findings and/or laboratory data (e.g., changes in skin or bones, significant loss of lean body mass, abnormal serum/urine albumin, protein, iron or calcium levels, or physiological disorders resulting from surgery, etc.)
- Documentation for beneficiaries who qualify for enteral formula benefit must include an established diagnostic condition and the pathological process causing malnutrition and one or more of the following items:
  (a)Clinical findings related to the malnutrition such as a recent involuntary weight loss or a child with no weight or height increase for six months.
  (b)Laboratory evidence of low serum proteins (i.e., serum albumin less than 3 gms/dl; anemia or leukopenia less than 1200/cmm);
  (c)Failure to increase body weight with usual solid or oral liquid food intake.

Additional Information:

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

Related Links:
The NYS Medicaid Program Enteral Formula Prior Authorization Dispenser Worksheet is available at:
http://emedny.org/ProviderManuals/DME/communications.html
The enteral product classification list is available at:
http://www.emedny.org/ProviderManuals/DME/communications.html

4.3 HEARING AID BATTERY

CODE	DESCRIPTION	QUANTITY
V5266	**Battery for use in hearing device** (any type) (up to a 60 day supply may be dispensed on one date of service)	each (up to 24)
L8621[F8]	**Zinc air battery for use with cochlear implant device, replacement, each**	up to 60
L7360[F10]	**Six volt battery, each**	one
L7364[F7]	**Twelve volt battery, each**	one
L7367[F7]	**Lithium ion battery, replacement**	one

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

CODE **DESCRIPTION**

4.4 DURABLE MEDICAL EQUIPMENT

HOSPITAL BEDS AND ACCESSORIES

General Guidelines:

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

E0251[F3] '-RR' **#Hospital bed, fixed height, with any type side rails, without mattress**

A standard hospital bed is one with manual head and leg elevation adjustments but no height adjustment, which conforms to accepted industry standards, consisting of a modified gatch spring assembly, bed ends with casters, two manually operated foot end cranks, is equipped with IV sockets and is capable of accommodating/supporting a trapeze bar, side rails (any type), an overhead frame and other accessories.

Coverage Criteria:

- A fixed height hospital bed (E0251) is covered if one or more of the following criteria (1-4) are met:
  1. The beneficiary 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 beneficiary requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain; or
  3. The beneficiary 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

CODE	DESCRIPTION

or wedges must have been considered and ruled out; or

4. The beneficiary 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 beneficiary meets one of the criteria 1-4 above and:

5. The beneficiary 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 beneficiary meets one of the criteria 1-4 above and:

6. The beneficiary 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 beneficiary can independently effect the adjustment by operating the controls.

E0266[F3] '-RR' **#Hospital bed, total electric (head, foot and height adjustments), with any type side rails, without mattress**

Coverage Criteria:

● A total electric hospital bed (E0266) is covered if the beneficiary meets one of the criteria 1-4 and both criteria 5 and 6 above, and:

7. The beneficiary 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 beneficiary meets one of the criteria 1-4 above and:

8. The beneficiary'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 beneficiary meets one of the criteria 1-4 above and:

9. The beneficiary's weight exceeds 600 pounds.

CODE	DESCRIPTION
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) Coverage Criteria: ● A Pediatric hospital bed is covered when the beneficiary 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)**
E0316 [F3] '-RR'	**Safety enclosure frame/canopy for use with hospital bed, any type** Coverage Criteria: ●A hospital bed safety enclosure frame/canopy is covered when criteria 10-15 are met, and 16 and 17, if applicable: 14. The beneficiary's bed mobility results in risk for safety in bed that cannot be accommodated by an enclosed pediatric manual hospital bed; and 15. A written monitoring plan approved by the ordering and all treating practitioners has been completed which describes when the bed will be used, how the beneficiary will be monitored at specified time intervals, how all of the beneficiary'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 beneficiary and an explanation of how any medical conditions (e.g., seizures) will be managed while the beneficiary is in the enclosed bed; and

CODE **DESCRIPTION**

16. In the absence of injury relating to bed mobility, a successful trial in the home or facility; and
17. For beneficiaries residing in an OMRDD certified residence, approval as a restraint with the agency's Human Rights Committee.

PRESSURE REDUCING SUPPORT SURFACES

General Guidelines:

- Covered benefit when a beneficiary 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. beneficiary cannot make changes in body position, **or**
- Limited mobility, i.e. beneficiary 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 beneficiary 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 beneficiary 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] **#Dry pressure mattress**
'-RR'

E0185[F6] **#Gel or gel-like pressure pad for mattress, standard mattress length and width**

CODE	DESCRIPTION
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**
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 beneficiary'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 beneficiary'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 beneficiary suffers from a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, the beneficiary's blood gas levels indicate the need for oxygen therapy, the alternative treatment measures have been tried or considered and been deemed clinically ineffective.
  3. Coverage is provided for beneficiaries with significant hypoxia evidenced by any of the following blood gas levels/oxygen saturation levels:

CODE **DESCRIPTION**

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

4. Coverage is available for PO2 56 to 59 mm Hg or oxygen saturation is 89% if any of the following are documented:
   (a) Dependent edema suggesting congestive heart failure; or
   (b) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale of EKG (P wave greater than 3mm in Standard Leads II, III, or AVF); or
   (c) Erythrocythemia with a hematocrit greater than 56%
5. Liquid oxygen therapy coverage is limited to the following conditions:
   (a) Beneficiary requires constant (24 hours per day) liter flow greater than 5LPM; or
   (b) Beneficiary must be away from the home for long periods of time on a daily basis (e.g., school);
   (c) Beneficiaries who qualify for coverage of liquid oxygen will not receive coverage for any other delivery system during the same time period.

- Oxygen and related supplies are covered when prescribed for home oxygen therapy to treat a demonstrated severe breathing impairment. For many high volume oxygen users an oxygen concentrator represents a less expensive, medically appropriate alternative to containerized oxygen, quantity consumed should be a consideration in the type of equipment dispensed.
- Portable oxygen systems are covered when the practitioner's order specifies that the portable system is medically necessary.
- E0431 and E0434 may not be billed in combination.
- The DMEPOS provider must maintain the practitioner's documentation of medical necessity on file with the written order.
- Oxygen therapy must be re-ordered once every 365 days or more frequently if the beneficiary's need for oxygen changes, as well as all medical documentation to substantiate coverage criteria.

CODE **DESCRIPTION**

- All home oxygen therapy services are reimbursed on an all-inclusive rate that may be billed once per 30 days.
- As with all rentals the 30 day fee includes all necessary equipment (e.g. oxygen tank holder)

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

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

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

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

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

- The 30 day rate for code E1390 includes portable/emergency gaseous supply. This supply would be in place for a power outage, malfunction of the concentrator, etc. for the homebound beneficiary, and is included in the 30 day rate. However**,** portable oxygen can be billed in addition to the concentrator when the beneficiary 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[F3] **#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**

CODE	DESCRIPTION
A7034[F3]	**#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** (for replacement only)
A7036[F7]	**#Chinstrap used with positive airway pressure device**
A7037[F7]	**#Tubing used with positive airway pressure device** (for replacement only)
A7044[F3]	**#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**
E0445[F26]	**#Oximeter device for measuring blood oxygen levels non-invasively** ●Covered only in combination with oxygen therapy. Not to be billed with apnea monitors or ventilators unless treatment plan calls for weaning from these devices. ●The 30 day rate for pulse oximeters includes all supplies.

VENTILATORS

E0450, E0461, E0463, E0464 and BiPAP ST equipment (E0471 and E0472) will:
- ●Only be rented and are not to be billed in combination, and
- ●As with all rentals, the 30 day fee includes all necessary equipment, delivery, maintenance and repair costs, parts, supplies (e.g. tracheostoma filters, any type) and services for equipment set-up, maintenance and replacement of worn essential accessories or parts, loading or downloading software, and backup equipment as needed.

E0450[F26]	**#Volume control ventilator, without pressure support mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube)**
E0461[F26]	**#Volume control ventilator, without pressure support mode, may include pressure control mode, used with non-invasive interface (e.g. mask)**
E0463[F26]	**#Pressure support ventilator with volume control mode, may include pressure control mode, used with invasive interface (e.g. tracheostomy tube)**
E0464[F26]	**#Pressure support ventilator with volume control mode, may include pressure control mode, used with non-invasive interface (e.g. mask)**

CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE (CPAP)

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

- The patient must have a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based, as defined by Medicare polysomnogram **and** meet the following criteria:

CODE **DESCRIPTION**

- 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.

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

RESPIRATORY ASSIST DEVICES

BiPAP – E0470
BiPAP ST- E0471 and E0472

Refer to Medicare LCD for Respiratory Assist Devices (L11504) Document for the **qualifying coverage criteria** of BiPAP and BIPAP ST for the following diagnoses:

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

Refer to the following:
http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

E0601[F3] #Continuous airway pressure (CPAP) device
'*-RR'* ● For purchase, filter, tubing and headgear are included with all new CPAP units and should NOT be billed with the initial setup. Supplies are also included if CPAP is initially rented.

E0470[F3] #Respiratory assist device, bi-level pressure capability without backup
'-RR' rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device**)** (BiPAP)(***'-RR'***= 190/30 days
●For purchase; filter, tubing and headgear are included with all new BiPAP units and should NOT be billed with the initial setup. Supplies are also included if BiPAP is initially rented.

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)

CODE **DESCRIPTION**

AIRWAY CLEARANCE DEVICES

E0480, E0481, E0482, E0483

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

E0480[F3] **#Percussor, electric or pneumatic, home model**
'-RR'

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).

E0483[F9] **#High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each**
- Purchase price reached at 1800 days (60 months).

A7025[F2] **#High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each**

A7026[F2] **#High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each**

E0550[F3] **#Humidifier, durable for extensive supplemental humidification**
'-RR' **during IPPB treatments or oxygen delivery**

E0561[F3] **#Humidifier, non heated, used with positive airway pressure**
'-RR' **device**
- For beneficiary-owned equipment only

E0562[F3] **#Humidifier, heated, used with positive airway pressure device**
'-RR'
- For beneficiary-owned equipment only. Not to be billed in combination with a rental.
- Covered only with documented treatment failure with non-heated humidification.

E0565[F3] **#Compressor, air power source for equipment which is not**
'-RR' **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**

CODE	DESCRIPTION
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 lloprost 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 beneficiary 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 beneficiary meets the criteria for regular trapeze equipment and the beneficiary's weight is more than 250 pounds.

E0849[F2]	**#Traction equipment, cervical, free-standing stand/frame,**
'*-RR*'	**pneumatic, applying traction force to other than mandible**
E0855[F2]	**#Cervical traction equipment not requiring additional stand or**
'*-RR'*	**frame**
E0860[F3]	**Traction equipment, overdoor, cervical**
E0890[F3]	**Traction frame, attached to footboard, pelvic traction**
E0900[F3]	**Traction stand, free standing, pelvic traction (e.g., Buck's)**
E0910[F3]	**#Trapeze bars, also known as Patient Helper, attached to bed,**
'-RR'	**with grab bar**
E0911[F3]	**#Trapeze bar, heavy duty, for patient weight capacity greater**
'-RR'	**than 250 pounds, attached to bed, with grab bar**
E0912[F3]	**#Trapeze bar, heavy duty, for patient weight capacity greater**
'-RR'	**than 250 pounds, free standing, complete with grab bar**
E0940[F3]	**#Trapeze bar, free standing, complete with grab bar**
'-RR'	
E0946[F3]	**#Fracture, frame, dual with cross bars, attached to bed (e.g.**
'-RR'	**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 of

CODE **DESCRIPTION**

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.

- Walkers with trunk support should be rented initially to determine the specific prompts required for mobility and training and to measure treatment success. Rental requests must be submitted on a paper prior approval. The monthly rental fee is $100.00 and includes all necessary supports and prompts.
- Clinical documentation from the rental trial period must be submitted with the prior approval request.

Coverage Criteria:

- The beneficiary 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 beneficiary's lower extremities are such that they can tolerate a standing or upright position
- The beneficiary does not have complete paralysis of the lower extremities (Walkers with trunk support have no proven value for persons with complete paralysis of the lower extremities)
- The beneficiary does not have orthostatic hypotension, postural tachycardia syndrome, osteogenesis imperfecta, osteoporosis and other brittle bone diseases.
- The beneficiary has demonstrated improved mobility, function and physiologic symptoms or has maintained status with the use of the requested walker with trunk support (when other alternatives have failed) and is able to follow a home ambulation program incorporating the use of the walker with trunk support (as documented by a clinical ambulation program or a home trial with the requested walker).
- There is a home therapy plan outlining the use of the requested walker with trunk support.
- The beneficiary 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 beneficiary's functional and physical assessment including strength, range of motion, tone, sensation, balance, ADL's, and functional status.
    4. Documentation of failure of less costly alternatives (include make and model of alternatives tried as well as the length of

CODE	DESCRIPTION

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 beneficiary 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 beneficiary'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[F2] **#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[F3] **#Seat attachment, walker**

E0157[F7] **Crutch attachment, walker, each**

E0159[F7] **Brake attachment for wheeled walker, replacement, each**

E8000[F3] **Gait trainer, pediatric size, posterior support, includes all accessories and components**

E8001[F3] **Gait trainer, pediatric size, upright support, includes all accessories and components**

E8002[F3] **Gait trainer, pediatric size, anterior support, includes all accessories and components**

- Rental requests must be submitted on a paper prior approval. The monthly rental fee is $100.00 and includes all necessary supports and prompts.
- Home pediatric gait trainers provide support and encourage upright positioning for walking children requiring gait training/retraining due to **mild to moderate** motor and balance dysfunction.
- With additional prompts, they provide complete adjustment of 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.
- Pediatric gait trainers should be rented initially to determine the

CODE **DESCRIPTION**

specific prompts required for mobility and training and to measure treatment success.
- Clinical documentation from the rental trial period must be submitted with the prior approval request.

Coverage Criteria:
- The beneficiary 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 beneficiary's lower extremities are such that they can tolerate a standing or upright position.
- The beneficiary does not have complete paralysis of the lower extremities (Gait trainers have no proven value for persons with complete paralysis of the lower extremities).
- The beneficiary does not have orthostatic hypotension, postural tachycardia syndrome, osteogenesis imperfecta, osteoporosis and other brittle bone diseases.
- The beneficiary 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 beneficiary 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 Guidelines:
- A prescription including the gait trainer and any modifications/accessories requested
- A detailed letter of medical necessity (LMN) that includes:
    1. A comprehensive history and physical exam by a licensed physician, physical therapist or occupational therapist.
    2. A summary of the existing medical condition, age at diagnosis, prognosis and co-morbid conditions.
    3. The beneficiary's functional and physical assessment including strength, range of motion, tone, sensation, balance, ADL's, and functional status.
    4. Documentation of failure of less costly alternatives (include make and model of alternatives tried as well as the length of the trial with each alternative).
    5. A home therapy plan outlining the planned use of the requested gait trainer
- Documentation that the beneficiary does not have sufficient access to equipment in an alternative setting, e.g. clinic, outpatient therapy, etc.

CODE **DESCRIPTION**

- Documentation regarding the level of caregiver assistance available/needed on daily basis.
- Documentation that the beneficiary's home can accommodate the requested gait trainer and that the family/caregiver has been trained in the use and maintenance of the requested gait trainer.

WHEELED MOBILITY EQUIPMENT (WME), SEATING AND POSITIONING COMPONENTS (SPC)

General Clinical 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).
- Wheeled mobility equipment is covered if the beneficiary's medical condition(s) and mobility limitation(s) are such that without the use of the WME, the beneficiary's ability to perform mobility related activities of daily living (MRADL) in the home and/or community is significantly impaired and the beneficiary is not ambulatory or functionally ambulatory.
- When a beneficiary presents for a medical evaluation for WME and SPC (Seating and Positioning Components), the sequential consideration of the questions below by ordering and treating practitioners provides clinical guidance for the ordering of an appropriate device to meet the medical need of treating and restoring the beneficiary's ability to perform MRADLs. MRADLs include dining, personal hygiene tasks and activities specified in a medical treatment plan completed in customary locations in the home and community.
  1. Does the beneficiary 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 beneficiary from accomplishing the MRADLs entirely, or,
     (b). Places the beneficiary at a reasonably determined heightened risk of morbidity or mortality secondary to attempts to participate in MRADLs, or,
     (c). Prevents the beneficiary from completing the MRADLs within a reasonable time frame.
  2. Are there other conditions that limit the beneficiary's ability to participate in MRADLs?
     (a). Some examples are significant impairment of cognition or judgment and/or vision.
     (b). For these beneficiaries, the provision of WME and SPC might not enable them to participate in MRADLs if the co-morbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with WME and SPC.
  3. If these other limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of WME and SPC will be reasonably expected to significantly improve the beneficiary's ability to perform or obtain assistance to participate in MRADLs?

CODE **DESCRIPTION**

(a). A caregiver, for example a family member, may be compensatory, if consistently available and willing and able to safely operate and transfer the beneficiary to and from the wheelchair and to transport the beneficiary using the wheelchair. The caregiver's need to use a wheelchair to assist the beneficiary in the MRADLs is to be considered in this determination.

(b). If the amelioration or compensation requires the beneficiary'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 beneficiary 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 beneficiary 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 beneficiary 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 beneficiary for this evaluation.
   (b). Assess the beneficiary's ability to safely use a cane or walker.
6. Does the beneficiary's typical environment support the use of WME and SPC?
   (a). Determine whether the beneficiary'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 beneficiary have sufficient upper 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 beneficiary 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 beneficiary's physical characteristics and anticipated intensity of use.
   (c). The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.
   (d). Assess the beneficiary's ability to safely use a manual wheelchair.

CODE **DESCRIPTION**

NOTE: If the beneficiary is unable to self-propel a manual wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair may be appropriate.

8. Does the beneficiary 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 beneficiary must be able to maintain stability and position for adequate operation without additional SPC (a 3-wheeled device is not covered).
   (b). The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a POV.
   (c). Assess the beneficiary's ability to safely use a POV/scooter.
9. Are the additional features provided by a power wheelchair or powered SPC needed to allow the beneficiary to participate in one or more MRADLs?
   (a). The pertinent features of a power wheelchair compared to a POV are typically control by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.
   (b). The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.
   (c). The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a power wheelchair.
   (d). Assess the beneficiary's ability to safely and independently use a power wheelchair and powered SPC.

NOTE: If the beneficiary 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.

General Coverage Criteria for WME:

- The coverage criteria for Medicaid reimbursement of WME is based on a stepwise progression of medical necessity listed in the clinical criteria above and the specific criteria in this section
- In order for these criteria to be met, the beneficiary 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 beneficiary'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 beneficiary'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 beneficiary's weight, seating needs, amount and type of use and needs for other medically necessary features.
- 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.

