Orthotics and Prosthetics

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Overview

Orthotic and prosthetic devices are used to support weak body parts, replace body parts, or restore ambulation. Orthoses support weak body parts and are considered medically necessary for the treatment of musculoskeletal deformity or injury, neuromuscular disorders, and chronic pain. Prostheses replace body parts or restore ambulation and are considered medically necessary for the treatment of amputation or congenital birth defect impacting a limb.

Eligible Providers

The following providers may provide orthotics and prosthetics:

- Federally qualified health centers
- Home health agencies
- Hospitals
- Indian Health Services
- Medical suppliers

- Pharmacies
- Rural health clinics

TPL and Medicare
Providers must meet any provider criteria, including accreditation, for third party insurance or for Medicare to assist members for whom Minnesota Health Care Programs (MHCP) is not the primary payer.

MHCP quantity limits and thresholds apply to all members unless only Medicare coinsurance or deductible is requested.

Refer to the Medicare and Other Insurance section of the MHCP Provider Manual for more information.

Eligible Members
Orthotic and prosthetic devices are covered for all eligible Medical Assistance and MinnesotaCare members.

Covered Services
MHCP covers orthotic and prosthetic devices, supplies, and services that are medically necessary and prescribed by a physician or licensed health care prescriber who has authority in Minnesota to prescribe orthoses and prostheses, including devices customized to the member's everyday needs. Members must be appropriately examined, fitted, and trained by an orthotist or prosthetist before using their device and requesting authorization, if applicable. MHCP covers an additional device for all members for purposes of bathing or showering. For eligible members, MHCP also covers a recreational device for purposes of performing physical activities including, but not limited to, running, biking, swimming, and maximizing the member's limb function.

When providing orthotics and prosthetics, providers must:
- Provide the product that is specified by the treating physician; and
- Ensure the treating physician's medical record justifies the need for the type of device; and
- Only bill for the HCPCS code that accurately reflects both the type of device and appropriate level of fitting; and
- Have detailed documentation in the record justifying the HCPCS code selected.

Refer to the Medical Supply Coverage Guide (PDF) for information on MHCP authorization requirements, billing frequencies, and quantity limits by HCPCS code. The quantity limits reflected on the Medical Supply Coverage Guide represent the quantity limit per limb per device.

Orthoses
Evaluation and Management
Evaluation of the member's condition and functional ability is required. For members with existing orthoses, for whom a similar replacement is requested, evaluation can be based on the member's history and current condition. For members for whom a first orthosis is requested or for whom a significantly different orthotic is requested, evaluation must be based on clinical observation.

Evaluations must be performed by a professional certified by the American Board of Certification in Orthotics and Prosthetics, or the Board of Certification in Orthotics and Prosthetics or a professional who has similar training or expertise. Document the evaluation. The evaluation must be less than 180 days old.

Medical records must include:

- Order
- Member's diagnosis and clinical history
- Status of impacted body part or extremity
- Description of the orthotic being provided

Use the following categories for orthotics for the spine, hip, and extremities when evaluating the member: prefabricated, custom fitted, or custom fabricated. Provide specific information about the member's condition and the type of orthotic.

Prefabricated or off-the-shelf (OTS) orthoses are devices that are prefabricated. These devices require minimal self-adjustment. Minimal self-adjustment refers to adjustments that may be made by the member or their caregiver. These devices do not involve bending, molding, trimming, or altering beyond minimal self-adjustment. Prefabricated orthoses do not require expertise of a certified orthotist or professional who has similar training or expertise.

Custom fitted orthoses are devices that are prefabricated. These devices require modification of the prefabricated item to provide a customized fit. Custom fitted orthoses may or may not be supplied with a kit that requires assembly. Assembly of the device or installation of components in preparation of the device does not change classification from OTS to custom fitted. Classification as custom fitted requires substantial modification. Modifications must involve bending, molding, trimming, or altering beyond minimal self-adjustment. Suppliers must document the customizations of the device.

Custom fabricated orthoses are devices that are individually made for a specific member. These devices require substantial customization from castings, measurements, tracings, and imaging of the body part. Custom fabricated orthoses may involve calculations, components, and templates. Materials required may include cloth, leather, metal, plastic, and other raw materials for construction of the device. Classification as custom fabricated requires substantial modification including bending, cutting, drilling, molding, sewing, and vacuum forming the device to the member. This fitting requires expertise of a certified orthotist or professional who has similar training or expertise.

MHCP covers orthoses for the spine, hip, lower and upper limbs, cranial remolding orthoses, protective helmets, and orthopedic and therapeutic footwear. There is no separate payment for the evaluation, fitting, molding, or training of use for equipment as these services are included in the applicable HCPCS codes. The usual reasonable useful lifetime (RUL) of five years for durable medical equipment (DME) does not apply to custom fitted or custom fabricated orthotics. Refer to the Reasonable Useful Lifetime subsection of this MHCP Provider Manual section for information on subsequent new or replacement custom orthotics.

Authorization is not required for prefabricated or custom orthotic devices for everyday use and for purposes of bathing or showering, unless the individual HCPCS codes always require authorization. Authorization is required for recreational orthotics, excess quantities, and subsequent new custom orthotics if the current orthotic is less than three years old for members age 21 or older or if the current orthotic is less than one year old for members under age 21. Refer to the Devices for Bathing or Recreation subsection of this MHCP Provider Manual section for information on devices for purposes of bathing or showering or recreation.

Spinal Orthoses

Codes: L0112-L1499

Orthotics for the spine are considered medically necessary to:

- Facilitate healing of the spine or related soft tissues; or
- Reduce pain by restricting mobility; or

- Support weak spinal muscles or a deformed spine; or
- Treat scoliosis.

MHCP covers one unit of prefabricated orthotics for the spine for purposes of everyday use and for bathing per calendar year without authorization. MHCP covers one custom orthotic device for purposes of everyday use and for bathing without authorization. Authorization is required for recreational orthotics, excess quantities, and subsequent new custom orthotics if the current orthotic is less than three years old for members age 21 or older or if the current orthotic is less than one year old for members under age 21.

Types of orthotics for the spine include cervical orthotics, thoracic-lumbar-sacral orthotics (TLSOs), sacral orthotics (SOs), lumbar orthotics (LOs), lumbar-sacral orthotics (LSOs), cervical-thoracic-lumbar-sacral orthotics (CTLSOs), cervical halo procedures, scoliosis orthotic devices, accessories, and additions.

Spinal orthotics (L1499) and additions (L0999) that are not otherwise specified require authorization if the submitted charge is more than $400. HCPCS codes L0999 and L1499 should only be used when there is not a more specific HCPCS code. Documentation must clearly indicate the need for the unspecified item.

Hip Orthoses

Codes: L1600-L1755, L2040-L2090

Orthotics for the hip are considered medically necessary to:

- Stabilize the hip; or
- Correct and maintain hip abduction.

MHCP covers one unit of prefabricated orthotics for the hip for purposes of everyday use and for bathing per calendar year without authorization. MHCP covers one custom orthotic device for purposes of everyday use and for bathing without authorization. Authorization is required for recreational orthotics, excess quantities, and subsequent new custom orthotics if the current orthotic is less than three years old for members age 21 or older or if the current orthotic is less than one year old for members under age 21.

Types of orthotics for the hip include hip orthotics (HOs), Legg Perthes orthotics, and hip-knee-ankle-foot orthotics (HKAFOs).

