51315.1 Requirements Applicable to the Prior Authorization of Orthotic Appliances and Services

Orthotic appliances and services shall be authorizedunder the Medi-Cal program when the supporting documentation and all otherrequirements specified in Section 51315 and in this section aremet.

For purposes of this section, medical conditions citedwith each appliance/service or group of appliances/services shall not beconstrued to represent an exhaustive list of medical conditions appropriate toeach appliance/service or group of appliances/services. Likewise, such medicalconditions may not be appropriate for authorization of the requestedappliance/service if medical necessity for the specific appliance/service isnot documented.

(a)

Shoe Supplies for Diabetics shall include shoes and their fitting(s), modifications and inserts; and shall be authorized when the patient has a diagnosis of diabetes mellitus and requires one or more of the following shoe(s), shoe modification(s) or shoe insert(s) to accommodate for or prevent foot ulceration and related foot conditions:(1) For prefabricated shoe(s) or shoe insert(s), or modification(s) to prefabricated shoe(s) or shoe insert(s), the patient has one or more of the following medical conditions, appropriate to the requested procedure code(s):(A) Foot ulcer(s). (B) Previous amputation of the contralateral foot, or part of either foot, due to microvascular disease secondary to diabetes. (C) History of foot

ulceration(s) of either foot. (D) Peripheral neuropathy with evidence of callous formation of either foot. (E) Deformity of either foot, such as rocker bottom foot or Charcot foot. (F) Compromised vascular disease in either foot. (G) Positive monofilament examination indicating diabetic neuropathy. (2) For custom-made shoe(s) or shoe insert(s), or modification(s) to custom-made shoe(s) or shoe insert(s), the patient has one or more of the listed medical conditions in subsection (a)(1), and one or more of the following, appropriate to the requested procedure code(s):(A) Neurological manifestation(s). (B) Peripheral circulatory disorder(s). (C) Treatment or prevention of other foot conditions secondary to diabetes mellitus.

(1)

For prefabricated shoe(s) or shoe insert(s), or modification(s) to prefabricated shoe(s) or shoe insert(s), the patient has one or more of the following medical conditions, appropriate to the requested procedure code(s):(A) Foot ulcer(s). (B) Previous amputation of the contralateral foot, or part of either foot, due to microvascular disease secondary to diabetes. (C) History of foot ulceration(s) of either foot. (D) Peripheral neuropathy with evidence of callous formation of either foot. (E) Deformity of either foot, such as rocker bottom foot or Charcot foot. (F) Compromised vascular disease in either foot. (G) Positive monofilament examination indicating diabetic neuropathy.

(A)

Foot ulcer(s).

(B)

Previous amputation of the contralateral foot, or part of either foot, due to microvascular disease secondary to diabetes.

(C)

History of foot ulceration(s) of either foot.

(D)

Peripheral neuropathy with evidence of callous formation of either foot.

(E)

Deformity of either foot, such as rocker bottom foot or Charcot foot.

(F)

Compromised vascular disease in either foot.

(G)

Positive monofilament examination indicating diabetic neuropathy.

(2)

For custom-made shoe(s) or shoe insert(s), or modification(s) to custom-made shoe(s) or shoe insert(s), the patient has one or more of the listed medical conditions in subsection (a)(1), and one or more of the following, appropriate to the requested procedure code(s):(A) Neurological manifestation(s). (B) Peripheral circulatory disorder(s). (C) Treatment or prevention of other foot conditions secondary to diabetes mellitus.

(A)

Neurological manifestation(s).

(B)

Peripheral circulatory disorder(s).

(C)

Treatment or prevention of other foot conditions secondary to diabetes mellitus.

(b)

Compression Burn Garments shall be authorized when the patient requires a custom-fabricated garment to provide physician-ordered compression to facilitate the healing of burn tissue or a similar injury, or to prevent scarring.

(c)

Gradient Compression Stockings shall include custom-made stockings and garter

belts and shall be authorized when one or both of the following criteria is met, appropriate to the requested procedure code(s):(1) For custom-made compression stockings, the patient has a medical condition that results in symptomatic venous insufficiency or lymphedema in one or both lower extremities that requires the use of a custom-made compression stocking(s). (2) For garter belts, the patient has an existing or authorized compression stocking or residual limb shrinker and requires the use of a garter belt to hold the compression stocking or shrinker in place.

(1)

For custom-made compression stockings, the patient has a medical condition that results in symptomatic venous insufficiency or lymphedema in one or both lower extremities that requires the use of a custom-made compression stocking(s).

(2)

For garter belts, the patient has an existing or authorized compression stocking or residual limb shrinker and requires the use of a garter belt to hold the compression stocking or shrinker in place.

(d)

Spinal Orthoses shall include all of the following: (1) Cranial Orthoses (helmets) shall be authorized when cranial molding is required in children two years of age and younger with plaglocephaly or craniosynostosis. For purposes of cranial molding in children, the appliance shall be manufactured by a Federal Drug Administration-approved laboratory. (2) Cervical and Multiple Post Collar Orthoses (collars) shall be authorized when the patient has a medical condition(s) or a medical need(s) that requires support to the cervical spine to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, such as one of the following, appropriate to the requested procedure code(s):(A) Whiplash or other injury to the neck. (B) Post-surgical repair of a cervical fracture. (C)

Post-surgical treatment of a ligamentis injury or torticollis. (D) Treatment in place of surgical intervention for a cervical fracture or ligamentis injury. (E) Any related medical condition that requires support to the cervical spine. (3) Thoracic Orthoses (rib belts) shall be authorized when the patient has a medical condition that requires support to the thoracic area to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, such as for fractured ribs or torn intercostal ligaments. (4) Thoracic Orthoses (anterior-posterior-lateral-rotary control) shall be authorized when both of the following criteria are met:(A) The patient has one of the following medical conditions: 1. A slipped or herniated disk. 2. Osteoporosis of the thoracic area. 3. A vertebral fracture, with or without surgery. 4. A related medical condition of the thoracic area. (B) The patient requires one or more of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s):1. Trunk support. 2. Reduction of load on the intervertebral discs. 3. Reduction of gross trunk motion in the sagittal plane. (5) Thoracic Orthoses (triplanar control -- modular segmented spinal system [prefabricated]) shall be authorized when both of the following criteria are met:(A) The patient has one or more of the following medical conditions: 1. Post neck or back surgery. 2. Post laminectomy. 3. A vertebral fracture. 4. A related medical condition of the thoracic area. (B) The patient requires one or both of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury: 1. Reduction of gross trunk motion in three planes (sagittal, coronal and transverse). 2. Spinal support and stabilization or immobilization of the spine. (6) Thoracic Orthoses (triplanar control -- rigid frame) shall be authorized when the patient has a medical condition that requires one or more of the following treatments to decrease pain, to increase functional capacity,

or to prevent or ameliorate further injury, appropriate to the requested procedure code(s):(A) Reduction of load on the intervertebral discs. (B) Reduction of gross trunk motion in three planes (sagittal, coronal and transverse). (C) Hyperextension of the thoracic, lumbar and sacral areas of the back. (7) Thoracic Orthoses (triplanar control -- rigid plastic shell) shall be authorized when the patient has one of the following medical conditions that requires reduction of gross trunk motion in three planes (sagittal, coronal and transverse) when spinal support and immobilization are required to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury: (A) Post neck surgery. (B) Post back surgery (laminectomy or vertebral fracture). (C) A related medical condition of the neck or back.

(1)

Cranial Orthoses (helmets) shall be authorized when cranial molding is required in children two years of age and younger with plaglocephaly or craniosynostosis. For purposes of cranial molding in children, the appliance shall be manufactured by a Federal Drug Administration-approved laboratory.

(2)

Cervical and Multiple Post Collar Orthoses (collars) shall be authorized when the patient has a medical condition(s) or a medical need(s) that requires support to the cervical spine to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, such as one of the following, appropriate to the requested procedure code(s):(A) Whiplash or other injury to the neck. (B) Post-surgical repair of a cervical fracture. (C) Post-surgical treatment of a ligamentis injury or torticollis. (D) Treatment in place of surgical intervention for a cervical fracture or ligamentis injury. (E) Any related medical condition that requires support to the cervical spine.

(A)

Whiplash or other injury to the neck.

(B)

Post-surgical repair of a cervical fracture.

(C)

Post-surgical treatment of a ligamentis injury or torticollis.

(D)

Treatment in place of surgical intervention for a cervical fracture or ligamentis injury.

(E)

Any related medical condition that requires support to the cervical spine.

(3)

Thoracic Orthoses (rib belts) shall be authorized when the patient has a medical condition that requires support to the thoracic area to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, such as for fractured ribs or torn intercostal ligaments.

(4)

Thoracic Orthoses (anterior-posterior-lateral-rotary control) shall be authorized when both of the following criteria are met:(A) The patient has one of the following medical conditions: 1. A slipped or herniated disk. 2. Osteoporosis of the thoracic area. 3. A vertebral fracture, with or without surgery. 4. A related medical condition of the thoracic area. (B) The patient requires one or more of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s):1. Trunk support. 2. Reduction of load on the intervertebral discs. 3. Reduction of gross trunk motion in the sagittal plane.

(A)

The patient has one of the following medical conditions: 1. A slipped or herniated disk. 2.

Osteoporosis of the thoracic area. 3. A vertebral fracture, with or without surgery. 4. A related medical condition of the thoracic area.

1.

A slipped or herniated disk.

2.

Osteoporosis of the thoracic area.

3.

A vertebral fracture, with or without surgery.

4.

A related medical condition of the thoracic area.

(B)

The patient requires one or more of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s):1. Trunk support. 2. Reduction of load on the intervertebral discs. 3. Reduction of gross trunk motion in the sagittal plane.

1.

Trunk support.

2.

Reduction of load on the intervertebral discs.

3.

Reduction of gross trunk motion in the sagittal plane.