SEATING AND POSITIONING COMPONENTS (SPC)

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 beneficiary 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 E1399 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 beneficiary, the cushion must be billed as a customized cushion, not custom fabricated.

General Guidelines:
- The code for a seat or back cushion includes any rigid or semi-rigid base or posterior panel, respectively, which is an integral part of the cushion.
- Payment for all wheelchair seats, backs and accessory codes includes fixed, removable and/or quick-release mounting hardware if hardware is applicable to the item. If adjustable hardware is requested and found to be medically appropriate (e.g. pediatrics), it will be payable at invoice cost (not cost + 50%) in addition to the MRA for the seat, back or accessory component. If the code description includes any type of mounting or adjustable hardware, no additional payment for this hardware will be made.
- The swing away, multi-positioning or removable mounting hardware upgrade code (E1028) may only be billed in addition to the codes for a headrest, lateral trunk supports, hip supports, medial thigh supports, calf supports, abductors/pommels, and foot supports when medically justified. It must not be billed in addition to the codes for shoulder harness/straps or chest straps,

wheelchair seat cushions or back cushions, or power wheelchairs with swing away, fixed or retractable joysticks.

- 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 general use, skin protection, positioning, powered and custom made components.
    2. A POV or PWC with Captain's Chair seating is not appropriate for a beneficiary who needs a separate SPC
    3. If a beneficiary 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 beneficiary'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.

Documentation Requirements for WME:

- 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 beneficiary'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 beneficiary 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 beneficiary'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 beneficiary'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 beneficiary'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 beneficiary.
   - ●Describe other physical limitations or concerns (e.g., respiratory)
   - ●Describe any recent or expected changes in medical, physical, or functional status

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

CODE **DESCRIPTION**

Functional assessment:
- ●Describe MRADL capabilities and any problems with performing MRADLs, including the need to use a cane, walker, or the assistance of another person
- ●Describe activities, other than MRADLs, performed while in wheelchair
- ●Transferring between a bed, chair, commode, toilet and WME
- ●Walking around customary environment – provide information on distance walked, speed, and balance.
- ●Ability to carry out a functional weight shift
- ●Describe in detail any significant postural asymmetries with applicable quantitative measurements (e.g., scoliosis leg length discrepancy).
- ●Describe feeding capabilities and seating modifications required to facilitate feeding capabilities
- ●Specifics why less costly alternatives are not medically appropriate based on the beneficiary'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 beneficiary 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 beneficiary 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-9 Diagnosis code(s) and expected surgery date.
- ●Describe anticipated modifications or changes to the equipment within the next three years
- ●Describe the growth potential of the requested equipment in number of years
- ●For SPC, describe whether it can be integrated into a new or existing wheelchair

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

CODE **DESCRIPTION**

- 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 beneficiary'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.

MANUAL WHEELCHAIRS

Manual Wheelchairs are covered when:

- Criterion 1, 2, 3, 4, and 5 are met; and
- Criterion 6 or 7 is met, and
- Criterion is met for specific devices listed below

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

CODE **DESCRIPTION**

●Reimbursement price for all manual wheelchairs includes:
1. any type arm style or armrest, arm pad
2. seat or cushion (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)

(The above parts may not be billed separately with a new wheelchair.)

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 beneficiary is dependent for transfers, and
(b). The beneficiary 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 feature growth capability, attendant or user controlled tilt, multi position tilt, transit system, attendant handles, 10-18" width, 13-18" depth and standard back heights.

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

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

K0001[F4] **#Standard wheelchair**
'-RR' A standard wheelchair is covered when
(a). The beneficiary is able to 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.

CODE	DESCRIPTION
K0002[F4]	**#Standard hemi (low-seat) wheelchair**
'-RR'	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 beneficiary 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]	**#Lightweight wheelchair**
'-RR'	A lightweight wheelchair is covered (a). When a beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel, or (b). For a beneficiary 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]	**#High strength, lightweight wheelchair**
'-RR'	A high strength lightweight wheelchair is covered when (a).The beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel while engaging in frequent MRADLs that cannot be performed in a standard or lightweight wheelchair, or (b). The beneficiary 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, 12/13/14/16/18/20" width, 16-18" depth and 16-19" back.
K0005[F3]	**#Ultra lightweight wheelchair** An ultra lightweight multi-adjustable wheelchair is covered when: (a). The beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel while engaging in frequent MRADLs that cannot be performed in a standard, lightweight or high strength lightweight wheelchair, and (b).The beneficiary's medical condition and the position of the push rim in relation to the beneficiary's arms and hands is integral to the ability to self-propel the wheelchair effectively, and (c).The beneficiary has demonstrated the cognitive and physical ability to independently and functionally self-propel the wheelchair, or (d). The beneficiary'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 wheelchair features low rolling resistance, a fully adjusting rear axle, any type push handles,

CODE	DESCRIPTION
	transport option, 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 11/12/13/14/15/16/17/18" width, 12-18" depth, and 17-20" back. ● Ultra lightweight wheelchairs should not be dispensed as back up manual wheelchairs unless due to the required dimensions not being available in less costly alternatives (e.g., pediatric size and growth options).
K0006[F3]	**#Heavy-duty wheelchair**
'-RR'	A heavy duty wheelchair is covered when: (a). The beneficiary weighs more than 250 pounds, or (b).The beneficiary 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, 16/17/18" depth, and 18-20" back.
K0007[F3]	**#Extra heavy-duty wheelchair** An extra heavy duty (K0007) wheelchair is covered when (a) the beneficiary 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, 19/20/22/24" width, 16-20" depth and low/medium/tall backs are featured.
K0009[F5]	**Other manual wheelchair/base** ● This code is to be used for beneficiaries with medical needs for features in addition to those indicated for the wheelchair and/or accessory codes listed. Custom-made wheelchairs feature a wheelchair frame that is uniquely constructed or substantially modified for a specific beneficiary and is covered if the feature needed is not available in an already manufactured wheelchair or accessory. The assembly of a wheelchair from modular components and the use of customized options do not meet the requirements for a custom-made wheelchair

Other:

- Back-up manual wheelchairs are covered when:
  (a). The beneficiary meets the criteria for a power mobility device, and
  (b).The beneficiary meets the criteria for the rented or purchased back-up manual wheelchair, and
  (c).The beneficiary is unable to complete MRADLs without a back-up manual wheelchair, and
  (d.)The back up wheelchair accommodates the SPC on the primary wheelchair.

CODE **DESCRIPTION**

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

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

POWERED MOBILITY DEVICES (PMD)
Are covered when:
- Criterion 1, 2 and 3 are met, and
- Criterion is met for specific devices listed below.

1. The beneficiary has a mobility limitation that impairs his or her ability to participate in one or more MRADL, and
2. The beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker, and
3. The beneficiary 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), 4 wheeled, are covered if all of the basic coverage criteria (1-3) for PMDs have been met and if criteria (4-9) are also met.

4. The beneficiary is able to:
   (a). Safely transfer to and from a POV, and
   (b). Operate the tiller steering system, and
   (c). Maintain postural stability and position in standard POV seating while operating the POV without the use of any additional positioning aids
5. The beneficiary'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 beneficiary's home provides adequate access between rooms, in and out of the home, maneuvering space, over surfaces and a secure storage space for the operation of the POV that is provided, and
7. The beneficiary's weight is less than or equal to the weight capacity of the POV that is provided, and

CODE **DESCRIPTION**

8. Use of a POV will significantly improve the beneficiary's ability to participate in MRADLs, and
9. The beneficiary 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 beneficiary'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.

Accessories

Reimbursement price for all POV includes:

- Battery or batteries required for operation
- Battery charger single mode
- Weight appropriate upholstery and seating system
- Tiller steering
- Non-expandable controller with proportional response to input
- Complete set of tires
- All accessories needed for safe operation

(The above parts may not be billed separately with a new POV.)

Group 1 POV features

Width less than or equal to 28 inches, length less than or equal to 48 inches, minimum top end speed-flat 3mph, minimum range 5 miles, minimum obstacle climb 20 mm, radius pivot turn less than or equal to 54 inches, dynamic stability incline 6 degrees, fatigue cycle test 200,000 cycles, and drop test 6,666 cycles.

K0800[F3] **Power operated vehicle, group 1 standard, patient weight capacity up to and Including 300 pounds**

K0801[F3] **Power operated vehicle, group 1 heavy duty, patient weight capacity 301 to 450 Pounds**

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

Group 2 POV 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**

CODE **DESCRIPTION**

Power Wheelchairs (PWC) are covered if all of the basic coverage criteria (1-3) for PMDs have been met and

- The beneficiary 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 beneficiary has the mental and physical capabilities to safely and independently operate the power wheelchair that is provided, and
11. The beneficiary's weight is less than or equal to the weight capacity of the power wheelchair that is provided, and
12. The beneficiary's home and community environments provide adequate access between rooms, in and out of the home, maneuvering space, over surfaces and a secure storage space for the operation of the power wheelchair that is provided, and
13. The beneficiary has not expressed an unwillingness to use a power wheelchair.

Reimbursement price for all power wheelchairs (PWCs) includes the following accessories:

- Lap belt or safety belt
- Battery or batteries required for operation
- Battery charger single mode
- Complete set of tires and casters, any type
- Fixed, swing away, or detachable non-elevating leg rests with or without calf pad.
  - -Elevating leg rests may be billed separately.
- Fixed, swing away or detachable footrests or a foot platform without angle adjustment.
  - -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
- Fixed, swing away, or detachable non-adjustable height armrests with arm pad.
  - -Adjustable height armrests may be billed separately.
- 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.
- Joystick hardware, fixed, swing away and/or retractable.
- Controller and Input Device- Non-expandable controller and a standard proportional joystick (integrated or remote).
- Any weight specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient weight capacity.
- Any seat width and depth. Exception: for Group 3 and 4 PWCs with a sling/solid seat/back the following may be billed separately:
  - -For Standard Duty, seat width and/or depth greater than 20 inches;

CODE **DESCRIPTION**

- For Heavy Duty, seat width and/or depth greater than 22 inches;
-For Very Heavy Duty, seat width and/or greater than 24 inches;
-For Extra Heavy Duty, no separate billing

- Any back width. Exception: for Group 3 and 4 PWCs with a sling/solid seat/back, the following may be billed separately:
  -For Standard Duty, back width greater than 20 inches:
  -For Heavy Duty, back width greater than 22 inches:
  -For Very Heavy Duty, back width greater than 24 inches;
  -For Extra Heavy Duty, no separate billing
- Transit option/Transport brackets

(The above parts may not be billed separately with a new PWC.)

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 captains 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

CODE **DESCRIPTION**

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.

Group 1 PWC
Group 1 PWC 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 PWC
Group 2 PWC Standard features

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

Group 2 PWC No Power Option 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).

CODE	DESCRIPTION
K0820[F3]	**Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds**
K0821[F3]	**Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds**
K0822[F3]	**Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds**
K0823[F3]	**Power wheelchair, group 2 standard, captains chair, patient weight capacity up to and including 300 pounds**
K0824[F3]	**Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds**
K0825[F3]	**Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pounds**
K0826[F3]	**Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds**
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**

Group 2 Single Power Option PWC Coverage Criteria (K0835 – K0840):

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

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

Group 2 PWC Single Power Options 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**

CODE	DESCRIPTION
K0840[F3]	**Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more**

Group 2 Multi Power Option PWC Coverage Criteria (K0841-K0843):

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

1. The beneficiary meets coverage criteria for a power tilt and recline seating system and the system is being used on the wheelchair, or
2. The beneficiary uses a ventilator which is mounted on the wheelchair

Group 2 PWC with Multi Power Options 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 PWC
Group 3 PWC Standard features

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

Group 3 PWC with no power options Coverage Criteria (K0848-K0855):

Covered if all of the coverage criteria (1-3, 10-13) for a PWC are met and if the beneficiary's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity.

CODE **DESCRIPTION**

Group 3 PWC No Power option 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**

Group 3 PWC with Single Power Option (K0856-K0860) or with **Multiple Power Options** (K0861-K0864) Coverage Critiera:

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

Group 3 PWC Single Power option 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**

CODE	DESCRIPTION
K0860[F3]	**Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds**

Group 3 PWC Multiple Power option 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 PWC
Group 4 PWC Standard 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).

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

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

Group 4 PWC No Power Option 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**

CODE	DESCRIPTION
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**

Group 4 PWC with Single Power Option (K0877-K0880) or with **Multiple Power Options** (K0884-K0886) Coverage Criteria:

Covered if all of the coverage criteria (1-3, 10-13) for a PWC are met and if
1. The Group 4 no power option criteria are met, and
2. The Group 2 Single Power Option criteria or Multiple Power Options are met.

Group 4 PWC Single Power Option 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**

Group 4 PWC Multiple Power Option features

In addition to Group 4 standard features, expandable controller at initial issue, capable of upgrade to alternative control devices, accommodates more than one powered seating system at a time on the base, and accommodates ventilators.

K0884[F3]	**Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds**
K0885[F3]	**Power wheelchair, group 4 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds**

CODE	DESCRIPTION
K0886[F3]	**Power wheelchair, group 4 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds**

Group 5 PWC
Group 5 PWC Standard 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).

A **Group 5 (Pediatric) PWC with Single Power Option** (K0890) or with **Multiple Power Options** (K0891) is covered if the coverage criteria (1-3, 10-13) for a PWC are met; and

1. The beneficiary is expected to grow in height, and
2. The Group 2 Single Power Option criteria or Multiple Power Options are met.

Group 5 PWC Single Power Option

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**

Group 5 PWC Multiple Power Option 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**

CODE **DESCRIPTION**

Group 6 PWC Miscellaneous Code

K0898[F3] **Power wheelchair, not otherwise classified**

WHEELED MOBILITY ACCESSORIES

- Wheeled mobility accessories that are included in new equipment (as indicated in the Manual and Powered Mobility sections) are reimbursable ONLY as replacement parts outside of warranty and are not to be billed with a new wheelchair. For new wheeled mobility devices, use accessory codes ONLY when included accessories do not meet a specific medical need.
- Coverage of flat free, zero pressure and foam filled tires is limited to beneficiaries who are independent in mobility or whose medical conditions indicate such tires.

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 (e.g.: protraction 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**

E0955[F3] **#Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each**

- Covered when the beneficiary 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.

E0956[F3] **#Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each** (up to 4 supports/prompts)

E0957[F3] **#Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each**

CODE	DESCRIPTION
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 beneficiary has a covered manual tilt-in space, manual semi or fully reclining back, or power tilt and/or recline power seating system or needs additional head support. The code for a headrest includes any type of cushioned headrest, fixed, removable or non-removable hardware.
E0967[F3]	**#Manual wheelchair accessory, hand rim with projections, any type, each**
E0971[F6]	**#Manual wheelchair accessory, anti-tipping device, each**
E0973[F3]	**#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 activated power assist, each** ●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: 1. The beneficiary has been self-propelling in a manual wheelchair for at least one year, and 2. The beneficiary has a non-progressive disease, and 3. The beneficiary has successfully completed a two month trial period (reimbursable with prior approval as a rental).
E0990[F3] ‘-RR’	**#Wheelchair accessory, elevating leg rest, complete assembly, each**
E0992[F6]	**#Manual wheelchair accessory, solid seat insert**
E0995[F6]	**#Wheelchair accessory, calf rest/pad, each**
E1002[F3]	**Wheelchair accessory, power seating system, tilt only** Covered when: ●The beneficiary meets criterion 1-3 of the Seating and Positioning Components coverage criteria, and ●The beneficiary meets the coverage criteria for manual tilt, and ●The beneficiary has the mental and physical capabilities 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 beneficiary meets the coverage criteria for both components and, when provided alone one function will not meet their seating and positioning needs.

CODE	DESCRIPTION
E1003[F3]	**Wheelchair accessory, power seating system, recline only, without shear reduction** Covered when: ●The beneficiary meets criteria 1-3 of the Seating and Positioning component coverage criteria, and ●The beneficiary meets the above criteria for manual recline, and ●The beneficiary has the mental and physical capabilities to safely and independently operate the power recline feature that is provided.
E1004[F3]	**Wheelchair accessory, power seating system, recline only, with mechanical shear reduction** Covered when: ●The beneficiary meets criteria 1-3 of the Seating and Positioning component coverage criteria, and ●The beneficiary meets the above criteria for manual recline, and ●The beneficiary has the mental and physical capabilities to safely and independently operate the power recline feature that is provided.
E1005[F3]	**Wheelchair accessory, power seating system, recline only, with power shear reduction** Covered when: ●The beneficiary meets criteria 1-3 of the Seating and Positioning component coverage criteria, and ●The beneficiary meets the above criteria for manual recline, and ●The beneficiary has the mental and physical capabilities 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 beneficiary 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 beneficiary 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 beneficiary 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**

CODE	DESCRIPTION
E1011[F3]	**Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair)**
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 swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory**
E1225[F3]	**Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each** Covered when: ●The beneficiary meets criteria 1-3 of the Seating and Positioning component coverage criteria, and 4. The beneficiary has a plan of care that requires a recline position to complete Mobility Related Activities of Daily Living (MRADL's), and 5. The beneficiary has positioning needs that cannot be met by upright or fixed angle chair, or 6. The beneficiary's postural control requires a recline feature, or 7. The beneficiary utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed.
E1226[F3] *'-RR'*	**#Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each** Covered when: ●The beneficiary meets criteria 1-3 of the Seating and Positioning component coverage criteria, and 4. The beneficiary has a plan of care that requires a recline position to complete Mobility Related Activities of Daily Living (MRADL's), and 5. The beneficiary has positioning needs that cannot be met by upright or fixed angle chair, or 6. The beneficiary's postural control requires a recline feature, or 7. The beneficiary utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed.
E1228[F6]	**Special back height for wheelchair**
E1298[F3]	**Special wheelchair seat depth and/or width, by construction**
E2201[F3]	**Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches**
E2202[F3]	**Manual wheelchair accessory, nonstandard seat frame width, 24-27 inches**
E2203[F3]	**Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches**
E2204[F3]	**Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches**

CODE	DESCRIPTION
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, each** (any type of brakes)
E2207[F6]	**#Wheelchair accessory, crutch and cane holder, each**
E2209[F6]	**#Arm trough, with or without hand support, each**
E2210[F6]	**Wheelchair accessory, bearings, any type, replacement only, each**
E2211[F7]	**#Manual wheelchair accessory, pneumatic propulsion tire, any size, each**
E2212[F7]	**#Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each**
E2213[F6]	**#Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each**
E2214[F7]	**#Manual wheelchair accessory, pneumatic caster tire, any size, each**
E2215[F7]	**#Manual wheelchair accessory, tube for pneumatic caster tire, any size, each**
E2218[F6]	**#Manual wheelchair accessory, foam propulsion tire, any size, each**
E2219[F6]	**#Manual wheelchair accessory, semi pneumatic foam caster tire, any size, each**
E2220[F7]	**#Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each**
E2221[F7]	**#Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, each**
E2222[F6]	**#Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, each**
E2224[F6]	**#Manual wheelchair accessory, propulsion wheel excludes tire, any size, 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**
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**

CODE	DESCRIPTION
E2292[F3]	**#Seat, planar, for pediatric size wheelchair including fixed attaching hardware**
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, non proportional, including all related electronics, mechanical stop switch, and manual swing away mounting hardware**
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**
E2328[F3]	**Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware**
E2329[F3]	**Power wheelchair accessory, head control interface, contact switch mechanism, non proportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware**
E2330[F3]	**Power wheelchair accessory, head control interface, proximity switch mechanism, non proportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware**
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**

CODE	DESCRIPTION
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**
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**

CODE	DESCRIPTION
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**
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.
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 beneficiary has one of the following diagnoses/conditions: (a). A current pressure ulcer (707.03, 707.04, 707.05) or past history of a pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface; 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

CODE **DESCRIPTION**

paraplegia (344.00- 344.1), other spinal cord disease (336.0-336.3), multiple sclerosis (340), other demyelinating disease (341.0-341.9), cerebral palsy (343.0-343.9), anterior horn cell diseases including amyotrophic lateral sclerosis (335.0-335.21, 335.23-335.9), post polio paralysis (138), traumatic brain injury resulting in quadriplegia (344.09), spina bifida (741.00-741.93), childhood cerebral degeneration (330.0-330.9), Alzheimer's disease (331.0), Parkinson's disease (332.0); 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 (344.00-344.1), other spinal cord disease (336.0-336.3), multiple sclerosis (340), other demyelinating disease (341.0-341.9), cerebral palsy (343.0-343.9), anterior horn cell diseases including amyotrophic lateral sclerosis (335.0-335.21, 335.23-335.9), post polio paralysis (138), traumatic brain injury resulting in quadriplegia (344.09), spina bifida (741.00-741.93), childhood cerebral degeneration (330.0- 330.9), Alzheimer's disease (331.0), Parkinson's disease (332.0); or

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

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

E2604[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 beneficiary 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 (344.30- 344.32, 438.40- 438.42), hemiplegia due to stroke, traumatic brain injury, or other etiology (342.00-342.92, 438.20-438.22), muscular dystrophy (359.0, 359.1), torsion dystonias (333.4, 333.6, 333.7), spinocerebellar disease (334.0-334.9).