Lower Limb Orthoses

Codes: L1810-L2038, L2106-L2999, L4350-L4631

Lower limb orthotics are considered medically necessary to:

- Treat contractures; or
- Immobilize a limb to promote healing; or
- Provide support and stability during ambulation.

MHCP covers two units of prefabricated orthotics per each impacted extremity per type of orthotic for purposes of everyday use and one unit for bathing per calendar year without authorization. MHCP covers one custom orthotic device per each impacted extremity per type of orthotic for purposes of everyday use and for bathing without authorization. Authorization is required for recreational orthotics, excess quantities, and subsequent new custom orthotics if the current orthotic is less than three years old for members age 21 or older or if the current orthotic is less than one year old for members under age 21.

Types of orthotics for the lower limb include knee orthotics (KOs), ankle-foot orthotics (AFOs), knee-ankle-foot orthotics (KAFOs), accessories, and additions. Documentation must include physician order and medical necessity for each type of orthotic dispensed.

Lower limb orthotics that are not otherwise specified (L2999) require authorization if the submitted charge is more than $400. HCPCS code L2999 should only be used when there is not a more specific HCPCS code. Documentation must clearly indicate the need for the unspecified item.

Custom-Fabricated Swing-Phase Release and Microprocessor-Controlled KAFOs (L2005, L2006)
Custom-fabricated KAFOs with automatic lock and swing-phase release (L2005) and microprocessor-controlled KAFOs (L2006) are covered with authorization if all of the following criteria are met:

- The member is ambulatory and use of a KAFO is appropriate; and
- The member has cardiovascular, cognitive, and physical ability to use the device; and
- Documentation articulates reasonable likelihood of improved mobility or stability with the device instead of a standard KAFO; and
- Documentation articulates need for ambulation and how device enhances member's ability to perform activities of daily living (ADLs); and
  - If requesting microprocessor-controlled KAFO (L2006), the muscle to which the electrode is attached generates sufficient microvoltage to operate the device; and
- Consideration of less costly alternatives; and
- A trial demonstrates the member is able to use the device.

Upper Limb Orthoses

Codes: L3650-L3999, L8701, L8702
Upper limb orthotics are considered medically necessary to:

- Treat contractures; or
- Immobilize a limb to promote healing; or
- Provide support and stability during ADLs.

MHCP covers two units of prefabricated orthotics per each impacted extremity per type of orthotic for purposes of everyday use and one unit for bathing per calendar year without authorization. MHCP covers one custom orthotic device per each impacted extremity per type of orthotic for purposes of everyday use and for bathing without authorization. Authorization is required for recreational orthotics, excess quantities, and subsequent new custom orthotics if the current orthotic is less than three years old for members age 21 or older or if the current orthotic is less than one year old for members under age 21.

Types of orthotics for the upper limb include shoulder orthotics (SOs), elbow orthotics (EOs), finger orthotics (FOs), elbow-wrist-hand orthotics (EWOs), wrist-hand-finger orthotics (WHFOs), wrist-hand orthotics (WHOs), shoulder-elbow-wrist-hand-finger orthotics (SEWHFOs), accessories, and additions. Documentation must include physician order and medical necessity for each type of orthotic dispensed.

Upper limb orthotics that are not otherwise specified (L3999) require authorization if the submitted charge is more than $400. HCPCS code L3999 should only be used when there is not a more specific HCPCS code. Documentation must clearly indicate the need for the unspecified item.

Custom-Fabricated Powered Upper-Extremity Assist Devices (L8701, L8702)
Custom-fabricated powered upper-extremity range-of-motion assist devices are covered with authorization if all of the following criteria are met:

- Member use of an upper limb orthotic is appropriate; and
- The member has a diagnosis of one of the following:
  - Amyotrophic lateral sclerosis (ALS); or
  - Brachial plexus injury; or
  - Brain or spinal cord injury; or
  - Cerebral palsy; or
  - Long-term muscle weakness; or
  - Multiple sclerosis; or
  - Partial paralysis; or
  - Neuromuscular or neurological disease or injury; or
  - Other medical condition that severely limits mobility and range of motion in upper extremities; and
- The member has the cardiovascular, cognitive, and physical ability to use the device; and
- The member does not have a comorbidity that may impede with functioning of the device; and
- Documentation articulates reasonable likelihood of improved mobility with the device instead of a standard upper limb orthotic; and
- Documentation articulates need for mobility and how the device enhances the member's ability to perform ADLs; and
- The muscle to which the electrode is attached generates sufficient microvoltage to operate the device; and
- Consideration of less costly alternatives; and
- A trial demonstrates the member is able to use the device.

Powered upper extremity assist devices are contraindicated for any of the following:

- During recovery from acute injury; and
- Environments that limit safe use of the device, including flammable areas; and
- Excess pain in arm, hand, or shoulder during facilitated range of motion; and
- Insufficient myoelectric signal output for full operational use of the device; and
- Medical conditions that limit safe use of the device; and
- Physical measurements that do not meet specifications of the manufacturer; and
- Rigid spasticity in the impacted muscle groups; and
- Severe shoulder subluxation; and
- Upper extremity contracture that prevents functional movement to benefit from the device.

Cranial Remolding Orthoses

Code: S1040

Cranial remolding orthotics are considered medically necessary for treatment of head deformities associated with:

- Premature birth; or
- Restrictive intrauterine positioning; or
- Torticollis; or
- "Back to Sleep" sleeping positions.

Up to two cranial remolding orthotics are covered without authorization for members under age 2. Authorization is required for the third and subsequent cranial remolding orthotic.

Protective Helmets

Codes: A8000-A8004

Protective helmets, including prefabricated and custom fabricated items and soft interface replacements, are considered medically necessary for members at risk of head injury due to a

medical condition such as seizures or developmental disability. Most members older than 2 years old can be served with one protective helmet per year. Members younger than 2 years old may require more frequent replacements. Documentation needs to explain why a prefabricated helmet does not suffice.

Orthopedic and Therapeutic Footwear

Codes: A5500-A5501, A5503-A5507, A5510-A5513, A9283, L3000-L3595, L3600-L3649

Orthopedic footwear is considered medically necessary for treatment of structural conditions of the foot. Therapeutic footwear is considered medically necessary to prevent diabetic ulcers.

Orthopedic Footwear

Custom-made orthopedic shoes, modifications, additions, and inserts are considered medically necessary when the shoes are an integral part of the leg brace, or the member has one or more of the following:

- Acute or chronic calcaneal bursitis; or
- Calcaneal spurs; or
- Foot deformity; or
- Hallus valgus deformities in children; or
- Inflammatory conditions; or
- Medical osteoarthritis of the knee; or
- Musculoskeletal or arthropathic deformities; or
- Neurologically impaired feet; or
- Vascular conditions.

MHCP covers two units each of orthopedic shoes and inserts per each impacted extremity per calendar year without authorization. Deluxe features of orthopedic shoes (A5508) are noncovered.

Orthopedic shoes, modifications, additions, and inserts must be prescribed by a podiatrist or physician knowledgeable in the fitting of orthopedic shoes and inserts. All items must be fitted and furnished by a qualified individual such as a podiatrist, pedorthist, orthotist, or prosthetist.

Therapeutic Shoes and Inserts for Diabetes

Custom-made or prefabricated therapeutic shoes, modifications, and inserts are considered medically necessary for members with diabetes and one or more of the following:

- Foot deformity; or
- History of foot ulceration or pre-ulcerative calluses; or
- Peripheral neuropathy; or
- Poor circulation of foot; or
- Previous amputation of foot.

