Orthotic and Prosthetic Appliances and Services: Criteria for Authorization and Reimbursement – Prosthetics

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This section contains criteria for the authorization and reimbursement of prosthetic appliances and services (*California Code of Regulations*, [CCR], Title 22, Sections 51315 and 51315.3). Additional information is located in the following manual sections in this manual:

Orthotic and Prosthetic Appliances and Services

‹‹*Orthotic and Prosthetic Appliances: Billing Codes – Prosthetics*››

Orthotics and Prosthetics: Frequency Limits for Prosthetics

Orthotic and Prosthetic Appliances: Billing Examples

Authorization and Restrictions

The criteria for authorization and reimbursement listed in this section refer only to those HCPCS codes that are Medi-Cal benefits. Reimbursable prosthetic HCPCS codes are listed in the *Orthotic and Prosthetic Appliances: Billing Codes – Prosthetics* section of this manual.

Note: Pursuant to CCR, Title 22, Section 51315.1, the lists of medical conditions that follow specification of orthotic appliances and services are not intended to be exhaustive, and not all of the listed medical conditions will necessarily require the orthotic appliance or service. Documented medical necessity is required to be submitted with the *Treatment Authorization Request* (TAR), specific to the individual recipient and specific to the prosthetic appliance or service being requested.

For all HCPCS codes that require a TAR, documentation that the recipient meets the criteria specified for each code must be submitted with the TAR and maintained in the recipient's medical record.

For frequency limits refer to *Orthotics and Prosthetics: Frequency Limits for Prosthetics* section of this manual.

Documentation Requirements

For codes that do not require a TAR, documentation requirements refer to information verifying medical necessity that must be submitted by the prescribing practitioner to the prosthetic provider. If audited, the prosthetic provider must demonstrate that this documentation was received by the prescribing practitioner.

Lower Limb Prostheses – Partial Foot (L5000 thru L5020)

Coverage

Partial foot prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had an amputation of part or all of the foot and requires a definitive prosthesis to permit ambulation or other functional activities (all codes).

Documentation Requirements

HCPCS codes L5000 thru L5020 require all of the following documentation:

- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5000 thru L5020 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Ankle (L5050, L5060)

Coverage

Ankle prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had an amputation through or at the ankle (Syme's procedure) and requires a definitive prosthesis to permit ambulation or other functional activities (both codes).

Documentation Requirements

HCPCS codes L5050 and L5060 require all of the following documentation:

- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of "1" or higher. Recipients with a functional level of "0" will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5050 and L5060 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Below Knee (L5100, L5105)

Coverage

Below knee prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had an amputation between the ankle and the knee and requires an exoskeletal definitive prosthesis to permit ambulation or other functional activities (both codes).

Documentation Requirements

HCPCS codes L5100 and L5105 require all of the following documentation:

- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of“0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5100 and L5105 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Knee Disarticulation (L5150, L5160)

Coverage

Knee disarticulation prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had an amputation through or near the knee and requires an exoskeletal definitive prosthesis to permit ambulation or other functional activities (both codes).

Documentation Requirements

HCPCS codes L5150 and L5160 require all of the following documentation:

- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5150 and L5160 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Above Knee (L5200 thru L5230)

Coverage

Above knee prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had an amputation between the knee and the hip and requires a definitive prosthesis to permit ambulation or other functional activities (all codes).

Documentation Requirements

HCPCS codes L5200 thru L5230 require all of the following documentation:

- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5200 thru L5230 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Hip Disarticulation (L5250, L5270)

Coverage

Hip disarticulation prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had an amputation through or near the hip and requires an exoskeletal definitive prosthesis to permit ambulation or other functional activities (both codes).

Documentation Requirements

HCPCS codes L5250 and L5270 require all of the following documentation:

- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5250 and L5270 must be billed with either the modifier LT (left side) or RT (right side)

Lower Limb Prostheses – Hemipelvectomy (L5280)

Coverage

Hemipelvectomy prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had an amputation with removal of half of the pelvis and requires an exoskeletal definitive prosthesis to permit ambulation or other functional activities.

Documentation Requirements

HCPCS code L5280 requires all of the following documentation:

- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS code L5280 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Endoskeletal (L5301 thru L5341)

Coverage

Endoskeletal lower limb prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had a lower limb amputation and requires an endoskeletal definitive prosthesis after the residual limb has matured to permit ambulation or other functional activities:

- Amputation below the knee (L5301); or,
- Amputation through or near the knee (L5312); or
- Amputation above the knee (L5321); or
- Amputation through or near the hip (L5331); or,
- When amputation involves removal of half of the pelvis (L5341).