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.

CODE	DESCRIPTION
E2608[F5]	**#Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth** ●See coverage criteria for E2607
E2609[F3]	**Custom fabricated wheelchair seat cushion, any size** (pediatric or adult) ●A custom fabricated seat cushion (E2609) is covered if the criterion 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 beneficiary'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
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
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 beneficiary 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 (344.30- 344.32, 438.40- 438.42), hemiplegia due to stroke, traumatic brain injury, or other etiology (342.00-342.92, 438.20-438.22), muscular dystrophy (359.0, 359.1), torsion dystonias (333.4, 333.6, 333.7), spinocerebellar disease (334.0-334.9).
E2614[F5]	**#Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware** ●See coverage criteria for E2613

CODE	DESCRIPTION
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 beneficiary 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 (344.30- 344.32, 438.40- 438.42), hemiplegia due to stroke, traumatic brain injury, or other etiology (342.00-342.92, 438.20-438.22), muscular dystrophy (359.0, 359.1), torsion dystonias (333.4, 333.6, 333.7), spinocerebellar disease (334.0-334.9).
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
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 criterion 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 beneficiary'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**
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**

CODE	DESCRIPTION
E2631 F3	**#Wheelchair accessory, addition to mobile arm support, elevating proximal arm**
E2632F3	**#Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control**
E2633F3	**#Wheelchair accessory, addition to mobile arm support, supinator**
K0015F3	**#Detachable, nonadjustable height armrest, each**
K0017F3	**#Detachable, adjustable height armrest, base, each**
K0018F3	**#Detachable, adjustable height armrest, upper portion, each**
K0019F6	**#Arm pad, each**
K0037F3	**#High mount flip-up footrest, each**
K0038F6	**#Leg strap, each**
K0039F6	**#Leg strap, H style, each**
K0040F3	**#Adjustable angle footplate, each**
K0041F3	**#Large size footplate, each**
K0042F3	**#Standard size footplate, each**
K0043F3	**#Footrest, lower extension tube, each**
K0044F3	**#Footrest, upper hanger bracket, each**
K0045F3	**#Footrest, complete assembly**
K0046F3	**#Elevating leg rest, lower extension tube, each**
K0047F3	**#Elevating leg rest, upper hanger bracket, each**
K0052F3	**#Swing away, detachable footrests, each**
K0053F3	**#Elevating footrests, articulating (telescoping), each**
K0056F3	**Seat height less than 17" or equal to or greater than 21" for a high strength, lightweight, or ultra lightweight wheelchair**
K0065F5	**#Spoke protectors, each**
K0071F6	**#Front caster assembly, complete, with pneumatic tire, each**
K0072F6	**#Front caster assembly, complete, with semi pneumatic tire, each**
K0073F6	**#Caster pin lock, each**
K0077F6	**#Front caster assembly, complete, with solid tire, each**
K0098F6	**#Drive belt for power wheelchair**
K0105F4	**#IV hanger, each** (for wheelchair)
K0108F6	**Other accessories** (limited to wheeled mobility parts not listed) Examples: Lateral knee support pads and hardware: • Defined as positioning supports providing adduction support used on the knee or distal thigh. • Do not use E0956 or E0957. 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

CODE **DESCRIPTION**

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 beneficiary does not meet the coverage criteria for a UESS.

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

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

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

Foot box:
- Covered when the beneficiary's lower extremity posture/positioning needs can not be met by less costly alternatives, such as standard or angle adjustable footplates, padding, straps, etc, and there is a history of skin breakdown and/or injury with the use of footplates alone, and there is evidence that less costly alternatives (padding, straps, and other less costly foot boxes) were tried and failed to meet the beneficiary's medical needs.
- For custom sizes/features additional evidence that less costly alternatives were tried with specifics why they did not meet the beneficiary's medical needs.

Shock absorbers (non-standard caster forks, i.e.: Frog Legs or any other brands):
- Covered when the beneficiary 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 beneficiary has shown a decrease in any of the above symptoms during a trial with the shock absorbers

CODE **DESCRIPTION**

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)
A4557[F6] **Lead wires (e.g., Apnea monitor), per pair** (up to 2 pair, any type)
A4630[F7] **#Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient**
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] **#Enteral nutrition infusion pump – with alarm**
'-RR'
B9004[F3] **#Parenteral nutrition infusion pump, portable**
'-RR'
B9006[F3] **#Parenteral nutrition infusion pump, stationary**
'-RR'

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

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

CODE	DESCRIPTION
E0248[F3]	**#Transfer bench, heavy duty, for tub or toilet with or without commode opening**
E0604[F7]	**#Breast pump, hospital grade, electric (AC and/or DC), any type (rental only)** ●Hospital or professional grade breast pump coverage is limited to cases of prematurity (including multiple gestation), neurologic disorders, genetic abnormalities (e.g., Down's Syndrome), anatomic and mechanical malformations (e.g., cleft lip and palate), congenital malformations requiring surgery (e.g., respiratory, cardiac, gastrointestinal, CNS), prolonged infant hospitalization, or other conditions that prevent normal 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.

CODE	DESCRIPTION

E0619[F9] **#Apnea monitor, with recording feature**

- Apnea monitors will only be rented. As with all rentals, the monthly fee includes all necessary features and equipment, delivery, maintenance and repair costs, parts, supplies and services for equipment set-up, maintenance and replacement of worn essential accessories or parts, loading or downloading software, and backup equipment as needed.
- For children under 1 year of age, an electronic DVS prior authorization number must be obtained prior to providing an apnea monitor. Board certified pulmonologists or neonatologists are qualified to order apnea monitors.
- Prior approval is still required for beneficiaries over 1 (one) year of Age.

Related Links:
Infant Apnea Monitor billing

E0621[F6] **Sling or seat, patient lift, canvas or nylon**

E0628[F2] **#Separate seat lift mechanism for use with patient owned furniture-electric**

E0629[F2] **#Separate seat lift mechanism for use with patient owned furniture-non-electric**

- A separate seat lift mechanism is covered if all of the following criteria are met:
  1. The beneficiary 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 beneficiary'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 beneficiary to transfer from a chair to a standing position.)
  3. The beneficiary must be completely incapable of standing up from a regular armchair or any chair in their home. (The fact that a beneficiary has difficulty, or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all beneficiaries who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.)
  4. Once standing, the beneficiary must have the ability to ambulate.
- Coverage is limited to those types which operate smoothly, can be controlled by the beneficiary, and effectively assist a beneficiary in standing up and sitting down without other assistance.

CODE **DESCRIPTION**

- Excluded from coverage is the type of lift which operates by spring release mechanism with a sudden, catapult-like motion and jolts the beneficiary from a seated to a standing position.
- Patient (beneficiary) and seat lift equipment (E0628, E0629 & E0630) 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.

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 beneficiary 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 beneficiary 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 beneficiary 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 beneficiary's lower extremities are such that they can tolerate a standing or upright position.
- The beneficiary does not have complete paralysis of the lower extremities (Standers have no proven value for persons with complete paralysis of the lower extremities).
- The beneficiary does not have orthostatic hypotension, postural tachycardia syndrome, osteogenesis imperfecta, osteoporosis and other brittle bone diseases, or hip and knee flexion contractures of more than 20°.
- The beneficiary 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 beneficiary is unable to stand or ambulate with caregiver assistance or ambulatory assistive device a sufficient duration/distance to achieve a medical benefit.
- The beneficiary 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

CODE **DESCRIPTION**

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 beneficiary is able to self-propel the mobile stander (code E0642 only), the documentation establishes the specific medical need(s) that will be met while using the mobile stander, and why these medical needs must be met while utilizing the mobile stander.

Documentation Requirements:
- A prescription including the stander and any modifications/accessories requested.
- A detailed letter of medical necessity (LMN) that includes:
  1. A comprehensive history and physical exam by a licensed physician, physical therapist or occupational therapist.
  2. A summary of the existing medical condition, age at diagnosis, prognosis and co-morbid conditions.
  3. The beneficiary's functional and physical assessment including strength, range of motion, tone, sensation, balance, ADL's, and functional status.
  4. Documentation of failure of less costly alternatives (include make and model of alternatives tried as well as the length of the trial with each alternative).
  5. A home therapy plan outlining the planned use of the requested stander.
- Documentation that the beneficiary 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 beneficiary'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 beneficiary 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 beneficiary is able to self-propel the mobile stander (code E0642 only), the specific medical need(s) that will be met while using the mobile stander, and why these medical needs must be met while utilizing the mobile stander.
- The fees listed for home standing systems include all necessary prompts and supports.
- Home standing systems should be rented initially.

E0637 [F2] **Combination sit to stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels**
'-RR'

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

CODE	DESCRIPTION
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)
E0650 [F2]	**Pneumatic compressor, non-segmental home model, (Lymphedema pump)** ●Pneumatic compression devices are covered for the treatment of generalized or refractory lymphedema or refractory edema from venous insufficiency only when all less invasive treatments have been attempted and are unsuccessful. ●The following documentation is required as an attachment to all claims for pneumatic compression devices: 1. Beneficiary history 2. Diagnosis 3. Underlying causes and prognosis 4. Symptoms and objective findings (including measurements, the pressures to be used and expected duration of use of device) 5. Full description of attempts to use less invasive treatments and outcomes of such treatments 6. Responsible party for monitoring beneficiary compliance and response to treatment 7. Plan of care for post-compression pump treatment 8. Rental or purchase 9. A copy of the fiscal order
E0655 [F3]	**Non-segmental pneumatic appliance for use with pneumatic compressor, half arm**
E0660 [F3]	**Non-segmental pneumatic appliance for use with pneumatic compressor, full leg**
E0665 [F3]	**Non-segmental pneumatic appliance for use with pneumatic compressor, full arm**
E0666 [F3]	**Non-segmental pneumatic appliance for use with pneumatic compressor, half leg**
E0700 [F5]	**#Safety equipment, device or accessory, any type** (limited to gait belt)
E0705 [F6]	**Transfer device, any type, each**
E0730 [F5]	**#Transcutaneous electrical nerve stimulation (tens) device, four or more leads, for multiple nerve stimulation** (dual channel)
E0747 [F23]	**#Osteogenesis stimulator electrical, noninvasive, other than spinal applications** Covered when: ●There is long-standing (three months or more) non-union of long bone or tarsal/metatarsal fracture, and ●Failed fusion or congenital pseudarthrosis, and ●The alternative to using the device would be surgery (bone graft or

CODE	DESCRIPTION
	amputation). Related Links: The osteogenesis stimulator worksheet is available at: http://www.emedny.org/providermanuals/DME/communications.html
E0748 F23	**#Osteogenic stimulator electrical, noninvasive, spinal applications** Covered when: ●At least one of the following circumstances exists: 1. Failed spinal fusion where a minimum of nine months has elapsed since the last surgery 2. Following multilevel spinal fusion surgery 3. Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site. Related Links: The osteogenesis stimulator worksheet is available at: http://www.emedny.org/providermanuals/DME/communications.html
E0760 23	**#Osteogenesis stimulator, low intensity ultrasound, non-invasive** Covered when: ●Medically necessary and ordered by a board certified or board eligible orthopedic surgeon for non-union fractures of the tibial shaft as evidenced by: 1. An assessment of why the fracture is non-union. 2. No evidence of healing based on a minimum of three sequential monthly examinations. 3. At least 50% of the fractures are in apposition. 4. No more than ten degrees of anterior or posterior angulation. 5. No more than fifteen degrees of lateral angulation in either varus or valgus, and 6. No other contributing factors that would affect bone growth such as age, smoking, etc. Non-Covered Indications: ●Under no circumstances will ultrasound bone growth stimulation be approved for true synovial synarthrosis. Related Links: The osteogenesis stimulator worksheet is available at: http://www.emedny.org/providermanuals/DME/communications.html
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 F2	**#External ambulatory infusion pump, insulin** ●An external insulin infusion pump will be covered for Diabetes Mellitus as medically necessary when ordered by an endocrinologist if the following criteria are demonstrated and documented in the clinical and DMEPOS providers' records: 1. Failure to achieve acceptable control of blood sugars on 3-4

CODE **DESCRIPTION**

injections that is not explained by poor motivation or compliance, and
2. Documented frequency of glucose testing of at least 4 times/day during 2 months prior to initiation of pump therapy, and
3. Must have one or more of the following criteria while receiving multiple daily injections:
(a) HbA1c >7%
(b) History of recurring hypoglycemia (<60mg/dl)
(c) Wide fluctuations in blood glucose before mealtime (>140mg/dl)
(d) Dawn phenomenon in a fasting state (>200mg/dl)
(e) History of severe glycemic excursions, and
4. Beneficiary has completed a comprehensive diabetes education program, and has been on multiple injections with frequent self adjustments for at least 6 months, or
5. Diagnosis of gestational diabetes.

E0791[F3] **#Parenteral infusion pump, stationary, single or multichannel**
'-RR' ●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.

E1399[F9] **Durable medical equipment, miscellaneous**

Examples:
Positioning bath chair, tub or shower stand:
● Positioning bath chair: is covered when the documented medical and hygiene needs of the beneficiary require proper positioning and alignment while providing a stable and safe means of support during bathing.
●Tub stand addition: is covered when the documented medical and safety needs of the beneficiary require a tub stand and when the dimension of the beneficiary's tub will accommodate the requested stand.
● Shower stand addition: is covered when the documented medical and safety needs of the beneficiary require the use of a shower stand in a roll-in shower stall for bathing and when the beneficiary's shower stall is able to accommodate the requested shower stand.

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

CODE	DESCRIPTION

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

Standing frame systems:
- Use E1399 only for beneficiary's requiring a standing frame over 60 inches tall. See Home Standing Systems guidelines above.

Related Links:
For information on how to obtain a prior approval number for a positioning bath chair, stand, or reclining shower-commode chair, or for information on these products maximum reimbursable amounts, see the following links;
Positioning bath chair and/or stand
Reclining shower-commode chair

A4575[F2] **#Topical hyperbaric oxygen chamber, disposable**

General Definitions:
- Topical oxygen wound therapy (TOWT) is the controlled application of 100% oxygen directly to an open moist wound at slightly higher then atmospheric pressure. An oxygen concentrator is connected to a FDA approved O2 boot and/or O2 sacral device that are for onetime use and disposable, therefore reducing the risk of cross contamination. Studies indicate that concentration of oxygen at the wound site increases the local cellular oxygen tension, which in turn promotes wound healing.
- 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.

CODE **DESCRIPTION**

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 beneficiary'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 beneficiary has been appropriately turned and positioned, and
   (b). The beneficiary 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 beneficiary's moisture and incontinence have been appropriately managed, or
3. Neuropathic (for example, diabetic) ulcers:
   (a). The beneficiary 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;

CODE	DESCRIPTION

5 Stage I, II or III pressure ulcers.

General Guidelines:

- The procedure codes for billing TOWT are A4575 Topical oxygen chamber, disposable and E1390 Oxygen concentrator, single delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate.
- Payment for E1390 includes all necessary equipment, delivery, maintenance and repair costs, parts, supplies and services for equipment set-up, maintenance and replacement of worn essential accessories and parts.
- Payment for A4575 includes the dressing set and canister set used in conjunction with E1390 and contains all necessary components, including but not limited to an occlusive dressing which creates a seal around the wound site for maintaining the desired concentration of oxygen at the wound.
- Payment for E1390 and A4575 are considered payment in full for TOWT.
- An initial electronic prior authorization (DVS) will be granted for A4575 for a maximum of 16 days in a 28 day period, as treatment is 4 days on, 3 days off. The DMEPOS provider should request authorization once for the number of days (units) based on the written order. Prior approval is required for treatment exceeding 4 weeks. E1390 is prior authorized (DVS) and is billed monthly.
- TOWT should be attempted first in a hospital or another health care facility prior to discharge to the home setting. In these continuing cases, documentation should reflect beneficiary 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 beneficiary meets the coverage criteria above must be maintained in the beneficiary'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 beneficiary/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 beneficiary meets the coverage criteria, status of wound healing, weekly quantitative measurements of wound characteristics, wound length, width and

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depth (surface area) and amount of wound exudate (drainage) and beneficiary compliance with the treatment plan. If detailed documentation is insufficient or if any measurable degree of wound healing has failed to occur, prior approval beyond the initial approved period of service will not be granted.

