Effective for dates of service on or after March 1, 2010, benefit criteria for orthoses and prostheses will change for the Texas Medicaid Comprehensive Care Program (CCP).

Orthoses

Orthoses, including orthopedic shoes, wedges, and lifts, are a benefit of Texas Medicaid when provided by a licensed orthotist or a licensed prosthetist/orthotist under the Texas Health Steps-Comprehensive Care Program (THSteps-CCP) for clients who are birth through 20 years of age.

- Orthoses may be reimbursed using the procedure codes listed in table A in this article.
- Orthopedic devices may be reimbursed using the procedure codes listed in table B in this article.

The following orthoses are a benefit of Texas Medicaid when medical necessity criteria are met as outlined in this article:

- Spinal orthoses and additions to spinal orthoses, including those for scoliosis.
- Thoracic-hip-knee-ankle (THKA) orthoses and hip orthoses.
- Lower-limb orthoses and additions to lower-limb orthoses, including fracture orthoses.
- Foot orthoses, including inserts, orthopedic shoes, surgical boots, heel lifts, and wedges.
- Upper-limb orthoses and additions to upper-limb orthoses, including fracture orthoses.
- Other orthopedic devices as outlined in this article, including protective helmets and dynamic splints.

Definitions for Orthoses

Texas Medicaid uses the definitions of the Texas State Board of Orthotics and Prosthetics, as listed in the Texas Administrative Code (TAC).

The following definitions are not listed in TAC, but help define the benefits included in this article:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct supervision</td>
<td>The supervising licensed orthotist or licensed prosthetist/orthotist is in the same office, building, or facility where the service is provided, and is immediately available to furnish assistance and direction.</td>
</tr>
<tr>
<td>Custom-fitted orthosis</td>
<td>A prefabricated or off-the-shelf orthosis that is manufactured in quantity without a specific client in mind and is then trimmed, bent, or otherwise molded for use by a specific client.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Custom-fabricated orthosis</td>
<td>An orthosis specially manufactured for a specific client. This type of device requires substantial labor to construct and is custom-molded to the client’s specific body part.</td>
</tr>
<tr>
<td>Brace</td>
<td>An orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and allows for motion of that part. It must be a rigid or semirigid device used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured body part.</td>
</tr>
<tr>
<td>Prefabricated splint</td>
<td>An appliance for preventing movement of joints or for the fixation of a displaced or movable part. A prefabricated splint is not an orthosis as defined in this article.</td>
</tr>
</tbody>
</table>
| Orthopedic shoe              | Specialized footwear that requires a prescription and is available only from a supplier of orthopedic footwear (i.e., not available from a retail store). An orthopedic shoe has additional depth, may be used to accommodate foot deformities, and is fitted and furnished by a specially trained health professional. An orthopedic shoe:  
  - Has a full-length, heel-to-toe filler, which, when removed, provides a minimum of 3/16” of additional depth used to accommodate custom-molded or customized inserts.  
  - Is made from leather or from other suitable material of equal quality.  
  - Has some form of closure, such as Velcro, lace, or zipper.  
  - Is available in full and half sizes with a minimum of three widths so that the sole is graded to the size and width of the upper portions of the shoe according to the American standard last-sizing schedule or its equivalent. An orthopedic shoe does not include:  
  - Tennis shoes, even if prescribed by a physician and worn with a removable brace.  
  - A shoe insert when it is not part of a modified shoe or when the shoe in which it is inserted is not attached to a brace. Note: An exception is the University of California at Berkeley (UCB) removable foot insert, which is a benefit when medical necessity criteria are met. |
| Foot inserts                 | Total-contact, multiple-density, removable inlays that are directly molded to the plantar surface of the individual’s foot or a model of the foot. Total contact means that the insert has continuous physical contact with the weight-bearing portion of the foot. |

**Noncovered Orthotic Services**

The following circumstances are not a benefit of Texas Medicaid:
• Orthoses whose sole purpose is for restraint.
• Orthoses provided solely for use during sports-related activities in the absence of an acute injury or other indicated medical condition.
• Orthotic devices prescribed by a chiropractor.

Diagnoses that are not considered medically necessary include, but are not limited to, the following:
• Tired feet.
• Fatigued feet.
• Nonsevere bow legs.
• Valgus deformity of the foot, except as outlined in this article.
• Pes planus (flat feet), except when there is a coexisting medical condition as outlined in this article.

Orthopedic shoes with deluxe features, such as special colors, special leathers, and special styles, are not considered medically necessary, and the features do not contribute to the accommodative or therapeutic function of the shoe.

A foot drop splint and recumbent positioning device and replacement interface are not considered medically necessary in a client with foot drop who is nonambulatory, because there are other more appropriate treatment modalities.

A static ankle-foot orthosis (AFO) or AFO component is not medically necessary if:
• The contracture is fixed.
• The client has foot drop without an ankle flexion contracture.
• The component is used to address knee or hip positioning, because the effectiveness of this type of component is not established.

A pneumatic thoracic-lumbar-sacral orthosis is considered experimental and investigational and is not a benefit of Texas Medicaid.

**Prior Authorization Requirements for Orthoses**

Prior authorization is required for all orthoses and related services.

Before submitting a request for prior authorization for orthosis, the orthosis provider must have a completed THSteps-CCP Prior Authorization Form requesting the orthosis and/or related services that has been signed and dated by a physician who is familiar with the client. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures/dates will not be accepted. The completed THSteps-CCP Prior Authorization Form must include the procedure codes and quantities for requested services. A copy of the completed, signed, and dated form must be maintained by the orthosis provider in the client’s medical record. The completed THSteps-CCP Prior Authorization Form with the original dated signature must be maintained by the prescribing physician in the client’s medical record.