Documentation Requirements

HCPCS codes L5301 thru L5341 require all of the following documentation:

- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5301 thru L5341 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Immediate and Early Post-Surgical Procedures (L5400 thru L5460)

Coverage

Immediate and early post-surgical procedures may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had a lower limb amputation and requires one or more of the following:

- A temporary prosthesis applied soon after amputation before the wound (original amputation or residual limb revision) has completely healed, used to permit some lower extremity function after amputation between the knee and ankle (L5400); or,
- A temporary prosthesis applied soon after amputation before the wound (original amputation or residual limb revision) has completely healed, used to permit some lower extremity function after amputation between the hip and knee or through the knee (L5420); or,
- Additional cast change(s) and realignment(s) of the temporary prosthesis authorized under L5400 (L5410); or,
- Additional cast change(s) and realignment(s) of the temporary prosthesis authorized under L5420 (L5430); or,
- A temporary application of a non-weight bearing rigid dressing, applied soon after amputation before the wound (original amputation or residual limb revision) has completely healed, used when there is no expectation of use of a prosthesis until the wound has completely healed, after amputation between the knee and ankle (L5450); or,
- A temporary application of a non-weight bearing rigid dressing, applied soon after amputation before the wound (original amputation or residual limb revision) has completely healed, used when there is no expectation of use of a prosthesis until the wound has completely healed, after amputation between the hip and knee or through the knee (L5460).

Documentation Requirements

HCPCS codes L5400 thru L5460 require all of the following documentation:

- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

HCPCS codes L5410 and L5430 require documentation that the recipient has an existing or authorized prosthesis that is compatible with the requested cast change and realignment.

Billing

HCPCS codes L5400 thru L5460 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Initial Prostheses (L5500, L5505)

Coverage

Initial prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had a lower limb amputation and requires a temporary prosthesis that is applied when the wound (original amputation or residual limb revision) has healed but the residual limb has not reached its final shape:

- After amputation between the knee and ankle (L5500); or,
- After amputation between the hip and knee or through the knee (L5505).

Documentation Requirements

HCPCS codes L5500 and L5505 require all of the following documentation:

- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5500 and L5505 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Preparatory Prostheses-Below Knee (L5510 thru L5540)

Coverage

Preparatory prostheses – below knee may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had a below-the-knee amputation and requires a temporary prosthesis designed to permit some ambulation or other functional activities in preparation for the fitting of a definitive prosthesis, that is applied when the wound (original amputation or residual limb revision) has healed but the residual limb has not reached its final shape, within the first 18 months after the original amputation or revision surgery (all codes).

Documentation Requirements

HCPCS codes L5510 thru L5540 require all of the following documentation

- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5510 thru L5540 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Preparatory Prostheses-Above Knee (L5560 thru L5600)

Coverage

Preparatory prostheses, above knee may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had an above-the-knee amputation and requires a temporary prosthesis designed to permit some ambulation or other functional activities in preparation for the fitting of a definitive prosthesis, that is applied when the wound (original amputation or residual limb revision) has healed but the residual limb has not reached its final shape, within the first 18 months after the original amputation or revision surgery:

- Between the hip and knee or through the knee (L5560, L5570, L5580, L5585, L5590); or,
- Through or near the hip (disarticulation) (L5595, L5600); or,
- When amputation involves removal of half of the pelvis (hemipelvectomy) (L5595, L5600).

Documentation Requirements

HCPCS codes L5560 thru L5600 require all of the following documentation:

- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5560 thru L5600 must be billed with either the modifier LT (left side) or RT (right side).

‹‹Lower Limb Prostheses – Additions: Lower Extremity (Endoskeletal System-Above Knee) (L5926 and L5610 thru L5617)››

Coverage

Additions to lower extremity prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized lower limb prosthesis that is compatible with the requested addition(s) and requires a specialized knee joint to allow functional use of the prosthesis (all codes).

Authorization and Restrictions

‹‹Addition codes (L5926 and L5610 thru L5617) will be authorized and reimbursed separately only when the base appliances have been provided or when the addition is being replaced or repaired.››

Documentation Requirements

‹‹HCPCS codes L5926 and L5610 thru L5617 require all of the following documentation:››

- The recipient has an existing or authorized appliance that is compatible with the requested addition(s).
- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

‹‹HCPCS codes L5926 and L5610 thru L5617 must be billed with either the modifier LT (left side) or RT (right side).››

Lower Limb Prostheses – Additions: Test Sockets (L5618 thru L5629)

Coverage

Test sockets may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized lower limb prosthesis that is compatible with the requested addition(s) and requires a transparent sheet plastic socket to determine the accuracy of the fit of the prosthetic socket (all codes).

