# Durable Medical Equipment (DME) and Supplies


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# Durable Medical Equipment (DME) and Supplies

## Program Overview

The Colorado Medical Assistance Program covers Supplies and Durable Medical Equipment (DME) as described in this manual. Durable Medical Equipment is defined as equipment that can withstand repeated use and that generally would be of no value to the member in the absence of a disability, illness, or injury. This manual gives a summary of the covered DME benefits and is periodically modified as new billing information is implemented. Therefore, the information in this manual is subject to change.

The definitive list of covered diagnosis and procedure codes is located in the Supply Healthcare Common Procedure Coding System (HCPCS) Codes provided in this manual, which the Colorado Medical Assistance Program updates and makes available to all enrolled DME providers annually. Providers should consult the current Supply HCPCS Codes included in this manual for updated benefit coverage, limitations, and prior authorization request (PAR) requirements. Providers may refer to the Code of Colorado Regulations, Program Rules (10 CCR 2505-10 Section 8.590), for specific regulations and guidance on providing the DME benefit.

The Department of Health Care Policy and Financing (the Department) periodically modifies billing information. Therefore, the information in this manual is subject to change, and the manual is updated as new billing information is implemented.

## Eligible Providers

Providers must be enrolled as a Colorado Medical Assistance Program provider in order to:

- Treat a Colorado Medical Assistance Program member
- Submit claims for payment to the Colorado Medical Assistance Program

Note: For members with primary insurance refer to the PAR submission instructions below.

## Prescribing Providers

Supplies and DME must be prescribed by a physician, physician assistant or nurse practitioner. The prescription must be within the scope of the prescribing provider's license.

## Supply/Equipment Providers

Supply providers may be either enrolled pharmacies or durable medical equipment supply companies.

Pharmacies: In state or border pharmacies will be automatically enrolled as a DME supplier upon approval of pharmacy application.

Mail order pharmacies do not qualify to provide DME/Supplies. Pharmacies with less than 5% of total revenue received from DME are not required to obtain Medicare accreditation.

All DME providers must provide proof of Medicare accreditation with the exception of pharmacy and orthotics and prosthetics providers.

Out of state DME providers may only provide services for crossover Medicare/Medicaid members or have a specialized product that cannot be obtained through an in-state DME provider.

The rendering provider must retain the member's prescription for services and related documentation for at least six (6) years, and make it available for audit by the Department of Health Care Policy and Financing (the Department) and its agents or representatives.

# Covered Benefits

Supplies and DME must be medically necessary and prescribed by an authorized prescriptive authority for use by an eligible members. The following are categories of covered benefits and are further outlined in this section. Additional equipment and supply items are listed in the Supply HCPCS section of this manual.

# Durable Medical Equipment (DME)

DME refers to equipment that can withstand repeated use and allows member accessibility in the home and community. DME is covered in the following categories

**Inexpensive or Routinely Purchased**: These items are purchased for a recipient.

**Capped Rental/Purchased Equipment:** These items are rented or purchased as follows:

a. The item is **rented** if the physician, physician assistant, or nurse practitioner documents that the anticipated need is six (6) months or less.

b. The item may be **rented** or **purchased** if the physician, physician assistant, or nurse practitioner documents that the anticipated need exceeds six (6) months.

Once rental is initiated on an item, a subsequent request for prior approval of purchase of that item must be accompanied by additional supporting documentation validating the need for purchase. Rental reimbursements may not exceed the purchase price of the item. Once the purchase price of the item is reached, the rental will be considered purchased and no additional reimbursement will be made. Some items are rental only.

> **Example:** If the monthly rental for an item is $30 and the new purchase price is $200, the Colorado Medical Assistance Program will pay six (6) full months of rental, plus no more than $20 in the seventh month of rental. At that time, the item becomes the property of the recipient, and no more rental payments are made.

**Equipment Requiring Frequent and/or Substantial Servicing:** Most equipment will convert to purchase when purchase price is met. Exceptions to this policy include:

a. Oxygen Equipment

b. Specialized high-complexity hospital beds

c. Ventilators

# Supplies

## Related Medical Supplies

Supplies accompanying DME that has been prescribed and is currently being used by the member are covered.

## Rebates

If a rebate is available the provider must reflect Usual and Customary charge minus the rebate received or anticipated from the manufacturer.

## Disposable Supplies

Disposable supplies, including gloves, are a benefit the Colorado Medical Assistance Program for use by the member in his/her home. With the exception of gloves, the Home Health agency is responsible for providing all supplies necessary to meet the universal precaution requirement during a visit.

## Enteral Nutrition Products

Enteral nutrition (EN) refers to medical formula/solutions when ordered by a physician, physician assistant, or nurse practitioner and provided according to standards of practice. The allowance for all items includes delivery to a member's residence. Equipment, supplies, and nutrients for enteral feeding or food supplements are a benefit when prior authorized.

Durable Medical Equipment providers should request that members participate in the Women, Infants & Children (WIC) program as a primary resource for medically necessary enteral nutrition products. Enteral nutrition products prescribed over the WIC limit are a covered benefit. Providers have the option of requesting a three (3) month PAR for members in the process of applying for WIC. After WIC determination is completed, provider may then submit a new PAR for one (1) year less one (1) day.

PARs and claims must identify the calculated number of units as specified in the current Supply HCPCS Codes section of this billing manual. Nutritional supplements are not for replacement of conventional foods or for use as a convenience item.

## Home Intravenous (IV) Equipment

Home Intravenous (IV) equipment is a DME benefit for administration of Total Parenteral Nutrition (TPN), administration of antibiotics, maintenance of electrolyte balances, hydration, or other medications.

The home IV therapy solutions and medications in this manual that are indicated as a home mix are a pharmacy benefit. The following HCPCS codes must be provided by a pharmacy per pharmacy billing requirements using a rebateable National Drug Code (NDC): B4164, B4168, B4172, B4176, B4178, B4180, B4186, B4189, B4193, B4197, B4199, B4216, B5000, B5100, B5200. These codes are only reimbursed as supply benefit for crossover claims when provided as an inpatient therapy for full benefit Medicare-Medicaid members.

## Diabetic Supplies

Diabetic Supplies including glucose testing meters, test strips and other related supplies are a benefit with a prescription from a physician, physician assistant or nurse practitioner. Diabetic supplies are available for insulin, and non-insulin dependent members. Diabetic supplies MUST be billed as DME/Supply. Pharmacies billing supply must follow supply billing procedures and will not be reimbursed if billed as pharmacy or using NDC codes.

## Incontinence Products or Briefs

The prescribing practitioner's prescription must include incontinence as a condition of a primary or secondary diagnosis in order for the member to qualify for reimbursement by the Colorado Medical Assistance Program. COMBINATION LIMIT: Diapers or briefs for children 0-4 years old are an expected childhood expense and are not a Colorado Medical Assistance Program benefit. Products are limited to 240 per calendar month in any combination of diapers, liners, and undergarments. Medically necessary usage above that amount requires prior authorization. Incontinence wipes are not a benefit.

## Oxygen Contents and Oxygen Delivery Systems

Oxygen contents and delivery systems must be billed by the supply provider.

## Prosthetics and Orthotics

Prosthetics and orthotics are a covered Colorado Medical Assistance Program benefit for eligible members. The benefit includes items such as breast prostheses, braces, artificial limbs, implants, augmentative communication devices and orthopedic shoes for diabetic members. Some services require prior authorization.

## Wheelchair Purchase (Manual, Power and Scooter)

All wheelchair purchases require prior authorization and must be accompanied by a signed letter of medical necessity from a physician, physician assistant or nurse practitioner. Customized items must be identified separately and included in the letter of medical necessity.

Members who meet medical criteria guidelines may receive one (1) primary wheelchair and, when deemed necessary, one (1) secondary/backup wheelchair within a five-year time period. Replacement of stolen equipment requires a police report that conforms to criteria outlined in the Colorado Revised Statutes.

### Billing for Wheelchairs:

- Providers must retain record of the serial number for each approved item. ALL electronic and paper claims for wheelchairs must be submitted with the serial number of the equipment that was approved on the PAR.
- Primary and secondary/backup wheelchairs are identified by the unique PAR approval and serial numbers and should be indicated on all wheelchair claims to avoid duplicate claim denials. Providers should NOT submit claims with the 76 modifier, as it is not a valid DME modifier for the Colorado Medical Assistance Program.
- Beginning April 1, 2014, all prior authorization requests and claims for secondary/backup wheelchairs must be submitted with a TW modifier. All components associated with the secondary or backup wheelchair must also contain the TW modifier.

## Wheelchair Equipment Repair (Manual & Motorized)

Wheelchair and equipment repair costs are a Colorado Medical Assistance Program benefit when the member owns the equipment and the repair cost does not exceed the equipment's replacement cost. PARs for wheelchair repair no longer require a prescription or signature from the physician.

### Prior Authorization for Repairs:

A PAR is required for **EACH** wheelchair repair item. Prior Authorization Requests submitted with multiple repairs will be denied. The following information must be included in the request; requests lacking any of the following information will result in a denial or will be returned to the provider for the missing information:

- Wheelchair type indication: manual or motorized; and
- Manufacturer, make, and model; and
- Serial number: PARs for equipment repair must identify the serial number of the equipment in field 12 or 30 (paper) or field 12 (electronic) on the PAR form; and
- If available, please include the original wheelchair purchase date or PAR; and
- If the repair is for a secondary/backup wheelchair, the PAR and claim must contain the TW modifier.

***Note***: Wheelchair repairs for members residing in a nursing facility may be covered if the wheelchair was owned by the member prior to entering the facility. In this instance, the PAR must indicate that the

member is residing in the nursing facility by checking "yes" in the appropriate field on the PA request. The PAR will not be processed without this disclosure.

### Billing for Repairs:

Providers must retain record of the serial number for each approved repair item. The serial number must also be included on the CMS 1500 claim form in field 30 for all paper claims.

## Transcutaneous or Neuromuscular Electrical Nerve Stimulators (TENS or NMES)

TENS or NMES require a 2-month trial rental period. A PAR is required for the rental or purchase of a TENS or NMES unit. This benefit requires the use of Questionnaire #9.

## Augmentative and Alternative Communication Devices (AACDs)

The AACD Benefit Coverage Standard has been incorporated by reference to the Durable Medical Equipment and Disposable Medical Supplies rule 10 CCR 2505-10, §8.590.2.S, effective September 30, 2013. This coverage standard contains important information on updated prior authorization requirements and guidelines for providing tablet computers, which is an addition to the communication device options covered by Medicaid.

Please refer to the AACD Benefit Coverage Standard for detailed coverage guidelines and prior authorization requirements located on the Department's website (colorado.gov/hcpf)→ For Our Stakeholders → Committees, boards, & collaboration → Boards & Committees → Benefits Collaborative →Approved Benefit Coverage Standards.

## Complex Rehabilitation Technology (CRT)

### Program Overview

Complex Rehabilitation Technology (CRT) includes individually configured manual wheelchair systems, power wheelchair systems, adaptive seating systems, alternative positioning systems, standing frames, gait trainers, and specifically designed options and accessories classified as DME. Only qualified CRT suppliers may bill CRT procedure codes. The CRT procedure codes are listed beginning on page 170.

### Eligible Providers

#### Prescribing Providers

Complex Rehabilitation Technology must be prescribed by a physician, physician assistant or a nurse practitioner. The prescription must be within the scope of the prescribing provider's license.

#### Billing Providers

Only providers enrolled as a CRT supplier may bill for CRT codes. In order to qualify as a CRT supplier, providers must:

- Be accredited by a recognized accrediting organization as a supplier of CRT.
- Meet the supplier and quality standards established for DME suppliers under the Medicare or Medicaid program.
- Employ at least one (1) qualified CRT professional (ATP) for each location.
- Have CRT professionals present during member evaluation to:
    - Assist in selecting the appropriate CRT items for such needs and capacities

  - Provide the member technology- related training in the proper use and maintenance of the selected CRT items
  - Directly involve with the assessment, and determination of the appropriate individually configured complex rehabilitation technology for the member, with such involvement to include seeing the member visually either in person or by any other real-time means within a reasonable time frame during the determination process
- Maintain a reasonable supply of parts, adequate physical facilities, and qualified services or repair technicians to provide members with prompt service and repair of all CRT it sells or supplies; and
- Provide the member written information at the time of sale as to how to access service and repair.

Existing Colorado Medicaid DME providers that want to enroll as a CRT supplier, need to request a letter of intent to enroll as a CRT supplier. Suppliers with multiple Medicaid provider ID numbers need to submit a letter of intent for each provider ID number that will bill CRT for Medicaid.

# Special Considerations

## DME Rental

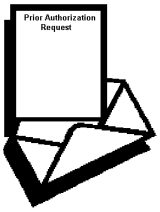
Unless specifically noted, the first month of equipment rental does not require prior authorization. The provider must use modifier -KH (first month's rental) in the modifier column on the claim form and one (1) unit of service per procedure code. There may be a financial cap on rental items. If the total cost for rental of any item reaches the cost of purchase, the item will be converted to a purchase unless otherwise specified. Rental amounts in excess of purchase amounts are subject to recovery.

## Used/Refurbished DME

Supply providers have the option to request refurbished durable medical equipment. Equipment may be donated, passed down from a sibling or purchased from a durable medical equipment provider post refurbishment. All refurbished equipment requires a PAR.

The durable medical equipment provider must guarantee that the equipment provided to the member is in "like new" condition, and that any modifications are made prior to the delivery of the equipment. The cost of repairs or modifications must not exceed the cost of replacement equipment. The provider will maintain a one (1) year limited warranty that covers all necessary parts or repairs. Comparison pricing for new equipment must be included in the PAR documentation. PAR documentation must include the make, model, and serial number of equipment. The Used Equipment (UE) modifier must be used on all used equipment.

Examples of allowable used or refurbished equipment are:




- Manual Wheelchairs
- Power Operated Vehicles (Scooters)
- Power Wheelchairs
- Hospital Beds (Frame only, new mattress must be purchased)
- Lifts
- Augmentative Communication Devices

## Dates of Service After the Death of a Medicaid Member

The Colorado Medical Assistance Program will reimburse supply providers for durable medical rental equipment, oxygen, and bulk supplies that are drop-shipped to the member's home for services rendered during the month of the member's death. The Colorado Medical Assistance Program will make recoveries

for other services following the date of the member's death, or for rental and bulk supplies billed after the month of the member's death.

## Shipped Supplies

Member must be contacted prior to shipping to ensure member information is correct. Members may not be charged for costs associated with shipping and handling.

# Pricing

## Maximum Purchase Amount

**Priced Code:** Purchase amount is available up to the maximum identified dollar amount listed on the fee schedule. This is not a guarantee of the printed amount if the actual cost of the item is less. No additional handling, shipping, or tax charges may be billed.

**MSRP or Invoice Pricing:** Fee schedule items that require manual pricing are reimbursed using the manufacturer suggested retail price (MSRP) or invoice methodology. Current pricing can be found in 10 CCR 2505-10, Section 8.590.7.I of the Colorado Medical Assistance Program rules regarding DME and Supplies.