MHCP covers two units of therapeutic shoes and three units of inserts per each impacted extremity per calendar year without authorization. The member's medical condition may impact one foot or both feet. Inserts are only covered for member-owned therapeutic shoes.

Therapeutic shoes, modifications, and inserts must be prescribed by a podiatrist or physician knowledgeable in the fitting of diabetic shoes and inserts. All items must be fitted and furnished by a qualified individual such as a podiatrist, pedorthist, orthotist, or prosthetist.

Foot Pressure Off-Loading Devices

Foot pressure off-loading devices are considered medically necessary for members with existing pressure ulcers of the foot.

Prostheses

Evaluation and Management

Evaluation of the member's condition and functional ability is required. For members with existing prostheses, for whom a similar replacement is requested, evaluation can be based on the member's history and current condition. For members for whom a first prosthesis is requested or for whom a significantly different prosthetic is requested, evaluation must be based on clinical observation.

Evaluations must be performed by a professional certified by the American Board of Certification in Orthotics and Prosthetics, or the Board of Certification in Orthotics and Prosthetics or a professional who has similar training or expertise. Document the evaluation. The evaluation must be less than 180 days old.

Medical records must include:

- Order
- Member's diagnosis and clinical history
- Status of impacted body part or extremity
- Description of the prosthetic being provided

MHCP covers prostheses for the lower and upper limbs, breasts, eyes, and face, medical wigs, and prosthetic supplies. There is no separate payment for the evaluation, fitting, molding, or training of use for equipment as these services are included in the applicable HCPCS codes. The usual RUL of five years for DME does not apply to prosthetics. Refer to the Reasonable Useful Lifetime subsection of this MHCP Provider Manual section for information on subsequent new or replacement prosthetics.

Authorization is not required for initial prosthetic devices for everyday use and for purposes of bathing or showering or for bilateral amputees, unless the individual HCPCS codes always require authorization. Authorization is required for recreational prosthetics and subsequent new prosthetics for any purpose. Refer to the Devices for Bathing or Recreation subsection of his MHCP Provider Manual section for information on devices for purposes of bathing or showering or recreation.

Lower Limb Prostheses

Codes: L5000-L5999

Lower limb prosthetics are considered medically necessary for treatment of amputation or congenital birth defects in lower extremities.

Medical records must include:

- Reason for amputation
- Date of amputation
- Status of current limb
- Description of prosthetic being provided
- Which ADLs are affected and how they are impacted
- Functional capabilities before and after amputation
- Functional level (0 to 4)

Use the following functional levels in the evaluation. Provide specific information about the member's ambulation history, performance, and ADLs to support assignment of a member to a functional level.

- 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.
    - The member does not have sufficient cognitive ability to safely use a prosthesis with or without assistance.

    - The member requires assistance from equipment or a caregiver to transfer and use of a prosthesis does not improve mobility or independence with transfers.
    - The member is wheelchair dependent for mobility and use of a prosthesis does not improve transfer abilities.
    - The member is bedridden and has no need or capacity to ambulate or transfer.
- 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.
    - The member has sufficient cognitive ability to safely use a prosthesis with or without an assistive device or the assistance or supervision of one person.
    - The member is capable of safe but limited ambulation within the home or on a similar flat surface like a home, with or without an assistive device or with or without the assistance or supervision of one person.
    - The member requires the use of a wheelchair for most activities outside of their residence.
    - The member is not capable of most of the functional activities designated in level 2.
- 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. This level is typical of the limited community ambulator.
    - The member can, with or without an assistive device (which may include one or two handrails) and/or with or without the assistance or supervision of one person:
        - Perform the level 1 tasks listed in this manual section
        - Ambulate on a flat, smooth surface (for example, concrete, asphalt) such as might be found outside the home (for example, porch, deck, patio garage, driveway).
        - Negotiate a curb.
        - Access public or private transportation.
        - Negotiate 1 to 2 stairs.
        - Negotiate a ramp built to ADA specifications.
    - The member may require a wheelchair for distances that are beyond the perimeters of the yard or driveway, apartment building, etc.
    - The member is only able to increase their generally observed speed of walking for short distances or with great effort.
    - The member is generally not capable of accomplishing most of the tasks at level 3 (or does so infrequently with great effort).
- 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.
    - With or without an assistive device (which may include one or two handrails), the member is independently capable (that is, requires no personal assistance or supervision) of performing the level 2 tasks listed in this manual section and can:
        - Walk on terrain that varies in texture and level (for example, grass, gravel, uneven concrete).
        - Negotiate 3 to 7 consecutive stairs.
        - Walk up/down ramps built to ADA specifications.
        - Open and close doors.
        - Ambulate through a crowded area (for example, grocery store, big box store, restaurant).
        - Cross a controlled intersection within their community within the time limit provided (varies by location).
        - Access public or private transportation.

        - Perform dual ambulation tasks (for example, carry an item or meaningfully converse while ambulating).
    - The member does not perform the activities of level 4.
- 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.
    - With or without an assistive device (which may include one or two handrails), this member is independently capable (that is, requires no personal assistance or supervision) or performing high-impact domestic, vocational, or recreational activities such as:
        - Running
        - Repetitive stair climbing
        - Climbing of steep hills
        - Being a caregiver for another individual
        - Home maintenance (for example, repairs, cleaning)

Members whose function level is 0 are not eligible for lower limb prosthetics as the device would not enhance mobility or quality of life.

Lower limb prosthetics that are not otherwise specified (L5999) require authorization if the submitted charge is more than $400. HCPCS code L5999 should only be used when there is not a more specific HCPCS code. Documentation must clearly indicate the need for the unspecified item.

Review the following categories of lower limb prosthetics for HCPCS code descriptions and required member functional level for prosthetic ankles, feet, hips, and knees.

Feet and Ankles

- A power-assist ankle-foot or ankle system (L5969) or multiaxial ankle with swing-phase active dorsiflexion feature (L5968) may be medically necessary for members whose functional level is 3 or above.
- An external keel SACH foot (L5970) or single-axis ankle or foot (L5974) may be medically necessary for members whose functional level is 1 or above.
- A flexible-keel foot (L5972) or multiaxial ankle/foot (L5978) may be medically necessary for members whose functional level is 2 or above.
- A microprocessor-controlled ankle foot system (L5973), energy-storing foot (L5976), dynamic response foot with multiaxial ankle (L5979), flex-foot system (L5980), flex-walk system of equal (L5981), or shank foot system with vertical loading pylon (L5987) may be medically necessary for members when one of the following criteria is met:
    - The member's functional level is 3 or above; or,
    - The member's functional level is 2; and,
        - Meets the functional level 2 coverage criteria for a fluid, pneumatic, or electronic/microprocessor control addition for a prosthetic knee; and,
        - A higher-level (that is, functional level 3) foot is required for the safe and proper use of the prescribed knee system.
- An axial rotation ankle unit (L5982 to L5986) may be medically necessary for members whose functional level is 2 or above.

Knees

- A fluid or pneumatic knee unit (L5610, L5613, L5614, L5615, L5722 to L5780, L5814, L5822 to L5841) or control addition, fluid (L5848), or electronic/microprocessor (L5856 to L5858) may be medically necessary for members whose functional level is 3 or above.