(5)

Thoracic Orthoses (triplanar control -- modular segmented spinal system [prefabricated]) shall be authorized when both of the following criteria are met:(A) The patient has one or more of the following medical conditions: 1. Post neck or back surgery. 2. Post laminectomy. 3. A vertebral fracture. 4. A related medical condition of

the thoracic area. (B) The patient requires one or both of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury: 1. Reduction of gross trunk motion in three planes (sagittal, coronal and transverse). 2. Spinal support and stabilization or immobilization of the spine.

(A)

The patient has one or more of the following medical conditions: 1. Post neck or back surgery. 2. Post laminectomy. 3. A vertebral fracture. 4. A related medical condition of the thoracic area.

1.

Post neck or back surgery.

2.

Post laminectomy.

3.

A vertebral fracture.

4.

A related medical condition of the thoracic area.

(B)

The patient requires one or both of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury: 1. Reduction of gross trunk motion in three planes (sagittal, coronal and transverse). 2. Spinal support and stabilization or immobilization of the spine.

1.

Reduction of gross trunk motion in three planes (sagittal, coronal and transverse).

2.

Spinal support and stabilization or immobilization of the spine.

(6)

Thoracic Orthoses (triplanar control -- rigid frame) shall be authorized when the patient has a medical condition that requires one or more of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s):(A) Reduction of load on the intervertebral discs. (B) Reduction of gross trunk motion in three planes (sagittal, coronal and transverse). (C) Hyperextension of the thoracic, lumbar and sacral areas of the back.

(A)

Reduction of load on the intervertebral discs.

(B)

Reduction of gross trunk motion in three planes (sagittal, coronal and transverse).

(C)

Hyperextension of the thoracic, lumbar and sacral areas of the back.

(7)

Thoracic Orthoses (triplanar control -- rigid plastic shell) shall be authorized when the patient has one of the following medical conditions that requires reduction of gross trunk motion in three planes (sagittal, coronal and transverse) when spinal support and immobilization are required to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury: (A) Post neck surgery. (B) Post back surgery (laminectomy or vertebral fracture). (C) A related medical condition of the neck or back.

(A)

Post neck surgery.

(B)

Post back surgery (laminectomy or vertebral fracture).

(C)

A related medical condition of the neck or back.

(e)

Thoracic Orthoses (sagittal or sagittal-coronal control) shall be authorized when the patient has a medical condition that requires one or more of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s): (1) Reduction of load on the intervertebral discs. (2) Reduction of gross trunk motion in the sagittal plane. (3) Reduction of gross trunk motion in the sagittal and coronal planes.

(1)

Reduction of load on the intervertebral discs.

(2)

Reduction of gross trunk motion in the sagittal plane.

(3)

Reduction of gross trunk motion in the sagittal and coronal planes.

(f)

Cervical-Thoracic-Lumbar-Sacral Orthoses shall include all of the following: (1) Sacroiliac Orthoses shall be authorized when the patient has a medical condition that requires one or more of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury:(A) Support to the pelvic-sacral area. (B) Reduction of gross trunk motion of the sacroiliac joint. (C) Pendulous abdomen support, such as in severe ptosis. (2) Lumbar Orthoses shall be authorized when the patient has a medical condition that requires one or more of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s): (A) Support to the lumbar area. (B) Reduction of load on the

intervertebral discs. (C) Reduction of gross trunk motion in the sagittal plane. (D) Pendulous abdomen support, such as in severe ptosis. (3) Lumbar-Sacral Orthoses shall be authorized when the patient has a medical condition that requires one or more of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s):(A) Support to the lumbar-sacral areas. (B) Reduction of load on the intervertebral discs. (C) Reduction of gross trunk motion in the sagittal or coronal plane. (D) Flexion of the lumbar spine. (E) Pendulous abdomen support, such as in severe ptosis. (4) Anterior-Posterior-Lateral Control Orthoses shall be authorized when the patient has a medical condition that requires support and maximum external restriction of anterior, posterior and lateral motion to the cervical, thoracic, lumbar and sacral spine to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury.

(1)

Sacroiliac Orthoses shall be authorized when the patient has a medical condition that requires one or more of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury:(A) Support to the pelvic-sacral area. (B) Reduction of gross trunk motion of the sacroiliac joint. (C) Pendulous abdomen support, such as in severe ptosis.

(A)

Support to the pelvic-sacral area.

(B)

Reduction of gross trunk motion of the sacroiliac joint.

(C)

Pendulous abdomen support, such as in severe ptosis.

(2)

Lumbar Orthoses shall be authorized when the patient has a medical condition that requires one or more of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s): (A) Support to the lumbar area. (B) Reduction of load on the intervertebral discs. (C) Reduction of gross trunk motion in the sagittal plane. (D) Pendulous abdomen support, such as in severe ptosis.

(A)

Support to the lumbar area.

(B)

Reduction of load on the intervertebral discs.

(C)

Reduction of gross trunk motion in the sagittal plane.

(D)

Pendulous abdomen support, such as in severe ptosis.

(3)

Lumbar-Sacral Orthoses shall be authorized when the patient has a medical condition that requires one or more of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s):(A) Support to the lumbar-sacral areas. (B) Reduction of load on the intervertebral discs. (C) Reduction of gross trunk motion in the sagittal or coronal plane. (D) Flexion of the lumbar spine. (E) Pendulous abdomen support, such as in severe ptosis.

(A)

Support to the lumbar-sacral areas.

(B)

Reduction of load on the intervertebral discs.

(C)

Reduction of gross trunk motion in the sagittal or coronal plane.

(D)

Flexion of the lumbar spine.

(E)

Pendulous abdomen support, such as in severe ptosis.

(4)

Anterior-Posterior-Lateral Control Orthoses shall be authorized when the patient has a medical condition that requires support and maximum external restriction of anterior, posterior and lateral motion to the cervical, thoracic, lumbar and sacral spine to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury.

(g)

Halo Procedures shall include the base appliance and additions, and shall be authorized when one or both of the following criteria is met, appropriate to the requested procedure code(s):(1) For the base appliance, the patient has a medical condition that requires support and maximum external restriction of anterior, posterior and lateral motion to the cervical, thoracic, lumbar and sacral spine to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury. (2) For the addition(s), all of the following are met:(A) The patient's medical condition requires the specific function for which the addition(s) was designed. (B) The addition(s) is required by the patient to improve the functionality of the halo procedure, without which the patient's medical need(s) would not be met. (C) The patient has an existing or authorized halo procedure that is compatible with the addition(s).

(1)

For the base appliance, the patient has a medical condition that requires support and maximum external restriction of anterior, posterior and lateral motion to the cervical, thoracic, lumbar and sacral spine to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury.

(2)

For the addition(s), all of the following are met:(A) The patient's medical condition requires the specific function for which the addition(s) was designed. (B) The addition(s) is required by the patient to improve the functionality of the halo procedure, without which the patient's medical need(s) would not be met. (C) The patient has an existing or authorized halo procedure that is compatible with the addition(s).

(A)

The patient's medical condition requires the specific function for which the addition(s) was designed.

(B)

The addition(s) is required by the patient to improve the functionality of the halo procedure, without which the patient's medical need(s) would not be met.

(C)

The patient has an existing or authorized halo procedure that is compatible with the addition(s).

(h)

Additions to Spinal Orthoses shall be authorized when all of the following criteria are met: (1) The patient's medical condition requires the specific function for which the addition(s) was designed. (2) The addition(s) is required by the patient to improve the functionality of the spinal orthosis, without which the patient's medical need(s) would not be met. (3) The patient has an existing or authorized spinal orthosis that is compatible with the addition(s).

(1)

The patient's medical condition requires the specific function for which the addition(s) was designed.

(2)

The addition(s) is required by the patient to improve the functionality of the spinal orthosis, without which the patient's medical need(s) would not be met.

(3)

The patient has an existing or authorized spinal orthosis that is compatible with the addition(s).

(i)

Orthotic Devices -- Scoliosis Procedures shall include all of the following:(1) Cervical-Thoracic-Lumbar-Sacral Orthoses.(A) Shall include all of the following:1. The Infant Immobilizer shall be authorized only for children under one year of age for stabilization of the cervical spine, upper thoracic spine and airway. The infant immobilizer shall not be authorized for use in restraining infants during surgical or radiological procedures. 2. The Tension Based Scoliosis Orthosis shall be authorized only for a child diagnosed with adolescent idiopathic scoliosis or a similar deformity or disease. 3. Additions to Cervical-Thoracic-Lumbar-Sacral Orthoses or Scoliosis Orthoses shall be authorized when all of the following criteria are met: a. The patient's medical condition requires the specific function for which the addition(s) was designed. b. The addition(s) is required by the patient to improve the functionality of the cervical-thoracic-lumbar-sacral orthosis or scoliosis orthosis, without which the patient's medical need(s) would not be met. c. The patient has an existing or authorized cervical-thoracic-lumbar-sacral orthosis or scoliosis orthosis that is compatible with the addition(s). (B) Shall be authorized when both of the following criteria are met:1. The patient has a diagnosis of

scoliosis or other curvature or instability of the spine. 2. The appliance is appropriate for the patient's degree and type of scoliosis, or spinal curvature or instability in which the degree of spinal curvature or instability, any lower extremity length discrepancy, and goals of treatment are considered. (2) Thoracic-Lumbar-Sacral Orthoses (Low Profile) shall include the base appliance and additions, and shall be authorized when one or both of the following criteria is met, appropriate to the requested procedure code(s): (A) For the base appliance, both of the following criteria are met: 1. The patient has a diagnosis of scoliosis or other curvature or instability of the spine. 2. The base appliance is appropriate for the patient's degree and type of scoliosis or spinal curvature or instability in which the degree of spinal curvature or instability, any lower extremity length discrepancy, and goals of treatment are considered. (B) For the addition(s), all of the following criteria are met: 1. The patient has a diagnosis of scoliosis or other curvature or instability of the spine. 2. The patient's medical condition requires the specific function for which the addition(s) was designed. 3. The addition(s) is required by the patient to improve the functionality of the thoracic-lumbar-sacral orthosis, without which the patient's medical need(s) would not be met. 4. The patient has an existing or authorized thoracic-lumbar-sacral orthosis that is compatible with the addition(s). (3) Other Scoliosis Procedures (body jackets) shall be authorized when both of the following criteria are met: (A) The patient has a diagnosis of scoliosis or other curvature or instability of the spine. (B) The appliance is appropriate for the patient's degree and type of scoliosis or spinal curvature or instability in which the degree of spinal curvature or instability, any lower extremity length discrepancy, and goals of treatment are considered.