***Please note:** The above listed maximum allowable purchase and rental price is subject to change. For current pricing, please refer to the Rates & Fee Schedules section on the Provider Services web page of the Department's website at colorado.gov/hcpf. Quotes are not allowed for pricing at any time.

## Maximum Allowable Rental Price

**Priced Code:** Rental benefit is available up to the identified dollar amount maximum listed on the fee schedule. This is not a guarantee of the printed amount if the actual cost of the item is less. Accessories, maintenance, and repairs are inclusive in the cost of the rental item.

**Per PAR:** Rental payment is based upon attachment of a manufacturer's invoice to the PAR. Reimbursement will be determined at the time of PAR approval as a percentage of invoice cost. A copy of the PAR must be attached to each submitted claim only if the PAR indicates the amount of reimbursement allowable in the Comments field. Otherwise, claims can be billed through the electronic media system. All approved prior authorized miscellaneous codes approved for rental must have a copy of the approved PAR attached to each submitted claim.

***Please note:** The above listed maximum allowable purchase and rental price is subject to change. Please refer to the fee schedule on the Provider Services web page of the Department's website at colorado.gov/hcpf for current pricing. Quotes are not allowed for pricing at any time.

# Prior Authorization Requests (PARs) for Supplies and DME

Some supply items and most DME items require prior authorization. A member may be required to receive an occupational therapy evaluation to determine appropriateness of prescribed equipment such as motorized chairs and lift chairs. This manual contains a detailed list of prior authorization requirements as well as the correct form and mailing address for each PAR.

Prior Authorization Requests must be submitted and approved before services are rendered. The service must be rendered by the identified supplier on the approved PAR. Services rendered must match the approved services exactly.

**Approval of a PAR does not guarantee Colorado Medical Assistance Program payment and does not serve as a timely filing waiver.** Prior authorization only assures that the approved service is a medical necessity and is considered a benefit of the Colorado Medical Assistance Program. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g., timely filing, detailed provider information, detailed description of medical necessity, all required attachments included, etc.) before payment can be made.

# CRT PAR Requirement

There are two (2) levels of documentation requirements associated with PARs for CRT:

**1) Basic Documentation**

- This level of documentation does not require a specialty evaluation. Basic documentation requirements apply to all CRT wheelchairs and wheelchair-related items that require a PAR. The basic documentation should include at a minimum the following information:
- Member's name, date of birth, residence address, height and weight, and all relevant medical diagnoses.
- A summary of the member's current medical condition, prognosis, previous and current treatments that are pertinent to the requested item.
- Length of anticipated need for the requested item.
- A brief description of the member's impairment in functional mobility that establishes that they have a mobility limitation and the item is needed for a medical purpose.
- If the recommended item is not the least costly option available to meet the member's medical need, documentation must contain a brief description of the impairments in body functions or structures that rule out use of the less costly item to justify the need for the recommended item.
- A description of how the member will operate the device (e.g. self-propel, tiller, joystick, etc.). Include a statement summarizing the member's mental and physical abilities/limitations as they pertain to member's ability to operate the recommended equipment appropriately for the duration of recommended use and in the environments in which it will routinely be used.
- If applicable, a brief description of the member's seating and positioning needs, and how these will be adequately met by the recommended device.
- If applicable, a brief description of where the equipment is to be used (example home, school, place of work, neighborhood, rural, city, train, etc...), including the accessibility of member's residence or non-institutional setting. Include if the equipment will be transported in a vehicle and how, as well as the capability of the member or caregiver to properly operate the equipment in these environments.
- A brief description of any anticipated changes in the member's physical size, medical or functional status which may require modifications to the equipment, and how the equipment will accommodate the member's needs over time. The recommended equipment should be capable of modification to meet the needs for anticipated improvement or deterioration of functional mobility when possible.
- Detailed description of all manually priced items that are requested including manufacturer's retail pricing or invoice information with itemized pricing, including the description of the specific base, any attached seating system components, and any attached accessories.

- All basic documentation paperwork (except for repair and replacement) requires the signature of the ordering physician, indicating that he or she agrees with the recommendation, and has evaluated the member within the past 12 months of signing and dating the required paperwork.

### 2) Specialty Evaluation Documentation

This level of documentation provides further details in order to establish medical necessity. A specialty evaluation is an assessment performed by a licensed/certified medical professional (such as a Physical Therapist, Occupational Therapist, or physician) who has no financial relationship with the DME supplier and who has specific training and experience in complex rehab technology wheelchair evaluations. The evaluation includes the physical and functional evaluation, treatment plan, goal setting, preliminary device feature determination, trials/simulations, fittings, function related training, determination of outcomes, and related follow-up. This evaluation is performed in conjunction with an equipment supplier who is a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified Assistive Technology Professional (ATP), and who assists with the home environment accessibility survey, system configuration, fitting, adjustments, programming, and product related follow up.

Specialty evaluation is required for:

- A new CRT wheelchair or a replacement CRT wheelchair after the 5th year mark for adults and 3rd year mark for children.
- A new custom contoured seating system or modification.
- An addition of power seating or alternative drive control to a wheelchair.
- Items that require a specialty evaluation must include both the basic and specialty evaluation documentation. Documentation for specialty evaluation should include the following information in addition to the basic documentation requirements previously listed:
- Date(s) of specialty evaluation; name and signature of licensed/certified medical professional completing the evaluation and assessment. A statement attesting that the person performing the assessment has no financial relationship with the DME provider should be included.
- A brief description of the specialty evaluation process that was completed, which includes a summary of the pertinent assessment findings/outcomes in the following assessment areas that apply:
    - Functional mobility, including transfers
    - Sitting balance/postural alignment
    - Existence and severity of postural asymmetries
    - Sensory function, if impaired
    - Neuromusculoskeletal function (movement, muscle tone, coordination)
    - Mat exam (joint range of motion, deformities, orthopedic impairment), addressing the existence and severity of orthopedic deformities
    - Equipment trials/simulations
- A description of the member's current mobility and/or seating equipment, how long the member has been using the current equipment and why it no longer meets the member's needs.
- Information on any recent changes in the member's physical or functional status, and any expected or potential surgeries that will improve or further limit mobility.

- If applicable, information regarding the member's seating and positioning needs and the specific seating equipment and accessories required to meet those needs.
- A summary of the type of mobility equipment that will best meet the member's medical and functional needs and an explanation of the basic and/or instrumental ADLs that will be possible with this equipment that would not be possible with a lower level or lower cost item.
- If applicable, documentation that supports why a tilt seat function is necessary to meet the member's medical and/or functional needs.
- If a member has a progressive disability, the documentation must indicate how the item will accommodate the member's needs over time. If a member is expected to grow, the wheelchair must have a growth potential.
- All specialty evaluation paperwork requires the signature of the ordering physician, indicating that he or she agrees with the recommendation and has evaluated the member within the past 12 months of signing and dating the required paperwork.

**NOTE:** Specialty evaluation is not required for CRT repair and replacement.

## PAR Submission

All PARs must be submitted by the supply provider that intends to submit the claim for the service and have an attached prescription from the prescribing authority and any other required documentation. Each PAR must include the name and phone number of the member's Primary Care Physician (if applicable). PAR requests for members with a non-Medicaid primary care physician must include the primary care provider's National Provider Identifier (NPI), contact information and note in the "comment" section stating that the referring provider is not a Colorado Medical Assistance Program provider and prescriptive authority has been verified. Pharmacies and providers shall not charge a member for items covered as a Colorado Medical Assistance Program benefit. This includes but is not limited to blood pressure monitors, blood glucose monitors, walkers, canes, nutritional supplements, and incontinence products.

Prior Authorization Request dates typically have a date span for one (1) year less one (1) day. Exceptions for decreased span dates less than one (1) year are allowed in certain circumstances such as short term rental or WIC application period. Dates must not exceed one (1) year and must match the dates on individual line items or the PAR will be denied.

All PARs and revisions processed by the ColoradoPAR Program must be submitted using CareWebQI (CWQI). Prior Authorization Requests submitted via fax or mail **will not** be processed by the ColoradoPAR Program and subsequently not reviewed for medical necessity. These PARs will be returned to providers via mail. This requirement only impacts PARs submitted to the ColoradoPAR Program.

The electronic PAR format will be required unless an exception is granted by the ColoradoPAR Program. Exceptions may be granted for providers who submit five (5) or less PARs per month.

To request an exception, more information on electronic submission, or any other questions regarding PARs submitted to the ColoradoPAR Program, please contact the ColoradoPAR Program at 1-888-454-7686 or refer to the Department's Colorado PAR Program web page

## PAR Review and Notification

The actual number of units approved for any item may be reduced or increased by the reviewer evaluating the PAR.

Once review is complete, the status of a PAR (approved, partially approved. or denied) is available through the Colorado Medical Assistance Program Secure Web Portal (Web Portal). In addition, both the provider and the member receive a letter indicating whether or not the services were authorized. The letter will include a PAR number that must be included on the claim.

## Submitting Claims after PAR Approval

Providers must receive an approval for all items/services that require a prior authorization before submitting a claim.

Once prior authorization is received, claims should only include the approved PAR number and, if applicable, the serial number of the approved equipment. In most cases, it is not necessary to submit a copy of the approved PAR. Providers will be notified if a copy of the approved PAR is needed.

## Questionnaires

All questionnaires are located in the Provider Services Forms section of the Department's website. Complete the corresponding questionnaire needed. Follow the links to the location.

colorado.gov/hcpf→ For Our Providers→Provider Services→Forms→DME-Supplies Questionnaires

# Record Keeping

Supply providers must maintain the records described below for all items provided to member. Supply providers must keep the information for 6 years, and provide a copy of any documentation to the Department and member or his/her representative upon request.

1. Prescribing practitioner's prescription(s);
2. Approved prior authorization requests;
3. Additional documentation received from physicians or other licensed practitioners;
4. Documentation that the member or caregiver has been provided with the following:

   - Manufacturer's instructions;
   - Warranty information;
   - Registration documents;
   - Service manual; and
   - Operating guides.
5. Documentation on all reimbursed equipment, which shall include:
   - Manufacturer's name and address;
   - Date acquired;
   - Acquisition cost;
   - Model number;
   - Serial number; and
   - Accessories, attachments or special features included in the item.
6. Verification that equipment requiring repairs belongs to the presenting member.

# National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions.

# General Billing Information

All of the requirements for member eligibility and proper claim submission must be met before reimbursement will be made. The provider is responsible for verifying the member's eligibility status on the date of service, securing appropriate physician authorizations, correct coding and billing information.

Failure to use the proper coding when billing may result in claims being denied or may place the provider in jeopardy of recovery actions and/or state or federal civil sanctions. Use procedure codes and modifiers as instructed in this manual.

# Paper and Electronic Billing

## Paper Claims for All Billing Types

Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department. Requests may be sent to the Department's fiscal agent, Xerox State Healthcare, P.O. Box 90, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit five (5) claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
- Reconsideration claims

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. Claims submitted on paper without pre-approval are processed, denied, and marked with the message "Electronic Filing Required."

## Electronic Claims

Instructions for completing and submitting electronic claims are available through the following:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com)
- Companion Guides for the 837P, 837I, or 837D in the Provider Services section of the Department's website
- Web Portal User Guide (within the Web Portal)

The Colorado Medical Assistance Program collects electronic claim information interactively through Web Portal or via batch submission through a host system. Please refer to the General Provider Information manual (Colorado.gov/hcpf) → For Our Providers → Provider Services → Billing Manuals → CMS 1500 for additional electronic billing information.

# Using Modifiers

Modifiers are used with HCPCS codes to describe circumstances that may change or alter payment. Refer to the approved modifiers for use with DME procedure codes in field locator 19c in the Paper Claim Reference Table section.

The following modifiers are approved for use with DME procedure codes and must be used when applicable:

22 Increased Procedural Services
52 Reduced Services
BO Orally administered nutrition, not by feeding tube
KH DMEPOS item, initial claim, purchase or first month rental
KI DMEPOS item, second or third month rental
KR Rental item, billing for partial month
MS Six (6) month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty
RR Rental (use the RR modifier when DME is to be rented)
SC Medical Necessary Service or Supply (to be used with MSRP priced codes only)
TT Individualized service provided to more than one (1) member in same setting
TW Secondary or back-up equipment
UB Invoice cost
UE Used Equipment

Actual acquisition costs are defined as the manufacturer's list price for the item less any standard trade discount applied to lower the actual cost to the provider, but excluding any time sensitive or otherwise conditional discounts available to the provider. Misrepresentation of actual acquisition costs could result in State or Federal, civil, or criminal sanctions.

# Pricing for Supplies and DME

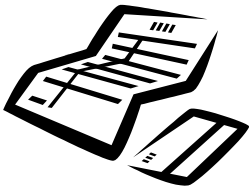
There are three (3) ways to determine the price for supplies and DME: the Fee Schedule, the Manufacturer's Suggested Retail Price (MSRP), and By Invoice.

## Fee Schedule

Supplies and DME that are on the Fee Schedule have a maximum allowable reimbursement. These items are reimbursed at the lesser of submitted charges or the Fee Schedule amount.

If the cost of the supply or DME is less than the maximum allowable rate listed on the Fee Schedule, the provider must submit claim for the actual cost.

## Manufacturer Suggested Retail Price (MSRP)



If there is no maximum purchase price listed on the Fee Schedule, the provider is reimbursed the current MSRP less the current percentage outlined in 10 CCR 2505-10, Section 8.590.7. The provider must keep a copy of the item invoice and documented MSRP.

The documented MSRP must include the name of the provider's employee that received and documented the MSRP, and the date the MSRP was received.

Member must be contacted prior to shipping to ensure member information is correct.

- Providers may not submit for reimbursement either state sales tax collection or shipping costs.
- Providers must add the "SC" (Medical Necessary Service or Supply (to be used with MSRP priced codes only) modifier when using the MSRP for pricing.
- Providers must attach a copy of the MSRP on all paper claims.
- Providers may not use MSRP pricing for procedure code A9901.

## Billing for "By Invoice" Services

DME/Supply items that have no Fee Schedule rate and no Manufacturer Suggested Retail Price (MSRP) are reimbursed at the actual acquisition invoice cost plus the percentage amount outlined in 10 CCR 2505-10 Section 8.590.7.

Claims submitted By Invoice must be submitted with the UB modifier. Invoiced claims submitted with procedure code A9901 must be billed at the current rate per the actual acquisition cost of the products.

# Procedure/HCPCS Codes Overview

The Colorado Department of Health Care Policy and Financing develops procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used for submitting claims for services provided to Colorado Medical Assistance Program members and represent services that may be provided by enrolled certified Colorado Medical Assistance Program providers.

The Healthcare Common Procedural Coding System (HCPCS) is divided into two (2) principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA).

