

Orthotic and Prosthetic Appliances

This section contains information about Orthotic and Prosthetic (O&P) appliances and program coverage (*California Code of Regulations*, [CCR], Title 22, Section 51315). For additional help, refer to the *Orthotic and Prosthetic Appliances: Billing Examples* section of this manual.

Note: Per Title 22, *California Code of Regulations*, Section 51321(g): Authorization for durable medical equipment shall be limited to the lowest cost item that meets the patient's medical needs.

Program Coverage

Medi-Cal covers O&P appliances when such appliances are necessary for the restoration of function or replacement of body parts, as prescribed in writing by physicians, podiatrists or dentists within the scope of their license. Charges for shipping and handling are not reimbursable.

Eligibility Requirements

For providers to receive reimbursement, a recipient must be Medi-Cal or California Children's Services (CCS) – eligible on the date of service.

Provider Types Authorized to Bill for O&P Appliances

The only provider types authorized to furnish and bill for O&P appliances are orthotists, as defined in CCR, Title 22, Section 51101; prosthetists, as defined in Section 51103; physicians, as defined in Section 51053; podiatrists, as defined in Section 51075, acting within the scope of their practice; and California Children's Services providers. Appliances listed in the *Orthotic and Prosthetic Appliances: Billing Codes and Reimbursement Rates – Orthotics* and *Orthotic and Prosthetic Appliances: Billing Codes and Reimbursement Rates – Prosthetics* sections of this manual and designated by double asterisks (**) may be furnished and billed by pharmacists.

Prescription Requirements

A written prescription by a licensed practitioner is required for all O&P appliances billed to Medi-Cal (CCR, Section 51315[a]). The prescription must be specific to the item(s) billed.

Health care services are limited to those necessary to protect life, prevent significant illness or significant disability or alleviate severe pain. Therefore, prescribed O&P appliances may be covered only as medically necessary to restore bodily functions essential to activities of daily living, prevent significant physical disability or serious deterioration of health or alleviate severe pain.

The practitioner prescribing the items must supply the O&P provider with information required to document the medical necessity for the item(s), according to the above criteria.

Note: The original written prescription should not be attached to the claim but must be kept in the provider's files.

Modifier Requirements

Claims for orthotic and prosthetic appliances require modifier LT (left side) and/or RT (right side), with the exception of the following HCPCS codes that can be billed without modifiers: A6501 – A6503, A6509 – A6511, A6513, A6544, A8002, A8003, L0113, L0121 – L0220, L0450 – L0488, L0490 – L0492, L0621 – L0643, L0648 – L0651, L0700 – L0710, L0810 – L0861, L0960 – L0981, L0983 – L0998, L1000 – L1652, L1690, L1700 – L1730, L1755, L2580, L2627 – L2628, L2640, L3212 – L3214, L4000, L4205, L4210, L7510, L7520, L8000, L8002, L8015, L8310, L8500, L8502 – L8510 and S1040.

Helmet Codes Exception

Prefabricated helmet HCPCS codes A8000 and A8001 must be billed as a purchase (modifier NU) or repair (modifier RB). These items are not rented (modifier RR is not allowed). Replacement interfacing code A8004 must be billed with modifier RB and the claims require documentation that the helmet is owned by the patient.

Repair and Labor

Prosthetic repair and labor HCPCS codes L7510 and L7520 require an LT and/or RT modifier unless the provider indicates in the *Additional Claim Information* field (Box 19) of the claim, or as an attachment, that the repair is not for a limb prosthesis. For code L7510, an invoice copy is required.

Authorization

Authorization is required for O&P services when the cost exceeds specified *Treatment Authorization Request* (TAR) threshold (limits).

A TAR is required each time the cumulative costs of purchase, replacement and repair exceed the amounts listed below per recipient, per provider, per 90-day period:

- Orthotics exceed \$250
- Prosthetics exceed \$500

All TARs for O&P appliances and services must be submitted to the Sacramento Medi-Cal Field Office (SMCFO) for review and processing. Refer to the *TAR Field Office Addresses* section in this manual for more information.