• To complete the prior authorization process electronically, the orthosis provider must complete the prior authorization requirements through any approved electronic
methods and retain a copy of the signed and dated CCP Prior Authorization Request form in the client's medical record at the provider's place of business.

- To complete the prior authorization process by paper, the orthosis provider must fax or mail the completed THSteps-CCP Prior Authorization Request Form to the CCP prior authorization unit and retain a copy of the signed and dated CCP form in the client's medical record at the provider's place of business.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the equipment and supplies requested. The physician must maintain documentation of medical necessity in the client’s medical record. The provider may be asked for additional information to clarify or complete a request for the service or device.

All requests for prior authorization must include documentation of medical necessity including, but not limited to, documentation that the device is needed for one of the following indications:

- To reduce pain by restricting mobility of the affected body part.
- To facilitate healing following an injury to the affected body part or related soft tissue.
- To facilitate healing following a surgical procedure on the affected body part or related soft tissue.
- To support weak muscles or a deformity of the affected body part.

Prior authorization requests for some types of orthosis require additional documentation which is detailed in the sections that follow.

The provider must keep the following written documentation in the client’s medical record:

- The prescription for the device.
  - Orthotic devices must be prescribed by a physician (Doctor of Medicine [M.D.] or Doctor of Osteopathy [D.O.]) or a podiatrist. A podiatrist prescription is valid for conditions of the ankle and foot.
  - The prescription must be dated on or before the initial date of the requested dates of service, which can be no longer than 90 days from the signature date on the prescription.
- Accurate diagnostic information that supports the medical necessity for the requested device (a retrospective review may be performed to ensure that the documentation included in the client's medical record supports the medical necessity of the requested service or device).

A prior authorization is valid for a maximum period of 6 months from the prescription signature date. At the end of the 6-month authorization period, a new prescription is required for prior authorization of additional services.

For the purpose of this article, the actual date of service is the date the supplier has placed an order for the equipment and has incurred liability for the equipment.

**Spinal Orthoses**
Spinal orthoses include, but are not limited to, cervical orthoses, thoracic rib belts, thoracic-lumbar-sacral orthoses (TLSO), sacroiliac orthoses, lumbar orthoses, lumbar-sacral orthoses (LSO), cervical-thoracic-lumbar-sacral orthoses (CTLSO), halo procedures, spinal corset orthoses, and spinal orthoses for scoliosis.

Spinal orthoses will be considered for prior authorization with documentation of one of the indications defined in the Prior Authorization Requirements for Orthoses section above.

**Thoracic-Hip-Knee-Ankle (THKA) Orthoses**

THKA orthoses will be considered for prior authorization with documentation of one of the indications defined in the Prior Authorization Requirements section above.

**Lower-Limb Orthoses**

Lower-limb orthoses include, but are not limited to, hip orthoses (HO), Legg Perthes orthoses, knee orthoses (KO), ankle-foot orthoses (AFO), knee-ankle-foot orthoses (KAFO), hip-knee-ankle-foot orthoses (HKAFO), fracture orthoses, and reciprocating gait orthoses (RGO).

In addition to the indications defined in the Prior Authorization Requirements for Orthoses section above, lower-limb orthoses will be considered for prior authorization with documentation of the following criteria for specific orthotic devices:

**Ankle-Foot Orthoses (AFO)**

AFOs used during ambulation will be considered for prior authorization for clients with documentation of all of the following:

- Weakness or deformity of the foot and ankle.
- A need for stabilization for medical reasons.
- Anticipated improvement in functioning during activities of daily living (ADLs) with use of the device.

AFOs not used during ambulation (static AFO) will be considered for prior authorization for clients with documentation of one of the following conditions:

- Plantar fasciitis.
- Plantar flexion contracture of the ankle, with additional documentation that includes all of the following:
  - Dorsiflexion on pretreatment passive range of motion testing is at least 10 degrees.
  - The contracture is interfering or is expected to interfere significantly with the client’s functioning during ADLs.
  - The AFO will be used as a component of a physician-prescribed therapy plan care, which includes active stretching of the involved muscles or tendons.
  - There is reasonable expectation that the AFO will correct the contracture.

**Knee-Ankle-Foot Orthoses (KAFO)**
KAFOs used during ambulation will be considered for prior authorization for clients with documentation that supports medical necessity for additional knee stabilization.

KAFOs that are custom-fabricated (molded-to-patient model) for ambulation will be considered for prior authorization when at least one of the following criteria is met:

- The client cannot be fit with a prefabricated AFO/KAFO.
- The condition that necessitates the orthosis is expected to be permanent or of long-standing duration (more than 6 months).
- There is a need to control the knee, ankle, or foot in more than one plane.
- The client has a documented neurological, circulatory, or orthopedic status that requires custom fabrication to prevent tissue injury.
- The client has a healing fracture that lacks normal anatomical integrity or anthropometric proportions.

Reciprocating Gait Orthoses (RGO)

Reciprocating gait orthoses will be considered for prior authorization for clients with spina bifida or similar functional disabilities.

The prior authorization request must include a statement from the prescribing physician that indicates medical necessity for the RGO, the physical therapy treatment plan, and documentation that the client/family is willing to comply with the treatment plan.

Foot Orthoses

Foot orthoses include, but are not limited to, foot inserts, orthopedic shoes, wedges, and lifts.

Foot orthoses will be considered for prior authorization for clients with documentation of all the following:

- The client has symptoms associated with the particular foot condition.
- The client has failed to respond to a course of appropriate, conservative treatment, including physical therapy, injections, strapping, or anti-inflammatory medications.
- The client has at least one of the following:
  - Torsional conditions, such as metatarsus adductus, tibial torsion, or femoral torsion.
  - Structural deformities.
  - Hallux valgus deformities.
  - In-toe or out-toe gait.
  - Musculoskeletal weakness.