The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

# Paper PAR Instructional Reference

| Field Label | Completion Format | Instructions |
|---|---|---|
| The upper margin of the PAR form must be left blank. This area is for authorizing agency use only. | | |
| **Invoice/Pat Account Number** | Text | Optional<br>Enter up to 12 characters (numbers, letters, hyphens) that help the provider identify the claim or member. |

| Field Label | Completion Format | Instructions |
|---|---|---|
| **1. Member Name** | Text | Required<br>Enter the member's last name, first name, and middle initial exactly as it appears on the eligibility verification.<br>Example: Adams, Mary A. |
| **2. Member Identification Number** | 7 characters | Required<br>This number consists of a letter prefix followed by six (6) numbers.<br>Example: A123456 |
| **3. Sex** | Check box<br>☐ M ☐ F | Required<br>Enter an "X" in the appropriate box. |
| **4. Date of Birth** | 6 digits | Required<br>Enter the member's birth date using a MMDDYY format.<br>Example: January 1, 2012 = 010112 |
| **5. Member Address** | Characters: numbers and letters | Required<br>Enter the member's full address: Street, city, state, and zip code. |
| **6. Member Telephone Number** | Text | Optional<br>Enter the member's telephone number. |
| **7. Prior Authorization Number** | None | Leave Blank<br>This field is automatically system assigned |
| **8. Dates Covered by This Request** | 6 digits for From date and 6 digits for Through date | Optional<br>Enter the date(s) within which service(s) will be provided. If left blank, dates are entered by the authorizing agent. Authorized services must be provided within these dates. Use the MMDDYY format.<br>Example: January 1, 2012 – January 31, 2010 = From 010112 Through 013112 |
| **9. Does Member Reside in a Nursing Facility?** | Check Box<br>☐ Yes ☐ No | Required<br>Check the appropriate box. |
| **10. Group Home Name if Member Resides in a Group Home** | Text | Conditional<br>Complete if member resides in a group home.<br>Enter the name of the group home or residence. |

| Field Label | Completion Format | Instructions |
|---|---|---|
| **11. Diagnosis** | Text | Required<br>Enter the diagnosis code and sufficient relevant diagnostic information to justify the request. Include the prognosis. Provide relevant clinical information, other drugs or alternative therapies tried in treating the condition, results of tests, etc., to justify a Colorado Medical Assistance Program determination of medical necessity. Approval of the PAR is based on documented medical necessity. Attach documents as required. |
| **12. Requesting Authorization for Repairs** | Text | Conditional<br>Complete if requesting repairs for equipment owned by the member.<br>Enter the serial number of the equipment. |
| **13. Indicate Length of Necessity** | Text | Conditional<br>Complete if renting equipment. Provide best estimate of how long equipment will be needed. |
| **14. Estimated Cost of Equipment** | Digits | Conditional<br>Complete if purchasing, replacing, or repairing equipment. Provide best estimate of cost for labor and replacement part(s) for repair or cost for purchases. |
| **15. Services To Be Authorized** | None | Preprinted<br>Do not alter preprinted lines. No more than five (5) items can be requested on one (1) form. |
| **16. Describe Procedure, Supply, or Drug to be Provided** | Text | Required<br>Enter the description of the service/procedure to be provided. Include model number for DME purchase or serial number for repair. |
| **17. Procedure, Supply or Drug Code** | 5 digits | Required<br>Enter the appropriate HCPCS code for each item that will be billed on the claim form. The authorizing agent may change any code.<br>The approved code(s) on the PAR form must be used on the claim form. |

| Field Label | Completion Format | Instructions |
|---|---|---|
| **18. Number of Services** | Digits | Required<br>Enter the number of units for supplies, services or equipment requested. If this field is blank, the authorizing agent will complete with one (1) unit. |
| **19. Authorized No. of Services** | None | Leave Blank<br>The authorizing agent indicates the number of services authorized which may or may not equal the number requested in Field 18 (Number Of Services). |
| **20. A=Approved D=Denied** | None | Leave Blank<br>Providers should check the PAR on-line or refer to the PAR letter. |
| **21. Primary Care Physician (PCP) Name** | Text | Conditional<br>Complete if member has a PCP. Enter the PCP's name as it appears on the current eligibility verification. |
| **Telephone Number** | Text | Optional<br>Enter the PCP's telephone number. |
| **22. Primary Care Physician Address** | Text | Conditional<br>Complete if member has a PCP. Enter the PCP's complete address. |
| **23. PCP Provider Number** | 8 Digits | Conditional<br>Complete if member has a PCP. Enter the PCP's eight-digit Colorado Medical Assistance provider number. This number must be obtained by contacting the PCP for the necessary authorization. |
| **24. Name and Address of Provider Requesting Prior Authorization** | Text | Required<br>Enter the complete name and address of the physician requesting prior authorization (the physician ordering/writing the prescription). |
| **25. Name of Provider Who will Render Service** | Text | Required<br>Enter the name and telephone number of the supplier who will render the service. |

| Field Label | Completion Format | Instructions |
|---|---|---|
| **26. Signature** | Text | Required<br>The prescribing authority must sign the PAR or the prescription must be attached. If prescription is attached notate "see attached." Do not send the original prescription; send a photocopy on an 8½ x 11 sheet. The written diagnosis must be entered in Field 11 (Diagnosis), even if a prescription form is attached.<br>A rubber stamp facsimile signature is not acceptable on the PAR. |
| **Telephone Number** | Text | Required<br>Enter the telephone number of the requesting provider. |
| **27. Date Signed** | 6 Digits | Required<br>Enter the date the PAR form is signed by the requesting provider. |
| **28. Requesting Provider Number** | 8 Digits | Required<br>Enter the eight-digit Colorado Medical Assistance Program provider number of the requesting provider. |
| **Telephone Number** | Text | Required<br>Enter the telephone number of the requesting provider. |
| **29. Billing Provider Number** | 8 Digits | Required<br>Enter the eight-digit Colorado Medical Assistance Program provider number of the billing provider. The rendering provider must be enrolled in the Colorado Medical Assistance Program. |
| **30. Comments or Reasons For Denial of Benefits** | None | Leave Blank<br>Refer to the PAR response for comments submitted by the authorizing agency. |
| **31. PA Number Being Revised** | Text | Leave Blank<br>This field is completed by the authorizing agency. |

# Prior Authorization Request (PAR) Form

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING

## MEDICAID PRIOR AUTHORIZATION REQUEST (PAR)

INVOICE/PAT. ACCOUNT NUMBER

DOES CLIENT HAVE PRIMARY INSURANCE? YES ☐ NO ☐

**To avoid delay, please answer all questions completely.**

1. CLIENT NAME (Last, First, Middle Initial)
2. CLIENT IDENTIFICATION NUMBER
3. SEX ☐ M ☐ F
4. DATE OF BIRTH (MMDDYY)
5. CLIENT ADDRESS (Street, City, State, ZIP Code)
6. CLIENT TELEPHONE NUMBER ( )
7. PRIOR AUTHORIZATION NUMBER * SYSTEM ASSIGNED
8. DATES COVERED BY THIS REQUEST FROM (MMDDYY) THROUGH (MMDDYY)
9. DOES CLIENT RESIDE IN A NURSING FACILITY? ☐ YES ☐ NO
10. GROUP HOME NAME - IF PATIENT RESIDES IN A GROUP HOME
11. ICD-9-CM DIAGNOSIS CODE and DESCRIPTION (Must Include Diagnosis Code and Description, Prognosis, Clinical Information and Other Medications presently prescribed)
12. REQUESTING AUTHORIZATION FOR REPAIRS. EQUIPMENT MUST BE OWNED BY THE CLIENT - THE SERIAL NUMBER MUST BE ENTERED
13. INDICATE LENGTH OF NECESSITY (IN MONTHS AND YEARS) I.E., HOW LONG WILL THIS EQUIPMENT BE NEEDED?
14. ESTIMATED COST OF EQUIPMENT

### SERVICES TO BE AUTHORIZED

| 15. LINE NO. | 16. DESCRIBE THE PROCEDURE OR SUPPLY TO BE PROVIDED — INCLUDE MODEL NUMBER FOR DME PURCHASE OR SERIAL NUMBER FOR REPAIR | 17. PROCEDURE OR SUPPLY CODE | 18. REQUESTED NUMBER OF SERVICES | 19. AUTHORIZED NO. OF SERVICES (LEAVE BLANK ** ) | 20. APPROVED/DENIED (LEAVE BLANK ** ) |
|---|---|---|---|---|---|
| 01 | | | | | |
| 02 | | | | | |
| 03 | | | | | |
| 04 | | | | | |
| 05 | | | | | |

21. PRIMARY CARE PHYSICIAN (PCP) NAME
22. PRIMARY CARE PHYSICIAN ADDRESS (Street, City, State, ZIP code)
TELEPHONE NUMBER ( )
23. PCP PROVIDER NUMBER
24. NAME AND ADDRESS OF PHYSICIAN REFERRING FOR PRIOR AUTHORIZATION
25. NAME AND ADDRESS OF PROVIDER WHO WILL BILL SERVICE
26. REQUESTING PHYSICIAN SIGNATURE
27. DATE SIGNED
TELEPHONE NUMBER ( )
28. REQUESTING PHYSICIAN PROVIDER NUMBER
TELEPHONE NUMBER ( )
29. BILLING PROVIDER NUMBER

If services are provided according to the manner prescribed by State of Colorado Laws and Regulations, reimbursement will be provided for authorized services following submission of an appropriately completed Medicaid claim.

30. COMMENTS **

☐ ATTACH COPY OF THIS PAR TO CLAIM(S) **

SIGNATURE OF STATE AGENCY REPRESENTATIVE **
DATE **
31. PA NUMBER BEING REVISED **

* THE ASSIGNED PAR NUMBER APPEARS ON THE PAR LETTER. ENTER THE PAR NUMBER FROM THE LETTER ON THE CLAIM WHEN BILLING FOR THE SERVICES. ** THESE FIELDS ARE COMPLETED BY THE AUTHORIZING AGENT

FORM NO. 10013 (REV. 0811)
COL — 106

# Paper Claim Reference Table

Supply and DME claims are submitted on the CMS 1500 claim form or as an 837P transaction. The following paper claim form reference table shows required fields and detailed field completion instructions.

| CMS Field # | Field Label | Field is? | Instructions |
|---|---|---|---|
| **1** | **Insurance Type** | Required | Place an "X" in the box marked as Medicaid. |
| **1a** | **Insured's ID Number** | Required | Enter the member's Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456. |
| **2** | **Patient's Name** | Required | Enter the member's last name, first name, and middle initial. |
| **3** | **Patient's Date of Birth / Sex** | Required | Enter the patient's birth date using two (2) digits for the month, two (2) digits for the date, and two (2) digits for the year. Example: 070114 for July 1, 2014.<br>Place an "X" in the appropriate box to indicate the sex of the member. |
| **4** | **Insured's Name** | Conditional | Complete if the member is covered by a **Medicare** health insurance policy.<br>Enter the insured's full last name, first name, and middle initial. If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. |
| **5** | **Patient's Address** | Not Required | |
| **6** | **Patient's Relationship to Insured** | Conditional | Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder. |
| **7** | **Insured's Address** | Not Required | |
| **8** | **Reserved for NUCC Use** | | |

| CMS Field # | Field Label | Field is? | Instructions |
|---|---|---|---|
| **9** | **Other Insured's Name** | Conditional | If field 11d is marked "yes", enter the insured's last name, first name, and middle initial. |
| **9a** | **Other Insured's Policy or Group Number** | Conditional | If field 11d is marked "yes", enter the policy or group number. |
| **9b** | **Reserved for NUCC Use** | | |
| **9c** | **Reserved for NUCC Use** | | |
| **9d** | **Insurance Plan or Program Name** | Conditional | If field 11d is marked "yes", enter the insurance plan or program name. |
| **10a-c** | **Is Patient's Condition Related to?** | Conditional | When appropriate, place an "X" in the correct box to indicate whether one (1) or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other. |
| **10d** | **Reserved for Local Use** | | |
| **11** | **Insured's Policy, Group or FECA Number** | Conditional | Complete if the member is covered by a **Medicare** health insurance policy.<br>Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed. |
| **11a** | **Insured's Date of Birth, Sex** | Conditional | Complete if the member is covered by a **Medicare** health insurance policy.<br>Enter the insured's birth date using two (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 070114 for July 1, 2014.<br>Place an "X" in the appropriate box to indicate the sex of the insured. |
| **11b** | **Other Claim ID** | Not Required | |

| CMS Field # | Field Label | Field is? | Instructions |
|---|---|---|---|
| **11c** | **Insurance Plan Name or Program Name** | Not Required | |
| **11d** | **Is there another Health Benefit Plan?** | Conditional | When appropriate, place an "X" in the correct box. If marked YES, complete 9, 9a and 9d. |
| **12** | **Patient's or Authorized Person's signature** | Required | Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File".<br>Enter the date the claim form was signed. |
| **13** | **Insured's or Authorized Person's Signature** | Not Required | |
| **14** | **Date of Current Illness Injury or Pregnancy** | Conditional | Complete if information is known. Enter the date of illness, injury or pregnancy, (date of the last menstrual period) using two (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 070114 for July 1, 2014.<br>Enter the applicable qualifier to identify which date is being reported<br>431 Onset of Current Symptoms or Illness<br>484 Last Menstrual Period |
| **15** | **Other Date** | Not Required | |
| **16** | **Date Patient Unable to Work in Current Occupation** | Not Required | |
| **17** | **Name of Referring Physician** | Not Required | |
| **18** | **Hospitalization Dates Related to Current Service** | Conditional | Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 070114 for July 1, 2014. If |

| CMS Field # | Field Label | Field is? | Instructions |
|---|---|---|---|
| | | | the member is still hospitalized, the discharge date may be omitted. This information is not edited. |
| **19** | **Additional Claim Information** | Conditional | **LBOD**<br>Use to document the Late Bill Override Date for timely filing.<br>**Durable Medical Equipment**<br>Complete for DME purchases, repairs, and labor.<br>Enter the make, model and serial number of the equipment. |
| **20** | **Outside Lab?**<br>**$ Charges** | Not Required | |
| **21** | **Diagnosis or Nature of Illness or Injury** | Required | Enter at least one (1) but no more than 12 diagnosis codes based on the member's diagnosis/condition.<br>Enter applicable ICD indicator to identify which version of ICD codes is being reported.<br>9 ICD-9-CM<br>0 ICD-10-CM |
| **22** | **Medicaid Resubmission Code** | Conditional | List the original reference number for resubmitted claims.<br>When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field.<br>7 Replacement of prior claim<br>8 Void/Cancel of prior claim<br>This field is not intended for use for original claim submissions. |
| **23** | **Prior Authorization** | Conditional | Complete for medical equipment and supplies that require prior authorization. If the procedure code requires prior authorization, enter the prior authorization from the approved Prior Authorization Request (PAR). Do not combine services from more than one (1) approved PAR on a single claim form. Do not attach a copy of the approved PAR unless advised to do so by the authorizing agency or the fiscal agent. |

