Orthotics and Prosthetics

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14.1 Enrollment
To enroll in the CSHCN Services Program, orthotics and prosthetics providers must be actively enrolled in the Texas Medicaid Program, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN enrollment process, and comply with all applicable state laws and requirements.

14.2 Reimbursement
Orthotics and prosthetics services are reimbursed according to a maximum allowable fee schedule based on Medicare and Medicaid allowable rates. A completed CSHCN Documentation of Receipt for Durable Medical Equipment (DME) must be kept on file.

14.3 Benefits and Limitations
The CSHCN Services Program may provide coverage for orthotics and prosthetics when medically necessary. Items must be prescribed by a licensed physician or podiatrist (for conditions below the ankle) and supplied by an orthotist or prosthetist who meets CSHCN Services Program enrollment criteria. Noncustom commercial products may be supplied through a physician’s office. Extremity splints and inhibitive casting may be provided by occupational therapists (OTs) or physical therapists (PTs) as appropriate.

Training in the use of an orthotic/prosthetic device for a client who has not worn one previously, has not worn one for a prolonged time period, or is receiving a different type may be reimbursed when provided by a licensed physical or occupational therapist.

Specific procedure or diagnosis codes related to program benefits and coverage may be listed in sections that follow. These listings are intended to provide helpful information, but should not be considered all-inclusive. From time to time, codes are added, deleted, or revised. Coverage and coding information is updated in the CSHCN Provider Bulletin. Call the TMHP-CSHCN Contact Center at 1-800-568-2413 with questions regarding covered procedure or diagnosis codes.

14.4 Authorization Requirements
Requests for authorization must be in writing on the CSHCN Authorization Request for Durable Medical Equipment (DME). A copy of this form is provided on page C-29. Modifications of orthotic and prosthetic systems, due to growth or a change in medical status, may be authorized. Repairs required due to normal wear may be authorized. Additional information may be requested to determine if repairs and modifications are cost effective.

Medical justification is required for replacement of orthoses, if less than six months from the receipt of the initial system, and for prostheses if less than one year from receipt of the initial system.

Note: Fax transmittal confirmations are not accepted as proof of timely authorization submission.

14.5 Orthotics and Prosthetics
The list of orthotics and covered diagnosis codes on the following page are examples of services that the CSHCN Services Program reviews for authorization.
### 14.5.1 Orthotics

<table>
<thead>
<tr>
<th>Orthotics</th>
<th>Covered Diagnosis/Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ankle foot orthotics (AFO), plastic or metal</td>
<td>Foot anomalies, cerebral palsy, hemiplegia, spina bifida, club foot, arthrogryposis, and arthropathy associated with hematological disorder</td>
</tr>
</tbody>
</table>
| Dynamic splints | Case-by-case basis using the following criteria to be submitted by the physician:  
- The patient’s condition to be treated with the dynamic splint;  
- The patient’s current course of therapy to date, for the condition to be treated.  
- The rationale for the use of the dynamic splint at this time, including:  
  a. Quality of care considerations such as improved outcome, and  
  b. Potential cost effectiveness  
- The likelihood that the family/patient will comply with the use of the dynamic splint. |
| Foot orthotics | Foot anomalies, tibial torsion, club foot, varus deformities of feet, cerebral palsy, spina bifida, arthrogryposis, and arthritic conditions |
| Hip knee ankle foot orthotics (HKAFO) and knee ankle foot orthotics (KAFO) | Spina bifida, cerebral palsy, paraplegia, late effects of polio, late effects of cerebrovascular accident (CVA), spinal cord lesions, arthrogryposis, club foot, varus deformities of feet, genu varus and genu valgus if growth deformity, and arthropathy associated with hematological disorder |
| Hip orthotics (HO) | Dislocated hip, cerebral palsy, spina bifida, and congenital deformities of the hip |
| Inhibitive casting | Cerebral palsy or any central nervous system (CNS) deficit resulting in increased muscle tone in the extremities |
| Knee orthotics (KO), knee immobilizer | Arthropathy associated with hematological disorders related to lower extremity conditions |
| Protective helmets | Neoplasms of the brain, subarachnoid hemorrhage, subdural hemorrhage, hemophilia, epilepsy (if not well controlled), and cerebral palsy (severe) |
| Removable shoe insert, UCB (University of California at Berkeley) type | Case-by-case basis using the following criteria to be submitted by the physician:  
- Client must be 5 years or age, and  
- Client must have a valgus deformity and significant congenital pes planus (75461), which is symptomatic for pain, or  
- Client may have a structural problem that results in significant pes planus, or  
- Client may have an acute plantar fasciitis, or  
- Client may have a diagnosis of hemophilia |
| Spinal orthotics (SO), collars, corsets, and body jackets (TLSO, LSO, and LLSO) | Scoliosis, spinal injuries, paraplegia, kyphosis, neurofibromatosis, cerebral palsy, spina bifida, and spinal tumor |
| Thoracic—hip knee ankle orthotics (THKAO), parapodium, swivel walker, and reciprocating gait orthoses (RGOs) | Spina bifida, spinal injuries, spinal tumor, cerebral palsy, and paraplegia reciprocating gait orthoses may be covered for children with spina bifida or similar functional disabilities. The authorization request must include a statement from the prescribing physician indicating the medical necessity, a physical therapy plan, and a statement that the family is expected to comply with the treatment plan |
| Upper extremity orthotics, shoulder, elbow, wrist, hand, finger, and mobile arm support | Cerebral palsy, spinal cord injury, brachial plexus lesions, nerve lesions, paralysis, juvenile rheumatoid arthritis, and reduction deformities |
14.5.2 Noncovered Orthotics