Additional criteria for specific foot orthoses are outlined below.

Foot Inserts

Removable foot inserts will be considered for prior authorization for clients with documentation of at least one of the following medical conditions:

- Diabetes mellitus.
- History of amputation of the opposite foot or part of either foot.
- History of foot ulceration or pre-ulcerative calluses of either foot.
- Peripheral neuropathy with evidence of callus formation of either foot.
- Deformity of either foot.
- Poor circulation of either foot.

Removable foot inserts may be covered independently of orthopedic shoes with documentation that the client has appropriate footwear into which the insert can be placed.

A UCB removable foot insert will be considered for prior authorization with documentation that the device is required to correct or treat at least one of the following conditions:

- A valgus deformity and significant congenital pes planus with pain.
- A structural problem which results in significant pes planus, such as Down syndrome.
- Acute plantar fasciitis.

**Orthopedic Shoes**

Orthopedic shoes must be prescribed by a licensed physician (M.D. or D.O.) or a podiatrist. An orthopedic shoe is used by clients whose feet, although impaired, are essentially intact. An orthopedic shoe differs from a prosthetic shoe, which is used by clients who are missing all or most of the forefoot.

Orthopedic shoes will be considered for prior authorization when at least one of the following criteria is met:

- The shoe is permanently attached to a brace.
- The shoe is necessary to hold a surgical correction, postoperative casting, or serial or clubfoot casting.

An orthopedic shoe may be prior authorized up to one year from the date of the surgical procedure.

Only one pair of orthopedic shoes will be prior authorized every 3 months. Two pairs of shoes may be purchased at the same time; in such situations, however, additional requests for shoes will not be considered for another 6 months.

Requests for orthopedic shoes that do not meet the criteria listed above may be considered for prior authorization with documentation of medical necessity.

**Wedges and Lifts**

Wedges and lifts must be prescribed by a licensed physician (M.D. or D.O.) or a podiatrist and must be for treatment of unequal leg length greater than one-half inch.

**Upper-Limb Orthoses**

Upper-limb orthoses include, but are not limited to, shoulder orthoses (SO), elbow orthoses (EO), elbow-wrist-hand orthoses (EWHO), elbow-wrist-hand-finger orthoses (EWHFO), wrist-hand-finger orthoses (WHFO), wrist-hand orthoses (WHO), hand-finger
orthoses (HFO), finger orthoses (FO), shoulder-elbow-wrist-hand orthoses (SEWHO),
shoulder-elbow orthoses (SEO), and fracture orthoses.

Upper-limb orthoses will be considered for prior authorization with documentation of one
of the indications defined in the Prior Authorization Requirements for Orthoses section
above.

Other Orthopedic Devices

Protective Helmets

Protective helmets will be considered for prior authorization for clients with a
documented medical condition that makes the client susceptible to injury during ADLs.
Covered medical conditions include the following:

- Neoplasm of the brain
- Subarachnoid hemorrhage
- Epilepsy
- Cerebral palsy

Requests for all conditions other than those listed above require submission of additional
documentation that supports the medical necessity of the requested device.

Dynamic Splints

Dynamic splints such as Dynasplint ® will be considered for prior authorization for a
3-month trial period when the request is submitted with the following documentation:

- Client’s condition
- Client’s current course of therapy
- Rationale for the use of the dynamic splint
- Agreement by the client or family that the client will comply with the prescribed use of
  the dynamic splint

After completion of the 3-month trial period, the provider may submit a request for
purchase of the dynamic splint. Requests for purchase of the splint must include
documentation that the 3-month trial period was successful and showed improvement in
the client’s condition as measured by the following:

- Demonstrated increase in range of motion
- Demonstrated improvement in the ability to complete ADL’s or perform activities
  outside the home

Related Services

Orthotic Device Training

Training in the use of an orthotic device for a client who has not worn one previously,
has not worn one for a prolonged period, or is receiving a different type is a benefit when
the training is provided by a physical or occupational therapist, and Texas Medicaid
criteria for these services are met.
Repairs, Replacements, and Modifications to Orthoses

Repairs, replacements, and modifications to an orthosis are a benefit when medical necessity criteria are met.

Within the guarantee of the manufacturer, providers are responsible, without charge to the client or to Texas Medicaid, for replacement or repair of equipment or any part thereof that is found to be nonfunctional because of faulty material or workmanship. Service and repairs must be handled under any warranty coverage an item may have.

If there is no warranty, providers may request prior authorization for the necessary service and repairs.

A repair because of normal wear or a modification because of growth or change in medical status will be considered for prior authorization if it proves to be more cost effective than replacing the device.

The request for repairs must include a breakdown of charges for parts and the number of hours of labor required to complete the repairs. No charge is allowed for pickup or delivery of the item or for the assembly of Medicaid-reimbursed parts. The following information must be submitted with the request:

- The description and procedure code of the item being serviced or repaired.
- The age of the item.
- The number of times the item has been previously repaired.
- The replacement cost for the item.

The anticipated life expectancy of an orthotic device is 6 months. Requests for prior authorization for the replacement of a device before its usual life expectancy has ended must include documentation that explains the need for the replacement.

Replacement of orthotic equipment will be considered when the item is out of warranty and repairing the item is no longer cost-effective or when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted with the prior authorization request.

In situations where the equipment has been abused or neglected by the client, the client’s family, or the caregiver, a referral to the Department of State Health Services (DSHS) THSteps Case Management unit will be made by the THSteps-CCP Prior Authorization unit for clients who are birth through 20 years of age. Providers will be notified that the state will be monitoring this client’s services to evaluate the safety of the environment for both the client and equipment.