| CMS Field # | Field Label | Field is? | Instructions |
|---|---|---|---|
| **24** | **Claim Line Detail** | Information | The paper claim form allows entry of up to six (6) detailed billing lines. Fields 24A through 24J apply to each billed line.<br>**Do not enter more than six** (6) **lines of information** on the paper claim. If more than six (6) lines of information are entered, the additional lines will not be entered for processing.<br>Each claim form must be fully completed (totaled).<br>**Do not file continuation claims** (e.g., Page 1 of 2). |
| **24A** | **Dates of Service** | Required | The field accommodates the entry of two (2) dates: a "From" date of services and a "To" date of service. Enter the date of service using two (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 010115 for January 1, 2015<br>From To<br>**01 01 15** \| \| \|<br>Or<br>From To<br>**01 01 15 01 01 15**<br>Span dates of service<br>From To<br>**01 01 15 01 31 15**<br>Practitioner claims must be consecutive days.<br><u>Single Date of Service</u>: Enter the six (6) digit date of service in the "From" field. Completion of the "To field is not required. Do not spread the date entry across the two (2) fields.<br><u>Span billing</u>: permissible if the same service (same procedure code) is provided on consecutive dates.<br>**Durable Medical Equipment Rental**<br>The "To" date of service must represent the last date of the rental period. |
| **24B** | **Place of Service** | Required | Enter the Place of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance |

| CMS Field # | Field Label | Field is? | Instructions |
|---|---|---|---|
| | | | Program accepts the CMS place of service codes.<br>04 Homeless Shelter<br>11 Office<br>12 Home<br>15 Mobile Unit<br>20 Urgent Care Facility<br>21 Inpatient Hospital<br>22 Outpatient Hospital<br>23 Emergency Room Hospital<br>25 Birthing Center<br>26 Military Treatment Center<br>31 Skilled Nursing Facility<br>32 Nursing Facility<br>33 Custodial Care Facility<br>34 Hospice<br>41 Transportation – Land<br>52 Psychiatric Facility Partial Hospitalization<br>53 Community Mental Health Center<br>54 Intermediate Care Facility – MR<br>60 Mass Immunization Center<br>61 Comprehensive IP Rehab Facility<br>62 Comprehensive OP Rehab Facility<br>65 End Stage Renal Dialysis Trtmt Facility<br>71 State-Local Public Health Clinic<br>99 Other Unlisted |
| **24C** | **EMG** | Not Required | |
| **24D** | **Procedures, Services, or Supplies** | Required | Enter the HCPCS procedure code that specifically describes the service for which payment is requested.<br>All procedures must be identified with codes in the current edition of Physicians Current |

| CMS Field # | Field Label | Field is? | Instructions |
|---|---|---|---|
| | | | Procedural Terminology (CPT). CPT is updated annually.<br>HCPCS Level II Codes<br>The current Medicare coding publication (for Medicare crossover claims only).<br>Only approved codes from the current CPT or HCPCS publications will be accepted. |
| **24D** | **Modifier** | Conditional | Enter the appropriate procedure-related modifier that applies to the billed service. Up to four (4) modifiers may be entered when using the paper claim form.<br>22 Increased Procedural Services<br>52 Reduced Services<br>BO Orally administered nutrition, not by feeding tube<br>55 Surgery-related eyewear<br>KH DMEPOS item, initial claim, purchase or first month rental<br>KI DMEPOS item, second or third month rental<br>KJ DMEPOS item parenteral enteral nutrition pump or capped rental months 4 to 15<br>KR Rental item, billing for partial month<br>LL Lease/rental (use when rental is to be applied against the purchase price)<br>MS Six (6) month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty<br>RR Rental (use the RR modifier when DME is to be rented)<br>SC Medical necessary service or supply<br>TT Individualized service provided to more than one (1) patient in same setting<br>UB Invoice cost<br>UE Used equipment |

| CMS Field # | Field Label | Field is? | Instructions |
|---|---|---|---|
| **24E** | **Diagnosis Pointer** | Required | Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis.<br>At least one (1) diagnosis code reference letter must be entered.<br>When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.<br>This field allows for the entry of 4 characters in the unshaded area. |
| **24F** | **$ Charges** | Required | Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.<br>Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one (1) procedure from the same group is billed, special multiple pricing rules apply.<br>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one (1) procedure from the same grouping is performed.<br>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.<br>Do not deduct Colorado Medical Assistance Program co-payment or commercial insurance payments from the usual and customary charges. |
| **24G** | **Days or Units** | Required | Enter the number of services provided for each procedure code.<br>Enter whole numbers only- do not enter fractions or decimals. |
| **24H** | **EPSDT/Family Plan** | Conditional | **EPSDT** (shaded area)<br>For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the |

| CMS Field # | Field Label | Field is? | Instructions |
|---|---|---|---|
| | | | response in the shaded portion of the field as follows:<br>AV Available- Not Used<br>S2 Under Treatment<br>ST New Service Requested<br>NU Not Used<br>**Family Planning** (unshaded area)<br>Not Required |
| **24I** | **ID Qualifier** | Not Required | |
| **24J** | **Rendering Provider ID #** | Required | In the shaded portion of the field, enter the eight-digit Colorado Medical Assistance Program provider number assigned to the individual who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.<br>NOTE: When billing a paper claim form, do not use the individual's NPI. |
| **25** | **Federal Tax ID Number** | Not Required | |
| **26** | **Patient's Account Number** | Optional | Enter information that identifies the patient or claim in the provider's billing system.<br>Submitted information appears on the Provider Claim Report (PCR). |
| **27** | **Accept Assignment?** | Required | The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program. |
| **28** | **Total Charge** | Required | Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. |
| **29** | **Amount Paid** | Conditional | Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services.<br>Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number. |

| CMS Field # | Field Label | Field is? | Instructions |
|---|---|---|---|
| **30** | **Rsvd for NUCC Use** | | |
| **31** | **Signature of Physician or Supplier Including Degrees or Credentials** | Required | Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.<br>A holographic signature stamp may be used if authorization for the stamp is on file with the fiscal agent.<br>An authorized agent or representative may sign the claim for the enrolled provider if the name and signature of the agent is on file with the fiscal agent.<br>Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two (2) digits for the month, two (2) digits for the date and two (2) digits for the year. Example: 070114 for July 1, 2014.<br>**Unacceptable signature alternatives:**<br>Claim preparation personnel may not sign the enrolled provider's name.<br>Initials are not acceptable as a signature.<br>Typed or computer printed names are not acceptable as a signature.<br>"Signature on file" notation is not acceptable in place of an authorized signature. |
| **32** | **32- Service Facility Location Information**<br>**32a- NPI Number**<br>**32b- Other ID #** | Conditional | Complete for services provided in a hospital or nursing facility in the following format:<br>1st Line Name<br>2nd Line Address<br>3rd Line City, State and ZIP Code<br>32a- NPI Number<br>Enter the NPI of the service facility (if known).<br>32b- Other ID #<br>Enter the eight-digit Colorado Medical Assistance Program provider number of the service facility (if known).<br>The information in field 32, 32a and 32b is not edited. |

| CMS Field # | Field Label | Field is? | Instructions |
|---|---|---|---|
| **33** | **33- Billing Provider Info & Ph #**<br>**33a- NPI Number**<br>**33b- Other ID #** | Required | Enter the name of the individual or organization that will receive payment for the billed services in the following format:<br>1st Line Name<br>2nd Line Address<br>3rd Line City, State and ZIP Code<br>33a- NPI Number<br>Enter the NPI of the billing provider<br>33b- Other ID #<br>Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization. |

# Late Bill Override Date

For electronic claims, a delay reason code must be selected and a date must be noted in the "Claim Notes/LBOD" field.

Valid Delay Reason Codes

1 Proof of Eligibility Unknown or Unavailable

3 Authorization Delays

7 Third Party Processing Delay

8 Delay in Eligibility Determination

9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules

11 Other

The Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Colorado Medical Assistance Program providers have 120 days from the date of service to submit their claim. For information on the 60-day resubmission rule for denied/rejected claims, please see the General Provider Information manual located in the Provider Services Billing Manuals section of the Department's website.

Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to fine and imprisonment under state and/or federal law.

| Billing Instruction Detail | Instructions |
|---|---|
| **LBOD Completion Requirements** | Electronic claim formats provide specific fields for documenting the LBOD.<br>Supporting documentation must be kept on file for 6 years.<br>For paper claims, follow the instructions appropriate for the claim form being used.<br>UB-04: Occurrence code 53 and the date are required in FL 31-34.<br>CMS 1500: Indicate "LBOD" and the date in box 19 – Additional Claim Information.<br>2006 ADA Dental: Indicate "LBOD" and the date in box 35 - Remarks. |
| **Adjusting Paid Claims** | If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider.<br>**Adjust the claim within 60 days** of the claim payment. Retain all documents that prove compliance with timely filing requirements.<br>*Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.*<br>**LBOD =** the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment. |
| **Denied Paper Claims** | If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied.<br>**Correct the claim errors and refile within 60** days of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements.<br>**LBOD =** the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial. |
| **Returned Paper Claims** | A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information.<br>**Correct the claim errors and re-file within 60 days** of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent.<br>**LBOD =** the stamped fiscal agent date on the returned claim. |
| **Rejected Electronic Claims** | An electronic claim that was previously entered within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was rejected and information needed to submit the claim was not available to refile at the time of the rejection.<br>**Correct claim errors and refile within 60 days of the rejection**. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection. |

| Billing Instruction Detail | Instructions |
|---|---|
| | **LBOD =** the date shown on the claim rejection report. |
| **Denied/Rejected Due to Member Eligibility** | An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but were subsequently able to verify eligibility. Read also instructions for retroactive eligibility.<br>**File the claim within 60 days** of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the member and date of eligibility rejection.<br>**LBOD =** the date shown on the eligibility rejection report. |
| **Retroactive Member Eligibility** | The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive.<br>**File the claim within 120 days** of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that:<br>Identifies the member by name<br>States that eligibility was backdated or retroactive<br>Identifies the date that eligibility was added to the state eligibility system.<br>**LBOD =** the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system. |
| **Delayed Notification of Eligibility** | The provider was unable to determine that the member had Colorado Medical Assistance Program coverage until after the timely filing period expired.<br>**File the claim within 60 days** of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Appendix H) that identifies the member, indicates the effort made to identify eligibility, and shows the date of eligibility notification.<br>Claims must be filed within 365 days of the date of service. No exceptions are allowed.<br>This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage.<br>Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution.<br>The extension does not give additional time to obtain Colorado Medical Assistance Program billing information.<br>If the provider has previously submitted claims for the member, it is improper to claim that eligibility notification was delayed.<br>**LBOD =** the date the provider was advised the individual had Colorado Medical Assistance Program benefits. |

| Billing Instruction Detail | Instructions |
|---|---|
| **Electronic Medicare Crossover Claims** | An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/ payment. (Note: On the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.)<br>**File the claim within 120 days** of the Medicare processing/ payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file.<br>**LBOD =** the Medicare processing date shown on the SPR /ERA. |
| **Medicare Denied Services** | The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial.<br>*Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.*<br>**File the claim within 60 days** of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file.<br>**LBOD =** the Medicare processing date shown on the SPR/ERA. |
| **Commercial Insurance Processing** | The claim has been paid or denied by commercial insurance.<br>**File the claim within 60 days** of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the member, rendered services, and shows the payment or denial date.<br>Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in compliance with the 60-day rule until insurance processing information is available.<br>**LBOD =** the date commercial insurance paid or denied. |
| **Correspondence LBOD Authorization** | The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances.<br>**File the claim within 60 days** of the date on the authorization letter. Retain the authorization letter.<br>**LBOD =** the date on the authorization letter. |
| **Member Changes Providers during Obstetrical Care** | The claim is for obstetrical care where the member transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period.<br>**File the claim within 60 days** of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the member transferred to another provider for continuation of OB care.<br>**LBOD =** the last date of OB care by the billing provider. |

# Column Instructions for HCPCS Code Table

## Code Column:

HCPCS codes consist of a letter followed by four (4) numbers. Read the entire entry to determine the benefit status of the item. Providers are instructed to submit the HCPCS code most closely describing the item being requested on the PAR form. The Colorado Medical Assistance Program reserves the right to amend the coding for any approved item.

## Description Column:

A description of the item as provided by Centers for Medicare and Medicaid Services (CMS) is listed. When possible and appropriate, the description of the item includes a notation of the billing unit. For disposable supplies, one (1) billing unit represents one (1) item unless otherwise noted.

## PAR Column:

This column is used to identify if prior authorization is required for the item identified and to identify which reviewing agency to send the PAR to for review.

**Yes:** PARs for these items are reviewed by the ColoradoPAR Program.

**Con (Conditional):** The item requires prior authorization under certain circumstances. See the comments section next to the item or the subheading description for an explanation of the circumstances.

**None:** The identified item does not require special authorization when provided to an eligible member.

## Unit Limit Column:

Unit limits are displayed with the maximum unit allowable and the minimum time between requests. Some items may have special provisions for unit limits with more detail in the Comment Column.

**This column is being updated on a continual basis, further updates will be made to complete this column. No changes are being made to unit limits; they are only being identified in an easily accessible column. Unit limits may be identified in the comment column until changes are made.**

## Comment Column:

The comment section outlines specific or special instructions as well as more detailed information on unit limits where applicable.

Comments expand on the description and identify any required special PAR or billing instructions. The notation "DELETED" means that the code is invalid effective the day following the date shown in the "COMMENTS" column. Newly added codes become effective on the date shown. For example, procedure codes deleted effective 12/31/11 can be used only for non-prior authorized services provided prior to 1/1/12 or on PARs approved prior to 1/1/12.

# HCPCS Code Table

The following listing is divided into sections to assist providers who bill for specific types of service. For questions about billing or the use of the listing, please contact the Department's fiscal agent, Provider Services at 1-800-237-0757.