Appliances or Services	Authorization is required for all “unlisted,” “not otherwise specified,” “By Report” and “By Invoice” appliances or services, regardless of the dollar amount involved.
Repair	Repair of an appliance will not be authorized when cost of the repair equals or exceeds the cost of a new appliance.
TAR Requirements	<p>A copy of the written prescription signed by a licensed practitioner functioning within the scope of his/her practice must be submitted with the TAR to the appropriate Medi-Cal field office. In addition to the practitioner’s signature, all of the following information must be provided on the prescription form:</p> <ul style="list-style-type: none">• Name, address and telephone number of the prescribing practitioner• Date of prescription• Item being prescribed• California State license number of the prescribing practitioner <p>The physician should also provide the orthotist or prosthetist with the information listed below. Indicate the number of items needed, especially those that require laundering. Adequate documentation must be submitted with the TAR to justify the prescription, such as:</p> <ul style="list-style-type: none">• Medical diagnosis(es)• Explanation of need and the purpose for the appliance• Duration of medical necessity• Relevant history and physical documenting prior functional level and future anticipated functional level• Date and type of surgery or injury, if applicable• Identity item requested with associated HCPCS code <p>For repair, maintenance or replacement, include clinical documentation with reference to age of the appliance, physical condition of the appliance and the anticipated functional level of the patient.</p> <p>A specific length of time should be indicated, including “permanent” or “lifetime,” when the diagnosis supports such use. For short-term use, the specific number of weeks or months should be stated.</p>
Billing Authorized Items	When billing for items that require authorization, the claim line procedure code and modifier must match the corresponding TAR procedure code and modifier.

Lower Limb Protheses

Lower limb protheses (HCPCS codes L5610 – L5617) are reimbursable only when a referring physician has documented the medical necessity for these types of appliances. Code L5611 is appropriate only for recipients with a medical necessity for “swing phase control,” and is restricted to once per three-year period. The prosthetist must submit a TAR and include documentation that documents the recipient’s functional needs, including the recipient’s:

- Past history, including prior prosthetic use, if applicable;
- Current condition, including status of the residual limb and the nature of other medical problems;
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.

A patient’s functional level must be “1” or higher to qualify for this benefit. Any individual whose functional level is “0” is not a candidate for this type of prosthesis and Medi-Cal coverage will be denied.

Reimbursement

Reimbursement will not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar appliances. When there is no comparable Medicare-reimbursed appliance, reimbursement will not exceed an amount that is the lesser of:

- The amount billed to the general public for the provision of the same or similar appliance; or
- The maximum reimbursement rate as described in this manual

The maximum reimbursement rates apply to the basic appliance and to any component part(s) that may be added to the appliance. When applicable, claims must include both the basic appliance and the component part(s) necessary to complete the prescribed appliance.

For maximum reimbursement rates, refer to the *Orthotic and Prosthetic Appliances: Billing Codes and Reimbursement Rates – Orthotics* and *Orthotic and Prosthetic Appliances: Billing Codes and Reimbursement Rates – Prosthetics* sections of this manual.

Separate reimbursement will not be made for fitting, measuring, training or delivery of an appliance.

Pharmacists May Supply Selected Devices	Licensed pharmacists and pharmacies enrolled as Medi-Cal providers may be reimbursed by Medi-Cal for O&P devices as designated by double asterisks (**) in the orthotic and prosthetic appliances billing codes and reimbursement rates sections of this manual.
Claim Form	Pharmacists must bill these selected O&P appliances on the CMS-1500 claim form, not the <i>Pharmacy Claim Form</i> (30-1).
Repair or Maintenance of O&P	<p>Repair or maintenance of orthotic and prosthetic appliances is billed with the following HCPCS codes:</p> <p style="margin-left: 40px;">Orthotics: L4205 (labor) L4210 (parts)</p> <p style="margin-left: 40px;">Prosthetics: L7520 (labor) L7510 (parts)</p>
Labor	<p>Claims for labor (HCPCS code L4205 or L7520) require the following information:</p> <ul style="list-style-type: none"> • Description of the service provided • Reason/justification for repair • Labor time to accomplish the work (HCPCS codes L4205 and L7520 are billed in 15-minute units, but labor time may be rounded to the nearest half hour for the <u>total</u> repair job. For example, 1 hour and 20 minutes = 6 units.) • Labor rate or hourly charge
Labor Rate	HCPCS codes L4205 (orthotics) and L7520 (prosthetics) are reimbursed in 15-minute units at \$16.47 per unit. The hourly labor reimbursement rate for repair is \$65.88. Codes L4205 and L7520 may be billed up to a maximum of three hours (12 units) of labor time, without medical justification and authorization. Important information about limits for billing these codes is located under the “Authorization” heading in this section.
Replacement Parts	<p>Claims for replacement parts (HCPCS codes L4210 and L7510) require the following information:</p> <ul style="list-style-type: none"> • Description of the service provided • Reason/justification for repair (for code L7510, “not a limb prosthesis repair” must be indicated, when necessary) • An invoice copy