(1)

Cervical-Thoracic-Lumbar-Sacral Orthoses.(A) Shall include all of the following:1. The

Infant Immobilizer shall be authorized only for children under one year of age for stabilization of the cervical spine, upper thoracic spine and airway. The infant immobilizer shall not be authorized for use in restraining infants during surgical or radiological procedures. 2. The Tension Based Scoliosis Orthosis shall be authorized only for a child diagnosed with adolescent idiopathic scoliosis or a similar deformity or disease. 3. Additions to Cervical-Thoracic-Lumbar-Sacral Orthoses or Scoliosis Orthoses shall be authorized when all of the following criteria are met: a. The patient's medical condition requires the specific function for which the addition(s) was designed. b. The addition(s) is required by the patient to improve the functionality of the cervical-thoracic-lumbar-sacral orthosis or scoliosis orthosis, without which the patient's medical need(s) would not be met. c. The patient has an existing or authorized cervical-thoracic-lumbar-sacral orthosis or scoliosis orthosis that is compatible with the addition(s). (B) Shall be authorized when both of the following criteria are met:1. The patient has a diagnosis of scoliosis or other curvature or instability of the spine. 2. The appliance is appropriate for the patient's degree and type of scoliosis, or spinal curvature or instability in which the degree of spinal curvature or instability, any lower extremity length discrepancy, and goals of treatment are considered.

(A)

Shall include all of the following:1. The Infant Immobilizer shall be authorized only for children under one year of age for stabilization of the cervical spine, upper thoracic spine and airway. The infant immobilizer shall not be authorized for use in restraining infants during surgical or radiological procedures. 2. The Tension Based Scoliosis Orthosis shall be authorized only for a child diagnosed with adolescent idiopathic scoliosis or a similar deformity or disease. 3. Additions to Cervical-Thoracic-Lumbar-Sacral Orthoses or Scoliosis Orthoses shall be authorized when all of the following criteria are met: a. The patient's medical condition requires the specific function for which the addition(s) was designed. b. The addition(s) is

required by the patient to improve the functionality of the cervical-thoracic-lumbar-sacral orthosis or scoliosis orthosis, without which the patient's medical need(s) would not be met. c. The patient has an existing or authorized cervical-thoracic-lumbar-sacral orthosis or scoliosis orthosis that is compatible with the addition(s).

1.

The Infant Immobilizer shall be authorized only for children under one year of age for stabilization of the cervical spine, upper thoracic spine and airway. The infant immobilizer shall not be authorized for use in restraining infants during surgical or radiological procedures.

2.

The Tension Based Scoliosis Orthosis shall be authorized only for a child diagnosed with adolescent idiopathic scoliosis or a similar deformity or disease.

3.

Additions to Cervical-Thoracic-Lumbar-Sacral Orthoses or Scoliosis Orthoses shall be authorized when all of the following criteria are met: a. The patient's medical condition requires the specific function for which the addition(s) was designed. b. The addition(s) is required by the patient to improve the functionality of the cervical-thoracic-lumbar-sacral orthosis or scoliosis orthosis, without which the patient's medical need(s) would not be met. c. The patient has an existing or authorized cervical-thoracic-lumbar-sacral orthosis or scoliosis orthosis that is compatible with the addition(s).

a.

The patient's medical condition requires the specific function for which the addition(s) was designed.

b.

The addition(s) is required by the patient to improve the functionality of the cervical-thoracic-lumbar-sacral orthosis or scoliosis orthosis, without which the patient's medical need(s) would not be met.

c.

The patient has an existing or authorized cervical-thoracic-lumbar-sacral orthosis or scoliosis orthosis that is compatible with the addition(s).

(B)

Shall be authorized when both of the following criteria are met:1. The patient has a diagnosis of scoliosis or other curvature or instability of the spine. 2. The appliance is appropriate for the patient's degree and type of scoliosis, or spinal curvature or instability in which the degree of spinal curvature or instability, any lower extremity length discrepancy, and goals of treatment are considered.

1.

The patient has a diagnosis of scoliosis or other curvature or instability of the spine.

2.

The appliance is appropriate for the patient's degree and type of scoliosis, or spinal curvature or instability in which the degree of spinal curvature or instability, any lower extremity length discrepancy, and goals of treatment are considered.

(2)

Thoracic-Lumbar-Sacral Orthoses (Low Profile) shall include the base appliance and additions, and shall be authorized when one or both of the following criteria is met, appropriate to the requested procedure code(s): (A) For the base appliance, both of the following criteria are met: 1. The patient has a diagnosis of scoliosis or other curvature or instability of the spine. 2. The base appliance is appropriate for the patient's degree and type of scoliosis or spinal curvature or instability in which the degree of spinal curvature or instability, any lower extremity length discrepancy, and goals of treatment are considered. (B) For the addition(s), all of the following criteria are met: 1. The patient has a diagnosis of scoliosis or other curvature or instability of the spine. 2. The patient's medical condition requires the specific function for which the addition(s) was designed. 3. The addition(s) is required by the patient to improve the functionality of the thoracic-lumbar-sacral orthosis, without which the patient's medical need(s) would not be met. 4. The patient has an existing or authorized thoracic-lumbar-sacral orthosis

that is compatible with the addition(s).

(A)

For the base appliance, both of the following criteria are met: 1. The patient has a diagnosis of scoliosis or other curvature or instability of the spine. 2. The base appliance is appropriate for the patient's degree and type of scoliosis or spinal curvature or instability in which the degree of spinal curvature or instability, any lower extremity length discrepancy, and goals of treatment are considered.

1.

The patient has a diagnosis of scoliosis or other curvature or instability of the spine.

2.

The base appliance is appropriate for the patient's degree and type of scoliosis or spinal curvature or instability in which the degree of spinal curvature or instability, any lower extremity length discrepancy, and goals of treatment are considered.

(B)

For the addition(s), all of the following criteria are met: 1. The patient has a diagnosis of scoliosis or other curvature or instability of the spine. 2. The patient's medical condition requires the specific function for which the addition(s) was designed. 3. The addition(s) is required by the patient to improve the functionality of the thoracic-lumbar-sacral orthosis, without which the patient's medical need(s) would not be met. 4. The patient has an existing or authorized thoracic-lumbar-sacral orthosis that is compatible with the addition(s).

1.

The patient has a diagnosis of scoliosis or other curvature or instability of the spine.

2.

The patient's medical condition requires the specific function for which the addition(s) was designed.

3.

The addition(s) is required by the patient to improve the functionality of the thoracic-lumbar-sacral

orthosis, without which the patient's medical need(s) would not be met.

4.

The patient has an existing or authorized thoracic-lumbar-sacral orthosis that is compatible with the addition(s).

(3)

Other Scoliosis Procedures (body jackets) shall be authorized when both of the following criteria are met: (A) The patient has a diagnosis of scoliosis or other curvature or instability of the spine. (B) The appliance is appropriate for the patient's degree and type of scoliosis or spinal curvature or instability in which the degree of spinal curvature or instability, any lower extremity length discrepancy, and goals of treatment are considered.

(A)

The patient has a diagnosis of scoliosis or other curvature or instability of the spine.

(B)

The appliance is appropriate for the patient's degree and type of scoliosis or spinal curvature or instability in which the degree of spinal curvature or instability, any lower extremity length discrepancy, and goals of treatment are considered.

(j)

Orthotic Devices -- Lower Limb (Extremity) shall include all of the following: (1) Hip Orthoses -- Flexible shall be authorized when both of the following criteria are met: (A) The patient has one of the following medical conditions:1. Congenital hip dislocation or hip dysplasia in infants and children. 2. Post total hip replacement when post-operative hip stabilization is necessary to prevent dislocation or to facilitate healing of a fracture. 3. An injured or previously dislocated hip that requires rehabilitation as an alternative to surgery. 4. A related medical condition that requires control and stabilization of the hip(s). (B) The patient requires one of

the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s): 1. Abduction control, with or without ambulation. 2. Post-operative control of hip motion. 3. Control of adduction or rotational guidance of both hips. (2) Legg Perthes Orthoses shall be authorized when the patient has a diagnosis of Legg-Calve-Perthes deformity or similar deformity or disease, and requires control of hip abduction, adduction or weight bearing, appropriate to the requested procedure code(s). (3) Knee Orthoses shall be authorized when both of the following criteria are met:(A) The patient has a deformity or injury of, or affecting the knee, such as one of the following:1. Post surgical repair of ligament tears. 2. Post arthroscopy. 3. Osteoarthritis or other degenerative joint disease. 4. Post polio. 5. Rehabilitation of an injured knee. 6. Any related medical condition affecting the knee. (B) The patient requires one or more of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s):1. Support or protection of the knee. 2. Control or restriction of motion of the knee. 3. Medial-lateral and rotation control of the knee. 4. Sagittal plane control of the knee. 5. Prevention or control of recruvatum (hyperextension of the knee). 6. Control of hip flexion in bed. (4) Ankle-Foot Orthoses shall be authorized when the patient has a disease, deformity, injury or condition of, or affecting the lower extremity in which the patient experiences pain or diminished functional capacity of the lower extremity and requires one or more of the following treatments, appropriate to the requested procedure code(s):(A) Assistance in specific movements of the ankle and foot. (B) Support to the ankle and foot. (C) Maintenance of the foot in a neutral or functional position. (D) Stabilization of the knee or hip. (E) Control of movement of the ankle and foot. (5) Knee-Ankle-Foot