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| **MISCELLANEOUS CODES** | | | | |
| A4602 | Replacement battery for external infusion pump owned by patient, lithium, 1.5 volt, each | None | | |
| A4649 | Surgical supply; miscellaneous | Yes | | Must attach manufacturer's invoice, amounts, & description. Must be submitted on paper. Use for disposable supplies such as dressings, etc. |
| A7048 | Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with implanted catheter, each | None | | |
| A9606 | Radium ra-223 dichloride, therapeutic, per microcurie | None | | |
| A9999 | Miscellaneous DME supply or accessory, not otherwise specified | Yes | | Use for accessories or parts for DME other than wheelchairs. |
| B9998 | (NOC) For enteral supplies | Yes | | Include description & quantities on PAR. For rental, must submit manufacturer's invoice with PAR. Rental based on percentage of invoice & rate will be determined at the time of PAR approval. PAR copy must be submitted with claim. Do not use for items included in supply kits. |
| B9999 | For parenteral supplies | Yes | | Include description & quantity on par. Do not use for items included in kits. Submit paper claim with manufactures invoice attached. |
| E1399 | Durable medical equipment, miscellaneous | Yes | | Use for durable reusable equipment other than wheelchairs. |
| E2399 | Power wheelchair accessory, not otherwise classified interface, including all related electronics and any type mounting hardware | Yes | | Use only when appropriate and specific procedure codes are not available. |
| K0108 | Other accessories | Yes | | Use for wheelchair parts and accessories only when an appropriate code is not available. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| K0901 | Radium ra-223 dichloride, therapeutic, per microcurie | None | | |
| 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 | None | | |
| L3981 | Upper extremity fracture orthosis, humeral, prefabricated, includes shoulder cap design, with or without joints, forearm section, may include soft interface, straps, includes fitting and adjustments | None | | |
| L6026 | Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device, excludes terminal device(s) | None | | |
| L7259 | Electronic wrist rotator, any type | None | | |
| L8696 | Antenna (external) for use with implantable diaphragmatic/phrenic nerve stimulation device, replacement, each | None | | |
| Q0507 | Miscellaneous supply or accessory for use with an external ventricular assist device | | | |
| Q0508 | Miscellaneous supply or accessory for use with an implanted ventricular assist device | | | |
| Q0509 | Miscellaneous supply or accessory for use with any implanted ventricular assist device for which payment was not made under Medicare Part A | | | |
| S8189 | Tracheostomy supply, not otherwise classified | Yes | | Use for tracheostomy supplies when an appropriate code is not available. |
| S8301 | Infection control supplies, not otherwise specified | Yes | | Use for masks, disposable gowns, etc. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| T5999 | Supply, not otherwise specified | None | | Use for disposable humidifier bottles, Type B oxygen cylinder tanks, and large compressed air cylinders only. Submit on paper and, in remarks, identify the Item being billed. Claims for rental will be manually priced. |
| **AMBULATION DEVICES – GENERAL USE** | | | | |
| | **Canes** | | | |
| E0100 | Cane, all materials, adjustable or fixed with tip | None | | |
| E0105 | Cane, quad or three (3) prong, all materials, adjustable or fixed with tips | None | | |
| | **Crutches** | | | |
| E0110 | Crutches, forearm, all materials, adjustable or fixed, complete with tips & handgrips, pair | None | | 1 item = 1 pair |
| E0111 | Crutches, forearm, all materials, adjustable or fixed, with tip & handgrip, each | None | | 1 item = 1 crutch |
| E0112 | Crutches, underarm, wood, adjustable or fixed, with pads, tips & handgrips, pair | None | | 1 item = 1 pair |
| E0113 | Crutches, underarm, wood, adjustable or fixed, with pad, tip & handgrip, each | None | | 1 item = 1 crutch |
| E0114 | Crutches, underarm, other than wood, adjustable or fixed, pair with pads, tips and handgrips | None | | 1 item = 1 pair |
| E0116 | Crutch, underarm, other than wood, adjustable or fixed, with pat, tip, handgrip, with or without shock absorber, each | None | | 1 item = 1 crutch |
| E0117 | Crutch, underarm, articulating, spring assisted, each | Yes | | 1 item = 1 crutch |
| E0118 | Crutch substitute, lower leg platform, with or without wheels, each | None | | |
| | **Walkers** | | | |
| E0130 | Walker, rigid (pickup), adjustable or fixed height, each | None | | |
| E0135 | Walker, folding (pickup), adjustable or fixed height, each | None | | |
| E0140 | Walker, with trunk support, adjustable or fixed height, any type | Yes | | |
| E0141 | Walker, rigid, wheeled, adjustable or fixed height | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0143 | Walker, folding, wheeled, adjustable or fixed height | None | | |
| E0144 | Walker, enclosed, four (4) sided framed, rigid or folding, wheeled with posterior seat | Yes | | |
| E0147 | Walker, heavy duty, multiple braking system, variable wheel resistance | Yes | | |
| E0148 | Heavy duty walker, without wheels, rigid or folding, any type, each | Yes | | |
| E0149 | Walker, heavy duty, wheeled, rigid or folding, any type | Yes | | |
| | **Accessories for ambulation devices** | | | |
| A4635 | Underarm pad replacement, crutch, each | None | | |
| A4636 | Handgrip replacement, cane, crutch or walker, each | None | | |
| A4637 | Tip replacement, cane, crutch or walker, each | None | | |
| E0153 | Platform attachment, forearm crutch, each | None | | |
| E0154 | Platform attachment, walker, each | None | | |
| E0155 | Wheel attachment, rigid pick-up walker, per pair | None | | 1 unit = 1 pair |
| E0156 | Seat attachment, walker, each | None | | |
| E0157 | Crutch attachment, walker, each | None | | |
| E0158 | Leg extensions for walker, per set of four (4) | None | | 1 unit = 1 set of four (4) |
| E0159 | Brake attachment for wheeled walker, replacement, each | None | | |
| **BATH AND BATHROOM EQUIPMENT – GENERAL USE** | | | | |
| | **Bath equipment** | | | |
| E0160 | Sitz type bath, portable, fits over commode seat, each | Yes | | Limited to EPSDT program, up to age 20. |
| E0163 | Commode chair, mobile or stationary, with fixed arms | None | | |
| E0165 | Commode chair, mobile or stationary, with detachable arms | Yes | | |
| E0167 | Pail or pan for use with commode chair, replacement only | None | | Purchase for member owned equipment only. |
| E0168 | Extra wide and/or heavy duty commode chair, stationary or mobile, with or without arms, any type, each | Yes | | |
| E0170 | Commode chair with integrated seat lift mechanism, electric, any type | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0171 | Commode chair with integrated seat lift mechanism, non-electric, any type | Yes | | |
| E0172 | Seat lift mechanism placed over or on top of toilet, any type | Yes | | |
| E0175 | Foot rest, for use with commode chair, each | None | | Purchase for member owned equipment only. |
| E0240 | Bath/shower chair, with or without wheels, any size | Yes | | |
| E0241 | Bathtub wall rail, each | Yes | | |
| E0242 | Bathtub rail, floor base, each | Yes | | |
| E0243 | Toilet rail, each | Yes | | |
| E0244 | Toilet seat, raised, each | Yes | | |
| E0244-22 | Toilet seat, raised, each | Yes | | Use for padded raised toilet seat. |
| E0245 | Tub stool or bench, each | Yes | | |
| E0245-22 | Tub stool or bench, each | Yes | | Use for padded tub stool or bench. |
| E0246 | Transfer tub rail attachment, each | Yes | | |
| E0247 | Transfer bench for tub or toilet with or without commode opening | Yes | | |
| E0247-22 | Transfer bench for tub or toilet with or without commode opening | Yes | | Use for padded transfer bench for tub or toilet with or without commode opening. |
| E0248 | Transfer bench, heavy duty, for tub or toilet with or without commode opening | Yes | | |
| E0248-22 | Transfer bench, heavy duty, for tub or toilet with or without commode opening | Yes | | Use for padded transfer bench, heavy duty, for tub or toilet with or without commode opening. |
| E1399 | Durable medical equipment, miscellaneous | Yes | | Use for hand held shower, and other miscellaneous bath equipment. Clearly identify on par and on claim the particular item being requested or billed. |
| | **Whirlpool equipment** | | | |
| E1300 | Whirlpool, portable (over tub type) | Yes | | |
| E1310 | Whirlpool, nonportable (built-in type) | Yes | | |
| **BED AND BEDROOM EQUIPMENT – GENERAL USE** | | | | |
| | **Beds** | | | |
| E0194-KR | Bed, powered air flotation (low air loss therapy), per day | **Yes** | | 1 item = 1 day rental. Includes all necessary disposable supplies. Requires Questionnaires #1 & #2. |
| E0250 | Hospital bed, fixed height, with any type side rails, with mattress | Yes | | Requires Questionnaire # 1. |
| E0255 | Hospital bed, variable height, Hi-Lo, with any type side rails, with mattress | Yes | | Requires Questionnaire#1. |
| E0256 | Hospital bed, variable height, hi-lo, with any type side rails, without mattress | Yes | | Requires Questionnaire #1. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0260 | Hospital bed, semi-electric (head & foot adjustment), with any type side rails, with mattress | Yes | | Requires Questionnaire #1. |
| E0261 | Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress | Yes | | Requires Questionnaire #1. |
| E0265 | Hospital bed, total electric (head, foot & height adjustments) with any type side rails, with mattress | Yes | | Requires Questionnaire #1. |
| E0266 | Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress | Yes | | Requires Questionnaire #1. |
| E0270 | Hospital bed, institutional type includes: oscillating, circulating & Stryker frame, with mattress | Yes | | Requires Questionnaire #1. |
| E0280 | Bed, cradle, any type | Yes | | |
| E0290 | Hospital bed, fixed height, without side rails, with mattress | Yes | | Requires Questionnaire #1. |
| E0291 | Hospital bed, fixed height, without side rails, without mattress | Yes | | Requires Questionnaire #1. |
| E0292 | Hospital bed, variable height, hi-lo, without side rails, with mattress | Yes | | Requires Questionnaire #1. |
| E0293 | Hospital bed, variable height, hi-lo, without side rails, without mattress | Yes | | Requires Questionnaire #1. |
| E0294 | Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress | Yes | | Requires Questionnaire #1. |
| E0295 | Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress | Yes | | Requires Questionnaire #1. |
| E0296 | Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress | Yes | | Requires Questionnaire #1. |
| E0297 | Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress | Yes | | Requires Questionnaire #1 |
| E0300 | Pediatric crib, hospital grade, fully enclosed, with or without top enclosure | Yes | | Requires Questionnaire #1. |
| E0301 | Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress | Yes | | Requires Questionnaire #1. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0302 | Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress | Yes | | Requires Questionnaire #1. |
| E0303 | Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress | Yes | | Requires Questionnaire #1. |
| E0304 | Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress | Yes | | Requires Questionnaire #1. |
| E0328 | Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress | Yes | | Requires Questionnaire #1. |
| E0329 | Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress | Yes | | Requires Questionnaire #1. |
| E0462-KR | Rocking bed with or without side rails, per day | Yes | | 1 item = 1 day rental. Requires Questionnaire #1. |
| | **Mattresses & pads** | | | |
| A4640 | Replacement pad for use with medically necessary alternating pressure pad owned by patient | Yes | | Purchase for member owned equipment only. |
| E0181 | Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty | Yes | | Requires Questionnaire #2. |
| E0182 | Pump for alternating pressure pad, for replacement only | Yes | | |
| E0184 | Mattress, dry flotation | Yes | | Purchase for member owned hospital bed only. Requires Questionnaire #2. |
| E0185 | Gel or gel-like pressure pad for mattress, standard mattress length and width | Yes | | Requires Questionnaire #2. |
| E0186 | Mattress, air pressure | Yes | | Purchase for member owned bed only. Requires Questionnaire #2. |
| E0187 | Mattress, water pressure | Yes | | Purchase for member owned bed only. Requires Questionnaire #2. |
| E0188 | Sheepskin pad, synthetic | Yes | | |
| E0189 | Sheepskin pad, lambs wool, any size | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0190 | Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories | Yes | | |
| E0191 | Heel or elbow protector, each | Yes | | |
| E0193-KR | Air fluidized bed, per day | Yes | | Air loss bed. 1 item = 1 day rental. |
| E0196 | Mattress, Gel pressure | Yes | | Purchase for member owned bed only. Requires Questionnaire #2. |
| E0197 | Air pressure pad for mattress, standard mattress length and width | Yes | | Requires Questionnaire #2. |
| E0198 | Water pressure pad for mattress, standard mattress length and width | Yes | | |
| E0199 | Dry pressure pad for mattress, standard mattress length and width | None | | Egg crate for bed or wheelchair. |
| E0271 | Mattress, innerspring | Yes | | Purchase for member owned hospital bed only. |
| E0272 | Mattress, foam rubber | Yes | | Purchase for member owned hospital bed only. |
| E0277 | Powered pressure-reducing air mattress | Yes | | Requires Questionnaire #2. Identify brand. |
| E0370 | Air pressure elevator for heel | Yes | | Requires Questionnaire #2. |
| E0371 | Non-powered advanced pressure reducing overlay for mattress, standard mattress length and width | Yes | | Requires Questionnaire #2. |
| E0372 | Powered air overlay for mattress, standard mattress length and width | Yes | | Requires Questionnaire #2. |
| E0373 | Non-powered advanced pressure reducing mattress | Yes | | Requires Questionnaire #2. |
| E1399 | Durable medical equipment miscellaneous | Yes | | Must submit manufacturer's invoice with PAR. Rental is based on percentage of invoice & rate will be determined at the time of PAR approval. PAR copy must be submitted with claim. Claim and PAR must be submitted on paper. Requires Questionnaire #2 if used for pressure relief mattresses. |
| | **Accessories/safety equipment** | | | |
| A9281 | Reaching/grabbing device, any type, any length, each | Yes | | |
| E0273 | Bed board | Yes | | |
| E0274 | Over-bed table | Yes | | |
| E0275 | Bedpan, standard, metal or plastic | None | | |
| E0276 | Bedpan, fracture, metal or plastic | None | | |
| E0305 | Bed side rails, half length, pair | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0310 | Bed side rails, full length, pair | Yes | | |
| E0315 | Bed accessory: board, table, or support device any type | Yes | | Bed cane. Do not use for over bed table. |
| E0316 | Safety enclosure frame/canopy for use with hospital bed, any type | Yes | | |
| E0325 | Urinal, male, jug-type, any material, each | None | | |
| E0326 | Urinal, female, jug-type, any material, each | None | | |
| E0700 | Safety equipment, device or accessory, any type | Yes | | Includes gait belt. Not for use as wheelchair accessory. See E0960, E0978, and E0980 for wheelchairs. |
| E0710 | Restraints, any type (body, chest, wrist or ankle) | Yes | | Hip belt. Not for use as wheelchair accessory. |
| | **Lifts** | | | |
| E0621 | Sling or seat, patient lift, canvas or nylon | Yes | | |
| E0625 | Patient lift, bathroom or toilet, not otherwise classified | Yes | | Lift for bathtub, includes seat. |
| E0627 | Seat lift mechanism incorporated into a combination lift-chair mechanism | Yes | | Requires Questionnaire # 4. |
| E0628 | Separate seat lift mechanism for use with patient owned furniture, electric | Yes | | Requires Questionnaire # 4. |
| E0629 | Separate seat lift mechanism for use with patient owned furniture, non-electric | Yes | | Requires Questionnaire # 4. |
| E0630 | Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s) | Yes | | Requires Questionnaire # 3. |
| E0635 | Patient lift, electric, with seat or sling | Yes | | Requires Questionnaire # 3 |
| E0636 | Multipositional patient support system, with integrated lift, patient accessible controls | Yes | | Requires Questionnaire # 3. . |
| E0639 | Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories | Yes | | Requires Questionnaire # 3. Includes sling and chains. |
| E1035 | Multi-positional patient transfer system, with integrated seat operated by caregiver, patient weight capacity up to and including 300 lbs | Yes | | Requires Questionnaire # 3. |
| E1036 | Multi-positional patient transfer system, extra-wide, with integrated seat, operated by caregiver, patient weight capacity greater than 300 lbs | Yes | | Requires Questionnaire # 3. |