Authorization and Restrictions

Addition codes (L5618 thru L5629) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes L5618 thruL5629 require all of the following documentation:

- The recipient has an existing or authorized appliance that is compatible with the requested addition(s).
- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5618 thru L5629 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Additions: Socket Variations L5630 thru L5653)

Coverage

Socket variations may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized lower limb prosthesis that is compatible with the requested addition(s) and has a medical condition that requires a specialized socket or socket insert to allow functional use of the prosthesis, such as a skin breakdown, skin graft, deformed residual limb, or bone spur (all codes).

Authorization and Restriction

Addition codes (L5360 thru L5653) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes L5630 thru L5653 require all of the following documentation:

- The recipient has an existing or authorized appliance that is compatible with the requested addition(s).
- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5630 thruL5653 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Additions: Socket Inserts (L5654 thru L5665)

Coverage

Socket inserts may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized lower limb prosthesis that is compatible with the requested addition(s) and has a medical condition that requires an inner lining that fits between the residual limb and the socket of a lower extremity prosthesis to decrease irritation of the residual limb (all codes).

Authorization and Restrictions

Addition codes (L5654 thru L5665) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes L5654 thru L5665 require all of the following documentation:

- The recipient has an existing or authorized appliance that is compatible with the requested addition(s).
- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5654 thru L5665 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Additions: Suspension-Below Knee (L5666 thru L5690)

Coverage

Suspension – below knee additions may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized lower limb prosthesis that is compatible with the requested addition(s) and requires a suspension system to hold a below knee prosthesis in place (all codes).

Authorization and Restrictions

Addition codes (L5666 thru L5690) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes L5666 thru L5690 require all of the following documentation:

- The recipient has an existing or authorized appliance that is compatible with the requested addition(s).
- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5666 thru L5690 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Additions: Suspension – Above Knee (L5692 thru L5699)

Coverage

Suspension – above knee additions may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized lower limb prosthesis that is compatible with the requested addition(s) and requires a suspension system to hold an above knee prosthesis in place (all codes).

Authorization and Restrictions

Addition codes (all codes in this section) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes L5692 thru L5699 require all of the following documentation:

- The recipient has an existing or authorized appliance that is compatible with the requested addition(s).
- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5692 thru L5699 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Replacements (Feet-Ankle Units) (L5700 thru L5707)

Coverage

Replacements to lower limb prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized lower limb prosthesis that is compatible with the requested replacement(s) AND the cost of replacement is less than the cost of purchasing a new prosthesis:

- Replacement socket (L5700 thru L5703); or,
- Protective cover for a lower limb prosthesis (L5704 thru L5707).

Authorization and Restrictions

HCPCS codes L5704, L5705, L5706 and L5707 will be authorized and reimbursed separately only when the protective cover is being replaced or repaired.

Documentation Requirements

HCPCS codes L5700 thru L5707 require all of the following documentation:

- The recipient has an existing or authorized appliance that is compatible with the requested addition(s).
- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5700 thru L5707 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Additions: Exoskeletal Knee-Shin System (L5710 thru L5795)

Coverage

Exoskeletal knee-shin system additions may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized exoskeletal lower limb prosthesis that is compatible with the requested addition(s) and requires one or more of the following:

- A specially designed knee-shin assembly to allow maximum control of the knee joint and lower leg (L5710 thruL5780); or,
- Residual limb volume management and moisture evacuation (L5781, L5782); or,
- The use of ultralight construction material to decrease the weight of the prosthesis to allow more functional use of the prosthesis (L5785, L5790, L5795).

Authorization and Restrictions

HCPCS code L5782 always requires authorization (TAR required).

Addition codes (L5710 thru L5795) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes L5710 thru L5795 require all of the following documentation:

- The recipient has an existing or authorized appliance that is compatible with the requested addition(s) or component modification(s).
- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5710 thru L5795 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Additions: Endoskeletal Knee-Shin System (L5810 thru L5966)

Coverage

Endoskeletal knee-shin system additions may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized endoskeletal lower limb prosthesis that is compatible with the requested addition(s) and requires one or more of the following:

- A specially designed knee-shin assembly to allow maximum control of the knee joint and lower leg (L5810 thru L5930); or,
- The use of ultralight construction material to decrease the weight of the prosthesis to allow more functional use of the prosthesis (L5940, L5950, L5960).
- A protective outer covering to provide a water and tear resistant flexible surface (L5962, L5964, L5966).

