

# Lower Limb Prosthetics

Revised: [September 1, 2022](#)

- [Overview](#)
- [Eligible Providers](#)
- [Eligible Members](#)
- [Covered Services](#)
- [Noncovered Services](#)
- [Authorization](#)
- [Billing](#)
- [Definitions](#)

## Overview

Lower limb prosthetics are used to restore ambulation to people with missing or amputated legs.

## Eligible Providers

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

## Third Party Liability (TPL) and Medicare

Providers must meet any provider requirements including accreditation, for third party insurance coverage or for Medicare coverage 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 payment of only the Medicare coinsurance or deductible is requested.

## Eligible Members

Lower limb prosthetics are covered for all eligible MHCP members.

## Covered Services

### All Covered Lower Limb Prosthetics

A lower limb prosthetic must be prescribed by an enrolled MHCP provider that meets at least one of the criteria as follows:

- A physician, physician assistant or advance practice registered nurse who is knowledgeable in orthopedics, physiatry, or vascular surgery
- A physician, physician assistant or advance practice registered nurse in consultation with an orthopedist, physiatrist, or physical therapist
- A podiatrist within the scope of their professional practice (MHCP covers podiatrist services to treat below the knee).

## Evaluation and Management

Evaluation of the member's 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 and expertise.

## Medical records must include:

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

Use the following functional levels in the evaluation. Provide specific information about the member's ambulation history, performance and activities of daily living to support assignment of an individual 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.
- 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.

## Lower Limb Prosthetics

### Feet and Ankles

- 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.
- An energy storing foot (L5976) may be medically necessary for members whose functional level is 2 or above.
- An axial rotation ankle unit (L5982-L5986) may be medically necessary for members whose functional level is 2 or above.
- A microprocessor-controlled ankle foot system (L5973) may be medically necessary for members whose functional level is 3 or above.
- A power assist ankle-foot or ankle system (L5969), multiaxial ankle with swing phase active dorsiflexion feature (L5968), dynamic response foot with multi-axial ankle (L5979), flex foot system (L5980), flex-walk system or equal (L5981), or shank foot system with vertical loading pylon (L5987) may be medically necessary for members whose functional level is 3 or above.

### Knees

- A pneumatic knee (L5614, L5822, L5830-L5840) may be medically necessary for members whose functional level is 2 or above.
- A knee with stance phase microprocessor control feature (L5858) may be medically necessary for highly motivated members whose functional level is 2 or above.
- 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.
- A fluid/hydraulic knee (L5610, L5613, L5614, L5722-L5780, L5814, L5824-L5828, L5848) may be medically necessary for members whose functional level is 3 or above.
- A knee with powered and programmable flexion/extension assist control (L5859) may be medically necessary for highly motivated recipients whose functional level is 3 or above who have a documented comorbidity in their sound limb or spine, or for bilateral amputees.
- A knee with swing and stance phase microprocessor control feature (L5856) may be medically necessary for members whose functional level is 3 or above.
- Other knee systems (L5611, L5616, L5710-L5718, L5810-L5818) may be medically necessary for members whose functional level is 1 or above.

## Hips

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 system (L5781 or L5782) may be medically necessary for functional level 2 and above.

## Noncovered Services

The following devices, features, components, additions or repairs are not covered:

- A prosthetic device for which Medicare has denied the claim as not medically necessary.
- Lower limb prosthesis, not meeting the criteria as indicated in this policy are considered not medically necessary.
- Lower limb prosthesis for a member that is at functional level zero (0) are considered not medically necessary.
- Duplication or upgrade of a functional prosthesis are considered not medically necessary.
- 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.
- Prosthetic devices or additions or components not required for participation in normal activities of daily living, including those that are chiefly for convenience, for participation in recreational activities, or that otherwise exceed the medical needs of the amputee (for example, back-up prosthetic devices, waterproof leg prosthesis [for example, Water Leg, used for showering, swimming] are 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.
- Repair costs for a prosthetic device that is under warranty.
- Repair costs for any rented prosthetic equipment.
- User-adjustable heel height feature (L5990) is not considered medically necessary.
- Orthotic and prosthetic supply, accessory or service component (L9900) is not covered.