| | **Repairs/labor** | | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A9900 | Miscellaneous DME supply, accessory, and/or service component of another HCPCS code | Yes | | Labor and Dealer preparation. Limited to specialized, detailed or complex work in the initial preparation of a product. 1 unit = 15 mins |
| A9901 | DME delivery, set up, and/or dispensing service component of another HCPCS code | None | | |
| K0739 | Repair or non-routine service for durable medical equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes | Yes | | Cost of repair cannot exceed cost to purchase replacement equipment. Serial number of the equipment being repaired must be identified in field 12 of the PAR. Paper claims must include serial number. If codes are available to identify specific components, they must be used (e.g., tires, upholstery, batteries, etc.).<br>1 unit = 15 minutes. Annual maximum 480 units or 120 hours of service. (Average 40 units or 10 hours of service per month.)<br>See also K0739-MS. |
| K0739-MS | Repair or non-routine service for durable medical equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes | None | | Quick minor repairs to DME products. In addition to labor the costs of minor parts may be included under this code. Limited to a maximum reimbursement of $147.25 every 6 months. Paper claims must include serial number. |
| K0740 | Repair or non-routine service for oxygen equipment requiring the skill of a technician, labor component, per 15 minutes | Yes | | Cost of repair cannot exceed cost to purchase replacement equipment. Serial number of the equipment being repaired must be identified in field 12 of the PAR. Paper claims must include serial number. If codes are available to identify specific components, they must be used.<br>1 unit = 15 minutes. Annual maximum 480 units or 120 hours of service. (Average 40 units or 10 hours of service per month.)<br>See also K0740-MS. |
| K0740-MS | Repair or non-routine service for oxygen equipment requiring the skill of a technician, labor component, per 15 minutes | None | | Quick minor repairs to oxygen equipment. In addition to labor the costs of minor parts may be included under this code. Limited to a maximum reimbursement of $148.36 every 6 months. Paper claims must include serial number. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| **CHAIRS, WHEELCHAIRS, ACCESSORIES – GENERAL USE**<br>Providers are instructed to submit the HCPCS code most closely describing the wheelchair or related equipment being requested on the PAR form. Please refer to www.dmepdac.com for the most updated and complete information for product classification for wheelchairs, wheelchair accessories, etc.<br>Use Medicare procedures regarding weight and measurements to code appropriately. | | | | |
| | **Chairs** | | | |
| E1031 | Rollabout chair, any and all types with castors 5 in or greater | Yes | | |
| E1038 | Transport chair, adult size, patient weight capacity up to and including 300 pounds | Yes | | |
| E1039 | Transport chair, adult size, heavy duty, patient weight capacity greater than 300 pounds | Yes | | |
| | **Wheelchairs – motorized/powered vehicles** | | | |
| E1230 | Power operated vehicle, three (3) or four (4) wheel non-highway | Yes | | Must indicate brand name & model number on PAR. |
| K0010 | Standard – weight frame motorized/power wheelchair | Yes | | |
| K0011 | Standard – weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking | Yes | | |
| K0012 | Lightweight portable motorized/power wheelchair | Yes | | |
| K0014 | Other motorized/power wheelchair base | Yes | | |
| K0800 | Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds | Yes | | |
| K0801 | Power operated vehicle, group 1 heavy duty, patient weight capacity 301 to 450 pounds | Yes | | |
| K0802 | Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds | Yes | | |
| K0806 | Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds | Yes | | |
| K0807 | Power operated vehicle, group 2 heavy duty, patient weight capacity 301 to 450 pounds | Yes | | |
| K0808 | Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| K0812 | Power operated vehicle, not otherwise classified | Yes | | |
| K0813 | Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds | Yes | | |
| K0814 | Power wheelchair, group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds | Yes | | |
| K0815 | Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds | Yes | | |
| K0816 | Power wheelchair, group 1 standard, captains chair, patient weight capacity up to and including 300 pounds | Yes | | |
| K0820 | Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds | Yes | | |
| K0821 | Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds | Yes | | |
| K0822 | Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds | Yes | | |
| K0823 | Power wheelchair, group 2 standard, captains chair, patient weight capacity up to and including 300 pounds | Yes | | |
| K0824 | Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds | Yes | | |
| K0825 | Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pounds | Yes | | |
| K0826 | Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds | Yes | | |
| K0827 | Power wheelchair, group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds | Yes | | |
| K0828 | Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| K0829 | Power wheelchair, group 2 extra heavy duty, captains chair, patient weight 601 pounds or more | Yes | | |
| K0830 | Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds | Yes | | |
| K0831 | Power wheelchair, group 2 standard, seat elevator, captains chair, patient weight capacity up to and including 300 pounds | Yes | | |
| K0899 | Power mobility device, not coded by DME PDAC or does not meet criteria | Yes | | |
| | **Manual wheelchair codes**<br>Providers are instructed to submit the HCPCS code on the PAR form that most closely describes the requested wheelchair or related equipment. Colorado Medicaid reserves the right to amend the coding for any approved item | | | |
| E1050 | Fully-reclining wheelchair, fixed full-length arms, swing-away detachable elevating legrests | Yes | | |
| E1060 | Fully-reclining wheelchair, detachable arms, desk or full-length, swing-away detachable elevating legrests | Yes | | |
| E1070 | Fully-reclining wheelchair, detachable arms (desk or full-length) swing-away detachable footrest | Yes | | |
| E1083 | Hemi-wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests | Yes | | |
| E1084 | Hemi-wheelchair, detachable arms desk or full-length arms, swing-away detachable elevating legrests | Yes | | |
| E1085 | Hemi-wheelchair, fixed full-length arms, swing-away detachable footrests | Yes | | |
| E1086 | Hemi-wheelchair, detachable arms, desk or full-length, swing-away detachable footrests | Yes | | |
| E1087 | High strength lightweight wheelchair, fixed full-length arms, swing-away detachable elevating legrests | Yes | | |
| E1088 | High strength lightweight wheelchair, detachable arms desk or full-length, swing-away detachable elevating legrests | Yes | | |
| E1089 | High-strength lightweight wheelchair, fixed-length arms, swing-away detachable footrest | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E1090 | High-strength lightweight wheelchair, detachable arms, desk or full-length, swing-away detachable footrests | Yes | | |
| E1092 | Wide heavy-duty wheel chair, detachable arms (desk or full-length), swing-away detachable elevating legrests | Yes | | |
| E1093 | Wide heavy-duty wheelchair, detachable arms, desk or full-length, swing-away detachable footrests | Yes | | |
| E1100 | Semi-reclining wheelchair, fixed full-length arms, swing-away detachable elevating legrests | Yes | | |
| E1110 | Semi-reclining wheelchair, detachable arms (desk or full-length) elevating legrest | Yes | | |
| E1130 | Standard wheelchair, fixed full-length arms, fixed or swing-away detachable footrests | Yes | | |
| E1140 | Wheelchair, detachable arms, desk or full-length, swing-away detachable footrests | Yes | | |
| E1150 | Wheelchair, detachable arms, desk or full-length swing-away detachable elevating legrests | Yes | | |
| E1160 | Wheelchair, fixed full-length arms, swing-away detachable elevating legrests | Yes | | |
| E1170 | Amputee wheelchair, fixed full-length arms, swing-away detachable elevating legrests | Yes | | |
| E1171 | Amputee wheelchair, fixed full-length arms, without footrests or legrest | Yes | | |
| E1172 | Amputee wheelchair, detachable arms (desk or full-length) without footrests or legrest | Yes | | |
| E1180 | Amputee wheelchair, detachable arms (desk or full-length) swing-away detachable footrests | Yes | | |
| E1190 | Amputee wheelchair, detachable arms (desk or full-length) swing-away detachable elevating legrests | Yes | | |
| E1195 | Heavy-duty wheelchair, fixed full-length arms, swing-away detachable elevating legrests | Yes | | |
| E1200 | Amputee wheelchair, fixed full-length arms, swing-away detachable footrest | Yes | | |
| E1221 | Wheelchair with fixed arm, footrests | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E1222 | Wheelchair with fixed arm, elevating legrests | Yes | | |
| E1223 | Wheelchair with detachable arms, footrests | Yes | | |
| E1224 | Wheelchair with detachable arms, elevating legrests | Yes | | |
| E1240 | Lightweight wheelchair, detachable arms, (desk or full-length) swing-away detachable, elevating legrest | Yes | | |
| E1250 | Lightweight wheelchair, fixed full-length arms, swing-away detachable footrest | Yes | | |
| E1260 | Lightweight wheelchair, detachable arms (desk or full-length) swing-away detachable footrest | Yes | | |
| E1270 | Lightweight wheelchair, fixed full-length arms, swing-away detachable elevating legrests | Yes | | |
| E1280 | Heavy-duty wheelchair, detachable arms (desk or full-length) elevating legrests | Yes | | |
| E1285 | Heavy-duty wheelchair, fixed full-length arms, swing-away detachable footrest | Yes | | |
| E1290 | Heavy-duty wheelchair, detachable arms (desk or full-length) swing-away detachable footrest | Yes | | |
| E1295 | Heavy-duty wheelchair, fixed full-length arms, elevating legrest | Yes | | |
| K0001 | Standard wheelchair | Yes | | |
| K0002 | Standard Hemi (low seat) wheelchair | Yes | | |
| K0003 | Lightweight wheelchair | Yes | | |
| K0004 | High strength, lightweight wheelchair | Yes | | |
| K0006 | Heavy duty wheelchair | Yes | | Member greater than 200 lbs. |
| K0007 | Extra heavy duty wheelchair | Yes | | Member greater than 300 lbs. |
| K0009 | Other manual wheelchair/base | Yes | | Tilt in Space, strollers |
| | **Wheelchair accessories** | | | |
| A9900 | Miscellaneous DME supply, accessory, and/or service component of another HCPCS code | Yes | | Labor, dealer preparation. Limited to specialized, detailed or complex work in the initial preparation of a product. 1 unit = 15 mins. |
| A9999 | Miscellaneous DME supply or accessory, not otherwise specified | Yes | | Use for accessories or parts for DME **other** than wheelchairs. |
| E0181 | Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty | Yes | | Requires Questionnaire #2. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0182 | Pump for alternating pressure pad, for replacement only | Yes | | |
| E0188 | Sheepskin pad, synthetic | Yes | | |
| E0189 | Sheepskin pad, lambs wool, any size | Yes | | |
| E0705 | Transfer device, any type, each | Yes | | |
| E0710 | Restraints, any type (body, chest, wrist, ankle) | Yes | | |
| E0950 | Wheelchair accessory, tray, each | Yes | | Upper extremity support surface. |
| E0951 | Heel loop/holder, any type, with or without ankle strap, each | Con | 2/Y | 1 item = 1 heel loop<br>Over 2 require PAR |
| E0952 | Toe loop/holder, any type, each | Con | 2/Y | 1 item = I toe loop/holder. Over 2 require PAR |
| E0955 | Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each | Yes | | |
| E0958 | Manual wheelchair accessory, one-arm drive attachment, each | Yes | | 1 item = 1 attachment |
| E0959 | Manual wheelchair accessory, adapter for amputee, each | Yes | | |
| E0960 | Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware | Con | 1/Y | Over 1 requires PAR. |
| E0961 | Manual wheelchair accessory, wheel lock brake extension (handle), each | Con | 2/Y | Over 2 require PAR. |
| E0966 | Manual wheelchair accessory, headrest extension, each | Yes | | |
| E0968 | Commode seat, wheelchair | Yes | | |
| E0969 | Narrowing device, wheelchair | Yes | | For positioning. |
| E0970 | No. 2 footplates, except for elevating legrest | Yes | | |
| E0971 | Manual wheelchair accessory, anti-tipping device, each | Con | 2/Y | 1 item =1 device<br>Over 2 require PAR. |
| E0974 | Manual wheelchair accessory, anti-rollback device, each | Con | 2/Y | Over 2 require PAR. |
| E0978 | Wheelchair accessory, positioning belt/safety belt/pelvic strap, each | Con | 1/Y | Over 1 requires PAR. |
| E0980 | Safety vest, wheelchair | Yes | | Shoulder harness |
| E0983 | Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control | Yes | | |
| E0984 | Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0985 | Wheelchair accessory, seat lift mechanism | Yes | | Requires Questionnaire #4. |
| E0988-RR | Manual wheelchair accessory, lever-activated, wheel drive, pair | Yes | | New code effective 1/1/2012. |
| E0992 | Manual wheelchair accessory, solid seat insert | Yes | | |
| E0992-22 | Manual wheelchair accessory, solid seat insert | Yes | | Use for hook-in solid seat insert. |
| E1020 | Residual limb support system for wheelchair, any type | Yes | | |
| E1028 | Wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory | Yes | 4 | |
| E1029 | Wheelchair accessory, ventilator tray, fixed | Yes | | |
| E1030 | Wheelchair accessory, ventilator tray, gimbaled | Yes | | |
| E1225 | Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees but less than 80 degrees | Yes | | |
| E1226 | Manual wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each | Yes | | |
| E1227 | Special height arms for wheelchair | Yes | | |
| E1296 | Special wheelchair seat height from floor | Yes | | |
| E1297 | Special wheelchair seat depth, by upholstery | Yes | | |
| E1298 | Special wheelchair seat depth and/or width, by construction | Yes | | |
| E1399 | Miscellaneous durable medical equipment | Yes | | **Important**, please note: Use for durable medical equipment other than wheelchairs. Charges over $35.00 require invoice. Rental benefit based upon attached manufacturer's invoice as a percentage of invoice cost. Copy of approved PAR must be attached to each submitted claim. Must be submitted on paper. |
| E2201 | Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches | Yes | | |
| E2202 | Manual wheelchair accessory, nonstandard seat frame width, 24-27 inches | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E2203 | Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches | Yes | | |
| E2204 | Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches | Yes | | |
| E2207 | Wheelchair accessory, crutch and cane holder, each | Yes | | 1 item = 1 crutch and cane holder |
| E2208 | Wheelchair accessory, cylinder tank carrier, each | Yes | | 1 item = 1 carrier |
| E2340 | Power wheelchair accessory, nonstandard seat frame width, 20-30 inches | Yes | | |
| E2341 | Power wheelchair accessory, nonstandard seat frame width 24-27 inches | Yes | | |
| E2342 | Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches | Yes | | |
| E2343 | Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches | Yes | | |
| E2601 | General use wheelchair seat cushion, width less than 22 inches, any depth | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| E2602 | General use wheelchair seat cushion, width 22 inches or greater, any depth | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| E2603 | Skin protection wheelchair seat cushion, width less than 22 inches, any depth | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| E2604 | Skin protection wheelchair seat cushion, width 22 inches or greater, any depth | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| E2605 | Positioning wheelchair seat cushion, width less than 22 inches, any depth | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| E2606 | Positioning wheelchair seat cushion, width 22 inches or greater, any depth | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| E2607 | Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| E2608 | Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| E2611 | General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| E2612 | General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E2613 | Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| E2614 | Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| E2615 | Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| E2616 | Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| E2619 | Replacement cover for wheelchair seat cushion or back cushion, each | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| E2622 | Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| E2623 | Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| E2624 | Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| E2625 | Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth | Yes | | Identify specific brand/name of cushion requested on prior authorization request. |