Orthoses -- or Any Combination shall be authorized when the patient has a disease, deformity, injury or condition of, or affecting the knee or ankle joint(s) in which the patient experiences pain or diminished functional capacity of the knee or ankle joint(s) and requires one or more of the following treatments, appropriate to the requested procedure code(s): (A) Control of motion of the knee, ankle or foot. (B) Maintenance of the ankle and foot in a fixed position. (C) Correction of contractures of the knee and ankle joints. (6) Torsion Control: Hip-Knee-Ankle-Foot Orthoses shall be authorized when the patient has a disease, deformity, injury or condition of, or affecting the hip, knee or ankle joint(s) in which the patient experiences pain or diminished functional capacity of the hip, knee or ankle joint(s) and requires control in rotation of one or both hips, appropriate to the requested procedure code(s). (7) Torsion Control: Hip-Knee-Ankle-Foot Orthoses (Tibial Fracture Cast) shall be authorized when the patient has a fracture of the tibia or fibula and requires support and stabilization of the fracture site to facilitate healing, to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury. (8) Torsion Control: Hip-Knee-Ankle-Foot Orthoses (Femoral Fracture Cast) shall be authorized when the patient has a fracture of the femur and requires support and stabilization of the fracture site to facilitate healing, to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury. (9) Reciprocating Gait Orthoses shall be authorized when chronologically and developmentally appropriate (beginning around two years of age and up) and all of the following criteria are met: (A) The patient has both of the following conditions:1. Thoracic or upper lumbar spine lesions with spasticity. 2. Range of motion limitations that nevertheless allow joints to be put in appropriate position for ambulation. (B) The patient does not have any of the following conditions or contraindications:1. Severe irreducible contractures that

prevent establishing normal alignment. 2. Severe spasticity or other involuntary muscle activity that prevents free and coordinated mobility. 3. Severe obesity. 4. Poor upper extremity strength. 5. Advanced osteoporosis. 6. A fracture(s) or a history of fracture(s). 7. History of not following treatment plans (noncompliance). 8. A pressure sore(s) in an area(s) that would be in contact with the orthosis. (C) Documentation in the patient's medical record substantiates all of the following:1. Cardiopulmonary integrity. 2. That no other orthosis will meet the patient's medical need(s). 3. Spinal cord injury level above the third lumbar vertebrae. 4. No contractures and muscle atrophy that would preclude the use of the reciprocating gait orthosis. 5. Stability of the spine. 6. No advanced osteoporosis or fracture(s). 7. One of the following diagnoses: a. Paraplegia (diagnosis code 344.1). b. Spina bifida, without mention of hydrocephalus, dorsal [thoracic] region (diagnosis code 741.92). c. Spina bifida, without mention of hydrocephalus, lumbar region (diagnosis code 741.93). d. Any related medical condition affecting the spine. (D) For patients 21 years of age and older, in addition to the documentation requirements specified in subsection (j)(9)(C)1. through 7., all of the following shall also be documented in the patient's medical record: 1. Plantigrade feet. 2. Minimal contractures in the knees and hips. 3. Flexible hips without rigidity or spasticity. 4. Good upper extremity strength. 5. Realistic goals and expectations and a family or other support system. (10) (A) Orthotic Devices -- Lower Limb (Extremity) (Additions to Lower Extremity Orthoses) shall include all of the following: 1. Additions to Fracture Orthoses. 2. Additions to Lower Extremity Orthoses: Shoe-Ankle-Shin-Knee. 3. Additions to Straight Knee or Offset Knee Joints (Knee Joints). 4. Additions: Thigh-Weight Bearing -- Gluteal/Ischial Weight Bearing. 5. Additions: Pelvic and Thoracic Control. 6. Additions: General. 7. Custom Foot Orthoses. (B) Shall be authorized when all of the following criteria are met,

appropriate to the requested procedure code(s): 1. The patient's medical condition requires the specific function for which the addition(s) was designed. 2. The addition(s) is required by the patient to improve the functionality of the lower extremity orthosis, without which the patient's medical need(s) would not be met. 3. The patient has an existing or authorized lower extremity orthosis that is compatible with the addition(s). (C) In addition to the criteria specified in paragraph (B) above, paragraph (A)7. (Custom Foot Orthoses) shall be authorized when the orthosis is fabricated for a patient using the patient's individual measurements or pattern. This fabrication shall be constructed using a plaster casting of the patient's foot to create a mold, or with a three-dimensional negative impression or digital scanning (Computer-Aided Design/Computer Aided Manufacture Model [CAD/CAM]). The use of foam boxes shall not be an acceptable fabrication method.

(1)

Hip Orthoses -- Flexible shall be authorized when both of the following criteria are met: (A) The patient has one of the following medical conditions:1. Congenital hip dislocation or hip dysplasia in infants and children. 2. Post total hip replacement when post-operative hip stabilization is necessary to prevent dislocation or to facilitate healing of a fracture. 3. An injured or previously dislocated hip that requires rehabilitation as an alternative to surgery. 4. A related medical condition that requires control and stabilization of the hip(s). (B) The patient requires one of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s): 1. Abduction control, with or without ambulation. 2. Post-operative control of hip motion. 3. Control of adduction or rotational guidance of both hips.

(A)

The patient has one of the following medical conditions:1. Congenital hip dislocation or hip dysplasia in infants and children. 2. Post total hip replacement when post-operative hip stabilization is necessary to prevent dislocation or to facilitate healing of a fracture. 3. An injured or previously dislocated hip that requires rehabilitation as an alternative to surgery. 4. A related medical condition that requires control and stabilization of the hip(s).

1. Congenital hip dislocation or hip dysplasia in infants and children.
2. Post total hip replacement when post-operative hip stabilization is necessary to prevent dislocation or to facilitate healing of a fracture.
3. An injured or previously dislocated hip that requires rehabilitation as an alternative to surgery.
4. A related medical condition that requires control and stabilization of the hip(s).

(B)

The patient requires one of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s): 1. Abduction control, with or without ambulation. 2. Post-operative control of hip motion. 3. Control of adduction or rotational guidance of both hips.

1. Abduction control, with or without ambulation.
2. Post-operative control of hip motion.
3. Control of adduction or rotational guidance of both hips.

(2)

Legg Perthes Orthoses shall be authorized when the patient has a diagnosis of Legg-Calve-Perthes deformity or similar deformity or disease, and requires control of hip abduction, adduction or weight bearing, appropriate to the requested procedure code(s).

(3)

Knee Orthoses shall be authorized when both of the following criteria are met:(A) The patient has a deformity or injury of, or affecting the knee, such as one of the following:1. Post surgical repair of ligament tears. 2. Post arthroscopy. 3. Osteoarthritis or other degenerative joint disease. 4. Post polio. 5. Rehabilitation of an injured knee. 6. Any related medical condition affecting the knee. (B) The patient requires one or more of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s):1. Support or protection of the knee. 2. Control or restriction of motion of the knee. 3. Medial-lateral and rotation control of the knee. 4. Sagittal plane control of the knee. 5. Prevention or control of recruvatum (hyperextension of the knee). 6. Control of hip flexion in bed.

(A)

The patient has a deformity or injury of, or affecting the knee, such as one of the following:1. Post surgical repair of ligament tears. 2. Post arthroscopy. 3. Osteoarthritis or other degenerative joint disease. 4. Post polio. 5. Rehabilitation of an injured knee. 6. Any related medical condition affecting the knee.

1.

Post surgical repair of ligament tears.

2.

Post arthroscopy.

3.

Osteoarthritis or other degenerative joint disease.

4.

Post polio.

5.

Rehabilitation of an injured knee.

6.

Any related medical condition affecting the knee.

(B)

The patient requires one or more of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s):1. Support or protection of the knee. 2. Control or restriction of motion of the knee. 3. Medial-lateral and rotation control of the knee. 4. Sagittal plane control of the knee. 5. Prevention or control of recruvatum (hyperextension of the knee). 6. Control of hip flexion in bed.

1.

Support or protection of the knee.

2.

Control or restriction of motion of the knee.

3.

Medial-lateral and rotation control of the knee.

4.

Sagittal plane control of the knee.

5.

Prevention or control of recruvatum (hyperextension of the knee).

6.

Control of hip flexion in bed.

(4)

Ankle-Foot Orthoses shall be authorized when the patient has a disease, deformity, injury or condition of, or affecting the lower extremity in which the patient experiences pain or diminished functional capacity of the lower extremity and requires one or more of the following treatments, appropriate to the requested procedure code(s):(A) Assistance in specific movements of the ankle and foot. (B) Support to the ankle and foot. (C) Maintenance of the foot in a neutral or functional position. (D) Stabilization of the knee or hip. (E) Control of movement of the ankle and foot.

(A)

Assistance in specific movements of the ankle and foot.

(B)

Support to the ankle and foot.

(C)

Maintenance of the foot in a neutral or functional position.

(D)

Stabilization of the knee or hip.

(E)

Control of movement of the ankle and foot.

(5)

Knee-Ankle-Foot Orthoses -- or Any Combination shall be authorized when the patient has a disease, deformity, injury or condition of, or affecting the knee or ankle joint(s) in which the patient experiences pain or diminished functional capacity of the knee or ankle joint(s) and requires one or more of the following treatments, appropriate to the requested procedure code(s): (A) Control of motion of the knee, ankle or foot. (B) Maintenance of the ankle and foot in a fixed position. (C) Correction of contractures of the knee and ankle joints.

(A)

Control of motion of the knee, ankle or foot.

(B)

Maintenance of the ankle and foot in a fixed position.

(C)

Correction of contractures of the knee and ankle joints.

(6)

Torsion Control: Hip-Knee-Ankle-Foot Orthoses shall be authorized when the patient has a disease, deformity, injury or condition of, or affecting the hip, knee or ankle joint(s) in which the patient experiences pain or diminished functional capacity of the hip, knee or ankle joint(s) and requires control in rotation of one or both hips, appropriate to the requested procedure code(s).

(7)

Torsion Control: Hip-Knee-Ankle-Foot Orthoses (Tibial Fracture Cast) shall be authorized when the patient has a fracture of the tibia or fibula and requires support and stabilization of the fracture site to facilitate healing, to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury.