Custom Fabricated Orthotics

A custom fabricated item is one that is individually made for a specific patient. No other patient would be able to use this item. A custom fabricated item is a device, which is fabricated based on clinically derived and rectified castings, tracings, measurements, and/or other images (such as X-rays) of the body part. The fabrication may involve using calculations, templates, and components. This process requires the use of basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of uncut or unshaped sheets, bars, or other basic forms and involves substantial work such as vacuum forming, cutting, bending, molding, sewing, drilling and finishing prior to fitting on the patient.

Custom-Made Items

Claims for custom, in-house manufactured items must include a list of materials and the wholesale prices. If parts are ordered from a manufacturer and modified by adding other materials, list the materials, the ordered part and wholesale price for each. For the ordered part, list the manufacturer's name and catalog number. Attach invoices for any parts or materials ordered to make the custom-made item. If the manufacturer does not frequently supply Medi-Cal items, include a copy of the manufacturer's price list. List the number of labor hours and the hourly rate. Include a clear explanation of what was done to justify the number of hours and the rate.

For custom-made appliances, the *Date of Service* is the date of delivery to the recipient (or attempted delivery when not successful). Enter the date of delivery of the appliance to the recipient in the *Additional Claim Information* field (Box 19) of the claim.

Custom-Made Foot Orthoses

A custom-made foot orthosis is a foot orthosis fabricated for a specific patient using the patient's individual measurements and/or pattern. This is done by using a plaster casting of the patient's foot to create a mold, or with a computer (three-dimensional negative impression or digital scanning). The use of foam boxes is not an acceptable fabrication method. A TAR is required for these items, and an explanation of the fabrication process used must be included on the TAR. The TAR must also include documentation of medical necessity.

**Undeliverable
Custom-Made Items**

Claims submitted without a date of delivery are reviewed for documentation that shows diligent attempts to make the delivery or evidence of the impossibility of delivery.

If adequate documentation is presented, the claim is processed for reimbursement at 80 percent of the authorized maximum benefit.

Providers must retain undeliverable custom-made appliances for one year from the date of service if reimbursement has been made according to the conditions described above. These appliances must be ready on demand for delivery to the recipient or a representative of the Department of Health Care Services (DHCS). (If delivery can be made, submit a *Claims Inquiry Form* [CIF] for compensation of the 20 percent reduction made to the original maximum reimbursable amount.)

Ultralight Prosthetics

If a prosthetic item is constructed of an ultralight material, documentation of medical necessity is required.

Bilateral Appliances

Claims billed for bilateral appliances are reimbursable without authorization using modifiers LT (left side) and RT (right side). Appliances billed as left and right with the same procedure code must include LT and RT on separate claim lines and a quantity of "1" on each claim line.

Additional Quantities

With the exception of bilateral conditions, claims for a quantity of greater than one ("1") of the same procedure code on the same date of service or for billing in excess of the stated frequency limitations, require a *Treatment Authorization Request* (TAR). Examples of acceptable medical justification for authorization include, but are not limited to the following:

- Changes in the patient's physical condition, such as size, shape or weight
- Unusual physical activities
- Documented loss or damage
- Change in medical necessity

Appliance Additions

Appliance "addition to" codes will only be reimbursed when the base appliance has been provided. Addition codes may be reimbursed separately only if the item is being replaced or repaired.