Requirements for Dispensing, Fabricating, and Modifying Orthoses

To be considered for reimbursement, orthoses must be dispensed, fabricated, or modified by a licensed orthotist or licensed prosthetist/orthotist enrolled with Medicare and THSteps-CCP.

- Upper extremity customized splints made with low-temperature materials and inhibitive casting may be provided by occupational or physical therapists.
• Other orthopedic devices addressed in this article may be provided by a Medicaid-enrolled durable medical equipment (DME) vendor as outlined in this article.

• Orthopedic shoes must be provided by a shoe vendor enrolled as a DME provider. The date of service for a custom-made or custom-fitted orthosis is the date the supplier places an order for the equipment and incurs liability for the equipment. The custom-made or custom-fitted orthosis will be eligible for reimbursement as long as the service is provided during a month the client is eligible for Medicaid.

The following items and services are included in the reimbursement for an orthotic device and not reimbursed separately:

• Client evaluation, measurement, casting, or fitting of the orthosis.
• Repairs due to normal wear and tear during the 90 days following delivery.
• Adjustments or modifications of the orthotic device made when fitting the orthosis and for 90 days from the date of delivery (adjustments and modifications during the first 90 days are considered part of the purchase of the initial device).

Orthopedic shoes that are attached to a brace must be billed by the vendor that bills for the brace.

Reimbursement for lifts and wedges may include the cost of the prescription shoe.

**Reimbursement for Orthoses**

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the dated signatures of the provider and the client or primary caregiver. This signed and dated form must be kept by the DME provider in the client’s medical record.

The DME Certification and Receipt Form must be submitted for DME claims and appeals when any of the following occurs:

• A single item meets or exceeds a billed amount of $2,500.00.
• Multiple items submitted on the same date of service meet or exceed a total billed amount of $2,500.00.

Claims submitted without the DME Certification and Receipt Form (when required) will be denied.

Clients who receive DME that meets or exceeds a total billed amount of $2,500.00 may be contacted to verify receipt of the equipment. If receipt of the equipment cannot be verified, the claim payment will be eligible for recoupment.

Providers may be reimbursed for items that are addressed in this article either by the lesser of the provider's billed charges or the published fee determined by the Texas Health and Human Services Commission (HHSC) or through manual pricing. If manual pricing is used, the provider must request prior authorization and submit documentation of either of the following:

• The manufacturer's suggested retail price (MSRP) or average wholesale price (AWP), whichever is applicable
• The provider's documented invoice cost
Manually priced items are reimbursed as follows as is appropriate:
- MSRP less 18 percent or AWP less 10.5 percent, whichever is applicable
- The provider's documented invoice cost

Orthotic and Orthopedic Devices Procedure Codes

The following orthoses procedure codes may be reimbursed in the home setting to a medical supplier (DME) provider:

Table A: Orthoses Procedure Codes

<table>
<thead>
<tr>
<th>Cervical Orthoses</th>
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</thead>
<tbody>
<tr>
<td>L0112</td>
</tr>
<tr>
<td>L0172</td>
</tr>
<tr>
<td>Thoracic Rib Belts</td>
</tr>
<tr>
<td>L0220</td>
</tr>
<tr>
<td>DeWall Posture Protector</td>
</tr>
<tr>
<td>L0430</td>
</tr>
<tr>
<td>Thoracic-Lumbar-Sacral Orthoses</td>
</tr>
<tr>
<td>L0450</td>
</tr>
<tr>
<td>L0464</td>
</tr>
<tr>
<td>L0484</td>
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<tr>
<td>Sacroiliac Orthoses</td>
</tr>
<tr>
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<td>Lumbar Orthoses</td>
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<td>Lumbar-Sacral Orthoses</td>
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<td>Cervical-Thoracic-Lumbar-Sacral Orthoses</td>
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<td>L0700</td>
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<td>Halo Procedures</td>
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<tr>
<td>Spinal Corset Orthoses</td>
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<tr>
<td>L0970</td>
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<tr>
<td>Miscellaneous Devices</td>
</tr>
<tr>
<td>L0978</td>
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<td>Spinal Orthosis- Milwaukee Brace</td>
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<table>
<thead>
<tr>
<th>Spinal Orthoses for Scoliosis</th>
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</thead>
<tbody>
<tr>
<td>L1005</td>
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<thead>
<tr>
<th>Thoracic-Lumbar-Sacral Orthoses- Initial and Additions</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Other Spinal Orthoses</th>
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</thead>
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<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>L1600</td>
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<tr>
<th>Legg Perthes Orthoses</th>
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<tr>
<th>Knee Orthoses</th>
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<tr>
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<th>Fracture Orthoses- Lower Extremity</th>
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<th>Additions to Lower Extremity Orthoses</th>
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**Miscellaneous Lower Extremity Orthosis**

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**Foot Orthoses/Inserts and Arch Supports**

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**Orthopedic Shoes and Surgical Boots**

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**Heel Lifts and Wedges**

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**Additions to Orthopedic Shoes**

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**Transfer of Orthosis**

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**Shoulder Orthoses**

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**Elbow/Elbow-Wrist-Hand/Elbow-Wrist-Hand-Finger Orthoses**

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Wrist-Hand/Wrist-Hand-Finger/Hand-Finger Orthoses

L3806  L3807  L3808  L3900  L3901  L3904  L3905
L3906  L3908  L3912  L3913  L3915  L3917  L3919
L3921  L3923  L3925  L3927  L3929  L3931  L3933
L3935