Authorization and Restrictions

HCPCS code L5859 always requires authorization (TAR required)

Addition codes (L5810 thru L5966) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes L5810 thru L5966 require all of the following documentation:

- The recipient has an existing or authorized appliance that is compatible with the requested addition(s).
- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5810 thru L5966 must be billed with either the modifier LT (left side) or RT (right side).

Lower Limb Prostheses – Additions: Miscellaneous (L5968 thru 5999)

Coverage

Miscellaneous additions to lower limb prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized lower limb prosthesis that is compatible with the requested addition(s) and requires one or more of the following:

- An ankle that provides motion in all directions during walking and standing (L5968); or,
- An endoskeletal ankle-foot or system (L5973)
- A foot attachment (L5970, L5971, L5972, L5974 thru L5976, L5978, L5979); or,
- A flex foot system that allows greater mobility than a solid foot attachment (L5980, L5981); or,
- An axial rotation joint (L5982, L5984, L5986); or,
- A dynamic pylon that deflects with weight bearing or for shock absorption (L5985, L5988); or,
- A flex foot and dynamic pylon combination (L5987); or,
- An addition to a lower extremity prosthesis with adjustable heel height (L5990).
- ‹‹An addition to lower extremity prostheses with osseointegrated external prosthetic connector (L5991).››

Authorization and Restrictions

Addition codes (L5969 thru L5999) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes L5969 thru L5999 require all of the following documentation:

- The recipient has an existing or authorized appliance that is compatible with the requested addition(s).
- Past history, including prior prosthetic use, if applicable; and,
- Current medical condition, including status of the residual limb and the nature of other medical problems; and,
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.
- A functional level of “1” or higher. Recipients with a functional level of “0” will not be authorized and reimbursed for lower limb prostheses.

Billing

HCPCS codes L5968 thru L5999 must be billed with either the modifier LT (left side) or RT (right side).

‹‹Contraindications for L5991

Risk/Potential Benefit Information

The OPRA™ Implant System is not recommended for patients if any of the following is applicable:

- The patient’s bone growth is not complete based on X-ray examination.
- The patient has bone anatomy that is not typical and may affect treatment with OPRA™.

Examples of bone anatomy that is not typical:

- Bone measurements outside defined interval
- Unexpected development
- Conditions which are not favorable for device to be installed such as deformities, fracture, infection
  - The patient would have less than 2 mm of remaining cortex bone available around the implant, if implanted.
  - The patient has osteoporosis (weak bones).
  - The patient is older than 65 years or younger than 22 years.››

- ‹‹The patient's body weight is higher than 220 lbs including the prosthesis.
- The patient suffers from other diseases that might affect treatment with OPRA™. Examples of other diseases are:
  - ❖ Severe peripheral vascular (blood vessels outside the brain and heart) disease.
  - ❖ Diabetic mellitus (diabetes) with complications.
  - ❖ Skin disorders involving the stump.
  - ❖ Neuropathy or neuropathic disease (damage or disease to nerves) and severe phantom pain.
  - ❖ Active infection or dormant (currently not active) bacteria.
  - ❖ Metabolic bone disease and/or metastatic lesions in the residual femur.
- The patient is pregnant.
- The patient is not expected to be able to follow the treatment and follow up rules.››

Upper Limb Prostheses – Partial Hand (L6000 thru L6026)

Coverage

Partial hand prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had an amputation of part or all of the hand and requires a definitive prosthesis to permit functional use of the upper extremity:

- After amputation of the hand with only the thumb remaining (L6000); or,
- After amputation of the hand when the thumb is missing or the thumb and any other fingers are missing (L6010); or,
- After amputation of the hand when no fingers or thumb remains (L6020); or,
- Externally powered partial hand prosthesis to allow effective movement of the hand (L6026).

Documentation Requirements

HCPCS code L6026 requires documentation that the recipient cannot effectively use a manually operated appliance.

Billing

HCPCS codes L6000 thru L6026 must be billed with either the modifier LT (left side) or RT (right side).

Upper Limb Prostheses – Wrist Disarticulation (L6050, L6055)

Coverage

Wrist disarticulation prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had an amputation through or near the wrist and requires an exoskeletal definitive prosthesis to permit functional use of the upper extremity (both codes).