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

E2402[F2] #**Negative pressure wound therapy electrical pump, stationary or portable** (daily rate includes all necessary supplies, up to 30 days allowed without Prior Approval)

- Negative pressure wound therapy (NPWT) is the controlled application of subatmospheric pressure to a wound using an electrical pump (described in the definition of HCPCS coded E2402) to intermittently or continuously convey subatmospheric pressure through connecting tubing to a specialized wound dressing which includes a resilient, open-cell foam surface dressing, sealed with an occlusive dressing that is meant to contain the subatmospheric pressure at the wound site and thereby promote wound healing. Drainage from the wound is collected in a canister.
- A stationary or portable NPWT electrical pump provides controlled subatmospheric 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 subatmospheric pressure conveyed to the wound in a range from 23 to greater than 200 mm Hg subatmospheric pressure. The pump is capable of sounding an audible alarm when desired pressures are not being achieved (that is, where there is a leak in the dressing seal) and when the wound drainage canister is full. The pump is designed to fill the canister to full capacity.

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

Stage I: non-blanchable erythema of intact light toned skin or darker or violet hue in darkly pigmented skin.
Stage II: partial thickness skin loss involving epidermis and or dermis.
Stage III: full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia.
Stage IV: full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures.

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General Coverage criteria (for all wound types):

- Documentation of the history and previous treatment regimens must be maintained in the beneficiary'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 beneficiary 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 beneficiary compliance and pain management during application of NPWT.
- If NPWT has not been attempted, DMEPOS providers must obtain an initial authorization of two weeks only. Prior approval may then be requested for an extension of the treatment. In addition, documentation of the availability of licensed medical professionals to perform dressing changes and cleaning of the devices should be maintained and/or submitted for all cases.

Diagnosis Specific Coverage Criteria:

- All ulcers or wounds:
  1. Documentation in the beneficiary'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 beneficiary has been appropriately turned and positioned, and
  2. The beneficiary 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 beneficiary's moisture and incontinence have been appropriately managed.

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- Neuropathic (for example, diabetic) ulcers:
  1. The beneficiary has been on a comprehensive diabetic management program, and
  2. Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
- Venous insufficiency ulcers:
  1. Compression bandages and/or garments have been consistently applied, and
  2. Leg elevation and ambulation have been encouraged.
- Non-healing surgically created or traumatic wounds:
  1. Documentation of medical necessity for accelerated formation of granulated tissue which cannot be achieved by other topical wound treatments.

Non-covered conditions:

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

Documentation requirements (for continuation of services):

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

CODE **DESCRIPTION**

SPEECH GENERATING DEVICES

The purpose of these guidelines is to provide detailed coverage criteria for speech generating devices and accessories for all stake holders so that medically necessary equipment is provided to Medicaid beneficiaries in a timely manner in compliance with applicable policies. These guidelines are the product of collaboration with practitioners, therapists, medical equipment providers, advocates and NYS Medicaid medical review staff, utilizing state and national standards and are the basis for compliance with applicable Medicaid policies.

Coverage Guidelines for Speech Generating Devices (SGD's) and Related Accessories

- Speech generating devices are considered a form of Augmentative Communication Systems (ACS) or Communication Devices. Speech Generating Devices and related accessories are covered when the following guidelines and criteria are met.
- A beneficiary is eligible for a SGD when their ability to communicate using speech and/or writing is insufficient for normal conversation and when it has been demonstrated that a SGD will allow the individual to improve their communication to a functional level not achievable without the ordered device. Devices must be useful and medically necessary in the beneficiary's customary environments. Evidence that the prescribed SGD is the least costly form of ACS is a required component of the comprehensive evaluation.
- Speech Generating Devices and related accessories are covered when NYS Medicaid's minimum coverage criteria have been met and the ordered SGD is dedicated; or in the case of non-dedicated devices when one of the following is met; a) a SGD software/program is being ordered for use on beneficiary owned equipment (e.g.: laptop, tablet) as a less costly alternative to meet the beneficiary's functional communication needs, or b) the ordering practitioner establishes, with documentation of treatment failure with dedicated devices, that no available forever dedicated device meets the beneficiary's medical needs. Non dedicated devices (excluding SGD software/programs) are not eligible for coverage when the intention is to unlock the device for uses other than communication or for use by individuals other than the beneficiary for which the SGD was ordered.
- Medicaid provides funding for only one SGD concurrently (e.g.: dedicated SGD or a communication software/program).
- Within this policy, the term SGD also describes Speech Generating Device software/programs. While the software/program is a covered benefit when all other coverage criteria are met, the installation and technical support of the program on a non-dedicated device is not separately reimbursable. Additionally, funding (e.g.: repair, support, purchase) of the device itself (e.g.: laptop, tablet) is not a covered benefit as it is not primarily medical in nature and does not meet the definition of durable medical equipment.
- SGD's should be rented initially until such time the documentation establishes the coverage criteria for purchase of a device has been met. Documentation must include a detailed description of the beneficiary's trial of the SGD,

CODE **DESCRIPTION**

addressing the ability to functionally communicate with the device while demonstrating proficiency in accessing and using the device to meet communication needs in all customary environments. Purchase should not be pursued until such time the documentation, including trial results, demonstrates functional and proficient use of the device in the beneficiary's customary environments. When pursuing alternate access components (e.g.: head switch, eye gaze) or SGD software/programs, documentation of a successful trial is also required. The length of trial for alternate access components or software/programs should be sufficient length to demonstrate functional and proficient use of the component/software to allow the beneficiary to meet their communication needs in all customary environments. Rental fees include all the necessary components, including but not limited to, mounting systems, appropriate switches, access components, guards, and software necessary for an effective trial period. Rental is not required if the ordered SGD is a replacement of same/similar equipment and Medicaid's coverage criteria for purchase are met.

- Repairs will not be funded when the minimum coverage criteria for SGD's are not met.
- DMEPOS providers of SGD's are expected to a) be knowledgeable about the items they dispense and provide information to the individuals about the use and care of the item; and b) assist the physician and SLP in coordinating training/education on the device; and c) provide information regarding warranty services and uphold the terms of the warranty; and d) are responsible for any needed replacements or repairs that are due to defects in quality and workmanship.
- The reimbursement for a new SGD includes all necessary batteries, power source components, software, and any type carrying case.
- All documentation of medical necessity must be kept in the ordering practitioner's clinical file and the DMEPOS provider's file.
- The SLP performing the evaluation of the beneficiary may not be an employee or have any financial relationship with the SGD supplier. There must be a signed and dated attestation by the supplier that the licensed/certified medical professional (LCMP) has no financial relationship with the supplier.

General Clinical Documentation requirements

Documentation, at minimum, must include the following:

- Physician order which includes specifications for the device and related accessories/components being ordered. The prescription for rental of a device should also include the necessary therapy and training required to assess the beneficiary's ability to meet their functional communication needs. The ordered device and related accessories should provide the beneficiary with the ability to attain a level of functional communication consistent with his/her physical, language, and cognitive abilities.
- For the purchase of a new device (initial or replacement), a formal evaluation report (see section IV) completed by a licensed Speech Language Pathologist (SLP). The SLP may work in conjunction with other disciplines such as Physical Therapists, Occupational Therapists, or seating specialists as needed. All

clinicians contributing to part of or all of the comprehensive evaluation must provide their name, credentials, license number, date of evaluation/report, signature, and contact information.

- For modifications to an existing device that meets NYS Medicaid's coverage guidelines, including the addition of components or alternate access methods, an abbreviated evaluation, at minimum, by a Licensed SLP is required. If an abbreviated evaluation is provided, it should address at minimum, the beneficiary's current communication abilities and needs, changes in the beneficiary's communication and/or medical status warranting the change in equipment, and evidence that the requested component(s), including any required trials, resulted in an increased level of functional communication and a reduction of disability not available with the current components.
- For repairs to an existing device that meets NYS Medicaid's coverage guidelines, the ordering practitioner or evaluating therapist must document the specific problem(s) with the device and how it impacts the function of the device. 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.

Evaluation Report Guidelines

This guideline outlines the basic components of the written evaluation report for SGD's. The SLP should write a detailed narrative which addresses all of the major sections. The SLP may include other relevant information to justify the medical need for the requested device and related accessories.

1. Pertinent Background Information

- Medical diagnosis
- Significant medical history and medications
- Communication disorder(s)/diagnosis and severity of diagnosis
- Past speech/spoken language treatment
- Consumer's history, vocational status
- Living environment

2. Speech, Language and Communication Abilities

- Speech and language skills
  -Comprehension
  -Production
- Prognosis for significant speech improvement
- Current communications skills through multiple modes (e.g., interaction ability with gestures, vocalizations, etc.)
- Cognition as related to SGD uses (e.g. cognitive-language pre-skills evident; cause and effect). Documentation to establish cognitive level allows for functional and appropriate use of the device. Results of formal cognitive functioning testing.
- Associated behaviors needing consideration (e.g. attitude/motivation, memory, ability to focus/attention to task, reasoning skills, learning, concept/vocabulary knowledge)

CODE **DESCRIPTION**

- Reading, writing and spelling skills

3. Limitations of Current System and Communication Needs
- Summary of the limitations of current methods of communication (e.g. inadequate ability to express known vocabulary)
- Communication environments during a typical day
- Primary communication partners, including special challenges (e.g. visual impairment, wheelchair user, second language) and exchange needs (e.g. group, face to face)
- Message modes (e.g. attention getter, print, telephone)
- Consumer preferences (e.g. consumer opinions about devices and peripherals)
- Communication needs over next two years (e.g. large vocabulary access, spelling capability, communication with groups)

4. Sensory Functioning
- Visual ability as related to SGD system (e.g. visual tracking abilities, acuity for symbol size, material on screens)
- Auditory ability as related to SGD system (e.g. speech feedback)

5. Postural and Motor Abilities
- Mobility status (e.g. ambulatory, wheelchair user-manual/power)
- Primary postures/positions across a typical day and % of time in position (e.g. wheelchair, bed, stander)
- Information on positioning needs with regard to the communication device should be included (trunk and head position; needed supports)
- Need for integration of mobility related equipment with communication system (e.g. with walker, power wheelchair controls)

6. Access/Selection Techniques
- Description of optimal selection technique(s), the physical movement(s) used and any pointer, guards, etc. needed (e.g. direct selection with light pointing via head movements; group-item scanning, size of symbol needed to scan accurately)
- Ability to use selection technique(s) (e.g. movement quality, range of motion, endurance)
- Need for multiple techniques in device (e.g. progressive disease; use in chair/bed)
- Optimal placement and set-up of system (e.g. optimal height and angle of device/manual display, mounting system(s), optimal switch site(s))
- Alternative access methods explored, length of trial/training, education/training provided, and specific reason(s) why ruled out

7. Symbol Form
- Ability to use various graphic and auditory symbol forms (e.g. photographs, line drawings, spoken letters or words for auditory scanning, sight words, alphabet for spelling)
- Optimal symbol form(s) for current use

- Other symbol form(s) expected to be needed in the next 2 years

8. Vocabulary Storage and Rate Enhancement Techniques

- Vocabulary storage/rate enhancement techniques considered (e.g. semantic and letter coding; pages/pop-up pages; word prediction)
- Ability to use specific techniques under consideration
- Rate/storage options deemed appropriate

9. Delineation of Features of Communication System

Summarize required device features. This may include, but is not limited to;

- Memory needs for vocabulary storage
- Symbol form(s)
- Communication output(s) (e.g. paper printer, visual display(s), digitized or synthesized speech, etc.)
- Selection technique(s) and related adaptations (e.g. direct selection with medium sized keyboard; keyguard)
- Mounting system and stabilizers (e.g. mount to hold device; switch)
- Vocabulary storage and rate enhancements techniques (e.g. levels; word prediction)
- Portability (e.g. weight, size)
- Durability (as related to environment, mounting, transportation, etc.)
- Special needs (e.g. integration with other technologies such as computer or power wheelchair, ability to interface with environmental controls)

10. Communication Systems Considered and Ability To Functionally Utilize

- Communication devices considered as related to needed features
- Comparisons of systems' capabilities as related to user needs
- Optimal device from among those considered; how this meets communication needs and it's components for meaningful communication
- Discussion of the less costly alternative devices (including SGD software/programs for beneficiary owned equipment and lower level devices) pursued with specific justification why they were ruled out. Include results of any trials including length of trial, education/training provided, and specific reason(s) why they were ruled out
- If possible, consumer's opinion of SGD device selected
- Include data collected on simulated/trial device

11. Goals and Trial Results

- Functional communication goals (time framed, measurable, and functional) prior to trial and goals achieved at the completion of the trial. Must include quantitative measures of functional communication outcomes and goals.
- Length of trial, location(s) of trial, frequency/duration of use during trial period
- Long term goals should be provided when the minimum coverage criteria are met and the beneficiary's plan of care calls for a more advanced level of proficiency in the future (e.g.: first time users, children).

CODE **DESCRIPTION**

12. Environmental Supports

- Capacity and need of family/caregivers/staff/friends to assist in care and maintenance of SGD device (e.g. charging; daily set-up)
- If applicable, need of family/caregivers/staff/friends to participate in necessary training and facilitate use of SGD device
- Availability of clinical support in the consumers immediate area

13. Communication System Ordered

- Documentation as to how this system meets the beneficiary's medical needs for functional communication in all customary environments.
- Description of device and all components and accessories
- Benefits to user over other possible systems
- Intended location(s), frequency, and duration of use
- Indication of purchase or rental with statement of justification

14. Implementation and Follow-up Plan

- Initial treatment plan for implementing use of device. This may include but is not limited to: (Include the name of person/agency currently responsible for services if possible; if not provide a plan for establishing these services)
  - Initial set-up of system (e.g. initial check, setting up mounting system)
  - Establishing and implementing a treatment plan (e.g. goals for language and communication; device operations)
  - Initial vocabulary analysis and selection, display lay-outs and programming
  - Training significant partners (e.g. care and maintenance, facilitating interaction
- If rental is indicated, include goal plan initiated at the beginning of the rental period and objective measures achieved upon completion
- Probable modifications within ordered system that will require future funding (e.g. switch for individual with ALS, additional memory)
- Agency/Individual responsible for follow-up evaluation and recommendations

15. Upgrade or Replacement of a Previously Provided Device

- Upgrading devices is considered when an unanticipated change occurs in the beneficiary's needs, capabilities, or potential for communication. When upgrading devices, the documentation must establish what significant changes have occurred in the beneficiary's physical or linguistic abilities, or social environment, and how these changes impact the beneficiary's ability to functionally communication with the current SGD. The documentation must address the specific improvement in functional communication and reduction of disability to be achieved by the ordered device that cannot be achieved with the current device.
- When replacing an existing device with same or similar, the documentation must establish the reason(s) why the existing device is no longer medically appropriate and why replacement is required.

CODE **DESCRIPTION**

16. Signatures

- The speech language pathologist must sign the evaluation and provide his/her license number and pertinent contact information.
- All other professionals directly involved in the evaluation should sign and provide their license numbers, NPI, and contact information.

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**

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

K0602[F8] **#Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each**

K0603[F8] **#Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each**

K0604[F8] **#Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each**

K0605[F8] **#Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each**

K0606[F9] **Automatic external defibrillator, with integrated electrocardiogram analysis, garment type**

General Guidelines:

- A wearable automatic external defibrillator (WAED) is a vest-like device that is worn by the beneficiary and is capable of monitoring cardiac rhythms, detecting dysrhythmias and delivering a defibrillation shock to the heart when appropriate without any beneficiary decision making. A WAED is categorized as Durable medical equipment (DME) and is covered under the Home Health

CODE	DESCRIPTION

Benefit of the Medicaid (MA) State Plan.

- A WAED is subject to prior approval and if approved, will be approved as a rental at a reimbursement rate that will maximize at 10 months.
- The monthly rental payment includes all necessary equipment, delivery, maintenance and repair costs, parts, supplies and services for equipment set-up, maintenance and replacement of worn essential accessories or parts.
- After the initial 120 days of treatment, a new fiscal order must be written for the remaining 180 days. The prior approval request must include documentation of compliance with the treatment plan inclusive of, but not limited to, the read-out downloaded from the defibrillator and continued coverage as defined above.
- The WAED (K0606) is covered for beneficiaries at high risk of sudden cardiac death (SCD) who meet the criteria 1 through 4:
  1. (a) A documented episode of ventricular fibrillation or a sustained, lasting 30 seconds or longer, ventricular tachyarrhythmia. These dysrhythmias may be spontaneous and/or must be reproducible during an electrophysiologic (EP) study, but may not be due to a transient or reversible cause and not occur during the first 48 hours of an acute myocardial infarction, first 72 hours post coronary bypass, or within 5 days of a transplant (ICD-9 427.1, 427.42, 427.5) or
     (b) Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmia such as long QT syndrome (ICD-9 426.82) or hypertrophic cardiomyopathy (ICD-9 425.1) or
     (c) Either documented prior myocardial infarction (ICD-9 410.00-410.92, 412) or dilated cardiomyopathy (ICD-9 425.0-425.3 or 425.5-425.9) and a measured left ventricular ejection fraction less than or equal to 0.35; and
  2. (a) Implantation of an Implantable Cardioverter Defibrillator (ICD) is contraindicated (systemic infectious process) or a temporary condition that precludes initial implantation or
     (b) A previously implanted defibrillator now requires explantation (ICD-9 996.04, 996.61) due to infection or inflammatory process due to implant graft with waiting period before ICD reinsertion with documentation that severe infection is not due to poor beneficiary compliance; and
  3. The DMEPOS provider and ordering practitioner have assured that all less costly medically appropriate alternatives have been explored. If the alternatives are not adequate the ordering practitioner is required to provide clear documentation as to why the alternatives are not adequate (per 18NYCRR513.4); and
  4. The ordering practitioner of the wearable defibrillator is a

CODE **DESCRIPTION**

cardiologist and experienced in the management of beneficiaries at risk for SCD.

Non-Covered Indications:

- The WAED is considered **investigational, not medically necessary, medically contraindicated** and **not covered** for all other indications, including but not limited to, the following:
  1. Beneficiaries with a history of an acute myocardial infarction (MI) within 30 days;
  2. Beneficiaries with drug-refractory class IV congestive heart failure (CHF) who are not candidates for heart transplantation;
  3. Beneficiaries with a history of psychiatric disorders that interfere with the necessary care and follow-up;
  4. Beneficiaries in whom a reversible triggering factor (by drug therapy, definitive therapy, ablation) for VT/VF can be definitely identified, such as ventricular tachyarrhythmias in evolving acute myocardial infarction or electrolyte abnormalities;
  5. Beneficiaries with terminal illnesses or other disease processes that clearly and severely limits the beneficiary's life expectancy.