(8)

Torsion Control: Hip-Knee-Ankle-Foot Orthoses (Femoral Fracture Cast) shall be authorized when the patient has a fracture of the femur and requires support and stabilization of the fracture site to facilitate healing, to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury.

(9)

Reciprocating Gait Orthoses shall be authorized when chronologically and developmentally appropriate (beginning around two years of age and up) and all of the following criteria are met: (A) The patient has both of the following conditions:1.

Thoracic or upper lumbar spine lesions with spasticity. 2. Range of motion limitations that nevertheless allow joints to be put in appropriate position for ambulation. (B) The patient does not have any of the following conditions or contraindications:1. Severe irreducible contractures that prevent establishing normal alignment. 2. Severe spasticity or other involuntary muscle activity that prevents free and coordinated mobility. 3. Severe obesity. 4. Poor upper extremity strength. 5. Advanced osteoporosis. 6. A fracture(s) or a history of fracture(s). 7. History of not following treatment plans (noncompliance). 8. A pressure sore(s) in an area(s) that would be in contact with the orthosis. (C) Documentation in the patient's medical record substantiates all of the following:1. Cardiopulmonary integrity. 2. That no other orthosis will meet the patient's medical need(s). 3. Spinal cord injury level above the third lumbar vertebrae. 4. No contractures and muscle atrophy that would preclude the use of the reciprocating gait orthosis. 5. Stability of the spine. 6. No advanced osteoporosis or fracture(s). 7. One of the following diagnoses: a. Paraplegia (diagnosis code 344.1). b. Spina bifida, without mention of hydrocephalus, dorsal [thoracic] region (diagnosis code 741.92). c. Spina bifida, without mention of hydrocephalus, lumbar region (diagnosis code 741.93). d. Any related medical condition affecting the spine. (D) For patients 21 years of age and older, in addition to the documentation requirements specified in subsection (j)(9)(C)1. through 7., all of the following shall also be documented in the patient's medical record: 1. Plantigrade feet. 2. Minimal contractures in the knees and hips. 3. Flexible hips without rigidity or spasticity. 4. Good upper extremity strength. 5. Realistic goals and expectations and a family or other support system.

(A)

The patient has both of the following conditions:1. Thoracic or upper lumbar spine lesions with spasticity. 2. Range of motion limitations that nevertheless allow joints to be put in

appropriate position for ambulation.

1. Thoracic or upper lumbar spine lesions with spasticity.

2. Range of motion limitations that nevertheless allow joints to be put in appropriate position for ambulation.

(B)

The patient does not have any of the following conditions or contraindications:1. Severe irreducible contractures that prevent establishing normal alignment. 2. Severe spasticity or other involuntary muscle activity that prevents free and coordinated mobility. 3. Severe obesity. 4. Poor upper extremity strength. 5. Advanced osteoporosis. 6. A fracture(s) or a history of fracture(s). 7. History of not following treatment plans (noncompliance). 8. A pressure sore(s) in an area(s) that would be in contact with the orthosis.

1. Severe irreducible contractures that prevent establishing normal alignment.

2. Severe spasticity or other involuntary muscle activity that prevents free and coordinated mobility.

3. Severe obesity.

4. Poor upper extremity strength.

5. Advanced osteoporosis.

6. A fracture(s) or a history of fracture(s).

7.

History of not following treatment plans (noncompliance).

8.

A pressure sore(s) in an area(s) that would be in contact with the orthosis.

(C)

Documentation in the patient's medical record substantiates all of the following:1. Cardiopulmonary integrity. 2. That no other orthosis will meet the patient's medical need(s). 3. Spinal cord injury level above the third lumbar vertebrae. 4. No contractures and muscle atrophy that would preclude the use of the reciprocating gait orthosis. 5. Stability of the spine. 6. No advanced osteoporosis or fracture(s). 7. One of the following diagnoses: a. Paraplegia (diagnosis code 344.1). b. Spina bifida, without mention of hydrocephalus, dorsal [thoracic] region (diagnosis code 741.92). c. Spina bifida, without mention of hydrocephalus, lumbar region (diagnosis code 741.93). d. Any related medical condition affecting the spine.

1.

Cardiopulmonary integrity.

2.

That no other orthosis will meet the patient's medical need(s).

3.

Spinal cord injury level above the third lumbar vertebrae.

4.

No contractures and muscle atrophy that would preclude the use of the reciprocating gait orthosis.

5.

Stability of the spine.

6.

No advanced osteoporosis or fracture(s).

7.

One of the following diagnoses: a. Paraplegia (diagnosis code 344.1). b. Spina bifida, without

mention of hydrocephalus, dorsal [thoracic] region (diagnosis code 741.92). c. Spina bifida, without mention of hydrocephalus, lumbar region (diagnosis code 741.93). d. Any related medical condition affecting the spine.

a.

Paraplegia (diagnosis code 344.1).

b.

Spina bifida, without mention of hydrocephalus, dorsal [thoracic] region (diagnosis code 741.92).

c.

Spina bifida, without mention of hydrocephalus, lumbar region (diagnosis code 741.93).

d.

Any related medical condition affecting the spine.

(D)

For patients 21 years of age and older, in addition to the documentation requirements specified in subsection (j)(9)(C)1. through 7., all of the following shall also be documented in the patient's medical record: 1. Plantigrade feet. 2. Minimal contractures in the knees and hips. 3. Flexible hips without rigidity or spasticity. 4. Good upper extremity strength. 5. Realistic goals and expectations and a family or other support system.

1.

Plantigrade feet.

2.

Minimal contractures in the knees and hips.

3.

Flexible hips without rigidity or spasticity.

4.

Good upper extremity strength.

5.

Realistic goals and expectations and a family or other support system.

(10)

(A) Orthotic Devices -- Lower Limb (Extremity) (Additions to Lower Extremity Orthoses) shall include all of the following: 1. Additions to Fracture Orthoses. 2. Additions to Lower Extremity Orthoses: Shoe-Ankle-Shin-Knee. 3. Additions to Straight Knee or Offset Knee Joints (Knee Joints). 4. Additions: Thigh-Weight Bearing -- Gluteal/Ischial Weight Bearing. 5. Additions: Pelvic and Thoracic Control. 6. Additions: General. 7. Custom Foot Orthoses. (B) Shall be authorized when all of the following criteria are met, appropriate to the requested procedure code(s): 1. The patient's medical condition requires the specific function for which the addition(s) was designed. 2. The addition(s) is required by the patient to improve the functionality of the lower extremity orthosis, without which the patient's medical need(s) would not be met. 3. The patient has an existing or authorized lower extremity orthosis that is compatible with the addition(s). (C) In addition to the criteria specified in paragraph (B) above, paragraph (A)7. (Custom Foot Orthoses) shall be authorized when the orthosis is fabricated for a patient using the patient's individual measurements or pattern. This fabrication shall be constructed using a plaster casting of the patient's foot to create a mold, or with a three-dimensional negative impression or digital scanning (Computer-Aided Design/Computer Aided Manufacture Model [CAD/CAM]). The use of foam boxes shall not be an acceptable fabrication method.

(A)

Orthotic Devices -- Lower Limb (Extremity) (Additions to Lower Extremity Orthoses) shall include all of the following: 1. Additions to Fracture Orthoses. 2. Additions to Lower Extremity Orthoses: Shoe-Ankle-Shin-Knee. 3. Additions to Straight Knee or Offset Knee Joints (Knee Joints). 4. Additions: Thigh-Weight Bearing -- Gluteal/Ischial Weight Bearing. 5. Additions: Pelvic and Thoracic Control. 6. Additions: General. 7. Custom Foot Orthoses.

1.

Additions to Fracture Orthoses.

2.

Additions to Lower Extremity Orthoses: Shoe-Ankle-Shin-Knee.

3.

Additions to Straight Knee or Offset Knee Joints (Knee Joints).

4.

Additions: Thigh-Weight Bearing -- Gluteal/Ischial Weight Bearing.

5.

Additions: Pelvic and Thoracic Control.

6.

Additions: General.

7.

Custom Foot Orthoses.

(B)

Shall be authorized when all of the following criteria are met, appropriate to the requested procedure code(s): 1. The patient's medical condition requires the specific function for which the addition(s) was designed. 2. The addition(s) is required by the patient to improve the functionality of the lower extremity orthosis, without which the patient's medical need(s) would not be met. 3. The patient has an existing or authorized lower extremity orthosis that is compatible with the addition(s).

1.

The patient's medical condition requires the specific function for which the addition(s) was designed.

2.

The addition(s) is required by the patient to improve the functionality of the lower extremity orthosis, without which the patient's medical need(s) would not be met.

3.

The patient has an existing or authorized lower extremity orthosis that is compatible with the addition(s).

(C)

In addition to the criteria specified in paragraph (B) above, paragraph (A)7. (Custom Foot Orthoses) shall be authorized when the orthosis is fabricated for a patient using the patient's individual measurements or pattern. This fabrication shall be constructed using a plaster casting of the patient's foot to create a mold, or with a three-dimensional negative impression or digital scanning (Computer-Aided Design/Computer Aided Manufacture Model [CAD/CAM]). The use of foam boxes shall not be an acceptable fabrication method.