Authorization and Restrictions

Neither of the codes in this section includes a terminal device.

Billing

HCPCS codes L6050 and L6055 must be billed with either the modifier LT (left side) or RT (right side).

Upper Limb Prostheses – Elbow (L6100 thru L6250)

Coverage

Elbow prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had an amputation near the elbow and requires an exoskeletal definitive prosthesis to permit functional use of the upper extremity:

- After amputation between the wrist and elbow (L6100, L6110, L6120, L6130); or,
- After amputation at or near the elbow (L6200, L6205); or,
- After amputation between the shoulder and elbow (L6250).

Authorization and Restrictions

HCPCS codes L6100 thru L6250 do not include a terminal device.

Billing

HCPCS codes L6100 thru L6250 must be billed with either the modifier LT (left side) or RT (right side).

Upper Limb Prostheses – Shoulder (L6300 thru L6320)

Coverage

Shoulder prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had an amputation through or near the shoulder and requires an exoskeletal definitive prosthesis to permit functional use of the upper extremity (all codes).

Authorization and Restrictions

HCPCS codes L6300 thru L6320 do not include a terminal device.

Billing

HCPCS codes L6300 thru L6320 must be billed with either the modifier LT (left side) or RT (right side).

Upper Limb Prostheses – Interscapular Thoracic (L6350 thru L6370)

Coverage

Interscapular thoracic prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had an amputation with removal of both the shoulder joint and the scapula and requires an exoskeletal definitive prosthesis to permit functional use of the upper extremity (all codes).

Authorization and Restrictions

HCPCS codes L6350 thru L6370 do not include a terminal device.

Billing

HCPCS codes L6350 thru L6370 must be billed with either the modifier LT (left side) or RT (right side).

Upper Limb Prostheses – Immediate and Early Post-Surgical Procedures (L6380 thru L6388)

Coverage

Immediate and early post-surgical procedures may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had an upper limb amputation and requires one or more of the following:

- A temporary prosthesis applied soon after amputation before the wound (original amputation or residual limb revision) has completely healed, used to permit some upper extremity function after amputation between the wrist and elbow (L6380); or,
- A temporary prosthesis applied soon after amputation before the wound (original amputation or residual limb revision) has completely healed, used to permit some upper extremity function after amputation between the elbow and shoulder or through the elbow (L6382); or,
- A temporary prosthesis applied soon after amputation before the wound (original amputation or residual limb revision) has completely healed, used to permit some upper extremity function after amputation at or below the shoulder joint (L6384); or,
- Additional cast change(s) and realignment(s) of the temporary prosthesis authorized under L6380, L6382 or L6384 (L6386); or,
- A temporary application of a non-weight bearing rigid dressing, applied soon after amputation before the wound (original amputation or residual limb revision) has completely healed, used when there is no expectation of use of a prosthesis until the wound has completely healed (L6388).

Authorization and Restrictions

HCPCS codes L6380 thru L6388 do not include a terminal device.

Documentation Requirements

HCPCS code L6386 requires documentation that the recipient has an existing or authorized prosthesis that is compatible with the requested cast change and realignment.

Billing

HCPCS codes L6380 thru L6388 must be billed with either the modifier LT (left side) or RT (right side).

Upper Limb Prostheses – Endoskeletal-Elbow or Shoulder Area (L6400 thru L6550)

Coverage

Endoskeletal prostheses for the elbow and shoulder area may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had an upper extremity amputation and requires an endoskeletal definitive prosthesis after the residual limb (original amputation or residual limb revision) has matured to permit functional use of the upper extremity:

- Amputation between the elbow and wrist (L6400); or,
- Amputation through the elbow (L6450); or
- Amputation between the shoulder and elbow (L6500); or
- Amputation through the shoulder (L6550).

Authorization and Restrictions

HCPCS codes L6400 thru L6550 do not include a terminal device.

Billing

HCPCS codes L6400 thru L6550 must be billed with either the modifier LT (left side) or RT (right side).

Upper Limb Prostheses – Endoskeletal – Interscapular Thoracic (L6570 thru L6590)

Coverage

Endoskeletal prostheses for the upper limbs may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has had an upper limb amputation and requires a temporary (preparatory) prosthesis to permit some upper extremity function in preparation for the fitting of a definitive prosthesis, that is applied when the wound (original amputation or residual limb revision) has healed but the residual limb has not reached its final shape, within the first 18 months after the original amputation or revision surgery:

- Amputation between the elbow and wrist or through the wrist (L6580, L6582); or,
- Amputation between the shoulder and elbow or through the elbow (L6584, L6586); or,
- Amputation through the shoulder or when amputation involves removal of the entire shoulder (L6570, L6588, L6590).