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

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

CODE	DESCRIPTION
T5001[F2]	**#Positioning seat for persons with special orthopedic needs,** for use in vehicles (prior approval required for ages less than 2 or over 10) (up to 60 inches) Covered when the: ●Beneficiary'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. ●Beneficiary'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.

SERVICING, PARTS, REPAIRS

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

K0739, A9900, RB modifier

●For replacement parts that have a specific HCPCS code:
1. Report the replacement part code, and
2. Report K0739 for labor component.

●For replacement parts to base equipment with a specific HCPCS code:
1. Report the base equipment code with the -RB modifier (e.g., wheelchair base code with -RB, hospital bed code with -RB), for the replacement part(s) and
2. Report K0739 for the labor component.

●For miscellaneous DME with no specific or base code to report:
1. Report the appropriate miscellaneous code, E1399 or K0108 or A9900 with the –RB modifier for the replacement part(s), and
2. Report K0739 for labor component.

●A9900 miscellaneous DME supply, accessory, and/or service component of another HCPCS code will now require prior approval and will be priced manually.

●The fee for K0739 Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes (more than 2 hours requires prior approval) is $18.00.

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

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

CODE	DESCRIPTION

- 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**

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)

CODE **DESCRIPTION**

4.5 ORTHOTICS

GENERAL COVERAGE CRITERIA:

1. This schedule is applicable to both children and adults.
2. Base codes are covered when the physician's order and supporting documentation clearly establish the medical and functional need being met by the prescribed device. Where applicable, code specific coverage criteria must be met.
3. L Code "additions" are covered only when both the base codes coverage criteria has been met and specific documentation exists establishing the medical necessity of the addition code.
4. When providing a custom fabricated device, the documentation should establish specific reason(s) why a prefabricated alternative was not medically indicated. This should Include, where applicable, the documented failure of prefabricated alternatives. A prefabricated orthosis is one which is manufactured in quantity without a specific beneficiary in mind. It is preformed 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 beneficiary (i.e.: custom fitted). A custom fabricated orthosis is one which is individually made for a specific beneficiary (no other patient would be able to use this orthosis) starting with basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc.
5. The providers shall be responsible for any needed repairs or replacements due to defects in quality or workmanship that appear within three months of delivery. This does not include adjustments or replacements necessitated by anatomical changes.
6. Replacements and repairs: used to indicate replacement and repair of orthotic and prosthetic devices which have been in use for some time. Prior approval is not required when the charge is over $35.00 and is less than 10% of the price listed on the code for the device. When specific replacement and repair codes are available, they should be used instead of the code for the device with '-RB'. For charges $35.00 and under, use L4210.
7. The fees contained in this schedule will be paid under State-administered programs, and are to be considered full payment for the services rendered. The provider shall make no additional charge to the beneficiary.
8. Unless otherwise specified all fees are for the unilateral, single unit or "each."
9. All normal necessary pads and straps are included in the prices quoted.
10. For home visit, see L9900

CODE **DESCRIPTION**

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**
L0170 [F3] **#Cervical, collar, molded to patient model**
L0172 [F3] **#Cervical, collar, semi-rigid thermoplastic foam, two piece**
L0174 [F3] **#Cervical, collar, semi-rigid, thermoplastic foam, two piece with thoracic extension**
S1040 [F1] **#Cranial remolding orthosis, rigid, with soft interface material, custom fabricated, includes fitting and adjustment(s)**

Covered when:

- The beneficiary 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 beneficiary is between the ages of 3-18 months old and is considered to have a reasonable likelihood of continued skull growth.
- There is documentation of, at minimum, a 2 month trial of repositioning and stretching exercises as follows:
  1. Alternating back and side sleeping
  2. Supervised tummy time
  3. Rearranging the crib relative to the primary light source
  4. Limiting time spent in a supine position
  5. Limiting time in strollers, carriers and swings

CODE **DESCRIPTION**

6. Rotating chair activity
7. Neck motion exercises

Not covered for:
- ●Beneficiaries over the age of 24 months.
- ●Unmanaged hydrocephalus
- ●Craniosynostosis

Documentation requirements:
- ●A valid script 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**
L0430 [F2] #**Spinal orthosis, anterior-posterior-lateral control, with interface material, custom fitted (DeWall posture protector only)**

Thoracic-lumbar-sacral orthosis (TLSO)

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

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

CODE	DESCRIPTION
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, includes fitting and adjustment**
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, includes fitting and adjustment**
L0458 [F4]	**#TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment**
L0460 [F4]	**#TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment**
L0462 [F4]	**#TLSO, triplanar control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment**
L0464 [F4]	**#TLSO, triplanar control, modular segmented spinal system, four rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, prefabricated, includes fitting and adjustment**

CODE	DESCRIPTION
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, includes fitting and adjustment**
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, includes fitting and adjustment**
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**

CODE	DESCRIPTION
L0484 [F6]	**#TLSO, triplanar control, two piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated**
L0486 [F6]	**#TLSO, triplanar control, two piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from 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**

CODE	DESCRIPTION

CERVICAL-THORACIC-LUMBAR-SACRAL ORTHOSIS (CTLSO)

L0621 [F4]	**#SO, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment**
L0622 [F4]	**#SO, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated**
L0623 [F4]	**#SO, 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, includes fitting and adjustment**
L0624 [F4]	**#SO, 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 (LO)

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

L0625 [F4]	**#LO, 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, includes fitting and adjustment**
L0626 [F4]	**#LO, 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, includes fitting and adjustment**
L0627 [F4]	**#LO, 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, includes fitting and adjustment**

CODE	DESCRIPTION

Lumbar-sacral orthosis (LSO)

- 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	**#LSO, 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, includes fitting and adjustment**
L0629	F4	**#LSO, 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	**#LSO, 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, includes fitting and adjustment**
L0631	F4	**#LSO 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, includes fitting and adjustment**
L0632	F4	**#LSO, 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	**#LSO, 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, includes fitting and adjustment**

CODE	DESCRIPTION
L0634 [F4]	#**LSO, 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]	#**LSO, 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]	#**LSO, 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]	#**LSO, 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, includes fitting and adjustment**
L0638 [F4]	#**LSO, 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]	#**LSO, 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, includes fitting and adjustment**

CODE	DESCRIPTION
L0640 F4	#**LSO, 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**

ANTERIOR-POSTERIOR-LATERAL CONTROL

L0700 F2	#**CTLSO, anterior-posterior-lateral control, molded to patient model, (Minerva type)**
L0710 F2	#**CTLSO, anterior-posterior-lateral-control, molded to patient model, with interface material (Minerva type)**

HALO PROCEDURE

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

ADDITIONS TO SPINAL ORTHOSES

L0970 F6	**#TLSO, corset front**
L0972 F6	**#LSO, corset front**
L0974 F6	**#TLSO, full corset**
L0976 F6	**#LSO, full corset**
L0978 F6	**#Axillary crutch extension**
L0980 F6	**#Peritoneal straps, pair**
L0982 F6	**#Stocking supporter grips, set of four (4)**
L0984 F16	**#Protective body sock, 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 beneficiary'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.

CODE	DESCRIPTION

CERVICAL-THORACIC-LUMBAR-SACRAL ORTHOSIS (CTLSO)

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

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

L1200	F4	**#TLSO, inclusive of furnishing initial orthosis only**
L1210	F4	**#Addition to TLSO, (low profile), 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**
L1499	F10	**Spinal orthosis, not otherwise specified**

CODE	DESCRIPTION

ORTHOTIC DEVICES – LOWER LIMB

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

HIP ORTHOSIS (HO) – FLEXIBLE

L1600 F2 **#HO, abduction control of hip joints, flexible, Frejka type with cover, prefabricated, includes fitting and adjustment**
L1610 F2 **#HO, abduction control of hip joints, flexible, (Frejka cover only), prefabricated, includes fitting and adjustment**
L1620 F2 **#HO, abduction control of hip joints, flexible, (Pavlik harness), prefabricated, includes fitting and adjustment**
L1630 F2 **#HO, abduction control of hip joints, semi-flexible (Von Rosen type), custom fabricated**
L1640 F2 **#HO, abduction control of hip joints, static, pelvic band or spreader bar, thigh cuffs custom fabricated**
L1650 F2 **#HO, 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, any type**
L1660 F2 **#HO, 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 **#HO, abduction control of hip joint, post-operative hip abduction type, custom fabricated**
L1686 F2 **#HO, 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, (Tachdijan type), custom fabricated**
L1730 F2 **#Legg-Perthes orthosis, (Scottish Rite type), custom fabricated**
L1755 F2 **#Legg-Perthes orthosis, (Patten Bottom type), custom fabricated**

CODE **DESCRIPTION**

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. Ambulatory beneficiary's who have weakness or deformity of the knee and require stabilization.

L1810 [F16] **#KO, elastic with joints, prefabricated, includes fitting and adjustment**

L1820 [F16] **#KO, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment**

L1830 [F2] **#KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment**

- **Covered for:**
    1. **Beneficiary's with a recent injury to or a surgical procedure on the knee(s) and has one of the following ICD-9 diagnoses; 714.0-714.4, 715.16, 715.26, 715.36, 715.96, 717.0-717.5, 717.7, 717.81-717.9, 727.65, 733.15, 733.16, 733.49, 733.81-733.82, 733.93, 755.64, 821.20-821.39, 822.0, 822.1, 823.00-823.42, 836.0-836.69, 844.0-844.2, 844.8, 905.4 996.40-996.49, 996.66, 996.77, V43.65.**

L1831 [F3] **#KO, locking knee joint(s), positional orthosis, prefabricated, includes fitting and adjustment**

- **Covered for:**
    1. **Beneficiary's with flexion or extension contractures of the knee (ICD-9 718.46) with movement on passive range of motion testing of at least 10 degrees (i.e., a non fixed contracture).**

L1832 [F3] **#KO, knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, includes fitting and adjustment**

- **Covered for:**
    1. **Beneficiary's with a recent injury to or a surgical procedure on the knee(s) and has one of the following ICD-9 diagnoses; 714.0-714.4, 715.16, 715.26, 715.36,**

CODE	DESCRIPTION

715.96, 717.0-717.5, 717.7, 717.81-717.9, 727.65, 733.15, 733.16, 733.49, 733.81-733.82, 733.93, 755.64, 821.20-821.39, 822.0, 822.1, 823.00-823.42, 836.0-836.69, 844.0-844.2, 844.8, 905.4, 996.40-996.49, 996.66, 996.77, V43.65; or

2. **Ambulatory beneficiary's with knee instability due to one of the following ICD-9 diagnoses; 340, 342.90, 342.91, 342.92, 343.9, 344.1, 355.0, 355.2**

- **Documentation requirements include objective description of joint laxity (e.g., varus/valgus instability, anterior/posterior Drawer test).**

L1834 [F3] **#KO, 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] **#KO, rigid, without joint(s), includes soft interface material, prefabricated, includes fitting and adjustment**

- **Covered for:**
  1. **Beneficiary's with flexion or extension contractures of the knee (ICD-9 718.46) with movement on passive range of motion testing of at least 10 degrees (i.e., a non fixed contracture).**

L1840 [F3] **#KO, derotation, medial-lateral, anterior cruciate ligament, custom fabricated**

- **Covered for:**
  1. **Beneficiary's with instability due to internal ligamentous disruption of the knee (ICD-9 717.81-717.9).**

L1843 [F3] **#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, includes fitting and adjustment**

- **Covered for:**
  1. **Ambulatory beneficiary's with knee instability due to one of the following ICD-9 diagnoses; 714.0-714.4, 715.16, 715.26, 715.36, 715.96, 717.0-717.5, 717.7, 717.81-717.9, 727.65, 733.15, 733.16, 733.49, 733.81-733.82, 733.93, 755.64, 821.20-821.39, 822.0, 822.1, 823.00-823.42, 836.0-836.69, 844.0-844.2, 844.8, 905.4, 996.40-996.49, 996.66, 996.77, V43.65340, 342.90, 342.91, 342.92, 343.9, 344.1, 355.0, 355.2.**
- **Documentation requirements include objective description of joint laxity (e.g., varus/valgus instability, anterior/posterior Drawer test).**

CODE	DESCRIPTION
L1844 [F3]	**#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, 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]	**#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, includes fitting and adjustment** • **Covered for:** **1. Ambulatory beneficiary's with knee instability due to one of the following ICD-9 diagnoses; 714.0-714.4, 715.16, 715.26, 715.36, 715.96, 717.0-717.5, 717.7, 717.81-717.9, 727.65, 733.15, 733.16, 733.49, 733.81-733.82, 733.93, 755.64, 821.20-821.39, 822.0, 822.1, 823.00-823.42, 836.0-836.69, 844.0-844.2, 844.8, 905.4, 996.40-996.49, 996.66, 996.77, V43.65340, 342.90, 342.91, 342.92, 343.9, 344.1, 355.0, 355.2.** • **Documentation requirements include objective description of joint laxity (e.g., varus/valgus instability, anterior/posterior Drawer test).**
L1846 [F3]	**#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, 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]	**#KO, double upright with adjustable joint, with inflatable air support chamber(s), prefabricated, includes fitting and adjustment**
L1850 [F3]	**#KO, Swedish type, prefabricated, includes fitting and adjustment** • **Covered for:** **1. Ambulatory beneficiary's with knee instability due to genu recurvatum (ICD-9 736.5).** • **Documentation requirements include objective description of joint laxity (e.g., varus/valgus instability, anterior/posterior Drawer test).**
L1860 [F3]	**#KO, modification of supracondylar prosthetic socket, custom fabricated (SK)** • **Covered for:** **1. Ambulatory beneficiary's with knee instability due to genu recurvatum (ICD-9 736.5)**

CODE **DESCRIPTION**

ANKLE–FOOT ORTHOSIS (AFO)

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

L4396[F6] **#Static or dynamic ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, pressure reduction, may be used for minimal ambulation, prefabricated, includes fitting and adjustment**
L4398[F6] **#Foot drop splint, recumbent positioning device, prefabricated, includes fitting and adjustment**

- Ankle-foot orthoses (AFO) described by codes L1900-L1990 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.

L1900 [F6] **#AFO, spring wire, dorsiflexion assist calf band, custom fabricated**
L1902 [F2] **#AFO, ankle gauntlet, prefabricated, includes fitting and adjustment**
L1904 [F2] **#AFO, molded ankle gauntlet, custom fabricated**
L1906 [F2] **#AFO, multiligamentus ankle support, prefabricated, includes fitting and adjustment**
L1907 [F6] **#AFO, supramalleolar with straps, with or without interface/pads, custom fabricated**
L1910 [F6] **#AFO, posterior, single bar, clasp attachment to shoe counter, prefabricated, includes fitting and adjustment**
L1920 [F6] **#AFO, single upright with static or adjustable stop (Phelps or Perlstein type), custom fabricated**
L1930 [F6] **#AFO, plastic or other material, prefabricated, includes fitting and adjustment**
L1932 [F6] **#AFO, rigid anterior tibial section, total carbon fiber or equal material, prefabricated, includes fitting and adjustment**
L1940 [F6] **#AFO, plastic or other material, custom fabricated**
L1945 [F6] **#AFO, molded to patient model, plastic, rigid anterior tibial section (floor reaction), custom fabricated**
L1950 [F4] **#AFO, spiral (IRM type), plastic, custom fabricated**
L1951 [F4] **#AFO, spiral, (Institute of Rehabilitative Medicine type), plastic or other material, prefabricated, includes fitting and adjustment**

CODE	DESCRIPTION
L1960 F6	**#AFO, posterior solid ankle, plastic, custom fabricated**
L1970 F6	**#AFO, plastic, with ankle joint, custom fabricated**
L1971 F6	**#AFO, plastic or other material with ankle joint, prefabricated, includes fitting and adjustment**
L1980 F6	**#AFO, single upright free plantar dorsiflexion, solid stirrup, calf band/cuff (single bar "BK" orthosis), custom fabricated**
L1990 F6	**#AFO, 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 ambulatory patients 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 ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required.

L2000 F4	**#KAFO, single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar "AK" orthosis), custom fabricated**
L2005 F4	**#KAFO, 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	**#KAFO, single upright, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar "AK" orthosis), without knee joint, custom fabricated**
L2020 F4	**#KAFO, double upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar "AK" orthosis), custom fabricated**
L2030 F4	**#KAFO, double upright, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar "AK" orthosis), without knee joint, custom fabricated**
L2034 F4	**#KAFO, full plastic, single upright, with or without free motion knee, medial lateral rotation control, with or without free motion ankle, custom fabricated**
L2035 F4	**#KAFO, full plastic, static (pediatric size), without free motion ankle, prefabricated, includes fitting and adjustment**
L2036 F4	**#KAFO, full plastic, double upright, with or without free motion knee, with or without free motion ankle, custom fabricated**

CODE	DESCRIPTION
L2037 F4	**#KAFO, full plastic, single upright, with or without free motion knee, with or without free motion ankle, custom fabricated**
L2038 F4	**#KAFO, full plastic, with or without free motion knee, multi-axis ankle, custom fabricated**

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

L2040 F4	**#HKAFO, torsion control, bilateral rotation straps, pelvic band/belt, custom fabricated**
L2050 F4	**#HKAFO, torsion control, bilateral torsion cables, hip joint, pelvic band/belt, custom fabricated**
L2060 F4	**#HKAFO, torsion control, bilateral torsion cables, ball bearing hip joint, pelvic band/belt, custom fabricated**
L2070 F4	**#HKAFO, torsion control, unilateral rotation straps, pelvic band/belt, custom fabricated**
L2080 F4	**#HKAFO, torsion control, unilateral torsion cable, hip joint, pelvic band/belt, custom fabricated**
L2090 F4	**#HKAFO, 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	**#AFO, fracture orthosis, tibial fracture cast orthosis, thermoplastic type casting material, custom fabricated**
L2108 F2	**#AFO, fracture orthosis, tibial fracture cast orthosis, custom fabricated**
L2112 F2	**#AFO, fracture orthosis, tibial fracture orthosis, soft, prefabricated, includes fitting and adjustment**
L2114 F2	**#AFO, fracture orthosis, tibial fracture orthosis, semi-rigid, prefabricated, includes fitting and adjustment**
L2116 F2	**#AFO, fracture orthosis, tibial fracture orthosis, rigid, prefabricated, includes fitting and adjustment**
L2126 F2	**#KAFO, fracture orthosis, femoral fracture cast orthosis, thermoplastic type casting material, custom fabricated**
L2128 F2	**#KAFO, 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**

CODE	DESCRIPTION
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

L2210 **F6**	**#Addition to lower extremity, dorsiflexion assist (plantar flexion resist), each joint**
L2220 F6	**#Addition to lower extremity, dorsiflexion and plantar flexion assist/resist, each joint**
L2230 F6	**#Addition to lower extremity, split flat caliper stirrups and plate attachment**
L2232 F6	**#Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only**
L2250 F6	**#Addition to lower extremity, foot plate, molded to patient model, stirrup attachment**
L2260 F6	**#Addition to lower extremity, reinforced solid stirrup (Scott-Craig type)**
L2265 F6	**#Addition to lower extremity, long tongue stirrup**
L2270 F6	**#Addition to lower extremity, varus/valgus correction (“T”) strap, padded/lined or malleolus pad**
L2275 F6	**#Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined**
L2280 **F4**	**#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**

CODE	DESCRIPTION
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 beneficiary's with documented weight of more than 300 pounds.**
L2387 F4	**#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 beneficiary's with documented weight of more than 300 pounds.**
L2397 F7	**#Addition to lower extremity orthosis, suspension sleeve**
L2861 F3	**Addition to lower extremity joint, knee or ankle, concentric adjustable torsion**

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/WEIGHT BEARING- GLUTEAL/ISCHIAL WEIGHT BEARING

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**

CODE	DESCRIPTION
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**
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**
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 **F4**	**#Orthotic side bar disconnect device, per bar**
L2780 **F4**	**#Addition to lower extremity orthosis, non-corrosive finish, per bar**

CODE	DESCRIPTION
L2785 F4	**#Addition to lower extremity orthosis, drop lock retainer, each**
L2795 F6	**#Addition to lower extremity orthosis, knee control, full kneecap**
L2800 F6	**#Addition to lower extremity orthosis, knee control, knee cap, medial or lateral pull, for use with custom fabricated orthosis only**
L2810 F6	**#Addition to lower extremity orthosis, knee control, condylar pad**
L2820 F6	**#Addition to lower extremity orthosis, soft interface for molded plastic, below knee section** ●Covered for a documented history of skin breakdown.
L2830 F6	**#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**
L2999 F10	**Lower extremity orthoses, not otherwise specified** Refer to "2010 Orthotics and Prosthetics Procedure Code Changes" update dated December 28, 2009 for specific items that are billable using L2999. Billing code L2999 is not limited to only those items.