| K0038 | Leg strap, each | Con | 1/Y | 1 item = 1 leg strap<br>Over 1 requires PAR. |
| K0039 | Leg strap, H style, each | Con | 1/Y | 1 item = 1 leg strap<br>Over 1 requires PAR. |
| K0056 | Seat height < 17” or equal to or greater than 21” for a high strength, lightweight, or ultra lightweight wheelchair | Yes | | |
| K0105 | IV hanger, each | Yes | | 1 item = 1 IV hanger |
| K0108 | Wheelchair component or accessory, not otherwise specified | Yes | | Specific accessory must be identified on PAR. Claim must be submitted on paper. Use for wheelchair parts and accessories only when an appropriate code is not available. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| K0669 | Wheelchair accessory, wheelchair seat or back cushion, does not meet specific code criteria or no written coding verification from DME PDAC | Yes | | Use K0669 rather than K0108. |
| | **Wheelchair replacement parts and attachments** | | | |
| E0967 | Manual wheelchair accessory, hand rim with projections, any type, each | Yes | | Use for repair only. |
| E0971 | Anti-tipping device, wheelchair | Con | 2/Y | 1 item = 1 device |
| E0973 | Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each | Yes | | 1 item = 1 armrest |
| E0981 | Wheelchair accessory, seat upholstery, replacement only, each | Con | 1/Y | For repair only.<br>Over 1 requires PAR. |
| E0982 | Wheelchair accessory, back upholstery replacement only, each | Con | 1/Y | For repair only.<br>Over 1 requires PAR. |
| E0990 | Wheelchair accessory, elevating leg rest, complete assembly, each | Yes | | Articulating |
| E0994 | Armrest, each | Yes | | |
| E0995 | Wheelchair accessory, calf rest/pad, each | Con | 2/Y | For repair only.<br>Over 2 requires PAR. |
| E1011 | Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair) | Yes | | For modification of an existing wheelchair only. |
| E1015 | Shock absorber for manual wheelchair, each | Yes | | 1 item = 1 shock absorber |
| E1016 | Shock absorber for power wheelchair, each | Yes | | 1 item = 1 shock absorber |
| E1017 | Heavy duty shock absorber for heavy duty or extra heavy duty manual wheelchair, each | Yes | | 1 item = 1 shock absorber |
| E1018 | Heavy duty shock absorber for heavy duty or extra heavy duty power wheelchair, each | Yes | | 1 item = 1 shock absorber |
| E2205 | Manual wheelchair accessory, hand rim without projections (includes ergonomic or contoured), any type, replacement only, each | Yes | | Use for repair only. |
| E2206 | Manual wheelchair accessory, wheel lock assembly, complete, each | Yes | | Wheel locks |
| E2210 | Wheelchair accessory, bearings, any type, replacement only, each | Con | 16/Y | Over 16 units requires PAR. |
| E2211 | Manual wheelchair accessory, pneumatic propulsion tire, any size, each | Con | 2/Y | PAR required for purchase but not required for repair. 1 item = 1 tire.<br>Over 2 units requires PAR. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E2212 | Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each | Con | 2/Y | PAR required for purchase but not required for repair. 1 item = 1 tire tube.<br>Over 2 units requires PAR. |
| E2213 | Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each | Con | 2/Y | PAR required for purchase but not required for repair. 1 item = 1 tire insert.<br>Over 2 units requires PAR. |
| E2214 | Manual wheelchair accessory, pneumatic caster tire, any size, each | Con | 2/Y | PAR required for purchase but not required for repair. 1 item = 1 tire.<br>Over 2 units requires PAR. |
| E2215 | Manual wheelchair accessory, tube for pneumatic caster tire, any size, each | Con | 2/Y | PAR required for purchase but not required for repair. 1 item = 1 tire tube.<br>Over 2 units requires PAR. |
| E2216 | Manual wheelchair accessory, foam filled propulsion tire, any size, each | Con | 2/Y | PAR required for purchase but not required for repair. 1 item = 1 tire.<br>Over 2 units requires PAR. |
| E2217 | Manual wheelchair accessory, foam filled caster tire, any size, each | Con | 2/Y | PAR required for purchase but not required for repair. 1 item = 1 tire.<br>Over 2 units requires PAR. |
| E2218 | Manual wheelchair accessory, foam propulsion tire, any size, each | Con | 2/Y | PAR required for purchase but not required for repair. 1 item = 1 tire.<br>Over 2 units requires PAR. |
| E2219 | Manual wheelchair accessory, foam caster tire, any size, each | Con | 2/Y | PAR required for purchase but not required for repair. 1 item = 1 tire.<br>Over 2 units requires PAR. |
| E2220 | Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each | Con | 2/Y | PAR required for purchase but not required for repair. 1 item = 1 tire.<br>Over 2 units requires PAR. |
| E2221 | Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, each | Con | 2/Y | PAR required for purchase but not required for repair. 1 item = 1 tire.<br>Over 2 units requires PAR. |
| E2222 | Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, each | Con | 2/Y | PAR required for purchase but not required for repair. 1 item = 1 tire with wheel<br>Over 2 units requires PAR. |
| E2224 | Manual wheelchair accessory, propulsion wheel excludes tire, any size, each | Con | 2/Y | PAR required for purchase but not required for repair. 1 item = 1 wheel<br>Over 2 units requires PAR. |
| E2225 | Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each | Con | 2/Y | PAR required for purchase but not required for repair. 1 item = 1 caster wheel<br>Over 2 units requires PAR. |
| E2226 | Manual wheelchair accessory, caster fork, any size, replacement only, each | Con | 2/Y | PAR required for purchase but not required for repair. 1 item = 1 caster fork<br>Over 2 units requires PAR. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E2227 | Manual wheelchair accessory, gear reduction drive wheel, each | Con | | PAR required for purchase but not required for repair. 1 item = 1 gear reduction drive wheel |
| E2228 | Manual wheelchair accessory, wheel braking system and lock, complete, each | Con | | PAR required for purchase but not required for repair. 1 item = 1 wheel braking system and lock |
| E2230 | Manual wheelchair accessory, manual standing system | Yes | | |
| E2231 | Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware | Yes | | |
| E2358 | Power wheelchair accessory, group 34 nonsealed lead acid battery, each | Yes | | New code for 1/1/2012. |
| E2359 | Power wheelchair accessory, group 34 sealed lead acid battery, each (e.g., gel cell, absorbed glass mat) | Yes | | New code for 1/1/2012. |
| E2360 | Power wheelchair accessory, 22 NF non-sealed lead acid battery, each | Con | | PAR required for purchase but not for repair. |
| E2361 | Power wheelchair accessory, 22 NF sealed lead acid battery, each (e.g. Gel cell, absorbed glassmat) | Con | | PAR required for purchase but not for repair. |
| E2362 | Power wheelchair accessory, group 24 non-sealed lead acid battery, each | Con | | PAR required for purchase but not for repair. |
| E2363 | Power wheelchair accessory, group 24 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat) | Con | | PAR required for purchase but not for repair. |
| E2364 | Power wheelchair accessory, U-1 non-sealed lead acid battery, each | Con | | PAR required for purchase but not for repair. |
| E2365 | Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat) | Con | | PAR required for purchase but not for repair. |
| E2366 | Power wheelchair accessory, battery charger,, single mode, for use with only one (1) battery type, sealed or non-sealed, each | Con | | PAR required for purchase but not for repair. |
| E2367 | Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each | Con | | PAR required for purchase but not for repair. |
| E2368 | Power wheelchair component, drive wheel motor, replacement only | Con | 2 per 3 Y | PAR required for more than 2 per 3 fiscal years. |
| E2369 | Power wheelchair component, drive wheel gear box, replacement only | Con | 2 per 3 Y | PAR required for more than 2 per 3 fiscal years. |
| E2370 | Power wheelchair component, integrated drive wheel motor and gear box combination, replacement only | Con | 2 per 3 Y | PAR required for more than 2 per 3 fiscal years. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E2371 | Power wheelchair accessory, group 27 sealed lead acid battery, (e.g. gel cell, absorbed glassmat), each | Con | | PAR required for purchase but not for repair. |
| E2372 | Power wheelchair accessory, group 27 non-sealed lead acid battery, each | Con | | PAR required for purchase but not for repair. |
| E2375 | Power wheelchair accessory, non-expandable controller, including all related electronics and mounting hardware, replacement only | Con | 1/Y | Over 1 unit requires PAR. |
| E2378 | Power wheelchair component, actuator, replacement only | Yes | 1/Y | 1 unit per month may be approved for rental. |
| E2381 | Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each | Con | 2/Y | PAR required for purchase but not for repair.<br>Over 2 units require PAR. |
| E2382 | Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each | Con | 2/Y | PAR required for purchase but not for repair.<br>Over 2 units requires PAR. |
| E2383 | Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each | Con | 2/Y | PAR required for purchase but not for repair.<br>Over 2 units requires PAR. |
| E2384 | Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each | Con | 2/Y | PAR required for purchase but not for repair.<br>Over 2 units requires PAR. |
| E2385 | Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each | Con | 2/Y | PAR required for purchase but not for repair.<br>Over 2 units requires PAR. |
| E2386 | Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each | Con | 2/Y | PAR required for purchase but not for repair.<br>Over 2 units requires PAR. |
| E2387 | Power wheelchair accessory, foam filled caster tire, any size, replacement only, each | Con | 2/Y | PAR required for purchase but not for repair.<br>Over 2 units requires PAR. |
| E2388 | Power wheelchair accessory, foam drive wheel tire, any size, replacement only, each | Con | 2/Y | PAR required for purchase but not for repair.<br>Over 2 units requires PAR. |
| E2389 | Power wheelchair accessory, foam caster tire, any size, replacement only, each | Con | 2/Y | PAR required for purchase but not for repair.<br>Over 2 units requires PAR. |
| E2390 | Power wheelchair accessory, solid (rubber/plastic) drive wheel tire, any size, replacement only, each | Con | 2/Y | PAR required for purchase but not for repair.<br>Over 2 units requires PAR. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E2391 | Power wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each | Con | 2/Y | PAR required for purchase but not for repair.<br>Over 2 units requires PAR. |
| E2392 | Power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each | Con | 2/Y | PAR required for purchase but not for repair.<br>Over 2 units requires PAR. |
| E2394 | Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each | Con | 2/Y | PAR required for purchase but not for repair.<br>Over 2 units requires PAR. |
| E2395 | Power wheelchair accessory, caster wheel excludes tire, any size, replacement only, each | Con | 2/Y | PAR required for purchase but not for repair.<br>Over 2 units requires PAR. |
| E2396 | Power wheelchair accessory, caster fork, any size, replacement only, each | Con | 2/Y | PAR required for purchase but not for repair.<br>Over 2 units requires PAR. |
| E2397 | Power wheelchair accessory, lithium based battery, each | Con | | PAR required for purchase but not for repair. |
| K0015 | Detachable, non-adjustable height armrest, each | Yes | | 1 item = 1 armrest |
| K0017 | Detachable, adjustable height armrest, base, each | Yes | | 1 item = 1 armrest |
| K0018 | Detachable, adjustable height armrest, upper portion each | Yes | | 1 item = 1 armrest |
| K0019 | Arm pad, each | Con | 2/Y | For repair only. 1 item = 1 arm pad<br>Over 2 units requires PAR. |
| K0020 | Fixed, adjustable height armrest, pair | Yes | | 1 item = 1 pair |
| K0037 | High mount flip-up footrest, each | Yes | | 1 item = 1 leg strap |
| K0040 | Adjustable angle footplate, each | Con | 2/Y | 1 item = 1 footplate<br>Over 2 units requires PAR. |
| K0041 | Large size footplate, each | Con | 2/Y | 1 item = 1 footplate<br>Over 2 units requires PAR. |
| K0042 | Standard size footplate, each | Con | 2/Y | 1 item = 1 footplate<br>Over 2 units requires PAR. |
| K0043 | Footrest, lower extension tube, each | Con | 2/Y | For repair only, slider extension tubes<br>Over 2 units requires PAR. |
| K0044 | Footrest, lower extension bracket, each | Con | 2/Y | For repair only.<br>Over 2 units requires PAR. |
| K0045 | Footrest, complete assembly | Con | 2/Y | Swing away<br>Over 2 units requires PAR. |
| K0046 | Elevating leg rest, lower extension tube, each | Con | 2/Y | For repair only.<br>PAR required for more than 2 per fiscal year. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| K0047 | Elevating leg rest, upper hanger bracket, each | Con | 2/Y | For repair only.<br>PAR required for more than 2 per fiscal year. |
| K0050 | Ratchet assembly | Yes | | For repair only. |
| K0051 | Cam release assembly, footrest or leg rest, each | Yes | | For repair only. |
| K0052 | Swing away, detachable footrests, each | Con | 2/Y | New or repair.<br>Over 2 units requires PAR. |
| K0053 | Elevating footrests, articulating (telescoping), each | Yes | | |
| K0065 | Spoke protectors, each | Yes | | 1 item = 1 spoke protector |
| K0069 | Rear wheel assembly, complete, with solid tire, spokes or molded, each | Con | | PAR required for purchase but not required for repair. |
| K0070 | Rear wheel assembly, complete, with pneumatic tire, spokes or molded, each | Con | 2/Y | PAR required for purchase but not required for repair. 1 item = 1 assembly.<br>Over 2 units requires PAR. |
| K0071 | Front caster assembly, complete, with pneumatic tire, each | Con | 2 per 3 Y | PAR required for purchase but not required for repair. 1 item = 1 assembly.<br>PAR required for more than 2 per 3 fiscal years. |
| K0072 | Front caster assembly, complete, with semi-pneumatic tire, each | Con | 2 per 3 Y | PAR required for purchase but not required for repair.<br>1 item = 1 assembly.<br>PAR required for more than 2 per 3 fiscal years. |
| K0073 | Caster pin lock, each | None | | 1 item = 1 pin. |
| K0077 | Front caster assembly, complete, with solid tire, each | Con | 2 per 3 Y | PAR required for purchase but not required for repair. 1 item = 1 tire.<br>PAR required for more than 2 per 3 fiscal years. |
| K0098 | Drive belt for power wheelchair | Yes | | For repair only. |
| K0195 | Elevating leg rest, pair (for use with capped rental wheelchair base) | Yes | | |
| K0462-RR | Temporary replacement for patient owned equipment being repaired, any type | Yes | | Do not use when there is an appropriate code available for the rental equipment being provided. |
| K0733 | Power wheelchair accessory, 12 to 24 AMP hour sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) | Con | | PAR required for purchase but not for repair. |
| | **Support systems** | | | |
| E0956 | Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0957 | Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each | Yes | | |
| E2620 | Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware | Yes | | |
| E2621 | Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware | Yes | | |
| E2626 | Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable | Yes | | New code effective 1/1/2012. |
| E2627 | Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable Rancho type | Yes | | New code effective 1/1/2012. |
| E2628 | Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, reclining | Yes | | New code effective 1/1/2012. |
| E2629 | Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints) | Yes | | New code effective 1/1/2012. |
| E2630 | Wheelchair accessory, shoulder elbow, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support | Yes | | New code effective 1/1/2012. |
| E2631 | Wheelchair accessory, addition to mobile arm support, elevating proximal arm | Yes | | New code effective 1/1/2012. |
| E2632 | Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control | Yes | | New code effective 1/1/2012. |
| E2633 | Wheelchair accessory, addition to mobile arm support, supinator | Yes | | New code effective 1/1/2012. |
| T5001 | Positioning seat for persons with special orthopedic needs | Yes | | Use this code for custom seating/positioning car seats. |
| **COCHLEAR EQUIPMENT & SUPPLIES** | | | | |
| A4638 | Replacement battery for patient-owned ear pulse generator, each | None | | |