Authorization and Restrictions

HCPCS codes L6570 thru L6590 do not include a terminal device.

Billing

HCPCS codes L6570 thru L6590 must be billed with either the modifier LT (left side) or RT (right side).

Upper Limb Prostheses – Additions/Replacement (L6600 thru L6698, L6883 thru L6885, L7400 thru L7405)

Coverage

Additions/replacements to upper limb prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized upper limb prosthesis that is compatible with the requested addition(s)/replacement(s) and requires one or more of the following:

- A hinge for an upper extremity socket (L6600, L6605, L6610); or,
- A switch for an externally powered upper extremity prosthesis (L6611); or,
- A wrist unit to facilitate exchange between terminal devices (L6615, L6616, L6620, L6621, L6623 thru L6625, L6628, L6629); or,
- Addition of stainless steel into a wrist unit to add strength and durability (L6630); or,
- A suspension system for a below-the-elbow amputation to hold the prosthesis in place (L6632); or,
- An elbow unit or components for an above-the-elbow amputation to facilitate the lifting of the forearm of the prosthesis (L6635); or,
- A locking mechanism for an elbow joint (L6637, L6638, L6698); or,
- A socket hinge for an upper extremity prosthesis for an amputation at or through the shoulder (L6640, L6645, L6646, L6650); or,
- A locking mechanism for a shoulder joint (L6647, L6648); or,
- A device(s) for high level upper extremity amputations to allow a greater range of motion of the prosthesis (L6641, L6642); or,
- A control cable and components for operation and control of an upper extremity prosthesis (L6655, L6660, L6665, L6670); or,
- A shoulder harness for suspension and control of an upper extremity prosthesis (L6672, L6675, L6676, L6677); or,

- A test socket to determine the accuracy of the socket fit (L6680, L6682, L6684); or,
- A socket for an upper extremity prosthesis (L6686 – L6690); or,
- A socket insert to decrease the irritation of the residual limb (L6691, L6692, L6694 thru L6697); or,
- A locking elbow (L6693); or,
- A replacement socket for an amputation below the elbow or wrist disarticulation (L6883); or,
- A replacement socket for an amputation above the elbow or elbow disarticulation (L6884); or,
- A replacement socket for a shoulder disarticulation or Interscapular thoracic amputation (L6885); or,
- The use of ultralight construction material to decrease the weight of the prosthesis to allow more functional use of the prosthesis (L7400 thru L7402); or,
- The use of acrylic construction material to decrease the weight of the prosthesis to allow more functional use of the prosthesis (L7403 thru L7405).

Replacement codes (L6883 thru L6885) require that the cost of replacement be less than the cost of purchasing a new prosthesis.

Authorization and Restrictions

HCPCS codes L6611, L6624, L6694 thru L6698 always require authorization (TAR required).

Addition/replacement codes (L6600 thru L6698, L6883 thru L6885, L7400 thru L7405) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes L6600 thru L6698, L6883 thru L6885, L7400 thru L7405 require documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s)/replacement(s).

Billing

HCPCS codes L6600 thru L6698, L6883 thru L6885, L7400 thru L7405 must be billed with either the modifier LT (left side) or RT (right side).

Terminal Devices – Hooks (Includes Base Devices and Additions/Attachments) (L6703 thru L6707, L6711, L6712, L6805, L6810)

Coverage

Hook attachments and additions to hand prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized upper extremity prosthesis and requires a terminal device to permit functional use of the upper extremity (L6703, L6704, L6706, L6707, L6711, L6712).

The recipient has an existing or authorized terminal device that is compatible with the requested addition(s) and requires the addition(s) to allow functional use of the terminal device (L6805, L6810).

Authorization and Restrictions

HCPCS codes L6711 and L6712 may be authorized and reimbursed only for children 20 years of age and younger.

HCPCS codes L6805 and L6810 will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes L6703 thru L6707, L6711, L6712, L6805, L6810 require documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s)/attachment(s).

Billing

HCPCS codes L6703 thru L6707, L6711, L6712, L6805, L6810 must be billed with either the modifier LT (left side) or RT (right side).