ORTHOTIC DEVICES – UPPER LIMB

NOTE: Upper Limb: the procedures in this section are considered as "Base" or "Basic Procedures" and may be modified by listing procedures from the "Additions Section" and adding them to the base procedure.

SHOULDER ORTHOSIS (SO)

L3650 F2	**#SO, figure of "8" design abduction restrainer, prefabricated, includes fitting and adjustment**
L3660 F2	**#SO, figure of "8" design abduction restrainer, canvas and webbing, prefabricated, includes fitting and adjustment**
L3670 F2	**#SO, acromio/clavicular (canvas and webbing type), prefabricated, includes fitting and adjustment**
L3671 F2	**SO, 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	**#SO, vest type abduction restrainer, canvas webbing type, or equal, prefabricated, includes fitting and adjustment**
L3677 F2	**SO, hard plastic, shoulder stabilizer, prefabricated, includes fitting and adjustment**

CODE	DESCRIPTION

ELBOW ORTHOSIS (EO)

L3702 F4	**#EO, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment**
L3710 F4	**#EO, elastic with metal joints, prefabricated, includes fitting and adjustment**
L3720 F4	**#EO, double upright with forearm/arm cuffs, free motion, custom fabricated**
L3730 F4	**#EO, double upright with forearm/arm cuffs, extension/flexion assist, custom fabricated**
L3740 F4	**#EO, double upright with forearm/arm cuffs, adjustable position lock with active control, custom fabricated**
L3760 F2	**#EO, with adjustable position locking joint(s), prefabricated, includes fitting and adjustments, any type**
L3762 F4	**#EO, rigid, without joints, includes soft interface material, prefabricated, includes fitting and adjustment**
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 F4	**#WHFO, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, custom fabricated, includes fitting and adjustment**
L3807 F16	**#WHFO, without joint(s), prefabricated, includes fitting and adjustment, any type**
L3808 F4	**#WHFO, rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment**

ADDITIONS TO UPPER EXTREMITY ORTHOSIS

L3891 F4	**Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion**

CODE	DESCRIPTION

DYNAMIC FLEXOR HINGE, RECIPROCAL WRIST EXTENSION/FLEXION, FINGER FLEXION/EXTENSION

L3900	F4	**#WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven, custom fabricated**
L3901	F4	**#WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, cable driven, custom fabricated**

EXTERNAL POWER

L3904	F3	**WHFO, external powered, electric, custom fabricated**

OTHER WHFO'S – CUSTOM-FITTED

L3905	F4	**#WHO, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment**
L3906	F6	**#WHO, wrist hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment**
L3908	F6	**#WHO, wrist extension control cock-up, non-molded, prefabricated, includes fitting and adjustment**
L3912	F2	**#HFO, flexion glove with elastic finger control, prefabricated, includes fitting and adjustment**
L3913	F4	**#HFO, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment**
L3915	F4	**#WHO, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, includes fitting and adjustment**
L3917	F2	**#HO, metacarpal fracture orthosis, prefabricated, includes fitting and adjustment**
L3919	F4	**#HO, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment**
L3921	F4	**#HFO, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment**
L3923	F16	**#HFO, without joints, may include soft interface, straps, prefabricated, includes fitting and adjustment**
L3925	F6	**#Finger orthosis, proximal interphalangeal (pip)/distal interphalangeal (dip), nontorsion joint/spring, extension/flexion, may include soft interface material, prefabricated, includes fitting and adjustment**
L3927	F6	**#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, includes fitting and adjustment**

CODE	DESCRIPTION
L3929 F6	**#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**
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 F4	**#FO, without joints, may include soft interface, custom fabricated, includes fitting and adjustment**
L3935 F4	**#FO, nontorsion joint, may include soft interface, custom fabricated, includes fitting and adjustment**

SHOULDER-ELBOW–WRIST–HAND ORTHOSIS (SEWHO) ABDUCTION POSITION-CUSTOM FITTED

ABDUCTION POSITION-CUSTOM FITTED

L3960 F2	**#Shoulder elbow wrist hand finger orthosis, abduction positioning, airplane design, prefabricated, includes fitting and adjustment**
L3961 F2	**Shoulder elbow wrist hand finger orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment**
L3962 F2	**#Shoulder elbow wrist hand finger orthosis, abduction positioning, Erbs Palsy design, prefabricated, includes fitting and adjustment**
L3967 F3	**Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment**
L3971 F3	**Shoulder elbow wrist hand finger orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment**
L3973 F3	**Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment**
L3975 F3	**Shoulder elbow wrist hand finger orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment**
L3976 F3	**Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment**

CODE	DESCRIPTION
L3977 F3	**Shoulder elbow wrist hand finger orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment**
L3978 F3	**Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment**

FRACTURE ORTHOSES

L3980 F2	**#Upper extremity fracture orthosis, humeral, prefabricated, includes fitting and adjustment**
L3982 F2	**#Upper extremity fracture orthosis, radius/ulnar, prefabricated, includes fitting and adjustment**
L3984 F2	**#Upper extremity fracture orthosis, wrist, prefabricated, includes fitting and adjustment**
L3995 F7	**#Addition to upper extremity orthosis, sock, fracture or equal, each**
L3999 F10	**Upper limb orthosis, not otherwise specified** Refer to "2010 Orthotics and Prosthetics Procedure Code Changes" update dated December 28, 2009 for specific items that are billable using L3999. Billing code L3999 is not limited to only those items.

REPAIRS, REPLACEMENTS AND MAINTENANCE TO EXISTING ORTHOSES

NOTE: The following codes are to be used only in billing for repair, maintenance and/or replacements to existing orthoses. These codes are not to be billed in conjunction with codes for newly fitted orthoses.

SPECIFIC REPAIR

L4000 F6	**#Replace girdle for spinal orthosis (CTLSO or SO)** (e.g. Milwaukee)
L4002 F22	**#Replacement strap, any orthosis, includes all components, any length, any type**
L4010 F6	**#Replace trilateral socket brim**
L4020 F6	**#Replace quadrilateral socket brim, molded to patient model**
L4030 F6	**#Replace quadrilateral socket brim, custom fitted**
L4040 F6	**#Replace molded thigh lacer, for custom fabricated orthosis only**
L4045 F6	**#Replace non-molded thigh lacer, for custom fabricated orthosis only**
L4050 F6	**#Replace molded calf lacer, for custom fabricated orthosis only**
L4055 F6	**#Replace non-molded calf lacer, for custom fabricated orthosis only**
L4060 F6	**#Replace high roll cuff**
L4070 F6	**#Replace proximal and distal upright for KAFO**
L4080 F6	**#Replace metal bands KAFO, proximal thigh**
L4090 F6	**#Replace metal bands KAFO-AFO, calf or distal thigh**

CODE	DESCRIPTION
L4100 [F6]	**#Replace leather cuff KAFO, proximal thigh**
L4110 [F6]	**#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)

CODE **DESCRIPTION**

4.6 PRESCRIPTION FOOTWEAR

- Prescription footwear is orthopedic shoes, shoe modifications or shoe additions.
- Minimum orthopedic shoe specifications consist of Blucher or Bal construction, leather construction or synthetic material of equal quality, welt construction with a cement attached outsole or sewn on outsole, upper portion properly fitted as to length and width, no unit sole, bottom sized to the last, closure appropriate to foot condition (Velcro strap or lace closure preferred), full range of width; not just narrow, medium, wide; extended medial counter and firm heel counter.
- The additional charge for split size (mismating) orthopedic footwear may be billed using code L3257 (MEVS dispensing validation required).

Benefit coverage is limited to:

- **Children under 21 years of age**, who require orthopedic footwear 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.

- **When a shoe is attached to a lower limb orthotic brace. Prior Approval is required** for beneficiaries age 21 and older, using **only** codes L3224 and L3225 and any addition and/or modifications to those shoe codes.

- **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**.

Non-Covered Indications:

- Sneakers and athletic shoes are not considered orthopedic shoes by the Medicaid Program and therefore are not Medicaid reimbursable.

INSERT, REMOVABLE, MOLDED TO PATIENT MODEL

L3000 [F7] **#Foot, insert, removable, molded to patient model, "UCB" type, Berkeley shell, each**
L3001 [F7] **#Foot, insert, removable, molded to patient model, Spenco, each**
L3002 [F6] **#Foot, insert, removable, molded to patient model, plastazote or equal, each**
L3003 [F7] **#Foot, insert, removable, molded to patient model, silicone gel, each**
L3010 [F6] **#Foot, insert, removable, molded to patient model, longitudinal arch support, each**
L3020 [F6] **#Foot, insert, removable, molded to patient model, longitudinal/metatarsal support, each**
L3030 [F7] **#Foot, insert, removable, formed to patient foot, each**

CODE	DESCRIPTION

ARCH SUPPORT, REMOVABLE, PREMOLDED, EACH

L3040 [F6] **#Foot, arch support, removable, premolded, longitudinal, each**
L3050 [F7] **#Foot, arch support, removable, premolded, metatarsal, each**
L3060 [F6] **#Foot, arch support, removable, premolded, longitudinal/metatarsal, each**

ARCH SUPPORT, NON-REMOVABLE, ATTACHED TO SHOE

L3070 [F7] **#Foot, arch support, non-removable attached to shoe, longitudinal, each**
L3080 [F7] **#Foot, arch support, non-removable attached to shoe, metatarsal, each**
L3090 [F7] **#Foot, arch support, non-removable attached to shoe, longitudinal/metatarsal, each**
L3100 [F7] **#Hallus-valgus night dynamic splint**

ABDUCTION AND ROTATION BARS

L3140 [F7] **#Foot, abduction rotation bars, including shoes** (Dennis Browne type)
L3150 [F7] **Foot, abduction rotation bars, without shoe(s)** (Dennis Browne type)
L3160 [F7] **Foot, adjustable shoe-styled positioning device**
L3170 [F7] **#Foot, plastic, silicone or equal, heel stabilizer, each**

ORTHOPEDIC FOOTWEAR

L3201 [F7] **#Orthopedic shoe, oxford with supinator or pronator, infant** (each)
L3202 [F7] **#Orthopedic shoe, oxford with supinator or pronator, child** (each)
L3203 [F7] **#Orthopedic shoe, oxford with supinator or pronator, junior** (each)
L3204 [F7] **#Orthopedic shoe, hightop with supinator or pronator, infant** (each)
L3206 [F7] **#Orthopedic shoe, hightop with supinator or pronator, child** (each)
L3207 [F7] **#Orthopedic shoe, hightop with supinator or pronator, junior** (each)
L3208 [F7] **#Surgical boot, each, infant**
L3209 [F7] **#Surgical boot, each, child**
L3211 [F7] **#Surgical boot, each, junior**
L3212 [F7] **#Benesch boot, pair, infant**
L3213 [F7] **#Benesch boot, pair, child**
L3214 [F7] **#Benesch boot, pair, junior**
L3215 [F7] **#Orthopedic footwear, ladies shoe, oxford, each**
L3216 [F7] **#Orthopedic footwear, ladies shoe, depth inlay, each**
L3217 [F7] **#Orthopedic footwear, ladies shoe, hightop, depth inlay, each**
L3219 [F7] **#Orthopedic footwear, mens shoe, oxford, each**

CODE	DESCRIPTION
L3221 F7	**#Orthopedic footwear, mens shoe, depth inlay, each**
L3222 F7	**#Orthopedic footwear, mens shoe, hightop, depth inlay, each**
L3224 F7	**#Orthopedic footwear, woman's shoe, oxford, used as an integral part of a brace (orthosis) (each)**
L3225 F7	**#Orthopedic footwear, man's shoe, oxford, used as an integral part of a brace (orthosis) (each)**
L3230 F7	**#Orthopedic footwear, custom** (molded to patient) **shoe, depth inlay, each**
L3250 F7	**#Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each**
L3252 F7	**#Foot, shoe molded to patient model, plastazote (or similar), custom fabricated, each**
L3253 F7	**#Foot, molded shoe, plastazote (or similar), custom fitted, each**
L3254 F7	**#Non-standard size or width**
L3255 F7	**#Non-standard size or length**
L3257 F7	**#Orthopedic footwear, additional charge for split size**
L3260 F7	**#Surgical boot/shoe, each**
L3265 F7	**#Plastazote sandal, each**

SHOE MODIFICATION – LIFTS

L3300 F7	**#Lift, elevation, heel, tapered to metatarsals, per inch**
L3310 F7	**#Lift, elevation, heel and sole, neoprene, per inch**
L3320 F7	**#Lift, elevation, heel and sole, cork, per inch**
L3330 F7	**#Lift, elevation, metal extension (skate)**
L3332 F7	**#Lift, elevation, inside shoe, tapered, up to one-half inch**
L3334 F7	**#Lift, elevation, heel, per inch**

SHOE MODIFICATION – WEDGES

L3340 F7	**#Heel wedge, SACH**
L3350 F7	**#Heel wedge**
L3360 F7	**#Sole wedge, outside sole**
L3370 F7	**#Sole wedge, between sole**
L3380 F7	**#Clubfoot wedge**
L3390 F7	**#Outflare wedge**
L3400 F7	**#Metatarsal bar wedge, rocker**
L3410 F7	**#Metatarsal bar wedge, between sole**
L3420 F7	**#Full sole and heel wedge, between sole**

SHOE MODIFICATION – HEELS

L3430 F7	**#Heel, counter, plastic reinforced**
L3440 F7	**#Heel, counter, leather reinforced**
L3450 F7	**#Heel, SACH cushion type**
L3455 F7	**#Heel, new leather, standard**
L3460 F7	**#Heel, new rubber, standard**
L3465 F7	**#Heel, Thomas with wedge**

CODE	DESCRIPTION
L3470 F7	**#Heel, Thomas extended to ball**
L3480 F7	**#Heel, pad and depression for spur**
L3485 F7	**#Heel, pad, removable for spur**

MISCELLANEOUS SHOE ADDITIONS

L3540 F7	**#Orthopedic shoe addition, sole, full** (each)
L3570 F7	**Orthopedic shoe addition, special extension to instep (leather with eyelets)**
L3580 F7	**Orthopedic shoe addition, convert instep to velcro closure**

TRANSFERS OR REPLACEMENT

L3600 F7	**Transfer of an orthosis from one shoe to another, calliper plate, existing**
L3610 F7	**Transfer of an orthosis from one shoe to another, caliper plate, new**

SHOE CORRECTIONS AND MODIFICATIONS

L3620 F7	**Transfer of an orthosis from one shoe to another, solid stirrup, existing**
L3630 F7	**Transfer of an orthosis from one shoe to another, solid stirrup, new**
L3640 F7	**Transfer of an orthosis from one shoe to another, Dennis Browne splint (Riveton), both shoes**
L3649 F7	**#Orthopedic shoe, modification, addition or transfer, not otherwise specified** (more than two procedures require prior approval)

DIABETIC SHOES, FITTING, and MODIFICATIONS

A5500F7	**# 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**
A5501F7	**# 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**
A5503F7	**# 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**
A5504F7	**# For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with wedge(s), per shoe**
A5505F7	**# For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with metatarsal bar, per shoe**

CODE	DESCRIPTION
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[F7]	**# 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[F7]	**# 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 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each**

CODE **DESCRIPTION**

4.7 PROSTHETICS

1. This schedule is applicable to both children and adults.
2. Base codes are covered when the physician's order and supporting documentation clearly establish the medical and functional need being met by the prescribed device. Where applicable, code specific coverage criteria must be met.
3. L Code "additions" are covered only when both the base codes coverage criteria has been met and specific documentation exists establishing the medical necessity of the addition code.
4. The providers shall be responsible for any needed repairs or replacements due to defects in quality or workmanship that appear within three months of delivery. This does not include adjustments or replacements necessitated by anatomical changes.
5. Replacements and repairs: used to indicate replacement and repair of orthotic and prosthetic devices which have been in use for some time. Prior approval is not required when the charge is over $35.00 and is less than 10% of the price listed on the code for the device. When specific replacement and repair codes are available, they should be used instead of the code for the device with '-RB'. For charges $35.00 and under, use L7510.
6. The fees contained in this schedule will be paid under State-administered programs, and are to be considered full payment for the services rendered. The provider shall make no additional charge to the beneficiary.
7. Unless otherwise indicated all fees are for the unilateral, single unit or "each".
8. All normal necessary pads and straps are included in the prices quoted.
9. Polypropylene (ultra-light) should be used only when judged a medical necessity because of bilateral or multiple disabilities, frailty, cardiac disability, etc.
10. For home visit, see code L9900

LOWER LIMB

NOTE: The procedures in this section are considered as "Base" or "Basic Procedures", and may be modified by listing items/procedures or special materials from the "Additions Section", adding them to the "Base" Procedure.

A lower limb prosthesis is covered when the patient:

1. Will reach or maintain a defined functional state within a reasonable period of time; and
2. Is motivated to ambulate.