Additions to Upper Extremity Joint

L3956

Shoulder-Elbow/Shoulder-Elbow-Wrist-Hand Orthoses

L3960  L3961  L3962  L3964  L3965  L3966  L3967
L3968  L3969  L3970  L3971  L3972  L3973  L3974
L3975  L3976  L3977  L3978

Fracture Orthoses- Upper Extremity

L3980  L3982  L3984  L3995

Miscellaneous Upper Limb Orthosis

L3999

Orthoses Replacement Procedures

L4000  L4002  L4010  L4020  L4030  L4040  L4045
L4050  L4055  L4060  L4070  L4080  L4090  L4100
L4110  L4130

Repair of Orthoses

L4205  L4210

Walking Boots, Foot Drop Splints and Static Ankle Foot Orthoses

L4350  L4360  L4370  L4380  L4386  L4392  L4394
L4396  L4398

The following orthopedic device procedure codes may be reimbursed in the home setting to a medical supplier (DME) provider:

Table B: Orthopedic Devices Procedure Codes

Protective Helmets

A8000*  A8001*  A8002*  A8003*  A8004*

* These procedure codes may also be payable to home health (DME) providers in the home setting.

Dynamic Devices (Purchase and Rental)

E1800  E1802  E1805  E1810  E1812  E1815  E1820
E1825  E1830  E1840
**Prostheses**

External prostheses are a benefit of Texas Medicaid when provided by a licensed prosthetist or licensed prosthetist/orthotist under the Texas Health Steps-Comprehensive Care Program (THSteps-CCP) for clients who are birth through 20 years of age.

Prostheses may be reimbursed using the procedure codes listed in table C in this article.

The following prostheses are a benefit of Texas Medicaid when medical necessity criteria are met:
- Lower limb
- Upper limb
- Craniofacial
- External breast

**Definitions for Prostheses**

Texas Medicaid uses the definitions of the Texas State Board of Orthotics and Prosthetics, as listed in the TAC.

The following definitions are not listed in TAC, but help define the benefits as referenced in this article:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct supervision</td>
<td>The supervising licensed prosthetist or licensed prosthetist/orthotist is in the same office, building, or facility when and where the service is provided, and is immediately available to furnish assistance and direction.</td>
</tr>
<tr>
<td>Custom-fitted</td>
<td>A prefabricated device which is manufactured in quantity without a specific client in mind, and is then trimmed, bent, or otherwise molded for use by a specific client.</td>
</tr>
<tr>
<td>Custom-fabricated</td>
<td>A prosthesis specifically manufactured for a specific client. This type of device requires substantial labor to construct, and is custom molded to the client's specific body part.</td>
</tr>
<tr>
<td>Microprocessor-controlled or computer-controlled prosthetic device</td>
<td>A type of power enhancement or power-controlled device.</td>
</tr>
<tr>
<td>Myoelectric prosthesis</td>
<td>A prosthetic device whose movement is controlled by electromyographic (EMG) signals or potentials on the surface of the skin caused by voluntarily contracted muscles within a client's residual limb</td>
</tr>
<tr>
<td>Electric switch prosthesis</td>
<td>A prosthetic device whose movement is controlled by straps or cables actuated by body movements that operate switches</td>
</tr>
<tr>
<td>Prosthetic shoe</td>
<td>A device used when all or a substantial portion of the front part of the foot is missing (a prosthetic shoe can be considered as a terminal device in that it is a structural</td>
</tr>
</tbody>
</table>
Noncovered Prosthetic Services

Prosthetic devices prescribed by a chiropractor are not a benefit of Texas Medicaid.

A vacuum-assisted socket system (procedure code L5781 or L5782), which is a specialized vacuum pump, is considered experimental and investigational, and is not a benefit of Texas Medicaid.

Myoelectric hand prostheses for conditions other than the absence of forearm(s) and hand(s) are considered experimental and investigational and are not a benefit of Texas Medicaid.

A prosthetic device customized with enhanced features is not considered medically necessary if ADLs can be met with a standard prosthetic device.

Accessories that are not required for the effective use of a prosthetic device are not considered medically necessary.

Prior Authorization Requirements for Prostheses

Prior authorization is required for all prosthetic devices.

Before requesting prior authorization for any prosthesis, the provider must have a completed THSteps-CCP Prior Authorization Form requesting the prosthesis that has been signed and dated by a physician familiar with the client. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures/dates will not be accepted. The completed THSteps-CCP Prior Authorization Form must include the procedure codes and quantities for services requested. A copy of the completed, signed, and dated form must be maintained by the prosthesis provider in the client's medical record. The completed THSteps-CCP Prior Authorization Form with the original dated signature must be maintained by the prescribing physician in the client's medical record.

- To complete the prior authorization process electronically, the prosthesis provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated CCP Prior Authorization Request form in the client’s medical record at the provider’s place of business.
- To complete the prior authorization process by paper, the prosthesis provider must fax or mail the completed THSteps-CCP Prior Authorization Request Form to the CCP prior authorization unit and retain a copy of the signed and dated CCP form in the client's medical record at the provider’s place of business.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the equipment and/or supplies requested. The physician must maintain documentation of medical necessity in the client’s medical record. The provider may be asked for additional information to clarify or complete a request for the service or device.

All requests for prior authorization must include documentation of medical necessity including, but not limited to, documentation that the client meets the following indications for the requested device:
The prosthesis replaces all or part of the function of a permanently inoperative, absent, or malfunctioning part of the limb. The specific limb which is being replaced by the prosthesis must be identified.

The prosthesis is required for ADLs or for rehabilitation purposes, and identification of the ADLs or rehabilitation purpose for which the prosthesis is required.