(k)

Orthopedic Shoes shall include all of the following: (1) Hallux-Valgus Splint shall be authorized when the patient has a medical condition of the foot that requires a custom fitted orthosis to hold the big toe in the proper anatomical position. (2) Abduction and Rotation Bars shall be authorized when the patient has a medical condition of the foot (feet) that requires one or both of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s): (A) Increased internal or external rotation of the foot (feet). (B) Independent positioning of the hind foot and forefoot for adduction or abduction. (3) Orthopedic Footwear shall include both of the following: (A) Stock Orthopedic Shoes and Stock Conventional Shoes shall include in-depth shoes, and shall be authorized when both of the following criteria are met: 1. At least one of the shoes is attached to a prosthesis or brace. For purposes of this subsection, the following definitions shall apply: a. A "brace" means an orthosis involving the foot that extends above the ankle and is made of metal or other durable rigid material that immobilizes, restricts movement in a

given direction, controls mobility, assists with movement, reduces weight-bearing forces or holds body parts in the correct position. b. "Attached to a prosthesis or brace" means the prosthesis or brace is permanently affixed to the shoe as an integral part of the shoe. 2. The patient has a medical condition of the foot (feet) that requires one or more of the following treatments, appropriate to the requested procedure code(s): a. Increased pronation or supination of the foot (feet). b. Post surgical footwear to allow for changes in volume of the foot (feet). c. A shoe that holds the heel firmly in place. d. A firm heel counter and a strong shank. e. Accommodation of a deformed foot (feet) or a foot orthosis(es). f. Footwear to allow for changes in volume, fractures, amputation or ulcers of the foot (feet). (B) Custom-Made Orthopedic Shoes shall include both the base shoe(s) and any required addition(s) to the base shoe(s):1. The base shoe(s) shall be authorized when both of the following criteria are met: a. The patient does not require a shoe(s) provided under the diabetic footwear program covered under subsection (a), but has a medical need(s) that cannot be met by modification(s) to a stock orthopedic or stock conventional shoe(s) covered under subsections (k)(3)(A) and (k)(4). The prescribing practitioner shall document the nature, cause and severity of the foot problem(s) that substantiates the requirement for a custom-made shoe(s), such as one of the following medical conditions: i. Charcot or rheumatoid foot deformities. ii. Partial foot amputation. iii. Post muscle flap surgery to cover a large or unusual soft tissue foot defect. iv. A related medical condition that requires a custom-made orthopedic shoe(s), b. The patient's medical condition of the foot (feet) requires one or more of the following accommodations, appropriate to the requested procedure code(s):i. A severely deformed foot (feet). ii. A toe or distal partial foot amputation. iii. A sensitive foot (feet), or a pressure sore(s) or area(s). iv. A related foot condition. 2. The base shoe(s) shall be

authorized when it has all of the following characteristics: a. Made and molded to the patient model for a specific patient. b. Constructed over a positive model of the patient's foot. c. Made from leather or other suitable material of equal or better quality. d. Has removable inserts as an integral part of the shoe that can be altered or replaced as the patient's condition warrants. e. Has some form of shoe closure. 3. The addition(s) to the base shoe shall be authorized when all of the following criteria are met:a. The patient's medical condition requires the specific function for which the addition(s) was designed. b. The addition(s) is required by the patient to improve the functionality of the custom-made orthopedic shoe(s), without which the patient's medical need(s) would not be met. c. The patient has an existing or authorized custom-made orthopedic shoe(s) that is compatible with the addition(s). (4) Shoe Modifications of Stock Orthopedic Shoes and Stock Conventional Shoes, including additions, modifications and services:(A) Shall include all of the following:1. Shoe Modifications -- Lifts. 2. Shoe Modifications -- Wedges. 3. Shoe Modifications -- Heels. 4. Orthopedic Shoe Additions. 5. Transfer or Replacement. For purposes of subsection (k)(4), the terms "Transfer" and "Replacement" mean standard laboratory procedures for general shoe work for the purpose of transfer and fixation of an orthosis from one shoe to another. (B) Shall be authorized when all of the following criteria are met: 1. The patient's medical condition requires the specific function for which the addition(s), modification(s) or service(s) was designed. 2. The addition(s), modification(s) or service(s) is required by the patient to improve the functionality of the shoe(s), without which the patient's medical need(s) would not be met. 3. The patient has an existing or authorized shoe(s) that is compatible with the addition(s), modification(s) or service(s).

(1)

Hallux-Valgus Splint shall be authorized when the patient has a medical condition of the foot that requires a custom fitted orthosis to hold the big toe in the proper anatomical position.

(2)

Abduction and Rotation Bars shall be authorized when the patient has a medical condition of the foot (feet) that requires one or both of the following treatments to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s): (A) Increased internal or external rotation of the foot (feet). (B) Independent positioning of the hind foot and forefoot for adduction or abduction.

(A)

Increased internal or external rotation of the foot (feet).

(B)

Independent positioning of the hind foot and forefoot for adduction or abduction.

(3)

Orthopedic Footwear shall include both of the following: (A) Stock Orthopedic Shoes and Stock Conventional Shoes shall include in-depth shoes, and shall be authorized when both of the following criteria are met: 1. At least one of the shoes is attached to a prosthesis or brace. For purposes of this subsection, the following definitions shall apply: a. A "brace" means an orthosis involving the foot that extends above the ankle and is made of metal or other durable rigid material that immobilizes, restricts movement in a given direction, controls mobility, assists with movement, reduces weight-bearing forces or holds body parts in the correct position. b. "Attached to a prosthesis or brace" means the prosthesis or brace is permanently affixed to the shoe as an integral part of the shoe. 2. The patient has a medical condition of the foot (feet) that requires one or more of the following treatments, appropriate to the requested

procedure code(s): a. Increased pronation or supination of the foot (feet). b. Post surgical footwear to allow for changes in volume of the foot (feet). c. A shoe that holds the heel firmly in place. d. A firm heel counter and a strong shank. e. Accommodation of a deformed foot (feet) or a foot orthosis(es). f. Footwear to allow for changes in volume, fractures, amputation or ulcers of the foot (feet). (B) Custom-Made Orthopedic Shoes shall include both the base shoe(s) and any required addition(s) to the base shoe(s):1. The base shoe(s) shall be authorized when both of the following criteria are met: a. The patient does not require a shoe(s) provided under the diabetic footwear program covered under subsection (a), but has a medical need(s) that cannot be met by modification(s) to a stock orthopedic or stock conventional shoe(s) covered under subsections (k)(3)(A) and (k)(4). The prescribing practitioner shall document the nature, cause and severity of the foot problem(s) that substantiates the requirement for a custom-made shoe(s), such as one of the following medical conditions: i. Charcot or rheumatoid foot deformities. ii. Partial foot amputation. iii. Post muscle flap surgery to cover a large or unusual soft tissue foot defect. iv. A related medical condition that requires a custom-made orthopedic shoe(s), b. The patient's medical condition of the foot (feet) requires one or more of the following accommodations, appropriate to the requested procedure code(s):i. A severely deformed foot (feet). ii. A toe or distal partial foot amputation. iii. A sensitive foot (feet), or a pressure sore(s) or area(s). iv. A related foot condition. 2. The base shoe(s) shall be authorized when it has all of the following characteristics: a. Made and molded to the patient model for a specific patient. b. Constructed over a positive model of the patient's foot. c. Made from leather or other suitable material of equal or better quality. d. Has removable inserts as an integral part of the shoe that can be altered or replaced as the patient's condition warrants. e. Has some form of shoe closure. 3. The addition(s) to the base shoe shall be authorized when all of the following criteria are met:a. The patient's medical condition requires the

specific function for which the addition(s) was designed. b. The addition(s) is required by the patient to improve the functionality of the custom-made orthopedic shoe(s), without which the patient's medical need(s) would not be met. c. The patient has an existing or authorized custom-made orthopedic shoe(s) that is compatible with the addition(s).

(A)

Stock Orthopedic Shoes and Stock Conventional Shoes shall include in-depth shoes, and shall be authorized when both of the following criteria are met: 1. At least one of the shoes is attached to a prosthesis or brace. For purposes of this subsection, the following definitions shall apply: a. A "brace" means an orthosis involving the foot that extends above the ankle and is made of metal or other durable rigid material that immobilizes, restricts movement in a given direction, controls mobility, assists with movement, reduces weight-bearing forces or holds body parts in the correct position. b. "Attached to a prosthesis or brace" means the prosthesis or brace is permanently affixed to the shoe as an integral part of the shoe. 2. The patient has a medical condition of the foot (feet) that requires one or more of the following treatments, appropriate to the requested procedure code(s): a. Increased pronation or supination of the foot (feet). b. Post surgical footwear to allow for changes in volume of the foot (feet). c. A shoe that holds the heel firmly in place. d. A firm heel counter and a strong shank. e. Accommodation of a deformed foot (feet) or a foot orthosis(es). f. Footwear to allow for changes in volume, fractures, amputation or ulcers of the foot (feet).

1.

At least one of the shoes is attached to a prosthesis or brace. For purposes of this subsection, the following definitions shall apply: a. A "brace" means an orthosis involving the foot that extends above the ankle and is made of metal or other durable rigid material that immobilizes, restricts movement in a given direction, controls mobility, assists with movement, reduces weight-bearing forces or holds body parts in the correct position. b. "Attached to a prosthesis or brace" means the

prosthesis or brace is permanently affixed to the shoe as an integral part of the shoe.

a.

A "brace" means an orthosis involving the foot that extends above the ankle and is made of metal or other durable rigid material that immobilizes, restricts movement in a given direction, controls mobility, assists with movement, reduces weight-bearing forces or holds body parts in the correct position.

b.

"Attached to a prosthesis or brace" means the prosthesis or brace is permanently affixed to the shoe as an integral part of the shoe.

2.

The patient has a medical condition of the foot (feet) that requires one or more of the following treatments, appropriate to the requested procedure code(s): a. Increased pronation or supination of the foot (feet). b. Post surgical footwear to allow for changes in volume of the foot (feet). c. A shoe that holds the heel firmly in place. d. A firm heel counter and a strong shank. e. Accommodation of a deformed foot (feet) or a foot orthosis(es). f. Footwear to allow for changes in volume, fractures, amputation or ulcers of the foot (feet).

a.

Increased pronation or supination of the foot (feet).

b.

Post surgical footwear to allow for changes in volume of the foot (feet).

c.

A shoe that holds the heel firmly in place.

d.

A firm heel counter and a strong shank.

e.

Accommodation of a deformed foot (feet) or a foot orthosis(es).

f.