CODE **DESCRIPTION**

FUNCTIONAL LEVELS:

- A determination of the medical necessity for certain components/additions to the prosthesis is based on the patient's potential functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist, and treating physician, considering factors including, but not limited to:
  a. The patient's past history (including prior prosthetic use if applicable); and
  b. The patient's current condition including the status of the residual limb and the nature of other medical problems; and
  c. The patient's desire to ambulate.

- Clinical assessments of patient rehabilitation potential must be based on the following classification levels:
  Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.
  Level 1: Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
  Level 2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.
  Level 3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
  Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

- The records must document the patient's current functional capabilities and his/her expected functional potential, including an explanation for the difference, if that is the case. It is recognized, within the functional classification hierarchy, that bilateral amputees often cannot be strictly bound by functional level classifications.

- The determination of coverage for selected prostheses and components with respect to potential functional levels represents the usual case. Exceptions will be considered in an individual case if additional documentation is included which justifies the medical necessity. Prostheses will be denied as not reasonable and necessary if the patient's potential functional level is 0.

CODE **DESCRIPTION**

- A determination of the type of foot, or knee for the prosthesis will be made by the treating physician and the prosthetist based upon the functional needs of the patient. Basic lower extremity prostheses include a SACH foot. Basic lower extremity prostheses include a single axis, constant friction knee. Other prosthetic feet or and/or knees are considered for coverage based upon functional classification.

PARTIAL FOOT

L5000 F4 **#Partial foot, shoe insert with longitudinal arch, toe filler**
L5010 F4 **#Partial foot, molded socket, ankle height, with toe filler**
L5020 F4 **#Partial foot, molded socket, tibial tubercle height, with toe filler**

ANKLE

L5050 F4 **#Ankle, Symes, molded socket, SACH foot**

BELOW KNEE

L5100 F4 **#Below knee, molded socket, shin, SACH foot**
L5105 F4 **#Below knee, plastic socket, joints and thigh lacer, SACH foot**

KNEE DISARTICLUATION

L5150 F4 **#Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot**
L5160 F4 **#Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin, SACH foot**

ABOVE KNEE

L5200 F4 **#Above knee, molded socket, single axis constant friction knee, shin, SACH foot**
L5210 F4 **#Above knee, short prosthesis, no knee joint ("stubbies"), with foot blocks, no ankle joints, each**
L5220 F4 **#Above knee, short prosthesis, no knee joint ("stubbies"), with articulated ankle/foot, dynamically aligned, each**
L5230 F4 **#Above knee, for proximal femoral focal deficiency, constant friction knee, shin, SACH foot**

HIP DISARTICLUATION

L5250 F4 **#Hip disarticulation, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot**
L5270 F4 **#Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin, SACH foot**

CODE **DESCRIPTION**

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**

CODE	DESCRIPTION
L5430 F2	#**Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, "AK" or knee disarticulation, each additional cast change and realignment**
L5450 F18	#**Immediate post surgical or early fitting, application of non-weight bearing rigid dressing, below knee**
L5460 F18	#**Immediate post surgical or early fitting, application of non-weight bearing rigid dressing, above knee**

INITIAL PROSTHESIS

L5500 F2	#**Initial, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, direct formed**
L5505 F2	#**Initial, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, direct formed**

PREPARATORY AND DIAGNOSTIC PROSTHESES

- The preparatory prosthesis components will at all times remain the property of the prosthetic facility and will be used only on a loan basis.
- Diagnosis AK and BK prostheses are prostheses that allow various suspension, socket, knee, ankle systems to be utilized by the beneficiary to determine optimal prescription; same qualifications exist as with preparatory prostheses.

PREPARATORY PROSTHESIS

L5510 F2	#**Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, molded to model**
L5520 F2	#**Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed**
L5530 F2	#**Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model**
L5535 F2	#**Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, prefabricated, adjustable open end socket**
L5540 F2	#**Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model**
L5560 F2	#**Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, molded to model**
L5570 F2	#**Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed**

CODE	DESCRIPTION
L5580 [F2]	#**Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model**
L5585 [F2]	#**Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, prefabricated adjustable open end socket**
L5590 [F2]	#**Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model**
L5595 [F2]	#**Preparatory, hip disarticulation – hemipelvectomy, pylon, no cover, SACH foot, thermoplastic or equal, molded to patient model**
L5600 [F2]	#**Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, laminated socket, molded to patient model**

ADDITIONS TO LOWER EXTREMITY

- A fluid or pneumatic knee (L5610, L5613, L5614) is covered for beneficiary's whose functional level is 3 or above.

L5610 [F4]	#**Addition to lower extremity, endoskeletal system, above knee, hydracadence system**
L5611 [F4]	#**Addition to lower extremity, endoskeletal system, above knee–knee disarticulation, 4-bar linkage, with friction swing phase control**
L5613 [F4]	#**Addition to lower extremity, endoskeletal system, above knee–knee disarticulation, 4-bar linkage, with hydraulic swing phase control**
L5614 [F4]	#**Addition to lower extremity, endoskeletal system, above knee–knee disarticulation, 4-bar linkage, with pneumatic swing phase control**

ADDITIONS - TEST SOCKETS

L5618 [F4]	#**Addition to lower extremity, test socket, Symes**
L5620 [F4]	#**Addition to lower extremity, test socket, below knee**
L5622 [F4]	#**Addition to lower extremity, test socket, knee disarticulation**
L5624 [F4]	#**Addition to lower extremity, test socket, above knee**
L5626 [F4]	#**Addition to lower extremity, test socket, hip disarticulation**
L5628 [F4]	#**Addition to lower extremity, test socket, hemipelvectomy**
L5629 [F4]	#**Addition to lower extremity, below knee, acrylic socket**

ADDITIONS - SOCKET VARIATIONS

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**

CODE	DESCRIPTION
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**
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)**

CODE	DESCRIPTION
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 inset, silicone gel, elastomeric or equal, for use with locking mechanism
L5676 F4	#Additions to lower extremity, below knee, knee joints, single axis, pair
L5677 F4	#Additions to lower extremity, below knee, knee joints, polycentric, pair
L5678 F6	#Additions to lower extremity, below knee, joint covers, pair
L5679 F6	#Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism
L5680 F6	#Addition to lower extremity, below knee, thigh lacer, non-molded
L5681 F6	#Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism; initial only (for use other than initial, use code L5673 or L5679)
L5682 F6	#Addition to lower extremity, below knee, thigh lacer, gluteal/ischial, molded
L5683 F6	#Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L5673 or L5679)
L5684 F6	#Addition to lower extremity, below knee, fork strap
L5685 F6	#Addition to lower extremity prosthesis, below knee, suspension/sealing sleeve, with or without valve, any material, each
L5686 F6	#Addition to lower extremity, below knee, back check (extension control)
L5688 F7	#Addition to lower extremity, below knee, waist belt, webbing
L5690 F7	#Addition to lower extremity, below knee, waist belt, padded and lined
L5692 F7	#Addition to lower extremity, above knee, pelvic control belt, light
L5694 F7	#Addition to lower extremity, above knee, pelvic control belt, padded and lined
L5695 F7	#Addition to lower extremity, above knee, pelvic control, sleeve suspension, neoprene or equal, each
L5696 F4	#Addition to lower extremity, above knee or knee disarticulation, pelvic joint

CODE	DESCRIPTION
L5697 F7	#**Addition to lower extremity, above knee or knee disarticulation, pelvic band**
L5698 F7	#**Addition to lower extremity, above knee or knee disarticulation, Silesian bandage**
L5699 F7	#**All lower extremity prostheses, shoulder harness**

ADDITIONS - FEET ANKLE UNITS

L5700 **F4**	#**Replacement, socket, below knee, molded to patient model**
L5701 **F4**	#**Replacement, socket, above knee/knee disarticulation, including attachment plate, molded to patient model**
L5702 **F4**	#**Replacement, socket, hip disarticulation, including hip joint, molded to patient model**
L5703 F4	#**Ankle, symes, molded to patient model, socket without solid ankle cushion heel (SACH) foot, replacement only**
L5704 F6	#**Custom shaped protective cover, below knee**
L5705 F6	#**Custom shaped protective cover, above knee**
L5706 F6	#**Custom shaped protective cover, knee disarticulation**
L5707 F6	#**Custom shaped protective cover, hip disarticulation**
L5710 F6	#**Addition, exoskeletal knee-shin system, single axis, manual lock**
L5711 F6	#**Additions exoskeletal knee-shin system, single axis, manual lock, ultra-light material**
L5712 F6	#**Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)**
L5714 F6	#**Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control**

ADDITIONS – KNEE – SHIN SYSTEM

L5716 F6	#**Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock**

- A fluid or pneumatic knee (L5722-L5780) is covered for beneficiary'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**

CODE	DESCRIPTION

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 beneficiary'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 beneficiary's whose functional level is 3 or above.

L5822 [F4] #**Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control**
L5824 [F4] #**Addition, endoskeletal knee-shin system, single axis, fluid swing phase control**
L5826 [F4] #**Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame**
L5828 [F4] #**Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control**
L5830 [F4] #**Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control**
L5840 [F4] #**Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, pneumatic swing phase control**
L5845 [F4] #**Addition, endoskeletal, knee-shin system, stance flexion feature, adjustable**
L5850 [F4] #**Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist**
L5855 [F4] #**Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist**

CODE **DESCRIPTION**

- Electric knees (L5856-L5858) are covered for beneficiary's whose functional level is 3 or above, and when the clinical documentation establishes why a non electric knee fails to meet the beneficiary's medical needs and the beneficiary's maximimum functional level can not be achieved through the use of a non electric knee. Documentation should include, at minimum, a detailed specialist (Physiatrist, Therapist, etc.) evaluation and specific objective measures taken during the trial of both the electric knee and non electric knee.

L5856 F3 **Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type**

L5857 F3 **Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing phase only, includes electronic sensor(s), any type**

L5858 F3 **Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type**

L5910 F4 #**Addition, endoskeletal system, below knee, alignable system**

L5920 F4 #**Addition, endoskeletal system, above knee or hip disarticulation, alignable system**

L5925 F4 #**Addition, endoskeletal system, above knee, knee disarticulation or hip disarticulation, manual lock**

L5930 F4 #**Addition, endoskeletal system, high activity knee control frame**

- A high activity knee control frame (L5930) is covered for patients whose functional level is 4.

L5940 F4 #**Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)**

L5950 F4 #**Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)**

L5960 F4 #**Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)**

L5962 F4 #**Addition, endoskeletal system, below knee, flexible protective outer surface covering system**

L5964 F4 #**Addition, endoskeletal system, above knee, flexible protective outer surface covering system**

L5966 F4 #**Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system**

L5968 F3 #**Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature**

- An external keel SACH foot (L5970) or single axis ankle/foot (L5974) is covered for patients whose functional level is 1 or above.
- A flexible-keel foot (e) or multiaxial ankle/foot (L5978) is covered for patients whose functional level is 2 or above.

CODE **DESCRIPTION**

- A microprocessor controlled ankle foot system (L5973), energy storing foot (L5976), dynamic response foot with multiaxial ankle (L5979), flex foot system (L5980), flex-walk system or equal (L5981), or shank foot system with vertical loading pylon (L5987) is covered for patients whose functional level is 3 or above.
- Coverage is extended only if there is sufficient clinical documentation of functional need for the technologic or design feature of a given type of foot. This information must be retained in the physician's and prosthetist's files and be available upon request.

L5970 F4 #**All lower extremity prostheses, foot, external keel, SACH foot**
L5971 F4 #**All lower extremity prostheses, solid ankle cushion heel (SACH) foot, replacement only**
L5972 F4 #**All lower extremity prostheses, foot, flexible keel**
L5973 F3 **Endoskeletal ankle foot system, microprocessor controlled feature, dorsiflexion**
L5974 F4 #**All lower extremity prostheses, foot, single axis ankle/foot**
L5975 F4 #**All lower extremity prostheses, combination single axis ankle and flexible keel foot**
L5976 F4 #**All lower extremity prostheses, energy storing foot (Seattle Carbon Copy II or equal)**
L5978 F4 #**All lower extremity prostheses, foot, multi-axial ankle/foot** (Gressinger or equal)
L5979 F4 #**All lower extremity prostheses, multi-axial ankle, dynamic response foot, one piece system**
L5980 F3 **All lower extremity prostheses, flex foot system**
L5981 F3 **All lower extremity prostheses, flex-walk system or equal**
L5982 F4 #**All exoskeletal lower extremity prostheses, axial rotation unit**
L5984 F4 #**All endoskeletal lower extremity prostheses, axial rotation unit, with or without adjustability**
L5985 F3 #**All endoskeletal lower extremity prostheses, dynamic prosthetic pylon**
L5986 F4 #**All lower extremity prostheses, multi-axial rotation unit ("MCP" or equal)**
L5987 F3 **All lower extremity prosthesis, shank foot system with vertical loading pylon**
L5988 F4 #**Addition to lower limb prosthesis, vertical shock reducing pylon feature**
L5990 F4 #**Addition to lower extremity prosthesis, user adjustable heel height**
L5999 F10 **Lower extremity prosthesis, not otherwise specified**

UPPER LIMB

- The procedures in this section are considered as base or basic procedures and may be modified by listing procedures from the "Additions" sections. The base procedures include only standard friction wrist and control cable system unless otherwise specified.

CODE	DESCRIPTION
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)**
L6025 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**
WRIST DISARTICULATION	
L6050 F3	**#Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad**
L6055 F3	**#Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad**
BELOW ELBOW	
L6100 F3	**#Below elbow, molded socket, flexible elbow hinge, triceps pad**
L6110 F3	**#Below elbow, molded socket, (Muenster or Northwestern suspension types)**
L6120 F3	**#Below elbow, molded double wall split socket, step-up hinges, half cuff**
L6130 F3	**#Below elbow, molded double wall split socket, stump activated locking hinge, half cuff**
ELBOW DISARTICULATION	
L6200 F3	**#Elbow disarticulation, molded socket, outside locking hinge, forearm**
L6205 F3	**#Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm**
ABOVE ELBOW	
L6250 F3	**#Above elbow, molded double wall socket, internal locking elbow, forearm**
SHOULDER DISARTICULATION	
L6300 F3	**#Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm**
L6310 F3	**#Shoulder disarticulation, passive restoration (complete prosthesis)**
L6320 F3	**#Shoulder disarticulation, passive restoration (shoulder cap only)**

CODE	DESCRIPTION

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**

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**

ENDOSKELETAL – SHOULDER DISARTICULATION

L6550 [F2] **#Shoulder disarticulation, molded socket endoskeletal system, including soft prosthetic tissue shaping**

CODE	DESCRIPTION

ENDOSKELETAL – INTERSCAPULAR THORACIC

L6570 F2 #**Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping**
L6580 F2 #**Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, "USMC" or equal pylon, no cover, molded to patient model**
L6582 F2 #**Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, "USMC" or equal pylon, no cover, direct formed**
L6584 F2 #**Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, "USMC" or equal pylon, no cover, molded to patient model**
L6586 F2 #**Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, "USMC" or equal pylon, no cover, direct formed**
L6588 F2 #**Preparatory, shoulder disarticulation or interscapular thoracic, single wall, plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, "USMC" or equal pylon, no cover, molded to patient model**
L6590 F2 #**Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, "USMC" or equal pylon, no cover, direct formed**

ADDITIONS – UPPER LIMB

NOTE: The following procedures/modifications/components may be added to other base procedures. The items in this section should reflect the additional complexity of each modification procedure. In addition to base procedure, at the time of the original order.

L6600 **F3** #**Upper extremity additions, polycentric hinge, pair**
L6605 **F3** #**Upper extremity additions, single pivot hinge, pair**
L6610 **F3** #**Upper extremity additions, flexible metal hinge, pair**
L6611 **F3** #**Addition to upper extremity prosthesis, external powered, additional switch, any type**
L6615 **F3** #**Upper extremity addition, disconnect locking wrist unit**
L6616 **F3** #**Upper extremity addition, additional disconnect insert for locking wrist unit, each**
L6620 **F3** #**Upper extremity addition, flexion-friction wrist unit, with or without friction**
L6621 **F3** **Upper extremity prosthesis addition, flexion/extension wrist with or without friction, for use with external powered terminal device**

CODE	DESCRIPTION
L6623 F3	#Upper extremity addition, spring assisted rotational wrist unit with latch release
L6624 F3	Upper extremity addition, flexion/extension and rotation wrist unit
L6625 F3	#Upper extremity addition, rotation wrist unit with cable lock
L6628 F3	#Upper extremity addition, quick disconnect hook adapter, Otto Bock or equal
L6629 F3	#Upper extremity addition, quick disconnect lamination collar with coupling piece, Otto Bock or equal
L6630 F3	#Upper extremity addition, stainless steel, any wrist
L6632 F3	#Upper extremity addition, latex suspension sleeve, each
L6635 F3	#Upper extremity addition, lift assist for elbow
L6637 F3	#Upper extremity addition, nudge control elbow lock
L6638 F3	Upper extremity addition to prosthesis, electric locking feature, only for use with manually powered elbow
L6640 F3	#Upper extremity additions, shoulder abduction joint, pair
L6641 F3	#Upper extremity addition, excursion amplifier, pulley type
L6642 F3	#Upper extremity addition, excursion amplifier, lever type
L6645 F3	#Upper extremity addition, shoulder flexion-abduction joint, each
L6646 F3	Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable abduction friction control, for use with body powered or external powered system
L6650 F4	#Upper extremity addition, shoulder universal joint, each
L6655 F4	#Upper extremity addition, standard control cable, extra
L6660 F4	#Upper extremity addition, heavy duty control cable
L6665 F6	#Upper extremity addition, Teflon, or equal, cable lining
L6670 F4	#Upper extremity addition, hook to hand, cable adapter
L6672 F4	#Upper extremity addition, harness, chest or shoulder, saddle type
L6675 F4	#Upper extremity addition, harness, (e.g. figure of eight type) single cable design
L6676 F4	#Upper extremity addition, harness, (e.g. figure of eight type) dual cable design
L6677 F4	#Upper extremity addition, harness, triple control, simultaneous operation of terminal device and elbow
L6680 F3	#Upper extremity addition, test socket, wrist disarticulation or below elbow
L6682 F3	#Upper extremity addition, test socket, elbow disarticulation or above elbow
L6684 F3	#Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic
L6686 F3	#Upper extremity addition, suction socket
L6687 F3	#Upper extremity addition, suction 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

CODE	DESCRIPTION
L6690 F3	#**Upper extremity addition, frame type socket, interscapular-thoracic**
L6691 F6	#**Upper extremity addition, removable insert, each**
L6692 F6	#**Upper extremity addition, silicone gel insert or equal, each**
L6693 F3	**Upper extremity addition, locking elbow, forearm counterbalance**
L6694 F6	#**Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism**
L6695 F6	#**Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism**
L6696 F6	**Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695)**
L6697 F6	**Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695)**
L6698 F6	#**Addition to upper extremity prosthesis, below elbow/above elbow, lock mechanism, excludes socket insert**

TERMINAL DEVICES

HOOKS

L6703 F3	#**Terminal device, passive hand/mitt, any material, any size**
L6706 F3	#**Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined**
L6707 F3	#**Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined**
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**

CODE	DESCRIPTION
L6721 F3	**Terminal device, hook or hand, heavy duty, mechanical, voluntary opening, any material, any size, lined or unlined**
L6722 F3	**Terminal device, hook or hand, heavy duty, mechanical, voluntary closing, any material, any size, lined or unlined**
L6805 F3	**#Addition to terminal device, modifier wrist unit**
L6810 F3	**#Addition to terminal device, precision pinch device**

HANDS

L6881 F3	**Automatic grasp feature, addition to upper limb electric prosthetic terminal device**
L6882 F3	**Microprocessor control feature, addition to upper limb prosthetic terminal device**
L6883 F3	**Replacement socket, below elbow/wrist disarticulation, molded to patient model, for use with or without external power**
L6884 F3	**Replacement socket, above elbow/elbow disarticulation, molded to patient model, for use with or without external power**
L6885 F3	**Replacement socket, shoulder disarticulation/interscapular thoracic, molded to patient model, for use with or without external power**

GLOVES FOR ABOVE HANDS

L6890 F6	**#Addition to upper extremity prosthesis, glove for terminal device, any material, prefabricated, includes fitting and adjustment**
L6895 F6	**#Addition to upper extremity prosthesis, glove for terminal device, any material, custom fabricated**

HAND RESTORATION

L6900 F3	**#Hand restoration (casts, shading and measurements included), partial hand, with glove, thumb or one finger remaining**
L6905 F3	**#Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining**
L6910 F3	**#Hand restoration (casts, shading and measurements included), partial hand, with glove, no fingers remaining**
L6915 F3	**#Hand restoration (shading and measurements included), replacement glove for above**

EXTERNAL POWER

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**

CODE	DESCRIPTION
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

CODE	DESCRIPTION
L7040 F3	**Prehensile actuator, switch controlled**
L7045 F3	**Electric hook, switch or myoelectric controlled, pediatric**

MYOELECTRIC

- To be used only when medically necessary as determined by an approved amputee clinic.