**Reimbursement for
“By Report” Codes**

In compliance with *Welfare and Institutions Code (W&I Code)*, Section 14105.21, reimbursement for all O&P codes (“By Report”) is the least of the following:

- The amount billed pursuant to CCR, Title 22, Section 51008.1.
- Eighty (80) percent of the manufacturer’s suggested retail price (MSRP). The MSRP catalog published by the manufacturer on or prior to the date of service.
- The manufacturer’s purchase invoice (dated on or prior to the date of service) amount, plus a 67 percent markup.

Documentation Requirements

O&P codes billed “By Report” require the following information:

- Manufacturer’s purchase invoice and the MSRP (a catalog page)
- Item description
- Manufacturer name
- Model number
- Catalog number

**“By Report”
Requirements**

O&P appliances reimbursed through “By Report” billing require the following information:

- Item description
- Manufacturer name
- Model number
- Catalog number (if appropriate)
- Suggested retail price

Note: In lieu of the above items, claims for custom-made appliances may include a copy of the original purchase invoice for materials and parts used in preparing the device.

- Cost of part(s) used
- Cost of labor per hour and total cost/hours
- Description of and justification for any special features (custom modifications or special accessories)
- Medical condition necessitating the particular orthotic or prosthetic item

Helmets

HCPCS codes A8000, A8001 (prefabricated helmets), A8002 and A8003 (custom helmets) and A8004 (replacement interface) are reimbursable to physicians, certified orthotists and prosthetists, as well as CCS providers.

Codes A8000 – A8004 have specific modifier requirements (see earlier entry regarding modifier requirements in this section). Claims for code A8004 (replacement interface) billed with modifier RB must include documentation that the patient owns the helmet. Prefabricated helmet codes A8000, A8001 and A8004 are taxable items and subject to Durable Medical Equipment (DME) TAR thresholds.

Lithium Ion Battery

Claims for HCPCS code L7368 (lithium ion battery charger, replacement only) must include a statement that the equipment is patient-owned in the *Additional Claim Information* field (Box 19).

**Cranial Remolding
Orthoses**

HCPCS code S1040 (cranial remolding orthosis) requires a TAR and is reimbursable with the following restrictions:

- Maximum age is 2 years old
- Frequency is limited to two in 12 months
- Diagnosis code is limited to 754.0 (plagiocephaly) and 756.0 (craniosynostosis)
- Requires a TAR, which must include the name and address of the FDA-approved lab that made the helmet. The following are currently approved labs:
 - Becker Orthopedic Appliance Company (Becker Band Cranial Remolding Orthosis)
 - Beverly Hills Prosthetics Orthotics (Cranial Symmetry System)
 - Boston Brace International, Inc. (Static Cranioplasty Orthosis)
 - Center for Orthotic and Prosthetic Care (COPC Band)
 - Children’s Hospital & Medical Center (Clarren Helmet)
 - Children’s Hospital Minneapolis (Cranial Helmet)
 - Children’s Hospital and Regional Medical Center in Seattle, WA (Clarren Helmet)
 - Cranial Solutions (Cranial Solution Orthosis)
 - Cranial Technologies, Inc. (Doc Band)
 - Cranial Technologies, Inc. (Doc Band-Postop)
 - Cranial Technologies, Inc. (Dynamic Orthotic Cranioplasty Band)
 - Danmar Products (Cranial Adjustive Prosthesis)
 - Danmar Products (Danmar Products Michigan Cranial Helmet)
 - Eastern Cranial Affiliates (Static Cranioplasty Orthosis)
 - Fairview Orthopedic Laboratory (Molded Cranial Helmet)

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- Gema, Inc. (Ballert Cranial Molding Helmet)
 - Gillette Children’s Specialty Healthcare (Craniocap)
 - Hanger Orthopedic Group, Inc. (Hanger Cranial Band)
 - Lerman & Son (Lerman & Son Cranial Orthosis Helmet)
 - Mike Milner (Cranioccephalic Custom Remolding Orthosis)
 - Northeast Orthotics and Prosthetics, Inc. (Providence Molding Helmet)
 - Orthomerica Products, Inc. (Clarren Helmet [Orthomerica])
 - Orthomerica Products, Inc. (Opi Band)
 - Orthomerica Products, Inc. (Starband Cranial Orthosis)
 - Orthomerica Products, Inc. (Starlight)
 - Orthotic & Prosthetic Lab, Inc. (O&P Cranial Molding Helmet)
 - Orthotic & Prosthetic Lab, Inc. (O&P Bivalve Cranial Molding Helmet)
 - Orthotic Solutions (Cranial Molding Orthosis)
 - Otto Bock Health Care, LP (Cranial Helmet)
 - Precision Prosthetics & Orthotics (Orthosis Helmet Molding)
 - Rehabilitation Institute, Loma Linda University [Loma Linda University Medical Center (LLUMC)]
 - Restorative Health Services, Inc. (Rhs Helmet)
 - Scott E. Allen CP (Plagiocephalic Applied Pressure Orthosis)