(B)

Custom-Made Orthopedic Shoes shall include both the base shoe(s) and any required addition(s) to the base shoe(s):1. The base shoe(s) shall be authorized when both of the following criteria are met: a. The patient does not require a shoe(s) provided under the diabetic footwear program covered under subsection (a), but has a medical need(s) that cannot be met by modification(s) to a stock orthopedic or stock conventional shoe(s) covered under subsections (k)(3)(A) and (k)(4). The prescribing practitioner shall document the nature, cause and severity of the foot problem(s) that substantiates the requirement for a custom-made shoe(s), such as one of the following medical conditions: i. Charcot or rheumatoid foot deformities. ii. Partial foot amputation. iii. Post muscle flap surgery to cover a large or unusual soft tissue foot defect. iv. A related medical condition that requires a custom-made orthopedic shoe(s), b. The patient's medical condition of the foot (feet) requires one or more of the following accommodations, appropriate to the requested procedure code(s):i. A severely deformed foot (feet). ii. A toe or distal partial foot amputation. iii. A sensitive foot (feet), or a pressure sore(s) or area(s). iv. A related foot condition. 2. The base shoe(s) shall be authorized when it has all of the following characteristics: a. Made and molded to the patient model for a specific patient. b. Constructed over a positive model of the patient's foot. c. Made from leather or other suitable material of equal or better quality. d. Has removable inserts as an integral part of the shoe that can be altered or replaced as the patient's condition warrants. e. Has some form of shoe closure. 3. The addition(s) to the base shoe shall be authorized when all of the following criteria are met:a. The patient's medical condition requires the specific function for which the addition(s) was designed. b. The addition(s) is required by the patient to improve the functionality of the custom-made orthopedic shoe(s), without which the patient's medical need(s) would not be met. c. The patient has an existing or authorized custom-made orthopedic shoe(s) that is compatible with

the addition(s).

1.

The base shoe(s) shall be authorized when both of the following criteria are met: a. The patient does not require a shoe(s) provided under the diabetic footwear program covered under subsection (a), but has a medical need(s) that cannot be met by modification(s) to a stock orthopedic or stock conventional shoe(s) covered under subsections (k)(3)(A) and (k)(4). The prescribing practitioner shall document the nature, cause and severity of the foot problem(s) that substantiates the requirement for a custom-made shoe(s), such as one of the following medical conditions: i. Charcot or rheumatoid foot deformities. ii. Partial foot amputation. iii. Post muscle flap surgery to cover a large or unusual soft tissue foot defect. iv. A related medical condition that requires a custom-made orthopedic shoe(s), b. The patient's medical condition of the foot (feet) requires one or more of the following accommodations, appropriate to the requested procedure code(s):i. A severely deformed foot (feet). ii. A toe or distal partial foot amputation. iii. A sensitive foot (feet), or a pressure sore(s) or area(s). iv. A related foot condition.

a.

The patient does not require a shoe(s) provided under the diabetic footwear program covered under subsection (a), but has a medical need(s) that cannot be met by modification(s) to a stock orthopedic or stock conventional shoe(s) covered under subsections (k)(3)(A) and (k)(4). The prescribing practitioner shall document the nature, cause and severity of the foot problem(s) that substantiates the requirement for a custom-made shoe(s), such as one of the following medical conditions: i. Charcot or rheumatoid foot deformities. ii. Partial foot amputation. iii. Post muscle flap surgery to cover a large or unusual soft tissue foot defect. iv. A related medical condition that requires a custom-made orthopedic shoe(s),

i.

Charcot or rheumatoid foot deformities.

ii.

Partial foot amputation.

iii.

Post muscle flap surgery to cover a large or unusual soft tissue foot defect.

iv.

A related medical condition that requires a custom-made orthopedic shoe(s),

b.

The patient's medical condition of the foot (feet) requires one or more of the following accommodations, appropriate to the requested procedure code(s):i. A severely deformed foot (feet). ii. A toe or distal partial foot amputation. iii. A sensitive foot (feet), or a pressure sore(s) or area(s). iv. A related foot condition.

i.

A severely deformed foot (feet).

ii.

A toe or distal partial foot amputation.

iii.

A sensitive foot (feet), or a pressure sore(s) or area(s).

iv.

A related foot condition.

2.

The base shoe(s) shall be authorized when it has all of the following characteristics: a. Made and molded to the patient model for a specific patient. b. Constructed over a positive model of the patient's foot. c. Made from leather or other suitable material of equal or better quality. d. Has removable inserts as an integral part of the shoe that can be altered or replaced as the patient's condition warrants. e. Has some form of shoe closure.

a.

Made and molded to the patient model for a specific patient.

b.

Constructed over a positive model of the patient's foot.

c.

Made from leather or other suitable material of equal or better quality.

d.

Has removable inserts as an integral part of the shoe that can be altered or replaced as the patient's condition warrants.

e.

Has some form of shoe closure.

3.

The addition(s) to the base shoe shall be authorized when all of the following criteria are met:a. The patient's medical condition requires the specific function for which the addition(s) was designed. b. The addition(s) is required by the patient to improve the functionality of the custom-made orthopedic shoe(s), without which the patient's medical need(s) would not be met. c. The patient has an existing or authorized custom-made orthopedic shoe(s) that is compatible with the addition(s).

a.

The patient's medical condition requires the specific function for which the addition(s) was designed.

b.

The addition(s) is required by the patient to improve the functionality of the custom-made orthopedic shoe(s), without which the patient's medical need(s) would not be met.

c.

The patient has an existing or authorized custom-made orthopedic shoe(s) that is compatible with the addition(s).

(4)

Shoe Modifications of Stock Orthopedic Shoes and Stock Conventional Shoes, including additions, modifications and services:(A) Shall include all of the following:1. Shoe Modifications -- Lifts. 2. Shoe Modifications -- Wedges. 3. Shoe Modifications -- Heels. 4. Orthopedic Shoe Additions. 5. Transfer or Replacement. For purposes of subsection

(k)(4), the terms "Transfer" and "Replacement" mean standard laboratory procedures for general shoe work for the purpose of transfer and fixation of an orthosis from one shoe to another. (B) Shall be authorized when all of the following criteria are met: 1. The patient's medical condition requires the specific function for which the addition(s), modification(s) or service(s) was designed. 2. The addition(s), modification(s) or service(s) is required by the patient to improve the functionality of the shoe(s), without which the patient's medical need(s) would not be met. 3. The patient has an existing or authorized shoe(s) that is compatible with the addition(s), modification(s) or service(s).

(A)

Shall include all of the following:1. Shoe Modifications -- Lifts. 2. Shoe Modifications -- Wedges. 3. Shoe Modifications -- Heels. 4. Orthopedic Shoe Additions. 5. Transfer or Replacement. For purposes of subsection (k)(4), the terms "Transfer" and "Replacement" mean standard laboratory procedures for general shoe work for the purpose of transfer and fixation of an orthosis from one shoe to another.

1.

Shoe Modifications -- Lifts.

2.

Shoe Modifications -- Wedges.

3.

Shoe Modifications -- Heels.

4.

Orthopedic Shoe Additions.

5.

Transfer or Replacement. For purposes of subsection (k)(4), the terms "Transfer" and "Replacement" mean standard laboratory procedures for general shoe work for the purpose of transfer and fixation of an orthosis from one shoe to another.

(B)

Shall be authorized when all of the following criteria are met: 1. The patient's medical condition requires the specific function for which the addition(s), modification(s) or service(s) was designed. 2. The addition(s), modification(s) or service(s) is required by the patient to improve the functionality of the shoe(s), without which the patient's medical need(s) would not be met. 3. The patient has an existing or authorized shoe(s) that is compatible with the addition(s), modification(s) or service(s).

1.

The patient's medical condition requires the specific function for which the addition(s), modification(s) or service(s) was designed.

2.

The addition(s), modification(s) or service(s) is required by the patient to improve the functionality of the shoe(s), without which the patient's medical need(s) would not be met.

3.

The patient has an existing or authorized shoe(s) that is compatible with the addition(s), modification(s) or service(s).

(I)

Orthotic Devices -- Upper Limb shall include all of the following:(1) Shoulder Orthoses shall be authorized when the patient has a medical condition of, or affecting the shoulder joint that requires that the shoulder be held in place to prevent or limit motion in order to protect the shoulder joint from injury or provide support/stabilization during functional activities. (2) Elbow Orthoses shall include elbow orthoses, elbow-wrist-hand orthoses and elbow-wrist-hand-finger orthoses, and shall be authorized when the patient has a medical condition of, or affecting the elbow, wrist, hand or finger joint(s) that requires support, stabilization, restriction or enhancement of movement of the elbow, wrist, hand or finger joint(s)

to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s). (3) Wrist-Hand-Finger Orthoses shall be authorized when the patient has a medical condition of, or affecting the wrist, hand or finger(s) that requires support, stabilization, restriction or enhancement of movement of the wrist, hand or finger(s) to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s). (4) Additions to Upper Limb Orthoses shall be authorized when all of the following criteria are met: (A) The patient's medical condition requires the specific function for which the addition(s) was designed. (B) The addition(s) is required by the patient to improve the functionality of the upper extremity wrist, finger or elbow joint(s), without which the patient's medical need(s) would not be met. (C) The patient has an existing or authorized upper extremity orthosis that is compatible with the addition(s). (5) Dynamic Flexor Hinge, Reciprocal Wrist Extension/Flexion, Finger Flexion/Extension Orthoses shall be authorized when the patient has a medical condition of, or affecting the wrist, hand or finger(s) that requires a custom-made orthosis to hold the hand, finger or wrist in a prescribed position and to enhance and control movement of the hand, finger or wrist. (6) External Power shall be authorized when both of the following criteria are met:(A) The patient has a medical condition of, or affecting the wrist, hand or finger(s) that requires a custom-made, electrically powered wrist-hand-finger orthosis to allow effective movement of the wrist, hand or finger(s) in the performance of activities of daily living or instrumental activities of daily living. (B) The patient is not able to otherwise effectively use a manually operated orthosis. (7) Other Wrist-Hand-Finger Orthoses -- Custom Fitted shall include both of the following: (A) Custom Fitted Wrist-Hand-Finger Orthoses shall be authorized when the patient has a medical

condition of, or affecting the wrist, hand or finger(s) that requires a custom-fitted orthosis to provide support, stabilization, restriction or enhancement of movement of the wrist, hand or finger(s), appropriate to the requested procedure code(s). (B) Addition of a joint(s) to an upper extremity orthosis shall be authorized when all of the following criteria are met:1. The patient has a medical condition that requires the specific function for which the joint(s) was designed. 2. The joint(s) is required by the patient to improve the functionality of the upper extremity orthosis, without which the patient's medical need(s) would not be met. 3. The patient has an existing or authorized upper extremity orthosis that is compatible with the joint(s).