- A fluid or pneumatic knee unit (L5610, L5613, L5614, L5615, L5722 to L5780, L5814, L5822 to L5841) or control addition, fluid (L5848), or electronic/microprocessor (L5856 to L5858) may be medically necessary for members whose functional level is 2 or above when all of the following criteria are met:
  - The member has had a clinical evaluation to determine their functional level; and,
  - Documentation in the medical record outlines the rationale for selection of a fluid, pneumatic, or electronic/microprocessor-controlled knee, including how the selected knee will:
    - Improve the member's functional health outcomes (for example, fall-reduction, injury prevention, lower energy expenditure); and,
    - Help the member accomplish their ADLs; and,
  - Lower-level knee systems (for example, knee systems which exclude use of fluid, pneumatic, or microprocessor) have been considered and ruled out based on the member's specific functional and medical needs.
  - An electronic/microprocessor-controlled knee system (L5856, L5857, or L5858 plus associated components) may be medically necessary for members whose functional level is 2 or above when all of the following criteria are met:
    - The electronic/microprocessor knee is indicated for functional level 2; and,
    - The electronic/microprocessor knee has integrated technology that allows the knee to detect when the user trips or stumbles and can automatically adjust to stabilize the knee unit (for example, stumble recovery); and,
    - The member is able to make use of a product that requires daily charging; and,
  - The member is able to understand and respond to error alerts and alarms indicating problems with the function of the unit.
- A knee with powered and programmable flexion/extension assist control (L5859) may be medically necessary for members when all of the following criteria are met:
  - The member has a microprocessor (swing and stance phase type (L5856)) controlled (electronic) knee; and,
  - The member has a functional level of 3; and,
  - The member has a comorbidity of the spine or sound limb affecting hip extension or quadriceps function that impairs level 3 function with the use of a microprocessor-controlled knee alone; and,
  - The member is able to make use of a product that requires daily charging; and,
  - The member is able to understand and respond to error alerts and alarms indicating problems with the function of the unit.
- A high-activity knee control frame (L5930) may be medically necessary for members whose functional level is 3 or above, or for members whose weight requires the increased strength of this kind of frame.
- Other knee systems (L5611, L5616, L5710 to L5718, L5810 to L5818) may be medically necessary for members whose functional level is 1 or above.

Hip

A pneumatic or hydraulic polycentric hip joint (L5961) may be medically necessary for highly motivated members whose functional level is 2 or above.

Additional Criteria

Vacuum suspension systems (L5781 or L5782) may be medically necessary for members whose functional level is 2 or above.

Osseointegrated External Prosthetic Connectors (L5991)
Osseointegrated external prosthetic connectors, components of bone-anchored prosthetic devices, are covered with authorization if all of the following criteria are met:

- The member has transfemoral, transhumeral, or transtibial amputation; and
- The member has failed to receive benefit from prosthetic devices with sockets or the member is not expected to tolerate socket use due to one of the following:
  - A short stump preventing use of a socket prosthetic device; or
  - Extensive skin grafting; or
  - Recurrent skin infections and ulcerations in the socket contact area; or
  - Restricted mobility; or
  - Socket retention problems; or
  - Soft tissue scarring; or
  - Volume fluctuation in the stump; and
- The member has the cardiovascular, cognitive, and physical ability to use the device; and
- The member does not have a comorbidity that may impede with functioning of the device; and
- Documentation articulates reasonable likelihood of improved mobility with the device instead of a standard prosthetic; and
- Documentation articulates need for mobility and how the device enhances the member's ability to perform ADLs; and
- Consideration of less costly alternatives; and
- A trial demonstrates the member is able to use the device.

Osseointegrated external prosthetic connectors are contraindicated for any of the following:

- Atypical member skeletal anatomy which may impede with functioning of the device; and
- Incomplete member skeletal growth; and
- The member has a concurrent diagnosis of one of the following:
  - Active infection or dormant bacteria; or
  - Diabetic mellitus with complciations; or
  - Metabolic bone disease or metastatic lesions in the residual femur; or
  - Neuropathy or neuropathic diseases and severe phantom pain; or
  - Severe peripheral vascular disease; or
  - Skin disorders involving the residual limb; and
- The member has less than 2 millimeters of remaining cortex bone available around the implant, if implanted; and
- The member's body weight is greater than 220 pounds (or 100 kilograms); and
- The member is older than 65 years or younger than 22 years; and
- The member is pregnant; and
- The member has osteoporosis.

Complete skeletal growth is defined as the finding of generally closed epiphyseal zones through X-rays. Atypical skeletal anatomy includes but is not limited to conditions which are not amenable to device insertion, development anomalies, and skeletal dimensions outside of the defined interval.

Upper Limb Prostheses
Codes: L6000-L7259, L7400-L7499
Upper limb prosthetics are considered medically necessary for treatment of amputation or congenital birth defects in upper extremities.

Medical records must include:

- Reason for amputation

- Date of amputation
- Status of current limb
- Description of prosthetic being provided
- Which ADLs are affected and how they are impacted
- Functional capabilities before and after amputation

Use the following categories for upper limb prosthetics when evaluating the member. Provide specific information about the member's history, performance, and ADLs to support assignment of a particular device.

Passive Prostheses
Passive prostheses do not move on their own, are lightweight, and enhance the member's condition by stabilizing or carrying objects. A passive upper extremity prosthetic is covered for members if all of the following criteria are met:

- The member is an amputee or has a congenital limb deficiency or absence of limb; and
- The member has the cognitive ability and desire to perform ADLs using the device; and
- The member's evaluation demonstrates the anticipated functioning goals using the device to accomplish daily tasks, appropriate to the member's condition, in a reasonable time period; and
- The member is cognitively, developmentally, or physically unable to use a body-powered prosthetic and is able to use the passive prosthetic; and
- The member is able to lock the prosthetic in place or, if a child, with the assistance of a parent or caregiver; and
- The device is the least costly alternative that meets the member's medical needs.

Body-Powered Prostheses
Body-powered prostheses use body movements to control the device. A body-powered upper extremity prosthetic is covered for members if all of the following criteria are met:

- The member is an amputee or has a congenital limb deficiency or absence of limb; and
- The member has the cognitive and musculoskeletal ability and desire to perform ADLs using the device; and
- The member's evaluation demonstrates the anticipated functioning goals using the device to accomplish daily tasks, appropriate to the member's condition, in a reasonable time period; and
- A passive device does not meet the member's functional needs to perform daily tasks; and
- The member does not have a comorbidity that may impede with functioning of the device; and
- The device is the least costly alternative that meets the member's medical needs.

Myoelectric or Hybrid Prostheses
Myoelectric prostheses use electromyographic signals in muscle contractions to control the device. A myoelectric or hybrid upper extremity prosthetic is covered for members if all of the following criteria are met:

- The member is an amputee or has a congenital limb deficiency or absence of limb; and
- The member has the cognitive and musculoskeletal ability and desire to perform ADLs using the device; and
- The member's evaluation demonstrates the anticipated functioning goals using the device to accomplish daily tasks, appropriate to the member's condition, in a reasonable time period; and
- A passive or body-powered device does not meet the member's functional needs to perform daily tasks; and

- The muscle to which the electrode is attached generates sufficient microvoltage to operate the device; and
- Documentation establishes that the member's environmental factors, including wet environments, do not contraindicate using the device.

Upper limb prosthetics that are not otherwise specified (L7499) require authorization if the submitted charge is more than $400. HCPCS code L7499 should only be used when there is not a more specific HCPCS code. Documentation must clearly indicate the need for the unspecified item.

Breast Prostheses

Codes: L8000-L8002, L8010, L8015, L8020, L8030-L8033, L8035, L8039

Breast prosthetics are covered for members who have had a mastectomy or other conditions that result in absence or defect of the breast.