ELBOW

L7170 F3	**Electronic elbow, Hosmer or equal, switch controlled**
L7180 F3	**Electronic elbow, microprocessor sequential control of elbow and terminal device**
L7181 F3	**Electronic elbow, microprocessor simultaneous control of elbow and terminal device**
L7185 F3	**Electronic elbow, adolescent, Variety Village or equal, switch controlled**
L7186 F3	**Electronic elbow, child, Variety Village or equal, switch controlled**
L7190 F3	**Electronic elbow, adolescent, Variety Village or equal, myoelectronically controlled**
L7191 F3	**Electronic elbow, child, Variety Village or equal, myoelectronically controlled**
L7260 F3	**Electronic wrist rotator, Otto Bock or equal**
L7261 F3	**Electronic wrist rotator, for Utah arm**

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, replacement**
L7368 F4	**#Lithium ion battery charger** (Replacement only)
L7499 F10	**Upper extremity prosthesis, not otherwise specified**
L7510 F7	**#Repair of prosthetic device, repair or replace minor parts** (not to be billed in conjunction with L7520)
L7520 F9	**#Repair prosthetic device, labor component, per 15 minutes** (includes evaluation) (more than 2 hours requires prior approval)

GENERAL

BREAST AND HAIR PROSTHESIS (Also see Section 4.1)

L8010 F21	**#Breast prosthesis, mastectomy sleeve**
L8035 F22	**#Custom breast prosthesis, post mastectomy, molded to patient model**
A9282 F2	**Wig, any type, each** ●Coverage limited to medically-induced or congenital hair loss.

CODE	DESCRIPTION

UPPER EXTREMITY ELASTIC SUPPORTS

S8421 [F21] **#Gradient pressure aid (sleeve and glove combination), ready made**
S8424 [F21] **#Gradient pressure aid (sleeve), ready made**
S8427 [F21] **#Gradient pressure aid (glove), ready made**
S8428 [F21] **#Gradient pressure aid (gauntlet), ready made**

LOWER EXTREMITY COMPRESSION SUPPORTS

Benefit coverage is limited to:

- The following gradient compression stocking codes when used only in the treatment of an open venous stasis ulcer.

Non-covered Indications:

- The prevention of ulcers, prevention of the reoccurrence of ulcers, or the treatment of lymphedema without ulcers, varicose veins, or circulation disorders.

A6531 [F7] **#Gradient compression stocking, below knee, 30-40 mmHg, each**
A6532 [F7] **#Gradient compression stocking, below knee, 40-50 mmHg, 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**

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**

CODE	DESCRIPTION
L9900 [F12]	**#Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code** (limited to home visit)

BURN GARMETS

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

4.8 Definitions

The presence of a definition does not constitute a coverage determination.

Actuator – A motor that operates a specific function of a power seating system – i.e., tilt, recline, power sliding back, elevating leg rest(s), seat elevation, or standing.

Alternative Control Device - A device that transforms a user's drive commands by physical actions initiated by the user to input control directions to a power wheelchair that replaces a standard proportional joystick. Includes: mini-proportional, compact, or short throw joysticks, head arrays, sip and puff and other types of different input control devices.

Augmentative Communication Systems- A composite of communications components that may include, but are not limited to, communication devices, manual signs, and communication strategies.

Captains 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, swingaway, or detachable. It may or may not have a headrest, either integrated or separate.

Combination skin protection and positioning seat cushion – A standard or customized seat cushion which has the following features listed in (a) or (b), and (c), (d), and (e):

(a) Two or more of the following features which must be at least 25 mm in height in the pre-loaded state. Included in this definition are cushions which have a planar surface but have positioning features within the cushion which are made of a firmer material than the surface material:
- A pre-ischial bar or ridge which is placed anterior to the ischial tuberosities and prevents forward migration of the pelvis,
- Two lateral pelvic supports which are placed posterior to the trochanters and are intended to maintain the pelvis in a centered position in the seat and/or provide lateral stability to the pelvis,
- A medial thigh support which is placed in contact with the adductor region of the thigh and provides the prescribed amount of abduction and prevents adduction of the thighs,
- Two lateral thigh supports which are placed anterior to the trochanters and provide lateral stability to the lower extremities and prevent unwanted abduction of the thighs, or

(b) It has two or more air compartments located in areas which address postural asymmetries, each of which must have a cell height of at least 50 mm, must allow the user to add or remove air, and must have a valve which retains the desired air volume.

(c) It has a removable vapor permeable or waterproof cover or it has a waterproof surface; and
(d) It has a permanent label indicating the model and the manufacturer; and
(e) It has a warranty that provides for repair or full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 18 months.

Communication Devices- A general term used to describe a primary unit such as communication software/programs, speech generating device, manual board, or electro larynx, and accessories including but not limited to application programs, language symbols, interfaces, overlays, cables, and mounts.

Crash Testing - Successful completion of WC-19 testing.

Cross Brace Chair - A type of construction for a power wheelchair in which opposing rigid braces hinge on pivot points to allow the device to fold.

Custom fabricated seat or back cushion - Individually made for a specific patient starting with basic materials, may include certain prefabricated components (e.g., gel or multi-cellular air inserts) which may not be billed separately.
(a) liquid foam or a block of foam and
(b) sheets of fabric or liquid coating material.
(c) The cushion must be fabricated using molded-to-recipient-model technique, direct molded-to-recipient technique, CAD-CAM technology, or detailed measurements of the recipient used to create a configured cushion.
(d) The cushion must have structural features that significantly exceed the minimum requirements for a seat or back positioning cushion. The cushion must have a removable vapor permeable or waterproof cover or it must have a waterproof surface.

Custom-fitted/customized means componentry made or added to already existing model or device that is assembled, adjusted or modified in order to fit the beneficiary'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 beneficiary 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.)

An expandable controller may also be able to operate one or more of the following:

- A separate display (i.e., for alternate control devices)
- Other electronic devices (e.g., control of an augmentative speech device or computer through the chair's drive control)
- An attendant control

Foot-Ankle Padded Positioning Strap – A padded foot positioning strap that wraps around the ankle and attaches to the wheelchair footplates. The purpose of a FAPPS is to prevent unwanted inversion, eversion, extension or lifting of the foot, thereby reducing joint stress and increasing tolerance for positioning, creating a dynamic foot positioning system.

General use back cushion - A prefabricated cushion, which is planar or contoured; and has a removable vapor permeable or waterproof cover or it has a waterproof surface; and has a permanent label indicating the model and the manufacturer; and has a warranty that provides for repair or full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 12 months.

General use seat cushion - A prefabricated cushion with a removable vapor permeable or waterproof cover or has a waterproof surface; and has a permanent label indicating the model and the manufacturer; and has a warranty that provides for repair or full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 12 months.

Highway Use - Mobility devices that are powered and configured to operate legally on public streets.

Integral Control System - Non-expandable wheelchair control system where the joystick is housed in the same box as the controller. The entire unit is located and mounted near the hand of the user. A direct electrical connection is made from the Integral Control box to the motors and batteries through a high power wire harness.

Multiple Power Options - A category of PWCs with the capability to accept and operate a combination power tilt and recline seating system. It may also be able to accommodate power elevating leg rests. A PWC does not have to accommodate all features to qualify for this code.

No Power Options – A category of PWCs that is incapable of accommodating a power tilt, recline, seat elevation, or standing system. If a PWC can only accept power elevating leg rests, it is considered to be a No Power Option chair.

Non-Dedicated Speech Generating Device (non-DSGD)- Devices with one or more of the following characteristics;
a. The capability (locked or unlocked) of running software for purposes other than speech generation (e.g.: devices that can also run work processing package, an accounting program, or perform other non medical functions); or
b. Laptop computers, desktop computers, tablet computers, cell phones, or personal digital assistants, which may be programmed to perform the same function as a speech generating device, and are therefore not primarily

medical in nature and do not meet the regulatory definition of Durable Medical Equipment; or
c. A device that is useful to someone without severe speech impairment.

Non-Expandable Controller - An electronic system that controls the speed and direction of the power wheelchair drive mechanism. Only a standard proportional joystick (used for hand or chin control) can be used as the input device. This system may be in the form of an integral controller or a remotely placed controller. The non-expandable controller may have the ability to control up to 2 power seating actuators through the drive control (for example, seat elevator and single actuator power elevating legrests). (Note: Control of the power seating actuators though the Control Input Device would require the use of an additional component, E2310 or E2311.) May also allow for the incorporation of an attendant control.

Non-Proportional Control Input Device - A device that transforms a user's discrete drive command (a physical action initiated by the wheelchair user, such as activation of a switch) into perceptually discrete changes in the wheelchair's speed, direction, or both.

Obstacle Climb - Vertical height of a solid obstruction that can be climbed using the standing and/or 0.5 meter run-up RESNA test.

Patient Weight Capacity – The terms Standard Duty, Heavy Duty, etc., refer to weight capacity, not performance. For example, the term Group 3 heavy duty power wheelchair denotes that the PWC has Group 3 performance characteristics and patient weight handling capacity between 301 and 450 pounds. A device is not required to carry all the weight listed in the class of devices, but must have a patient weight capacity within the range to be included. For example, a PMD that has a weight capacity of 400 pounds is coded as a Heavy Duty device.

Performance Testing - Term used to denote the RESNA based test parameters used to test PMDs. The PMD is expected to meet or exceed the listed performance and durability figures for the category in which it is to be used when tested. There is no requirement to test the PMD with all possible accessories.

Portable - A category of devices with lightweight construction or ability to disassemble into lightweight components that allows easy placement into a vehicle for use in a distant location.

Positioning back cushion - a standard cushion customized to include materials or components that may be added, removed and or fabricated from commercially available components to help address orthopedic deformities or postural asymmetries. Included in this definition are cushions which have a

planar surface but have positioning features within the cushion which are made of a firmer material than the surface material. In addition, the back cushion has the following characteristics:

(a) There is at least 25 mm of posterior contour in the pre-loaded state. A posterior contour is a backward curve measured from a vertical line in the midline of the cushion; and
(b) For posterior-lateral cushions and for planar cushions with lateral supports there is at least 75 mm of lateral contour in the pre-loaded state. A lateral contour is backward curve measured from a horizontal line connecting the lateral extensions of the cushion; and
(c) For posterior pelvic cushions there is mounting hardware that is adjustable for vertical position, depth, and angle, and
(d) It has a removable vapor permeable or waterproof cover or it has a waterproof surface; and
(e) The cushion and cover meet the minimum standards of the California Bulletin 117 or 133 for flame resistance; and
(f) It has a permanent label indicating the model and the manufacturer; and
(g) It has a warranty that provides for repair or full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 18 months.

Positioning seat cushion - May have materials or components that can be added or removed (customized) to help address orthopedic deformities or postural asymmetries and has the following characteristics listed in a or b and c and d:

(a) Two or more of the following features which must be at least 25 mm in height in the pre-loaded state. Included in this definition are cushions which have a planar surface but have positioning features within the cushion which are made of a firmer material than the surface material:
    - A pre-ischial bar or ridge (e.g., anti-thrust) which is placed anterior to the ischial tuberosities and prevents forward migration of the pelvis,
    - Two lateral pelvic supports which are placed posterior to the trochanters and are intended to maintain the pelvis in a centered position in the seat and/or provide lateral stability to the pelvis,
    - A medial thigh support (e.g., built-in pommel) which is placed in contact with the adductor region of the thigh and provides the prescribed amount of abduction and prevents adduction of the thighs,
    - Two lateral thigh supports which are placed anterior to the trochanters and provide lateral stability to the lower extremities and prevent unwanted abduction of the thighs; or
(b) Two or more air compartments located in areas which address postural asymmetries, each of which must have a cell height of at least 50 mm, must allow the user to add or remove air, and must have a valve which retains the desired air volume; and
(c) A permanent label indicating the model and the manufacturer; and
(d) A warranty that provides for repair or full replacement if manufacturing

defects are identified or the surface does not remain intact due to normal wear within 18 months.

Power Mobility Device (PMD) - Base codes include both integral frame and modular construction type power wheelchairs (PWCs) and power operated vehicles (POVs).

Power Operated Vehicle - Chair-like battery powered mobility device for people with difficulty walking due to illness or disability, with integrated seating system, tiller steering, and four-wheel non-highway construction.

Power Options - Tilt, recline, elevating leg rests, seat elevators, or standing systems that may be added to a PWC to accommodate a patient's specific need for seating assistance.

Power Wheelchair - Chair-like battery powered mobility device for people with difficulty walking due to illness or disability, with integrated or modular seating system, electronic steering, and four or more wheel non-highway construction.

POV Basic Equipment Package - Each POV is to include all these items on initial issue (i.e., no separate billing/payment at the time of initial issue). See POV section of this manual.

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

Push-rim activated power assist – An option for a manual wheelchair in which sensors in specially designed wheels determine the force that is exerted by the patient on the wheel. Additional propulsive and/or braking force is then provided by motors in each wheel. Batteries are included.

PWC Basic Equipment Package - Each power wheelchair code is required to include all these items on initial issue (i.e., no separate billing/payment at the time of initial issue, unless otherwise noted). See PWC section of this manual.

Radius Pivot Turn – The distance required for the smallest turning radius of the PMD base. This measurement is equivalent to the "minimum turning radius" specified in the ANSI/RESNA bulletins.

Range - Minimum distance acceptable for a given category of devices on a single charge of the batteries. It is to be determined by the appropriate RESNA test for range.

Remotely Placed Controller - Non-expandable or expandable wheelchair control system where the joystick (or alternative control device) and the controller box are housed in separate locations. The joystick (or alternative control device) is connected to the controller through a low power wire harness. The separate controller connects directly to the motors and batteries through a high power wire harness.

Single Power Option - A category of PWC with the capability to accept and operate a power tilt or power recline, but not a combination power tilt and recline seating system. It may be able to accommodate power elevating leg rests in combination with a power tilt or power recline. A PMD does not have to be able to accommodate all features to qualify for this code. For example, a power wheelchair that can only accommodate a power tilt could qualify for this code.

Skin protection seat cushion - a prefabricated cushion with a removable vapor permeable or waterproof cover or a waterproof surface; and a permanent label indicating the model and the manufacturer; and a warranty that provides for repair or full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 18 months.

Sling Seat/Back - Flexible cloth, vinyl, leather or equal material designed to serve as the support for buttocks or back of the user respectively. They may or may not have thin padding but are not intended to provide cushioning or positioning for the user.

Solid seat insert – used for a seat cushion, a separate rigid piece of plastic or other material which is inserted in the cover of a seat cushion to provide additional support. The seat cushion is then placed on top of a sling sea or mounted with hardware in place of a sling seat.

Solid Seat/Back - Rigid metal or plastic material usually covered with cloth, vinyl, leather or equal material, with or without some padding material designed to serve as the support for the buttocks or back of the user respectively. They may or may not have thin padding but are not intended to provide cushioning or positioning for the user. PWCs with an automotive-style back and a solid seat pan are considered as a solid seat/back system, not a Captains Chair.

Solid seat support base – Used to support a seat cushion, a rigid piece of plastic or other material which is included with a PWC base and pediatric seating or attached with hardware to the seat frame of a folding wheelchair in place of a sling seat. A seat cushion is placed on top of the solid support base.

Speech Generating Device Software- Programs used on a laptop computer, desktop computer, tablet, cell phone, or personal digital assistant (PDA) that enable the user to improve their communication to a functional level.

Stadium Style Seat - A one or two piece stadium-style seat with rigid frame and cushioning material in both seat and back sections, covered in cloth, vinyl, leather or equal as upholstery, and designed to serve as a complete seating, support, and cushioning system for the user. It may have armrests that can be fixed, swingaway, or detachable. It will not have a headrest. Chairs with stadium style seats are billed using the Captains Chair codes.

Standard components are those components that are not made solely for one individual. They are prefabricated and readily available on the commercial market (off the shelf) and can be utilized by a variety of patients.

Test Standards - Performance and durability acceptance criteria defined by ANSI/RESNA standard testing protocols.

Top End Speed - Minimum speed acceptable for a given category of devices. It is to be determined by the RESNA test for maximum speed on a flat hard surface.

Upper Extremity Support System/Wheelchair tray – A flat surface across the abdominal area attached to a wheelchair at the armrests used to support proper positioning of upper extremities. Padded foam or foam like additions (i.e., protraction blocks, padding added to the flat surface) to a UESS are used to place the upper extremities in a protracted position to address strong spasticity or exaggerated muscle activity.