Terminal Devices – Hands (Includes Base Devices and Additions/Attachments) (L6708, L6709, L6713 thru L6722, L6880 thru L6895)

Coverage

Hand attachments may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized upper extremity prosthesis and requires a terminal device to permit functional use of the upper extremity (L6708, L6709, L6713, L6714, L6721, L6722).

The recipient has an existing or authorized terminal device that is compatible with the requested addition(s) and requires one or more of the following:

- Multiple articulating digit (L6715); or
- A powered grasp feature (L6880, L6881); or,
- A microprocessor control feature (L6882); or,
- Gloves for the hand attachment to provide a natural appearance and to protect the mechanism of the hand (L6890, L6895).

Authorization and Restrictions

HCPCS codes L6713 and L6714 may be authorized and reimbursed only for children 20 years of age and younger.

Addition codes (L6881, L6882, L6890, L6895) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

HCPCS codes L6881 and L6882 always require authorization (TAR required).

Documentation Requirements

HCPCS codes L6708 thru L6709, L6713 thru L6722, L6880 thru L6895 require documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s)/attachment(s).

Billing

HCPCS codes L6708 thru L6709, L6713 thru L6722, L6880 thru L6895 must be billed with either the modifier LT (left side) or RT (right side).

Terminal Devices – Hand Restoration Procedures (L6900 thru L6915)

Coverage

Hand restoration procedures may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized upper extremity prosthesis and requires a partial hand prosthesis to permit functional use of the upper extremity (L6900, L6905, L6910) OR a replacement glove(s) for a hand prosthesis (L6915).

Authorization and Restrictions

HCPCS code L6915 will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

HCPCS codes L6900 thru L6915 include casts, shading and measurements; no separate reimbursement will be made.

Documentation Requirements

HCPCS codes L6900 thru L6915 require documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s)/attachment(s)/replacement(s).

Billing

HCPCS codes L6900 thru L6915 must be billed with either the modifier LT (left side) or RT (right side).

External Power – Base Devices (L6920 thru L6975)

Coverage

Externally powered base devices may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient requires an upper extremity prosthesis with one or more electrically powered functional parts or electronic circuitry that is activated by the recipient in order to perform activities of daily living or instrumental activities of daily living:

- For a wrist disarticulation amputation (L6920, L6925); or,
- For a below-the-elbow amputation (L6930, L6935); or,
- For an elbow disarticulation amputation (L6940, L6945); or,
- For an above-the-elbow amputation (L6950, L6955); or,
- For a shoulder disarticulation amputation (L6960, L6965); or,
- For an interscapular-thoracic amputation (L6970, L6975).

Documentation Requirements

HCPCS codes L6920 thru L6975 require documentation that the recipient cannot effectively use a manually operated appliance.

Billing

HCPCS codes L6920 thru L6975 must be billed with either the modifier LT (left side) or RT (right side).

External Power – Terminal Devices (L7007 thru L7045)

Coverage

Electrically powered terminal devices may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized upper extremity prosthesis and requires a terminal device with one or more electrically powered functional parts or electronic circuitry that is activated by the recipient in order to perform activities of daily living or instrumental activities of daily living:

- Electric hand, adult (L7007); or,
- Electric hand, pediatric (L7008); or,
- Electric hook, adult (L7009, L7040); or,
- Electric hook, pediatric (L7040, L7045).

Authorization and Restrictions

HCPCS codes L7008 and L7045 may be authorized and reimbursed only for children 20 years of age and younger.

Documentation Requirements

HCPCS codes L7007 thru L7045 require documentation that the recipient has an existing or authorized appliance that is compatible with the requested attachment(s).

HCPCS codes L7007 thru L7045 require documentation that the recipient cannot effectively use a manually operated appliance.

Billing

HCPCS codes L7007 thru L7045 must be billed with either the modifier LT (left side) or RT (right side).

External Power – Elbow Attachments (L7170 thru L7191)

Coverage

Electrically powered elbow attachments may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized upper extremity prosthesis and requires an elbow joint attachment with one or more electrically powered functional parts or electronic circuitry that is activated by the recipient in order to perform activities of daily living or instrumental activities of daily living (all codes).

Authorization and Restrictions

Addition/attachment codes (L7170 thru L7191) will only be authorized and reimbursed when the base appliance has been provided.

Addition/attachment codes (L7170 thru L7191) may only be authorized and reimbursed separately if the addition is being replaced or repaired.

HCPCS code L7181 always requires authorization (TAR required).

HCPCS codes L7185, L7186, L7190 and L7191 may be authorized and reimbursed only for children 20 years of age and younger.