## Authorization

Authorization is not required for immediate postsurgical or early fittings (L5400-L5460), initial prostheses (L5500-L5505), preparatory prostheses (L5510-L5600) or the first test socket for any prostheses (L5618-L5628).

Authorization is required for the following:

- The second or subsequent test socket (L5618-L5628) for any prosthetic. Documentation must clearly show why the current test socket cannot be modified and must demonstrate that an additional test socket is needed before a final socket is selected. Test sockets which must be replaced due to provider error will not be approved.
- All lower limb prosthetic services L5000-L5999 not specified above, including repairs to existing prosthetics.
- Applicable repair codes for prosthetics include L7510 (repair of prosthetic device, repair or replacement of minor parts) and L7520 (repair prosthetic device, labor component, per 15 minutes).

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 [authorization medical review agent](#). Write the MN-ITS Authorization Request number on each page of each document.

- Submit the prosthetic base HCPCS code with appropriate modifiers on the first line of the authorization request if a new prosthetic 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.
- MHCP will not authorize more units per line than are allowed by Medicaid's Medically Unlikely Edits (MUEs). When requesting authorization for bilateral prosthetics where more units are required than are allowed by the MUEs, the

units must be requested on different lines, with modifiers NU RT (right side prosthetic) and NU LT (left side prosthetic) 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 address the member's medical and functional needs, and how the requested prosthetic meets those needs.
- Documentation for purchase must include the assessment of the member's functional status and how the member's functional status relates to the need for the requested items.
- Documentation for purchase must establish that the requested device is the least costly appropriate way to meet the member's needs.
- When requesting authorization for identical replacement of components on an existing prosthetic, it is not necessary to establish medical necessity for those components. Document 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 prosthetic, document the medical necessity for the requested components.
- Each line will be approved or denied, with the allowed dollar amount listed, if approved.

## Billing

- Use X12 Batch or MN-ITS 837P professional electronic claim
- Report the ordering provider in the "Other Provider Types" section of the MN-ITS interactive claim
- 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 prior authorization.
- Shipping, delivery and set-up costs are included in the MHCP maximum allowable payment and may not be separately billed to MHCP or the member.
- MHCP will not pay claims for more units per line than are allowed by Medicare's Medically Unlikely Edits (MUEs). When billing for bilateral prosthetics where more units are required than are allowed by the MUEs, the units must be billed on different lines, with modifiers NU RT (right side prosthetic) and NU LT (left side prosthetic) as appropriate.
- Prosthetic devices, for which fabrication has begun but which have not been dispensed as of the date of the member's termination from MHCP eligibility, may be reimbursed on a prorated basis to the extent that customization renders all or part of the device unsuitable for use by someone else.
- When billing labor for repairs, specify the number of units and the hourly rate. Do not bill for setup and delivery, or for service calls that do not involve actual labor time for repairs.
- When billing repairs use modifier RB and the HCPCS code of the item being repaired.

When billing for items approved through prior authorization:

- Submit one claim for all approved lines. Make sure the HCPCS codes, modifiers and descriptions on the claim match the same information on the prior authorization.
- Enter the authorization number in the authorization field for each line
- 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 payment.
- Bill items without an authorization number on a separate claim.

## 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.

**Ambulator:** One who walks.

**Ambulation:** The ability to walk from place to place independently with or without an assistive device.

**Community ambulator:** Independent mobility outside the home, which includes the ability to confidently negotiate uneven terrain, private venues and other public venues.

**Comorbidity:** The simultaneous presence of two chronic diseases or conditions in a patient.

**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.

**Prosthetic:** An artificial device, as defined by Medicare, to replace a missing or nonfunctional body part.