The provider must keep the following written documentation in the client’s medical record:

- The prescription for the device.
  - Prosthetic devices must be prescribed by a physician (M.D. or D.O.).
  - The prescription must be dated prior to or on the initial date of the requested dates of service, which can be no longer than 90 days from the signature date on the prescription.
- Accurate diagnostic information that supports the medical necessity for the requested device (a retrospective review may be performed to ensure that the documentation included in the client’s medical record supports the medical necessity of the requested service or device).
- The specific make, model, and serial number of the prosthetic components.
- The treatment plan outlining the therapy program prescribed by the treating physician, including expected goals with the use of the prosthesis.
- A statement submitted by the physician that indicates that the client or client’s family or caregiver demonstrates willingness to comply with the therapy program.

Prior authorization is valid for a maximum period of 6 months from the prescription signature date. At the end of the 6-month authorization period, a new prescription is required for prior authorization of additional services.

For the purpose of this article, the actual date of service is the date the supplier has placed an order for the equipment and has incurred liability for the equipment.

**Lower-Limb Prostheses**

Lower-limb prostheses include, but are not limited to, the following:

- Partial foot, ankle, and knee disarticulation sockets.
- Above-knee, short prostheses.
- Hip and knee disarticulation prostheses.
- Postsurgical prostheses.
- Preparatory prostheses.
- Additions to lower extremity prostheses.
- Replacement sockets.

A basic lower-limb prosthesis consists of the following:

- A socket or connection between the residual limb and the prosthesis.
- A suspension mechanism attaching the socket to the prosthesis.
• A knee joint that provides support during stance, smooth control during the swing phase, and unrestricted motion for sitting and kneeling.

• An exoskeleton or endoskeleton pylon (tube or shell) that attaches the socket to the terminal device.

• A terminal device (foot).

In addition to the indications defined in the Prior Authorization Requirements for Prostheses section above, the following additional documentation is also required for all lower-limb prostheses:

• Written documentation of the client’s current and potential functional levels. A functional level is defined as a measurement of the capacity and potential of individuals to accomplish their expected post-rehabilitation daily function. The potential functional ability is based on reasonable expectations of the treating physician and the prosthetist and includes, but is not limited to, the following:
  
  o The client’s history, including prior use of a prosthesis, if applicable.
  
  o The client’s current condition, including the status of the residual limb and any coexisting medical conditions.
  
  o The client’s motivation to ambulate and ability to achieve independent transfers or ambulation with the use of a lower-limb prosthesis.

The following functional classification levels have been defined by the Centers for Medicare & Medicaid Services (CMS):

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
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<tbody>
<tr>
<td>Level 0</td>
<td>Does not have the ability or potential to ambulate or transfer safely with or without assistance, and a prosthesis does not enhance quality of life or mobility.</td>
</tr>
<tr>
<td>Level 1</td>
<td>Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.</td>
</tr>
<tr>
<td>Level 2</td>
<td>Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator.</td>
</tr>
<tr>
<td>Level 3</td>
<td>Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.</td>
</tr>
<tr>
<td>Level 4</td>
<td>Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high-impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.</td>
</tr>
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</table>

A client whose functional level is zero (0) is not a candidate for a prosthetic device; the device is not considered medically necessary.

Microprocessor-Controlled Lower-Limb Prostheses
Microprocessor-controlled lower-limb prosthesis (e.g., Otto Bock C-Leg, Intelligent Prosthesis, or Ossur Rheo Knee) will be considered for prior authorization for clients who have a transfemoral amputation from a nonvascular cause, such as trauma or tumor and a functional level of 3 or above, and who meet the following criteria:

- The individual has adequate cardiovascular reserve and cognitive learning ability to master the higher level of technology and to allow for faster than normal walking speed.
- The individual demonstrates the ability to ambulate at a faster than baseline rate using a standard prosthetic application with a swing-and-stance-control knee.
- The individual has a demonstrated need for long-distance ambulation at variable rates (greater than 400 yards) on a daily basis. Use of the limb in the home or for basic community ambulation is not sufficient to justify provision of the computerized limb instead of standard limb applications.
- The individual has a demonstrated need for regular ambulation on uneven terrain or for regular use on stairs. Use of the limb for limited stair climbing in the home or employment environment is not sufficient evidence for prescription of this device over standard prosthetic application.

The licensed prosthetist or licensed prosthetist/orthotist providing the device must be trained in the fitting and programming of the microprocessor-controlled prosthetic device.

**Foot Prostheses**

The following foot prostheses will be considered for prior authorization for clients whose documented functional level is 1 or above:

- A solid ankle-cushion heel (SACH) foot.
- An external keel SACH foot or single axis ankle/foot.

A flexible-keel foot or multi-axial ankle/foot will be considered for prior authorization for clients whose documented functional level is 2 or above.

A flex foot system, energy storing foot, multi-axial ankle/foot, dynamic response, or flex-walk system or equivalent will be considered for prior authorization for clients whose documented functional level is 3 or above.

A prosthetic shoe will be considered for prior authorization if it is an integral part of a prosthesis for clients with a partial foot amputation.

**Ankle Prosthesis**

An axial rotation unit will be considered for prior authorization for clients whose documented functional level is 2 or above.

**Knee Prosthesis**

A single-axis, constant-friction knee and other basic knee systems will be considered for prior authorization for clients whose documented functional level is 1 or above.

A fluid, pneumatic, or electronic knee prosthesis will be considered for prior authorization for clients whose documented functional level is 3 or above.

A high-activity knee control frame will be considered for prior authorization for clients whose documented functional level is 4.
Prosthetic Substitutions or Additions for Below-Knee Prostheses

Procedure codes L5629, L5638, L5639, L5646, L5647, L5704, L5785, L5962, and L5980 are not considered medically necessary when an initial below-knee prosthesis (procedure code L5500) or a preparatory below-knee prosthesis (procedure codes L5510, L5520, L5530, or L5540) is provided.