Medical records must include:

- Order
- Member's diagnosis and clinical history
- Status of absence, defect, or condition of breast
- Description of prosthetic being provided

Use the following HCPCS code descriptions when evaluating the member.

Mastectomy bras without integrated prosthesis form (L8000) and with integrated prosthesis form (L8001 and L8002) come in various materials and sizes to fit patients who have undergone a mastectomy. Authorization is not required for mastectomy bras. MHCP covers only one breast prosthetic per side for members who have undergone bilateral mastectomies.

A mastectomy sleeve (L8010) is covered for members with post-mastectomy lymphedema.

An external breast prosthesis garment (L8015) is covered for the postoperative period before a permanent breast prosthetic, or as an alternative to a mastectomy bra and breast prosthetic.

A mastectomy bra (L8000) is covered for members with mastectomy form (L8020) or silicone breast prosthetic without integrated adhesive (L8030) when the pocket of the bra is used to hold the prosthetic.

MHCP covers silicone breast prosthetics with integrated adhesives (L8031), prefabricated and custom nipple prosthetics (L8032 and L8033), and custom breast prosthetics (L8035). Authorization is always required for custom breast (L8035) and nipple (L8033) prosthetics and not otherwise specified breast prosthetics (L8039). Documentation must clearly articulate why prefabricated prosthetics do not satisfy the needs of the member. HCPCS code L8039 should only be used when a breast prosthetic is not described by a more specific HCPCS code (L8000 to L8035).

Eye and Iris Prostheses

Codes: 66683, C1839, V2623-V2629

Eye and iris prosthetics are covered for members who have absence, defect, shrinkage, or specific conditions of the eyes or iris.

Medical records must include:

- Order
- Member's diagnosis and clinical history

- Status of absence, shrinkage, defect, or condition of eyes
- Description of prosthetic being provided

Authorization is not required for eye prosthetics. Authorization is only required for subsequent new eye prosthetics if the current prosthetic device is less than five years old. Authorization is required for iris prosthetics.

Use the following categories and HCPCS code descriptions when evaluating the member.

Eye Prostheses
Eye prostheses are covered for members with absence or shrinkage of an eye due to disease, congenital defect of eye, surgery, or trauma.

Use the following HCPCS code descriptions when evaluating the member.

An ocular prosthetic (V2623) is an artificial eye that fits over an orbital implant and under the eyelids that produces the appearance of a normal human eye. Eye prosthetics assist in maintaining the internal orbital eye structures by filling in the void created by the missing natural eye.

Polishing and resurfacing (V2624) is covered for members without authorization two times per calendar year.

One enlargement (V2625) or reduction (V2626) is covered without authorization. Additional enlargements or reductions are rarely medically necessary and are therefore covered only when there is documentation in the medical record which supports medical necessity. This information must be made available to DHS or its authorized agent upon request.

MHCP covers scleral cover shells (V2627) and the fabrication and fitting of ocular conformers (V2628). Authorization is always required for not otherwise specified eye prosthetics (V2629). Documentation must clearly articulate why prefabricated prosthetics do not satisfy the needs of the member. HCPCS code V2629 should only be used when an eye prosthetic is not described by a more specific HCPCS code (V2623 to V2628).

Iris Prostheses
Iris prosthetics compensate for a defect of the iris of an eye. An iris prosthetic (C1839) is considered medically necessary for treatment of aniridia for members three years of age and older. Authorization is always required for iris prosthetics and device implantation. The implantation is described by CPT code 66683. Iris prosthetics are not covered for members with certain eye conditions, such as uncontrolled inflammation, severe chronic uveitis, microphthalmos, untreated retinal detachment, untreated chronic glaucoma, rubella cataract, rubeosis of the iris, proliferative diabetic retinopathy, Stargardt's retinopathy, or intraocular infections, or in pregnant women.

Facial Prostheses
Codes: L8040-L8049
Facial prosthetics are covered for members with loss or absence of facial tissue due to disease, congenital defect, surgery, or trauma.

Medical records must include:
- Order
- Member's diagnosis and clinical history
- Status of facial tissue
- Description of prosthetic being provided

Authorization is not required for facial prosthetics. Authorization is only required for subsequent new facial prosthetics if the current prosthetic device is less than five years old.

Use the following HCPCS code descriptions when evaluating the member.

A nasal prosthesis (L8040) is a removable superficial prosthesis, which restores all or part of the nose. It may include the nasal septum.

A midfacial prosthesis (L8041) is a removable superficial prosthesis, which restores part or all of the nose plus significant adjacent facial tissue but does not include the orbit or any intraoral maxillary component. Adjacent facial tissue includes one or more of soft tissue of the cheek, upper lip, or forehead.

An orbital prosthesis (L8042) is a removable superficial prosthesis, which restores the eyelids and the hard and soft tissue of the orbit. It may also include the eyebrow. This code does not include the ocular prosthesis component.

An upper facial prosthesis (L8043) is a removable superficial prosthesis, which restores the orbit plus significant adjacent facial tissue but does not include the nose or any intraoral maxillary component. Adjacent facial tissue includes one or more of soft tissue of the cheek or forehead. This code does not include the ocular prosthesis component.

A hemi-facial prosthesis (L8044) is a removable superficial prosthesis, which restores part or all of the nose plus the orbit plus significant adjacent facial tissue but does not include any intraoral maxillary component. This code does not include the ocular prosthesis component.

An auricular prosthesis (L8045) is a removable superficial prosthesis, which restores all or part of the ear.

A partial facial prosthesis (L8046) is a removable superficial prosthesis which restores a portion of the face, but which does not specifically involve the nose, orbit, or ear.

A nasal septal prosthesis (L8047) is a removable prosthesis, which closes a hole in the nasal septum but does not include superficial nasal tissue.

Authorization is always required for unspecified maxillofacial prosthetics (L8048). HCPCS code L8048 should only be used when a facial prosthetic is not described by a more specific HCPCS code (L8040 to L8047) or for components used to attach the facial prosthetic to a bone-anchored implant or to an internal prosthesis. HCPCS code L8048 code should not be used for implanted prosthesis-anchoring components. Medically necessary modifications and repairs are covered under L8048 for materials used and L8049 for labor components. MHCP allows up to six units of L8049 per day.

Scalp Hair Prostheses

Code: A9282

Scalp hair prostheses are considered medically necessary for treatment of medical conditions that result in hair loss. One medical wig is covered per calendar year with an annual limit of $1,000.

Supplies for Prostheses

Codes: L5618-L5704, L8400-L8499

MHCP covers supplies for prosthetic devices. Supplies include sockets, test sockets, socket inserts, liners, suspension sleeves, sheaths, shrinkers, socks, and accessories. Supplies are covered if they

are medically necessary and are required for functioning of the prosthetic device. The following is not an exhaustive list. The reasonable useful lifetime (RUL) for durable medical equipment (DME) applies to prosthetic supplies. Refer to the Medical Supply Coverage Guide (PDF) for information on MHCP authorization requirements, billing frequencies, and quantity limits by HCPCS code.

Test sockets (L5618 to L5628, L6029, L6680 to L6684) are used to determine optimal fit and interface between the member's skin at the residual limb and the material of the device. Multiple test sockets may be required to determine optimal fit as the residual limb stabilizes following amputation. MHCP covers two test sockets per prosthetic device. Authorization is required for excess quantities.