The following procedure codes are not a benefit:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>L3001</td>
</tr>
<tr>
<td>L3030</td>
</tr>
</tbody>
</table>

14.5.3 Cranial Molding Devices

The CSHCN Services Program may reimburse for nonsynostotic deformational plagiocephaly with documentation supporting the use of the cranial molding device to modify or prevent an associated functional impairment. CSHCN may also reimburse for use of these devices after surgery for cranial deformities, including craniosynostosis. Cranial molding devices may only be approved for children 3 to 18 months of age.

14.5.3.1 Authorization Requirements

Cranial molding devices must be prior authorized for reimbursement through the CSHCN Services Program with documentation supporting medical necessity/appropriateness. Written documentation must include:

1) Child’s diagnosis and age
2) The recommendations of the appropriate pediatric subspecialty or craniofacial team (the team must include a pediatric neurosurgeon or craniofacial surgeon) or pediatric neurosurgeon
3) The determining factors used in recommendation of treatment
4) Any alternative treatment courses that have been tried
5) Plan of treatment and/or follow up schedule

14.5.3.2 Reimbursement

Cranial molding devices may be reimbursed using procedure code S1040.

14.5.4 Protective Helmets

Protective helmets used for conditions such as neoplasm of the brain, subarachnoid hemorrhage, epilepsy, or cerebral palsy may be reimbursed by CSHCN. These require authorization and the appropriate procedure codes are L0100 and L0110.

14.5.5 Prosthetics

The following are examples of prosthetics and diagnosis codes that the CSHCN Services Program reviews for authorization:

<table>
<thead>
<tr>
<th>Prosthetics</th>
<th>Covered Diagnosis/Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above knee</td>
<td>Congenital absence, surgical revision or traumatic amputation of lower extremity or hip</td>
</tr>
<tr>
<td>Ankle</td>
<td></td>
</tr>
<tr>
<td>Below knee</td>
<td></td>
</tr>
<tr>
<td>Hemipelvectomy</td>
<td></td>
</tr>
<tr>
<td>Hip disarticulation</td>
<td></td>
</tr>
<tr>
<td>Immediate post surgical</td>
<td></td>
</tr>
<tr>
<td>Partial foot/foot</td>
<td></td>
</tr>
</tbody>
</table>
14.5.6 Eye Prostheses

Eye prostheses must be authorized for CSHCN clients. The Healthcare Common Procedure Coding System (HCPCS) codes V2623 through V2629 are payable to ocularists and should be used when billing for eye prostheses and/or related services.

There are no specific time limitations on replacement of eye prostheses. A child’s eye socket may change size at variable times because of differences in bone growth rate and soft tissue change.

14.5.7 Prescription Shoes and Lifts

The CSHCN Services Program may authorize prescription shoes (corrective/orthopedic shoes) for eligible clients when prescribed by a licensed physician or podiatrist. An approved orthotist may supply shoes. For consideration of coverage, corrective shoes must be:

- Permanently attached to a brace, or
- Custom modified by an orthotist or orthotist/prosthetist at the direction of the prescribing physician, or
- Necessary to hold surgical correction or casting (does not have to be attached to a brace); may be authorized up to one year post procedure, or
- Documented by physician as to specific medical rationale.

Note: Lifts for unequal leg length greater than ½ inch are covered with documentation of medical need.

If the primary diagnosis is 754.6, Valgus deformities of the feet, medical justification is required.

Prescription shoes are limited to one pair every three months. Two pairs may be purchased at the same time, but they cannot be replaced until after six months.

Noncovered Shoes/Shoe Inserts

The following items are not a covered benefit:

- Noncorrective shoes, including tennis shoes, even if prescribed by a physician and worn with a removable brace
- Shoe inserts (other than UCB type) when not part of a modified shoe or when shoes are not attached to a brace

14.5.7.1 Authorization Requirements

Authorization requests for payment of prescription shoes must be submitted on the Authorization Request for Durable Medical Equipment (DME) form. A copy of this form is provided on page C-29.

Reimbursement for prescription shoes and lifts is based on HCPCS allowable fees.
14.6 Claims Information

Orthotic and prosthetic services must be submitted to TMHP in an approved electronic format or on a CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500, all pertinent information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Instructions for proper claims completion are provided on page C-2. Blocks that are not referenced are not required for processing by TMHP and may be left blank.