Prosthetic substitutions or additions (procedure codes L5620, L5629, L5645, L5646, L5670, L5676, L5704, and L5962) are not considered medically necessary when a below-knee preparatory, prefabricated prosthesis (procedure code L5535) is provided.

Prosthetic Substitutions or Additions for Above-Knee Prostheses

Prosthetic substitutions or additions (procedure codes L5610, L5631, L5640, L5642, L5644, L5648, L5705, L5706, L5964, L5980, L5710, L5780, L5790, and L5795) are not considered medically necessary when an above-knee initial prosthesis (procedure code L5505) or an above-knee preparatory prosthesis (procedure codes L5560, L5570, L5580, L5590, L5595, or L5600) is provided.

Prosthetic substitution or additions (procedure codes L5624, L5631, L5648, L5651, L5652, L5705, L5706, L5964 and L5966) are not considered medically necessary when an above-knee preparatory, prefabricated prosthesis (procedure code L5585) is provided.

Sockets

Prior authorization for test (diagnostic) sockets for an individual prosthesis is limited to a quantity of two test sockets.

Prior authorization for same-socket inserts for an individual prosthesis is also limited to a quantity of two.

Requests for test sockets or same-socket inserts beyond these limitations must include documentation of medical necessity that supports the need for the additional sockets.

Upper-Limb Prostheses

Upper-limb prostheses include, but are not limited to, the following:

- Partial hand prostheses.
- Wrist and elbow disarticulation prostheses.
- Shoulder and interscapular thoracic prostheses.
- Immediate postsurgical or early-fitting prostheses.
- Preparatory prostheses.
- Terminal devices.
- Replacement sockets.
- Inner sockets-externally powered.
- Electric hand, wrist, and elbow prostheses.

Upper-limb prostheses will be considered for prior authorization with documentation of all of the indications defined in the Prior Authorization Requirements for Prostheses.
The additional criteria in the following sections apply for specific prosthetic devices.

**Myoelectric Upper-Limb Protheses**

A myoelectric upper-limb prosthetic device is considered medically necessary when all of the following criteria have been met:

- The client has sufficient neurological, myocutaneous, and cognitive function to operate the prosthesis effectively.
- The client has an amputation or missing limb at the wrist or above (e.g., forearm, elbow, etc).
- The client is free of comorbidities that could interfere with maintaining function of the prostheses (e.g., neuromuscular disease).
- The client retains sufficient microvolt threshold in the residual limb to allow proper function of the prostheses.
- Standard body-powered prosthetic devices cannot be used or are insufficient to meet the functional needs of the client in performing ADLs.
- The client does not function in an environment that would inhibit function of the prosthesis (e.g., a wet environment or a situation involving electrical discharges that would affect the prosthesis).

**External Breast Prostheses**

External breast prostheses will be considered for prior authorization for clients who have congenital absence of a breast or have had a mastectomy.

**Craniofacial Prostheses**

Craniofacial prostheses include, but are not limited to, external nasal, ear, and facial prostheses.

Craniofacial prostheses will be considered for prior authorization with documentation that the device is necessary to correct an absence or deformity of the affected body part.

**Related Services for Prostheses**

**Accessories to Prostheses**

Accessories to prostheses, such as stump stockings and harnesses will be considered for prior authorization when they are essential to the effective use of the prosthetic device.

**Prosthetic Training**

Prosthetic training by a physical or occupational therapist for a lower-limb prosthesis or an upper-limb prosthesis is a benefit for clients who have not worn one previously or for a prolonged period or who are receiving a different type. Texas Medicaid criteria for physical or occupational therapist services must also be met.

**Note:** Refer to the 2009 Texas Medicaid Provider Procedures Manual, sections 43.4.8, "Occupational Therapists (CCP)" and 43.4.12, “Physical Therapists (CCP)” for specific benefit criteria for these services.
Repairs, Replacements, and Modifications to Prostheses

Repairs, replacements, and modifications to prostheses are a benefit when medical necessity criteria are met.

Repairs due to normal wear and tear will be considered for prior authorization after 90 days from the date of delivery of the initial prosthesis, when the repair is:

- Necessary to make the equipment functional.
- More cost-effective than the replacement of the prosthetic device.

Providers must include documentation that supports medical necessity when they request prior authorization. Additional information from the provider may be requested to determine cost-effectiveness.

Replacement of prosthetic equipment will be considered for coverage when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate and the measures to be taken to prevent reoccurrence must be submitted with the prior authorization request.

Socket replacements will be considered for prior authorization with documentation of functional or physiological need, including, but not limited to, changes in the residual limb, functional need changes, or irreparable damage or wear due to excessive weight or prosthetic demands of very active amputees.

When the equipment has been abused or neglected by the client, the client’s family or the caregiver, a referral to the Department of State Health Services (DSHS) THSteps Case Management unit will be made by the THSteps-CCP prior authorization unit for clients who are birth through 20 years of age. Providers will be notified that the State will be monitoring this client’s services to evaluate the safety of the environment for both the client and equipment.

Children typically require new prosthetic devices every 12 to 18 months, although the actual lifespan of a device depends on the child’s rate of skeletal growth. Prosthetic devices for children must accommodate growth and other physiological changes. Components and systems that allow for growth or increase the lifespan of the prosthesis may include the following:

- Growth-oriented suspension systems and modifications.
- Use of modular systems.
- Use of flexible sockets.
- Use of removable sockets (slip or triple-wall sockets).
- Use of distal pads.
- Modification of socket liners.
- Increasing or decreasing sock thickness.