Sockets (L5629 to L5632, L5634, L5636 to L5640, L5642 to L5653) are the part of the prosthetic device that fits around the residual limb and to which components and additions are attached. The socket must be precisely measured to ensure proper control and stability. Designs and features of sockets vary. Some socket designs include a flexible inner socket with an external frame or strapping (L5643, L5645, L5651). Some sockets have a release button to assist in removal of the prosthetic device. MHCP covers one socket per member-owned prosthetic device per year when the original item no longer functions. Authorization is required for excess quantities.

Total contact sockets (L5637, L5650) fully interface with the residual limb and allow more surface area to bear weight against the prosthetic device. Air cushion sockets (L5646, L5648) are used for active ambulators and running. Suction sockets (L5647) usually have a silicone interface that creates a vacuum from natural properties as the socket is worn and weight placed against the prosthetic device. Ischial containment sockets (L5649) are sockets for above-knee amputations that contain the ischial tuberosity within the socket.

Socket inserts (L5654 to L5658, L5661, L5665) serve as the interface between the residual limb and the prosthetic device. Socket inserts aid in the protection of fragile skin of the residual limb while compensating for changes in limb volume. Some prosthetic devices fit comfortably without use of a socket insert. MHCP covers one socket insert per member-owned prosthetic device per year when the original item no longer functions. Authorization is required for excess quantities.

Liners (L5673, L5679) are soft sleeves that are worn over the residual limb and inside the prosthetic socket. Liners protect the residual limb, support suspension, increase comfort, and reduce the risk of skin irritation. MHCP covers two liners per member-owned prosthetic device per year when the original item no longer functions. Authorization is required for excess quantities.

Molded distal cushions (L5668) are additions to liners that are fabricated from an impression of the residual stump.

Thigh lacers (L5680, L5682) are corset-like cuffs that are attached to lower limb prosthetic devices, usually by two vertical sidebars to form a suspension system. Thigh lacers are for members who have undergone below-knee amputations and cannot tolerate full-contact pressure on their residual limb.

Suspension sleeves (L5685) are used to hold the prosthetic device in place, distribute pressure, and reduce friction, rotation, and volume. Suspension locking mechanisms (L5671) use lanyards or pins that screw into the end of the socket to connect to the residual limb. Cuff suspension (L5666) allows the lower limb prosthetic device to make full contact with the residual limb by ensuring the integrity of the entire system. Cuffs are gripping devices that hold the residual limb below the knee.

Single-axis knee joints (L5676) act as a door-and-hinge device that allows one-speed ambulation, is free swinging, and does not allow stance control. Polycentric knee joints (L5677) have multiple

rotational axes that include four points of rotation attached by a linkage bar. They are stable in early stance and easy to flex in swing phase.

Waist belts (L5688, L5690) are used to provide suspension support, primarily for members who have weak musculature or cannot tolerate other forms of suspension. Pelvic control belts (L5692, L5694) are used to maintain proper gait mechanics for members with above-knee prosthetics. Pelvic control sleeve suspension (L5695) is pulled over the residual limb and extends over the pelvis. Pelvic joints (L5696) are composed of single and multiple axes and are mounted in the front of the prosthetic device. They provide flexibility at the hip and allow ambulation. Pelvic bands (L5697) are broad bands or wrappings worn around the waist and from which the prosthetic device is attached.

Molded-to-patient-model replacement sockets (L5700 to L5703, L6031, L6883 to L6885) are covered for member-owned prosthetic devices when the original item no longer functions. Documentation must clearly articulate why nonmolded-to-patient sockets do not satisfy the needs of the member. Authorization is always required.

Textile products include sheaths, shrinkers, and socks. Sheaths (L8400, L8410, L8415, L8417) are protective garments that are worn against skin beneath a sock (L8420, L8430, L8435, L8470, L8480, L8485). Sheaths are used to reduce friction and provide comfort and moisture management. Shrinkers (L8440, L8460, L8465) are used to reduce swelling, shape the limb, and prepare the limb for prosthetic fitting.

Authorization is always required for unlisted procedures for miscellaneous prosthetic services (L8499). HCPCS code L8499 should only be used when there is not a more specific HCPCS code. Documentation must clearly indicate the need for the unspecified procedure or service. Providers cannot bill noncovered services under miscellaneous HCPCS code L8499 or any other miscellaneous code. Refer to the Noncovered Services section of this MHCP Provider Manual section for information on which items and services are noncovered by MHCP.

Batteries and Chargers

Codes: L7360-L7368

MHCP covers powered prosthetics, batteries, and chargers. Powered-prosthetic base codes are items that contain the power source. When a base code is dispensed, MHCP considers all batteries (L7360, L7364, L7367) and chargers (L7362, L7366, L7368) as included in the payment for the base item. There is no separate payment for these items billed concurrently with powered prosthetics.

Payment for batteries and chargers is included in the payment for these base codes:

Base Codes	Battery and Charger Codes
L2005, L2006, L3904, L5781, L5782, L5856, L5857, L5858, L5859, L5973, L6026, L6700, L6920, L6925, L6930, L6935, L6940, L6945, L6950, L6955, L6960, L6965, L6970, L6975, L8701, L8702	L7360, L7362, L7364, L7366, L7367, L7368

Many powered prosthetic base codes are used concurrently with add-ons that derive power from the power source. When an add-on to a base code is dispensed, MHCP considers all batteries (L7360, L7364, L7367) and chargers (L7362, L7366, L7368) as included in the payment for the item. There is no separate payment for these items billed concurrently with powered prosthetic add-ons.

Payment for batteries and chargers is included in the payment for these add-on codes and the appropriate base code:

Add-On Codes	Base Codes	Battery and Charger Codes
L5827, L5969, L6621, L6638, L6646, L6648, L6715, L6880, L6881, L6882, L7007, L7008, L7009, L7040, L7045, L7170, L7180, L7181, L7185, L7186, L7190, L7191, L7259	L5781, L5782, L5856, L5857, L5858, L5859, L5973, L6026, L6700, L6920, L6925, L6930, L6935, L6940, L6945, L6950, L6955, L6960, L6965, L6970, L6975	L7360, L7362, L7364, L7366, L7367, L7368

MHCP pays for one battery and charger annually only when the original item no longer functions.

Devices for Bathing or Recreation

Devices for purposes of bathing or showering and for purposes of recreation are covered. Recreational devices are intended for performing physical activities including, but not limited to, running, biking, swimming, and maximizing the member's limb function. Members whose functional level is 2 or above are eligible for recreational prosthetics. Authorization is required for devices for recreation. Use modifier U2 for billing. Authorization is not required for orthotics or initial prosthetics for bathing or showering. Bathing devices are intended for member use while bathing, cleaning, or showering. Members whose functional level is 1 or above are eligible for bathing prosthetics. Use modifier U1 for billing. Bathing devices only require authorization if they are the member's third device. It is the expectation of MHCP that devices for bathing or showering are nonelectronic and made from the least costly items and waterproof materials.

Recreational devices are covered with authorization if all of the following criteria are met:

- The member meets criteria for the specific device; and
- The member has cardiovascular, cognitive, and physical ability to use the device; and
- Documentation articulates how the device enhances the member's ability to perform sports or recreational activities; and
- Documentation articulates how the member's other devices do not suffice for recreation; and
- A trial demonstrates the member is able to use the device.

Repairs and Replacements

Codes: L4000-L4210, L7510, L7520

Repairs to devices are covered without authorization with the following exceptions:

- Repairs to a device require authorization if the submitted combined charges for parts and labor are $1,000 or more.
- HCPCS codes without an MHCP fee schedule rate always require authorization if the submitted charge is $400 or more.