Documentation Requirements

HCPCS codes L7170 thru L7191 require documentation that the recipient has an existing or authorized appliance that is compatible with the requested attachment(s).

HCPCS codes L7170 thru L7191 require documentation that the recipient cannot effectively use a manually operated appliance.

Billing

HCPCS codes L7170 thru L7191 must be billed with either the modifier LT (left side) or RT (right side).

External Power – Control Modules and Battery Components (L7259 thru L7368)

Coverage

Control modules and battery components may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized upper extremity electrically powered prosthesis that requires a control module or battery component for functional use of the prosthesis (all codes).

Authorization and Restrictions

Control module/battery component codes (L7259 thru L7368) will be authorized and reimbursed separately only when the base appliance has been provided or when the control module or battery component is being replaced or repaired.

Documentation Requirements

HCPCS codes L7259 thru L7368 require documentation that the recipient has an existing or authorized appliance that is compatible with the requested control module or battery component.

Billing

HCPCS code L7259 must be billed with either the modifier LT (left side) or RT (right side).

Breast Prostheses (A4280, L8000 thru L8035)

Coverage

Breast prostheses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient requires a prosthesis, component or attachment to replace a breast(s) after surgical removal, to support the surgical recovery or to hold the prosthesis in place (all codes).

Authorization and Restrictions

HCPCS codes L8000 thru L8002, and L8015 may be authorized and reimbursed to a pharmacist or pharmacy when the pharmacy/pharmacist is licensed and enrolled in the Medi-Cal program as a provider.

HCPCS code L8033 (nipple prosthesis, custom fabricated, reusable, any material, any type, each) always requires authorization (TAR required).

Billing

‹‹HCPCS codes A4280, L8001, L8011 thru L8035 must be billed with either the modifier LT (left side) or RT (right side).››

Pharmacies billing for codes L8000 thru L8002, and L8015 must bill on the *CMS-1500* claim form.

General Items – Prosthetic Socks (L8400 thru L8485)

Coverage

Prosthetic socks may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized prosthesis and requires one or more of the following:

- A prosthetic sheath placed over a residual limb and under a prosthetic sock while the prosthesis is being worn to decrease the irritation of the residual limb; or,
  - Below the knee (L8400, L8417)
  - Above the knee (L8410, L8417)
  - Upper limb (L8415)
- A prosthetic sock worn between the residual limb and the prosthesis to decrease the irritation of the residual limb; or,
  - Below the knee (L8417, L8420, L8470)
  - Above the knee (L8417, L8430, L8480)
  - Upper limb (L8435, L8485)
- A prosthetic shrinker worn over the residual limb to provide pressure against the residual limb to decrease accumulation of fluid in the residual limb; or,
  - Below the knee (L8440)
  - Above the knee (L8460)
  - Upper limb (L8465)
- A thinly woven sock used over the residual limb during the fitting of a prosthesis.
  - Below the knee (L8470)
  - Above the knee (L8480)
  - Upper limb (L8485)

Billing

HCPCS codes L8400 thru L8485 must be billed with either the modifier LT (left side) or RT (right side).

General Items – Repairs for Prosthetic Appliances (L7510, L7520)

Coverage

Repairs of prosthetic appliances include labor and material and may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing prosthesis that requires repair, maintenance or replacement of minor parts and the repair, maintenance or replacement cost(s) is less than the cost(s) of purchasing a new prosthesis (both codes).

Authorization and Restrictions

Labor (L7520) may be authorized and reimbursed for up to a maximum of three hours (12 units). Additional labor time always requires authorization (TAR required).

Documentation Requirements

For repair, maintenance and replacement, documentation must include clinical information with reference to age of the appliance, physical condition of the appliance and the anticipated functional level of the recipient.

Billing

HCPCS codes L7510 and L7520 may be billed with modifier's LT (left side) or RT (right side) but these modifiers are not required for these codes.

Claims for parts (L7510) must be accompanied by all of the following information:

- Description of the service provided; and,
- Reason/justification for repair.
- An invoice copy.

Claims for labor (L7520) are reimbursed in 15-minute units on a per unit basis. However, labor may be rounded up to the nearest half-hour for the total repair job (for example, 1 hour and 20 minutes = 6 units of labor).

Claims for labor (L7520) must be accompanied by all of the following information:

- Description of the service provided; and,
- Reason/justification for the repair; and,
- Labor time to accomplish the work; and,
- Labor rate or hourly charge.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.