(1)

Shoulder Orthoses shall be authorized when the patient has a medical condition of, or affecting the shoulder joint that requires that the shoulder be held in place to prevent or limit motion in order to protect the shoulder joint from injury or provide support/stabilization during functional activities.

(2)

Elbow Orthoses shall include elbow orthoses, elbow-wrist-hand orthoses and elbow-wrist-hand-finger orthoses, and shall be authorized when the patient has a medical condition of, or affecting the elbow, wrist, hand or finger joint(s) that requires support, stabilization, restriction or enhancement of movement of the elbow, wrist, hand or finger joint(s) to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s).

(3)

Wrist-Hand-Finger Orthoses shall be authorized when the patient has a medical condition of, or affecting the wrist, hand or finger(s) that requires support, stabilization, restriction or enhancement of movement of the wrist, hand or finger(s) to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury,

appropriate to the requested procedure code(s).

(4)

Additions to Upper Limb Orthoses shall be authorized when all of the following criteria are met: (A) The patient's medical condition requires the specific function for which the addition(s) was designed. (B) The addition(s) is required by the patient to improve the functionality of the upper extremity wrist, finger or elbow joint(s), without which the patient's medical need(s) would not be met. (C) The patient has an existing or authorized upper extremity orthosis that is compatible with the addition(s).

(A)

The patient's medical condition requires the specific function for which the addition(s) was designed.

(B)

The addition(s) is required by the patient to improve the functionality of the upper extremity wrist, finger or elbow joint(s), without which the patient's medical need(s) would not be met.

(C)

The patient has an existing or authorized upper extremity orthosis that is compatible with the addition(s).

(5)

Dynamic Flexor Hinge, Reciprocal Wrist Extension/Flexion, Finger Flexion/Extension Orthoses shall be authorized when the patient has a medical condition of, or affecting the wrist, hand or finger(s) that requires a custom-made orthosis to hold the hand, finger or wrist in a prescribed position and to enhance and control movement of the hand, finger or wrist.

(6)

External Power shall be authorized when both of the following criteria are met:(A) The patient has a medical condition of, or affecting the wrist, hand or finger(s) that requires

a custom-made, electrically powered wrist-hand-finger orthosis to allow effective movement of the wrist, hand or finger(s) in the performance of activities of daily living or instrumental activities of daily living. (B) The patient is not able to otherwise effectively use a manually operated orthosis.

(A)

The patient has a medical condition of, or affecting the wrist, hand or finger(s) that requires a custom-made, electrically powered wrist-hand-finger orthosis to allow effective movement of the wrist, hand or finger(s) in the performance of activities of daily living or instrumental activities of daily living.

(B)

The patient is not able to otherwise effectively use a manually operated orthosis.

(7)

Other Wrist-Hand-Finger Orthoses -- Custom Fitted shall include both of the following: (A) Custom Fitted Wrist-Hand-Finger Orthoses shall be authorized when the patient has a medical condition of, or affecting the wrist, hand or finger(s) that requires a custom-fitted orthosis to provide support, stabilization, restriction or enhancement of movement of the wrist, hand or finger(s), appropriate to the requested procedure code(s). (B) Addition of a joint(s) to an upper extremity orthosis shall be authorized when all of the following criteria are met:1. The patient has a medical condition that requires the specific function for which the joint(s) was designed. 2. The joint(s) is required by the patient to improve the functionality of the upper extremity orthosis, without which the patient's medical need(s) would not be met. 3. The patient has an existing or authorized upper extremity orthosis that is compatible with the joint(s).

(A)

Custom Fitted Wrist-Hand-Finger Orthoses shall be authorized when the patient has a medical condition of, or affecting the wrist, hand or finger(s) that requires a custom-fitted orthosis to

provide support, stabilization, restriction or enhancement of movement of the wrist, hand or finger(s), appropriate to the requested procedure code(s).

(B)

Addition of a joint(s) to an upper extremity orthosis shall be authorized when all of the following criteria are met:1. The patient has a medical condition that requires the specific function for which the joint(s) was designed. 2. The joint(s) is required by the patient to improve the functionality of the upper extremity orthosis, without which the patient's medical need(s) would not be met. 3. The patient has an existing or authorized upper extremity orthosis that is compatible with the joint(s).

1.

The patient has a medical condition that requires the specific function for which the joint(s) was designed.

2.

The joint(s) is required by the patient to improve the functionality of the upper extremity orthosis, without which the patient's medical need(s) would not be met.

3.

The patient has an existing or authorized upper extremity orthosis that is compatible with the joint(s).

(m)

Shoulder-Elbow-Wrist-Hand Orthoses shall include all of the following:(1) Abduction Position, Custom Fitted Orthoses shall be authorized when both of the following criteria are met:(A) The patient has a medical condition of, or affecting the shoulder, elbow, wrist or hand, such as one of the following:1. Post surgery of the shoulder, elbow or wrist joint(s). 2. Treatment of Erbs Palsy. 3. A related medical condition of the shoulder, elbow or wrist joints. (B) The patient requires a custom-fitted orthosis to provide positioning, stabilization or restriction of

movement of the shoulder, elbow, wrist or hand, appropriate to the requested procedure code(s). (2) Mobile Arm Supports shall be authorized when the patient meets the criteria specified in paragraph (1) above and requires such support attached to a wheelchair, chair or table. (3) Additions to Mobile Arm Supports shall include both additions and adaptations to the mobile arm support or the addition(s), and shall be authorized when all of the following criteria are met:(A) The patient's medical condition requires the specific function for which the addition(s) or adaptation(s) was designed. (B) The addition(s) or adaptation(s) is required by the patient to improve the functionality of the mobile arm support, without which the patient's medical or functional need(s) would not be met. (C) The patient has an existing or authorized mobile arm support that is compatible with the addition(s) or adaptation(s). (4) Fracture Orthoses shall be authorized when the patient has a fracture of the upper extremity and requires support and stabilization of the fracture site to facilitate healing, to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s).

(1)

Abduction Position, Custom Fitted Orthoses shall be authorized when both of the following criteria are met:(A) The patient has a medical condition of, or affecting the shoulder, elbow, wrist or hand, such as one of the following:1. Post surgery of the shoulder, elbow or wrist joint(s). 2. Treatment of Erbs Palsy. 3. A related medical condition of the shoulder, elbow or wrist joints. (B) The patient requires a custom-fitted orthosis to provide positioning, stabilization or restriction of movement of the shoulder, elbow, wrist or hand, appropriate to the requested procedure code(s).

(A)

The patient has a medical condition of, or affecting the shoulder, elbow, wrist or hand, such as

one of the following:1. Post surgery of the shoulder, elbow or wrist joint(s). 2. Treatment of Erbs Palsy. 3. A related medical condition of the shoulder, elbow or wrist joints.

1.

Post surgery of the shoulder, elbow or wrist joint(s).

2.

Treatment of Erbs Palsy.

3.

A related medical condition of the shoulder, elbow or wrist joints.

(B)

The patient requires a custom-fitted orthosis to provide positioning, stabilization or restriction of movement of the shoulder, elbow, wrist or hand, appropriate to the requested procedure code(s).

(2)

Mobile Arm Supports shall be authorized when the patient meets the criteria specified in paragraph (1) above and requires such support attached to a wheelchair, chair or table.

(3)

Additions to Mobile Arm Supports shall include both additions and adaptations to the mobile arm support or the addition(s), and shall be authorized when all of the following criteria are met:(A) The patient's medical condition requires the specific function for which the addition(s) or adaptation(s) was designed. (B) The addition(s) or adaptation(s) is required by the patient to improve the functionality of the mobile arm support, without which the patient's medical or functional need(s) would not be met. (C) The patient has an existing or authorized mobile arm support that is compatible with the addition(s) or adaptation(s).

(A)

The patient's medical condition requires the specific function for which the addition(s) or

adaptation(s) was designed.

(B)

The addition(s) or adaptation(s) is required by the patient to improve the functionality of the mobile arm support, without which the patient's medical or functional need(s) would not be met.

(C)

The patient has an existing or authorized mobile arm support that is compatible with the addition(s) or adaptation(s).

(4)

Fracture Orthoses shall be authorized when the patient has a fracture of the upper extremity and requires support and stabilization of the fracture site to facilitate healing, to decrease pain, to increase functional capacity, or to prevent or ameliorate further injury, appropriate to the requested procedure code(s).

(n)

Repairs for orthotic appliances shall include repairs, maintenance, replacements and associated labor, and shall be authorized when all of the following criteria are met:(1) The patient has an existing orthosis that requires repair, maintenance or replacement. (2) The repair, maintenance or replacement cost(s), including the associated labor is less than the cost(s) of purchasing a new orthotic appliance. (3) The request or claim includes a list of the components to be repaired or replaced and a statement explaining the necessity for the repair or replacement.

(1)

The patient has an existing orthosis that requires repair, maintenance or replacement.

(2)

The repair, maintenance or replacement cost(s), including the associated labor is less than the cost(s) of purchasing a new orthotic appliance.

(3)

The request or claim includes a list of the components to be repaired or replaced and a statement explaining the necessity for the repair or replacement.

(o)

Ancillary Orthotic Devices shall be authorized when the patient has a medical condition that requires an upper or lower extremity orthosis not otherwise covered under this section to provide support and positioning to an upper or lower extremity joint(s), appropriate to the requested procedure code(s).

(p)

Trusses shall be authorized when the patient has an abdominal hernia or a similar deformity or disease and requires a truss to reduce the hernia.