Replacements for a device or parts of a device are covered, without regard to useful lifetime restrictions, if ordered by an eligible provider because:

- Of a change in the physiological condition of the enrollee; or
- Of an irreparable change in the condition of the device or in a part of the device; or
- The condition of the device or in a part of the device requires repairs and the cost of the repairs would be more than 60 percent of the cost of a replacement device or of the part being replaced.

Reasonable Useful Lifetime

The usual reasonable useful lifetime (RUL) of five years for durable medical equipment DME does not apply to prosthetics or custom orthotics. Custom orthotics include devices that are custom fabricated, or custom fitted to a specific member based on their unique physical condition. MHCP covers

medically necessary repairs and replacements for parts and devices. Members cannot automatically obtain a new device if the original is still in working order.

MHCP pays for the initial prosthetic devices for everyday use and bathing without authorization, unless the individual HCPCS codes always require authorization. Authorization is required for recreational prosthetics and subsequent new or replacement prosthetics for any purpose. MHCP pays for custom orthotic devices for everyday use and bathing without authorization, unless the individual HCPCS codes always require authorization. Authorization is required for recreational orthotics and subsequent new custom orthotics if the current orthotic is less than three years old for members age 21 or older or if the current orthotic is less than one year old for members under age 21.

Replacement Orthoses and Prostheses Requirements Chart
Refer to the Replacement orthoses and prostheses requirements chart to review MHCP requirements for replacement devices by type of orthotic or prosthetic device.

Replacement orthoses and prostheses requirements chart

Type of Device	Quantity Limits	Authorization Requirements
Prefabricated spinal and hip orthoses	**Everyday use (no U modifier):** 1 unit per year **Bathing (U1):** 1 unit per year **Recreation (U2):** 1 unit	Recreational orthoses Quantities that exceed MHCP quantity limits
Prefabricated lower and upper extremity orthoses	**Everyday use (no U modifier):** 2 units per limb per year per type of orthosis **Bathing (U1):** 1 unit per limb per year per type of orthosis **Recreation (U2):** 1 unit per limb	Recreational orthoses Quantities that exceed MHCP quantity limits
Custom fitted or custom fabricated spinal and hip orthoses	**Everyday use (no U modifier):** 1 device (combination of L HCPCS codes) **Bathing (U1):** 1 device **Recreation (U2):** 1 device	Recreational orthoses **Members under age 21:** Replacement orthoses if the current device is less than 1 year old **Members age 21 and older:** Replacement orthoses if the current device is less than 3 years old
Custom fitted or custom fabricated lower and upper extremity orthoses	**Everyday use (no U modifier):** 1 device per limb per type of orthosis (combination of L HCPCS codes) **Bathing (U1):** 1 device per limb per type of orthosis **Recreation (U2):** 1 device per limb	Recreational orthoses **Members under age 21:** Replacement orthoses if the current device is less than 1 year old **Members age 21 and older:** Replacement orthoses if the

		current device is less than 3 years old
Lower and upper extremity prostheses	**Everyday use (no U modifier):** 1 device per limb (combination of L HCPCS codes) **Bathing (U1):** 1 device per limb **Recreation (U2):** 1 device per limb	Recreational prostheses Replacement prostheses for any purpose (no U modifier, U1, or U2)
Eye and facial prostheses	Eyes: 1 unit per side Facial: 1 unit	Replacement prostheses if the current device is less than 5 years old

Noncovered Services

MHCP does not cover the following:

- An orthotic or prosthetic device for which Medicare has denied the claim as not medically necessary.
- A device that does not meet criteria as indicated in this policy is considered not medically necessary.
- A device whose primary purpose is to serve as a convenience to a person caring for the member.
- A device that serves to address social and environmental factors and that does not directly address the member's physical or mental health.
- A device that is supplied to the member by the physician who prescribed the device or by a provider who is an affiliate of the physician who prescribed the device.
- Costs for delivery, evaluation, fitting, setup, or service calls.
- Repair costs for an orthotic or prosthetic device that is under warranty.
- Repair costs for any rental equipment.
- Repair or replacement costs for devices or parts within 90 days of the date of delivery.
- Lower limb prosthetics for a member whose functional level is 0 are considered not medically necessary.
- Orthotics when used to prevent injury in a previously uninjured limb.
- Deluxe features of orthopedic shoes (A5508).
- A custom fabricated device when the member's needs can be met with a prefabricated device.
- Additions or components that are not required for the effective use of the device or do not serve a functional purpose are considered not medically necessary.
- Additions provided for cosmetic reasons are considered not medically necessary.

Refer to information under the Noncovered Services heading in the Billing the Member (Recipient) section of the MHCP Provider Manual to review the conditions required to bill the member.

Authorization

Authorization is required for the following:

- Quantities over MHCP quantity limits.
- Repairs or replacement of parts or accessories if the submitted combined charges for parts and labor are $1,000 or more.
- All unlisted or unspecified services, including HCPCS code L8499, and any repairs to devices.
- HCPCS codes without an MHCP fee schedule rate always require authorization if the submitted charge is more than $400.

- HCPCS codes on the MHCP fee schedule and the Medical Supply Coverage Guide (PDF) that indicate prior authorization is always required.
- Devices for recreational purposes, regardless of individual HCPCS codes.
- Third custom orthotic or prosthetic device of any type. While custom orthotic or initial prosthetic devices for bathing or showering do not require authorization, if a member has a device for everyday use and for recreation, then authorization is required for a bathing device.
- Subsequent new prosthetic devices for any purpose after the member's initial device when it is determined by the provider that the cost of repairs and replacements for the member's existing device exceed the cost of obtaining a new device.
- Subsequent new custom orthotic devices when the current device is less than three years old for members age 21 or older.
- Subsequent new custom orthotic devices when the current device is less than one year old for members under age 21.
- Subsequent new eye or facial prosthetic devices when the current device is less than five years old.
- Third or subsequent test sockets (L5618 to L5626, L6029, L6680 to L6684).
- The following types of devices always require authorization:
  - Microprocessor products (L2006, L5856, L5857, L5858, L5973, L6882, L7180, L7181, L8701, L8702)
  - Molded-to-patient-model replacement sockets for lower limbs (L5700 to L5703) and upper limbs (L6031, L6883 to L6885)
  - Disarticulation prosthetics, including those for the knees (L5150, L5160), hips (L5250, L5270), wrists (L6050, L6055), elbows (L6200, L6205), and shoulders (L6300 to L6320)
  - Custom-fabricated KAFO with automatic lock and swing-phase release (L2005)
  - Custom-fabricated external-powered WHFO (L3904)
  - Certain endoskeletal prosthetics (L5280, L5312, L5331, L5341)
  - Endoskeletal prosthetic additions (L5610 to L5617)
  - Certain endoskeletal knee or hip system additions (L5827, L5859, L5930, L5961)
  - Certain ankle or foot prosthetics and additions (L5969, L5987, L5991)
  - Transcarpal/metacarpal or partial hand disarticulation prosthesis (L6026)
  - Interscapular thoracic prosthetics (L6350, L6360, L6370)
  - Molded socket endoskeletal systems (L6400 to L6570)
  - Certain terminal devices and additions (L6715, L6880, L6881)
  - External power upper limb prosthetics (L6920 to L6975)
  - Electronic elbow additions (L7170 to L7259)
  - Custom prosthetics for breasts (L8035) and nipples (L8033)
  - Breast prosthetics that are not otherwise specified (L8039)
  - Maxillofacial prosthetics that are unspecified (L8048)
  - Eye prosthetics that are not otherwise specified (V2629)
  - Iris prosthetics (C1839) and implantation (66683)

Authorization is not required for immediate postsurgical or early fittings (L5400 to L5460, L6037, L6380 to L6388), initial prostheses (L5500, L5505), preparatory prostheses (L5510 to L5600, L6580 to L6590), or the first two test sockets (L5618 to L5628, L6029, L6680 to L6684). The device must be guaranteed to fit the member for a minimum of period of 90 days. Any modifications to a device or its parts are noncovered for 90 days after the date of delivery.