Modifications due to growth or change in medical status will be considered for prior authorization with documentation of medical necessity.

Medical necessity for requested components or additions to the prosthesis is based on the client’s current functional ability and the expected functional potential as defined by the prosthetist and the ordering physician.
**Requirements for Dispensing, Fabricating, and Modifying Prostheses**

To be considered for reimbursement, prostheses must be dispensed, fabricated, or modified by a licensed prosthetist or licensed prosthetist/orthotist enrolled with Medicare and THSteps-CCP.

The date of service for a custom-made or custom-fitted prosthesis is the date the supplier places an order for the equipment and incurs a liability for the equipment. The custom-made or custom-fitted prosthesis will be eligible for reimbursement as long as the service is provided during a month the client is eligible for Medicaid.

The following items and services are included in the reimbursement for a prosthetic device and not reimbursed separately:

- Evaluation of the residual limb and gait.
- Measurement, casting, or fitting of the prosthesis.
- Cost of base component parts and labor contained in the base procedure code description.
- Repairs due to normal wear and tear during the 90 days following delivery.
- Adjustments or modifications of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments are not necessitated by changes in the residual limb or the client’s functional ability.

In general, base codes do not represent a complete device. To include the additional components necessary for a complete device, providers may bill additional components with a code that is used in addition to a base code. Addition codes may also be used to indicate modifications to a device. The values assigned to the additional codes do not represent the actual value of the component or modification, but only the difference between the total value and the value of the base code. As a result, reimbursement of an addition does not involve subtraction of any amounts from the base code allowance.

**Reimbursement for Prostheses**

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the dated signatures of the provider and the client or primary caregiver. This signed and dated form must be kept by the DME provider in the client’s medical record.

The DME Certification and Receipt Form must be submitted for DME claims and appeals when either of the following occurs:

- A single item meets or exceeds a billed amount of $2,500.00.
- Multiple items submitted on the same date of service meet or exceed a total billed amount of $2,500.00.

Claims submitted without the DME Certification and Receipt Form (when required) will be denied.
Clients who receive DME that meets or exceeds a total billed amount of $2,500.00 may be contacted to verify receipt of the equipment. If receipt of the equipment cannot be verified, the claim payment will be eligible for recoupment.

Providers may be reimbursed for items that are addressed in this article either by the lesser of the provider’s billed charges or the published fee determined by HHSC or through manual pricing. If manual pricing is used, the provider must request prior authorization and submit documentation of either of the following:

- The MSRP or AWP, whichever is applicable.
- The provider’s documented invoice cost.

Manually priced items are reimbursed as follows as is appropriate:

- MSRP less 18 percent or AWP less 10.5 percent, whichever is applicable
- The provider’s documented invoice cost

**Prostheses Procedure Codes**

The following prostheses procedure codes may be reimbursed in the home setting to a medical supplier (DME) provider:

*Table C: Prostheses Procedure Codes*

<table>
<thead>
<tr>
<th>Prosthetic Shoe</th>
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<tr>
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<table>
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<tr>
<th>Partial Foot, Ankle and Knee Disarticulation Sockets</th>
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<tbody>
<tr>
<td>L5000 L5010 L5020 L5050 L5060 L5100 L5105</td>
</tr>
<tr>
<td>L5150 L5160</td>
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<th>Additions to Lower Extremity Prostheses</th>
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### Replacement Sockets

- L5631
- L5632
- L5634
- L5636
- L5637
- L5638
- L5639

### Protective Covers

- L5700
- L5701
- L5702
- L5703

### Additions to Lower Extremity Prosthesis - Exoskeletal and Endoskeletal

- L5710
- L5711
- L5712
- L5714
- L5716
- L5718
- L5722

- L5724
- L5726
- L5728
- L5780
- L5785
- L5790
- L5795

- L5810
- L5811
- L5812
- L5814
- L5816
- L5818
- L5822

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- L5840
- L5845
- L5848

- L5850
- L5855
- L5856
- L5857
- L5858
- L5910
- L5920

- L5925
- L5930
- L5940
- L5950
- L5960
- L5962
- L5964

- L5966
- L5968

### All Lower Extremity Prostheses

- L5970
- L5971
- L5972
- L5974
- L5975
- L5976
- L5978

- L5979
- L5980
- L5981
- L5982
- L5984
- L5985
- L5986

- L5987

### Additions to Lower Limb Prostheses

- L5988
- L5990
- L5999

### Partial Hand, Wrist, and Elbow Disarticulation Prostheses

- L6000
- L6010
- L6020
- L6025
- L6050
- L6055
- L6100

- L6110
- L6120
- L6130
- L6200
- L6205
- L6250

### Shoulder Disarticulation and Interscapular Thoracic Prostheses

- L6300
- L6310
- L6320
- L6350
- L6360
- L6370

### Immediate Postsurgical Wrist, Elbow, or Shoulder Disarticulation Prostheses

- L6380
- L6382
- L6384
- L6386
- L6388

### Endoskeletal Elbow, Shoulder and Interscapular Thoracic Prostheses

- L6400
- L6450
- L6500
- L6550
- L6570

### Preparatory Wrist, Elbow and Shoulder Disarticulation Prostheses
### Additions to Upper Extremity Prostheses

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### Terminal Devices

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### Replacement Sockets

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### Additions- Glove for Terminal Devices

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### Hand Restoration

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### Wrist, Elbow and Shoulder Inner Sockets- Externally Powered

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### Electronic Hand, Elbow and Wrist Prosthetic Device

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### Additions to Upper Extremity Prostheses

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### Miscellaneous Upper Extremity Prosthesis

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### Repair of Prosthetic Device

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### Prosthetic Donning Sleeve

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### Breast Prostheses

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