Note: If a cranial molding helmet laboratory that is not listed above is used, a copy of the laboratory’s FDA-approved “510k” letter for the helmet must accompany the *Treatment Authorization Request/Service Authorization Request (TAR/SAR)*.

Stock Orthopedic and Conventional Shoes

Stock orthopedic and stock conventional shoes, including in-depth shoes are reimbursable only when at least one of the shoes is attached to a prosthesis or brace and the shoe is supplied by a prosthetist or orthotist on the prescription of a physician or podiatrist. W&I Code, Section 14132(k) and CCR, Title 22, Section 51315 (d).

Shoes Attached to a Prosthesis or Brace

In the context of orthopedic shoes attached to a prosthesis or brace, a brace means a leg brace. For Medi-Cal purposes, a leg brace is 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 correct position.

“Attached to a prosthesis or brace” means the prosthesis or brace is permanently affixed to the shoe as an integral part. The shoe attachment is necessary for the device to function. The allowable brace device codes that may be affixed as an integral part of the shoe are limited to the following HCPCS codes: L1900, L1910, L1920, L1980, L1990, L2000, L2010, L2020, L2030, L2050, L2060, L2080 and L2090.

Note: HCPCS codes allowable for the shoes referenced above are limited to L3201 – L3222 and L3260.

When billing for a stock orthopedic in-depth or stock conventional shoe, the provider must state in the *Additional Claim Information* field (Box 19) of the claim form which shoe(s) is (are) attached to which device, and if that device is new or existing. For example, “Left shoe attached to a new L1990,” or “Left and right shoes attached to existing bilateral L2000s.”

Modifications

Modification of stock conventional shoes or stock orthopedic shoes is covered when a recipient’s medical need can be satisfied by such modification.

**Custom-Made
Orthopedic Shoes**

Custom-made orthopedic shoes are reimbursable if the recipient's medical need cannot be met by modifications to stock orthopedic or stock conventional shoes. Clinical conditions that might require custom-made shoes include but are not limited to Charcot or rheumatoid foot deformities, some partial foot amputations, or when a patient requires a muscle flap to cover a large or unusual soft tissue foot defect that then is too bulky to be accommodated by an in-depth shoe.

The prescribing physician must document the nature, cause and severity of the foot problem leading to the conclusion that a custom-made orthopedic shoe is the only alternative (CCR, Title 22, Section 51315). A custom-made shoe has the following characteristics:

- Made and molded to patient model for a specific patient
- Constructed over a positive model of the patient's foot
- Made from leather or other suitable material of equal quality
- Has removable inserts as an integral part of the shoe that can be altered or replaced as the patient's condition warrants
- Has some form of shoe closure

**Orthotic Heel Lifts
Arch Supports**

Claims for shoe modification lift/build-up codes L3300 – L3334 require the following documentation in the *Additional Claim Information* field (Box 19) or on an attachment:

- Exact description of the modification made to the shoe
- Name of provider or outside vendor performing the shoe modification
- If modification is performed by an outside vendor: Name, date and invoice number used to bill the provider for shoe modification services

Shoe modification lift/build-up codes L3300 – L3334 must be billed with either the modifier LT (left side) or RT (right side). Lifts are reimbursable for one side only. Reimbursement for lift/build-up codes is restricted to twice in 180 days for the same recipient by any provider.