Refer to the Medical Supply Coverage Guide (PDF) for information on MHCP authorization requirements, billing frequencies, and quantity limits by HCPCS code. The quantity limits reflected on the Medical Supply Coverage Guide represent the quantity limit per limb per device.

Submit authorization requests through MN–ITS Authorization Request 278. Fax the MN–ITS response with the required documentation, physician's orders and appropriate additional information to the Medical Review Agent. Write the MN–ITS authorization request number on each page of each document. Review the Authorization section of the MHCP Provider Manual for more information about authorization requests.

- Submit the base HCPCS code with appropriate modifiers on the first line of the authorization request if a new device is being requested.
- List all add-on items on separate lines on the authorization request. List each item by HCPCS code with appropriate modifiers, quantity, and submitted charge.
- Do not list items on an authorization request when the item never requires authorization. These items should be billed on a separate claim.
- If requesting authorization for quantities over the limit, document the reason the additional item is required, and how the requested item meets the member's medical and functional needs.
- If requesting authorization because MHCP does not have a fee schedule rate, include pricing documentation. For prefabricated devices, submit an invoice or manufacturer's suggested retail price (MSRP) list. For custom-fabricated devices, submit documentation of labor (in minutes) and invoices for materials.
- If requesting authorization for repairs, document that the repair can reasonably be expected to delay replacement by at least one year.
- MHCP will not authorize more units per line than are allowed by Medicare's Medically Unlikely edits (MUEs). When requesting authorization for bilateral devices where more units are required than are allowed by the MUEs, the units must be requested on different lines, with modifiers RT and LT as appropriate. Documentation must clearly establish that the greater number of units is required.
- When multiple items that are different but require the same miscellaneous code are requested, each item must be listed on a separate line of the authorization request. A unique description of each item must be entered into the model number field for each line. The unique description may be a model number or a narrative description up to 20 characters.
- Documentation for purchase must include:
  - Member's medical and functional needs, and how the requested device meets those needs.
  - Assessment of the member's functional status and how the member's functional status relates to the need for the requested items.
  - Consideration of less costly alternatives and why alternative devices do not meet the member's needs.
- When requesting authorization for a device for bathing or showering as a member's third device, include documentation explaining why the member's other devices do not suffice for bathing or showering.
- When requesting authorization for identical replacement of components on an existing device, it is not necessary to establish medical necessity for those components. Documentation that the component needs to be replaced and is not covered by a warranty.
- When requesting authorization for non-identical replacement of components on an existing device, document the medical necessity for the requested components.
- Each line will be approved or denied, with the allowed amount listed, if approved.

Billing

Providers are responsible to coordinate services. Refer to the Billing Policy Overview section of Provider Basics for general billing information.

Bill orthotic and prosthetic devices using MN–ITS 837P. Refer to the Billing for Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics, and Augmentative Devices MN–ITS user manual for claim instructions.

- If the member has Medicare, MHCP will pay only the deductible or coinsurance on any item for which Medicare made payment, regardless of any MHCP authorization.
- Shipping, delivery, or setup costs are included in the MHCP maximum allowable payment and may not be separately billed to MHCP or the member.
- Use modifiers RT and LT as appropriate.
- MHCP will not pay claims for more units per line than are allowed by Medicare's Medically Unlikely Edits (MUEs). When billing for bilateral devices where more units are required than are allowed by the MUEs, the units must be on different lines, with modifiers RT and LT as appropriate.
- Use modifiers K1, K2, K3, or K4 as appropriate for lower limb prosthetics.
- Use modifier U1 on all L HCPCS codes for devices for bathing or showering purposes.
- Use modifier U2 on all L HCPCS codes for devices for recreational purposes.
- Use modifier RA on the HCPCS code of the item being replaced.
- Use modifier RB on the HCPCS code of the item being repaired.
- When billing for labor for repairs, specify the number of units and the hourly rate.
- Do not bill for delivery, setup, or service calls.
- Do not bill for evaluation, fitting, molding, or training for devices.
- Do not bill for construction materials.
- When billing for items approved on an authorization, submit one claim for all approved lines, ensuring the HCPCS codes, modifiers, and descriptions on the claim match the same information on the authorization.
  - Enter the authorization number in the Authorization field for each line.
  - Bill items without an authorization on a separate claim.
  - When the Model Number field is used, do not use the Notes field on the Services tab in MN–ITS. Use the Claim Notes field on the Claim Information tab.
  - Submit the usual and customary charge for each line, not the approved amount from the authorization letter. Payment will be the balance of the lesser of the billed amount or the approved amount after any primary or secondary payers have made the payment.

Definitions

Affiliate: A person that directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, the referring physician or consultant.

Body-powered prosthetic: Upper body prosthetic that uses body movements to control the device. These protheses typically feature a cable and hardness, can withstand rugged environments, are lightweight, and used for performing heavy-duty activities and manual labor. Body-powered prostheses typically feature a cable and harness.

Custom-fabricated: Item that is made for a specific member from his or her individual measurements or pattern, starting with basic materials such as plastic, metal, leather, etc.

K-level: Medicare-assigned rating system to indicate an amputee's rehabilitation potential.

Myoelectric or hybrid prosthetic: Upper body prosthetic that uses electromyographic signals in muscle contractions to control the device. The member's physical movements in the residual limb generate electrical signals, which electrodes then send to a controller, thereby triggering the device to correspond with the member's intended movement. Hybrid systems use a combination of body and external power control components.

Orthotic: A rigid or semi-rigid device that is used for the purpose of supporting a weak or deformed body part or for restricting or eliminating motion in a diseased or injured part of the body. Elastic support garments do not meet the definition of an orthotic because they are not rigid or semi-rigid devices. Devices that are not rigid or semi-rigid should be coded A4466.

Passive prosthetic: Upper body prosthetic that does not move on its own. These prostheses are lightweight, may resemble the missing limb, and enhance the member's condition by stabilizing or carrying objects.

Physiatrist: A physician who specializes in physical medicine or who possesses specialized knowledge of rehabilitation and who is certified by the American Board of Physical Medicine and Rehabilitation.

Prefabricated or off-the-shelf (OTS): Item that is not made for a specific member's specifications. They may be adjusted or altered to meet the member's needs but are not made specifically for the member. An item that is assembled solely from prefabricated components is considered prefabricated.

Prosthetic: A device that is used for the purpose of replacing missing limbs to help individuals regain functionality and independence.

Legal References

Minnesota Statutes, 62Q.661 (Coverage for Orthotic and Prosthetic Devices)
Minnesota Statutes, 256B.0659, subdivision 2 (Orthotic and Prosthetic Devices, Supplies, and Services)
Code of Federal Regulations, title 42, Section 414.202 (3) (Prosthetic Definition)
Code of Federal Regulations, title 42, Section 414.210 (f) (Reasonable Useful Lifetime)
Centers for Medicare & Medicaid Services (CMS) Policy Article A52496 (Lower Limb Prostheses)
CMS Policy Article A55426 (Standard Documentation Requirements)