Therapeutic Diabetic Shoes and Inserts

Therapeutic diabetic shoes and inserts are a benefit for recipients with a diagnosis of diabetes mellitus. Shoes and inserts are billed with HCPCS codes A5500, A5501, A5503 – A5507, A5512 and A5513. Descriptions of these codes are included in the *Orthotic and Prosthetic Appliances: Billing Codes and Reimbursement Rates – Orthotics* section of this manual.

Authorization

These services require authorization. With the TAR, providers must submit a physician-signed *Physician Certification of Medical Necessity for Therapeutic Diabetic Shoes and Inserts* form (see copy at end of this section) to certify that the recipient has one or more of the following conditions:

- Foot ulcers
- Previous amputation of the contralateral foot, or part of either foot, due to microvascular disease secondary to diabetes
- History of previous foot ulceration of either foot
- Peripheral neuropathy with evidence of callous formation of either foot
- Deformity of either foot, that is, rocker bottom foot or Charcot foot
- Documentation of compromised vascular disease in either foot
- Positive monofilament examination indicating diabetic neuropathy

The following additional information is required on the *Physician Certification of Medical Necessity for Therapeutic Diabetic Shoes and Inserts* form for authorization of codes A5501 and A5513:

- Diabetes mellitus with neurological manifestations
- Diabetes mellitus with peripheral circulatory disorders
- Diabetes mellitus with other specified disorders (amputations, significant deformities and/or pre-ulcerations)

Billing Restrictions

Only orthotists and prosthetists may be reimbursed for the following services.

HCPCS codes A5500 (prefabricated shoes) and A5512 (prefabricated inserts) may each be reimbursed up to four in 12 months. The daily maximum allowable for each code is two, but they do not have to be billed in pairs. The maximum allowable in 12 months may be in any combination of right or left sides.

HCPCS codes A5501 (custom shoes) and A5513 (custom inserts) may each be reimbursed up to two in 12 months. The maximum allowable in 12 months may be in any combination of right or left sides.

Providers will not be reimbursed for both prefabricated and custom shoes or inserts for the same foot in the same 12 months, unless:

- The claim does not exceed the stated annual frequency limitation for the respective codes, and
- The medical condition has changed to the extent that a custom appliance would be required for the same side after a prefabricated shoe or insert has been tried.

Documentation of the medical justification for separate reimbursement of a prefabricated or custom item for the same foot in the same 12-month interval must be placed in the *Additional Claim Information* field (Box 19) of the claim or on an attachment.

Diabetic shoe inserts are reimbursable only if a diabetic shoe is billed on the same claim or in a 12-month history.

Compression Stockings

Pre-manufactured and off-the-shelf pantyhose-type, elastic support stockings are not a benefit of the Medi-Cal program. Custom-made elastic gradient compression stockings (HCPCS code A6549) are reimbursable with authorization when medically necessary to treat symptomatic venous insufficiency or lymphedema in the lower extremities. Code A6549 is billed "By Report."

HCPCS code A6545 (gradient compression wrap, nonelastic, below knee, 30 – 50 mm Hg, each) is reimbursable with authorization. It has a frequency limit of three in six months (six in six months if bilateral).

Providers billing for elastic gradient compression stockings must have a written prescription from a licensed practitioner for the item(s). A generic prescription for "elastic support stockings" is not acceptable.

Taxable Orthotic Procedures

Sales tax is applied for orthotic HCPCS codes L3100 (Hallus-valgus night dynamic splint, prefabricated, off-the-shelf) and L3201 – L3595 (orthotic footwear, modification and additions).

Infant Spinal Immobilizer

HCPCS code L1001 (infant spinal immobilizer) is reimbursable, with authorization, for custom-made devices designed for the stabilization of the cervical spine, upper thoracic spine and/or airway of a child younger than one year of age. A CCS denial is required for Medi-Cal authorization. Claims must include an invoice. Coverage of L1001 excludes an infant immobilizer used to restrain infants during surgical or radiological procedures (for example, Circumstraint device for restraint during circumcision).

Reciprocating Gait Orthoses

Reciprocating Gait Orthoses (RGOs) are reimbursable as a Medi-Cal benefit when billed with authorization and proof that they are medically necessary for recipients 2 years of age and older with the following conditions:

- Thoracic or upper lumbar spine lesions with spasticity;
- Contractures of all levels of the lower extremity(ies) as long as the joint(s) is (are) flexible to manipulation.

Orthotic devices are Medi-Cal benefits when the equipment is reasonable and necessary for the treatment of an illness or injury, or to improve the function of a malformed body member. Orthoses must meet all applicable Medi-Cal statutory requirements as set forth in CCR, Title 22, Sections 51321 and 51521.

Documentation Requirements

The following documentation must be included when submitting a TAR for RGOs (HCPCS codes L2010, L2020, L2035 – L2037, L2510, L2520, L2525, L2627 and L2628):

- A primary physician must document that the recipient has cardiopulmonary integrity.
- An orthopedist or Physical Medicine and Rehabilitation Physician (PMR) must document that no other orthoses would be helpful.
- A neurologist must document that the spinal cord injury level is above L3.
- An independent physical therapist, other than the one in the orthotic/rehab unit, must document that the recipient does not have contractures and/or muscle atrophy that would preclude use of the RGO.
- X-rays of the spine must document that there is stability of the spine.
- X-rays of the spine, hips and knees must document a lack of advanced osteoporosis and fractures.

- One of the following ICD-9-CM diagnosis codes must be included on the TAR:
 - 344.1 (paraplegia);
 - 741.92 (spina bifida, without mention of hydrocephalus, dorsal [thoracic] region); or
 - 741.93 (spina bifida, without mention of hydrocephalus, lumbar region)

In addition to the above documentation, the following documentation is required when a TAR for RGOs is submitted for recipients 21 years of age and older:

- Plantigrade feet
- Knees and hips must not have greater than 10 degrees of contracture
- The hips must be flexible without rigidity or spasticity
- Good upper extremity strength
- Motivated, has realistic goals and expectations, and has a support system

Contraindications to RGOs include the following:

- Severe irreducible contractures that prevent establishing normal alignment
- Spasticity or other voluntary muscle activity that prevents free and coordinated mobility
- Obesity (BMI > 32)
- Poor upper extremity strength
- Advanced osteoporosis
- Fractures or a history of fractures
- History of not following treatment plans (noncompliance)
- Pressure sores in areas that would be in contact with the orthosis

The treating therapist and/or orthotist must submit a report to the primary care physician at six months of use to document the recipient's success or failure with the RGO.

Removable Soft Interface

HCPCS code K0672 (addition to lower extremity orthosis, removable soft interface, all components, replacement only) is a replacement only code that may be billed for bilateral appliances on separate claim lines with modifiers LT (left side) and RT (right side). This code requires a TAR. The replacement interfacing is not separately reimbursable with Knee Orthoses (KO) for the same date of service.

Endoskeletal Knee Shin System

HCPCS code L5859 (addition to lower extremity, prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control) must be billed with modifiers LT or RT. This code requires a TAR.

Single and Double Upright Off-the-Shelf Knee Orthoses

HCPCS codes K0901 (knee orthosis [KO], single upright, thigh and calf, with adjustable flexion and extension joint [unicentric or polycentric], medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf) and K0902 (knee orthosis [KO], double upright, thigh and calf, with adjustable flexion and extension joint [unicentric or polycentric], medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf) may be billed with modifiers LT or RT. These non-taxable items have a frequency limit of one every five years for any provider.

Ancillary Orthotic Services

HCPCS codes L4361 (walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, off-the-shelf) and L4387 (walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated, off-the-shelf) require a TAR when payable to a podiatrist.

**Dynamic Adjustable
Knee Extension**

HCPCS code E1810 (dynamic adjustable knee extension/flexion device, includes soft interface material) is indicated for the following:

- As an adjunct to physical therapy in recipients with documented signs and symptoms of significant motion stiffness/loss in the subacute injury or post-operative period (i.e., at least three weeks but less than four months after injury or surgery) or
- In the acute post-operative period for recipients who have a prior documented history of motion stiffness/loss in a joint and are having additional surgery or procedures done to improve motion to that joint

The use of mechanical stretching devices in the management of chronic contractures (no significant change in motion for a four-month period) and chronic joint stiffness due to joint trauma, fractures, burns, head and spinal cord injuries, rheumatoid arthritis, multiple sclerosis, muscular dystrophy or cerebral palsy does not constitute medical necessity.