| E2120 | Pulse generator system for tympanic treatment of inner ear endolymphatic fluid | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L8615 | Headset/headpiece for use with cochlear implant device, replacement | None | | |
| L8616 | Microphone for use with cochlear implant device, replacement | None | | |
| L8617 | Transmitting coil for use with cochlear implant device, replacement | None | | |
| L8618 | Transmitter cable for use with cochlear implant device, replacement | None | | |
| L8619 | Cochlear implant external speech processor, replacement | None | | |
| L8621 | Zinc air battery for use with cochlear implant device, replacement, each | None | | |
| L8622 | Alkaline battery for use with cochlear implant device, any size, replacement, each | None | | |
| L8623 | Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each | None | | |
| L8624 | Lithium ion battery for use with cochlear implant device speech processor, ear level, replacement, each | None | | |
| L8627 | Cochlear implant, external speech processor, component, replacement | None | | |
| L8628 | Cochlear implant, external controller component, replacement | None | | |
| L8629 | Transmitting coil and cable, integrated, for use with cochlear implant device, replacement | None | | |
| **DIABETIC MONITORING EQUIPMENT & SUPPLIES** | | | | |
| A4206 | Syringe with needle, sterile, 1 cc or less, each | None | 120/M | Use for diabetic syringes. All syringes must be billed on the supply claim form. 1 item = 1 syringe |
| A4211 | Supplies for self administered injection | None | | |
| A4215 | Needle, sterile, any size, each | None | | Use for diabetic pen needles. Indicate frequency of administration. |
| A4230 | Infusion set for external insulin pump, non needle cannula type | Yes | | |
| A4231 | Infusion set for external insulin pump, needle type | Yes | | |
| A4232 | Syringe with needle for external insulin pump, sterile, 3cc | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A4233 | Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each | None | | |
| A4234 | Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each | None | | |
| A4235 | Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each | None | | |
| A4236 | Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each | None | | |
| A4250 | Urine test or reagent strips or tablets, each | None | | 1 item = 1 strip/tablet Albustix |
| A4252 | Blood ketone test or reagent strip, each | None | | |
| A4253 | Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips | None | 6/M | 1 item = 50 strips |
| A4255 | Platforms for home blood glucose monitor, 50 per box | None | | 1 item = 50 per box |
| A4258 | Spring-powered device for lancet, each | None | | 1 item = 1 device |
| A4259 | Lancets, per box of 100 | None | 3/M | 1 item = box of 100 |
| A4772 | Blood glucose test strips, for dialysis, per 50 | None | | 1 item = per 50<br>Also for diabetic use. |
| A9274 | External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories | Yes | | |
| E0607 | Home blood glucose monitor | None | 1/Y | |
| E0784 | External ambulatory infusion pump, insulin | Yes | | 1 item = 1 system |
| E2100 | Blood glucose monitor with integrated voice synthesizer | Yes | | Medical justification needed for upgrade. |
| E2101 | Blood glucose monitor with integrated lancing/blood sample | Yes | | Medical justification needed for upgrade. |
| **DISPOSABLE SUPPLIES – GENERAL USE** | | | | |
| | **Antiseptics/solutions** | | | |
| A4216 | Sterile water, saline and/or dextrose, diluent/flush, 10 ml | Yes | 62/M | |
| A4217 | Sterile water/saline, 500 ml | Yes | 30/M | |
| A4218 | Sterile saline or water, metered dose dispenser, 10 ml | Yes | 20/M | |
| A4244 | Alcohol or peroxide, per pint | Yes | | 1 item = 1 pint |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A4245 | Alcohol wipes, each | None | | Not allowable for incontinence/baby wipes use.<br>1 item = 1 wipe |
| A4246 | Betadine, per pint | Yes | | 1 item = 1 pint |
| A4247 | Betadine or Iodine swabs/wipes, each | Yes | | 1 item = 1 swab/wipe |
| A6250 | Skin sealants, protectants, moisturizers, ointment | None | | |
| S8301 | Infection control supplies, not otherwise specified | Yes | | Use for masks, disposable gowns, etc. |
| | **First aid/dressings** | | | |
| A4450 | Tape, non-waterproof, per 18 square inches | Yes | | |
| A4452 | Tape, waterproof, per 18 square inches | Yes | 31/M | |
| A4455 | Adhesive remover or solvent, each | None | | |
| A4456 | Adhesive remover, wipes, any type, each | None | | |
| A4461 | Surgical dressing holder, non-reusable, each | None | | |
| A4463 | Surgical dressing holder, reusable, each | None | | |
| A4561 | Pessary, rubber, any type | None | | |
| A4562 | Pessary, non-rubber, any type | None | | |
| A4565 | Sling, each | None | | |
| A4566 | Shoulder sling or vest design, abduction restrainer, with or without swathe control, prefabricated, includes fitting and adjustment | None | | |
| A4570 | Splint | None | | |
| A4927 | Gloves, non-sterile, per 100 | Yes | 2/M | 1 item = 100 gloves<br>Over 2 boxes requires PAR. |
| A4930 | Gloves, sterile, per pair | No | 5/D | 1 item = 1 pair<br>Limit 5 pair per day. |
| A6010 | Collagen based wound filler, dry form, sterile, per gram of collagen | Yes | | |
| A6011 | Collagen based wound filler, gel/paste, per gram of collagen | Yes | | |
| A6021 | Collagen dressing, sterile, size 16 sq. in. or less, each | Yes | | |
| A6022 | Collagen dressing, sterile, size more than 16 sq. in. but less than or equal to 48 sq. in., each | Yes | | |
| A6023 | Collagen dressing, sterile, size more than 48 sq. in., each | Yes | | |
| A6024 | Collagen dressing wound filler, sterile, per 6 inches | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A6025 | Gel sheet for dermal or epidermal application, (e.g., silicone, hydrogel, other), each | Yes | | 1 item = 1 sheet |
| A6154 | Wound pouch, each | Yes | | 1 item = 1 pouch |
| A6196 | Alginate or other fiber gelling dressing, wound cover, sterile, pad size 16 sq. in. or less, each dressing | Yes | | |
| A6197 | Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each dressing | Yes | | |
| A6198 | Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 48 sq. in., each dressing | Yes | | |
| A6199 | Alginate or other fiber gelling dressing, wound filler, sterile, per 6 inches | Yes | | |
| A6203 | Composite dressing, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing | Yes | | |
| A6204 | Composite dressing, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in. with any size adhesive border, each dressing | Yes | | |
| A6205 | Composite dressing, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing | Yes | | |
| A6206 | Contact layer, sterile, 16 sq. in. or less, each dressing | Yes | | |
| A6207 | Contact layer, sterile, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing | Yes | | |
| A6208 | Contact layer, sterile, more than 48 sq. in., each dressing | Yes | | |
| A6209 | Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing | Yes | | |
| A6210 | Foam dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing | Yes | | |
| A6211 | Foam dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A6212 | Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing | Yes | | |
| A6213 | Foam dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing | Yes | | |
| A6214 | Foam dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing | Yes | | |
| A6215 | Foam dressing, wound filler, sterile, per gram | Yes | | |
| A6216 | Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing | Yes | | |
| A6217 | Gauze, non-impregnated, non-sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing | Yes | | |
| A6218 | Gauze, non-impregnated, non-sterile, pad size more than 48 sq. in., without adhesive border, each dressing | Yes | | |
| A6219 | Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing | Yes | | |
| A6220 | Gauze, non-impregnated, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing | Yes | | |
| A6221 | Gauze, non-impregnated, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing | Yes | | |
| A6222 | Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing | Yes | | |
| A6223 | Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing | Yes | | |
| A6224 | Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size more than 48 sq. in., without adhesive border, each dressing | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A6228 | Gauze, impregnated, water or normal saline, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing | Yes | | |
| A6229 | Gauze, impregnated, water or normal saline, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing | Yes | | |
| A6230 | Gauze, impregnated, water or normal saline, sterile, pad size more than 48 sq. in., without adhesive border, each dressing | Yes | | |
| A6231 | Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size 16 sq. in. or less, each dressing | Yes | | |
| A6232 | Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size greater than 16 sq. in. but less than or equal to 48 sq. in., each dressing | Yes | | |
| A6233 | Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size more than 48 sq. in., each dressing | Yes | | |
| A6234 | Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing | Yes | | |
| A6235 | Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq. in but less than or equal to 48 sq. in., without adhesive border, each dressing | Yes | | |
| A6236 | Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing | Yes | | |
| A6237 | Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing | Yes | | |
| A6238 | Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing | Yes | | |
| A6239 | Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing | Yes | | |
| A6240 | Hydrocolloid dressing, wound filler, paste, sterile, per fluid ounce | Yes | | |
| A6241 | Hydrocolloid dressing, wound filler, dry form, sterile, per gram | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A6242 | Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing | Yes | | |
| A6243 | Hydrogel dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing | Yes | | |
| A6244 | Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing | Yes | | |
| A6245 | Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing | Yes | | |
| A6246 | Hydrogel dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing | Yes | | |
| A6247 | Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing | Yes | | |
| A6248 | Hydrogel dressing, wound filler, gel, per fluid ounce | Yes | | |
| A6251 | Specialty absorptive dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing | Yes | | |
| A6252 | Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing | Yes | | |
| A6253 | Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing | Yes | | |
| A6254 | Specialty absorptive dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing | Yes | | |
| A6255 | Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A6256 | Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing | Yes | | |
| A6257 | Transparent film, sterile, 16 sq. in. or less, each dressing | Yes | | |
| A6258 | Transparent film, sterile, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing | Yes | | |
| A6259 | Transparent film, sterile, more than 48 sq. in., each dressing | Yes | | |
| A6260 | Wound cleansers, any type, any size | Yes | | |
| A6261 | Wound filler, gel/paste, per fluid ounce, not otherwise specified | Yes | | |
| A6262 | Wound filler, dry form, per gram, not otherwise specified | Yes | | |
| A6266 | Gauze, impregnated, other than water, normal saline, or zinc paste, sterile, any width, per linear yard | Yes | | |
| A6402 | Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing | Yes | | |
| A6403 | Gauze, non-impregnated, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing | Yes | | |
| A6404 | Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing | Yes | | |
| A6407 | Packing strips, non-impregnated, sterile, up to 2 inches in width, per linear yard | Yes | | |
| A6441 | Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three (3) inches and less than five (5) inches, per yard | Yes | 62/M | 1 unit = one yard |
| A6442 | Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three (3) inches, per yard | Yes | 62/M | 1 unit = one yard |
| A6443 | Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three (3) inches and less than five (5) inches, per yard | Yes | 62/M | 1 unit = one yard |
| A6444 | Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to five (5) inches, per yard | Yes | 62/M | 1 unit = one yard |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A6445 | Conforming bandage, non-elastic, knitted/woven, sterile, width less than three (3) inches, per yard | Yes | 62/M | 1 unit = one yard |
| A6446 | Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three (3) inches and less than five (5) inches, per yard | Yes | 62/M | 1 unit = one yard |
| A6447 | Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five (5) inches, per yard | Yes | 62/M | 1 unit = one yard |
| A6448 | Light compression bandage, elastic, knitted/woven, width less than three (3) inches, per yard | Yes | 62/M | 1 unit = one yard |
| A6449 | Light compression bandage, elastic, knitted/woven, width greater than or equal to three (3) inches and less than five (5) inches, per yard | Yes | 62/M | 1 unit = one yard |
| A6450 | Light compression bandage, elastic, knitted/woven, width greater than or equal to five (5) inches, per yard | Yes | 62/M | 1 unit = one yard |
| A6451 | Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to three (3) inches and less than five (5) inches, per yard | Yes | 62/M | 1 unit = one yard |
| A6452 | High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50% maximum stretch, width greater than or equal to three (3) inches and less than (5) five (5) inches, per yard | Yes | 62/M | 1 unit = one yard |
| A6453 | Self-adherent bandage, elastic, non-knitted/non-woven, width less than three (3) inches, per yard | Yes | 62/M | 1 unit = one yard |
| A6454 | Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three (3) inches and less than five (5) inches, per yard | Yes | 62/M | 1 unit = one yard |
| A6455 | Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five (5) inches, per yard | Yes | 62/M | 1 unit = one yard |
| A6456 | Zinc paste impregnated bandage, non-elastic, knitted/non-woven, width greater than or equal to three (3) inches and less than five (5) inches, per yard | Yes | 62/M | 1 unit = one yard |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A6457 | Tubular dressing with or without elastic, any width, per linear yard | Yes | 100/M | |
| S8450 | Splint, prefabricated, digit (specify digit by use of modifier) | None | | |
| S8451 | Splint, prefabricated, wrist or ankle | None | | |
| S8452 | Splint, prefabricated, elbow | None | | |
| | **Compression burn garment** | | | |
| A6501 | Compression burn garment, bodysuit (head to foot), custom fabricated | Yes | | |
| A6502 | Compression burn garment, chin strap, custom fabricated | Yes | | |
| A6503 | Compression burn garment, facial hood, custom fabricated | Yes | | |
| A6504 | Compression burn garment, glove to wrist, custom fabricated | Yes | | |
| A6505 | Compression burn garment, glove to elbow, custom fabricated | Yes | | |
| A6506 | Compression burn garment, glove to axilla, custom fabricated | Yes | | |
| A6507 | Compression burn garment, foot to knee length, custom fabricated | Yes | | |
| A6508 | Compression burn garment, foot to thigh length, custom fabricated | Yes | | |
| A6509 | Compression burn garment, upper trunk to waist including arm openings (vest), custom fabricated | Yes | | |
| A6510 | Compression burn garment, trunk, including arms down to leg openings (leotard), custom fabricated | Yes | | |
| A6511 | Compression burn garment, lower trunk including leg openings (panty), custom fabricated | Yes | | |
| A6512 | Compression burn garment, not otherwise classified | Yes | | |
| A6513 | Compression burn mask, face and/or neck, plastic or equal, custom fabricated | Yes | | |
| | **Ostomy care** | | | |
| A4361 | Ostomy face plate, all sizes, each | None | | 1 item = 1 faceplate |
| A4362 | Skin barrier, solid, 4x4 or equivalent, each | None | | |
| A4363 | Ostomy clamp, any type, replacement only, each | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A4364 | Adhesive for ostomy or catheter, liquid (spray, brush, etc.), cement, powder or paste, any composition, per ounce | None | | 1 item = 1 ounce<br>Silicone, latex. |
| A4366 | Ostomy vent, any type, each | None | | |
| A4367 | Ostomy belt, each | None | | 1 item = 1 belt |
| A4368 | Ostomy filter, any type, each | None | | 1 item = 1 filter |
| A4369 | Ostomy skin barrier; liquid (spray, brush, etc.), per ounce | None | | 1 item = 1 ounce |
| A4371 | Ostomy skin barrier; powder, per ounce | None | | 1 item = 1 ounce |
| A4372 | Ostomy skin barrier; solid 4x4 or equivalent, standard wear, with built-in convexity, each | None | | 1 item = 1 skin barrier |
| A4373 | Ostomy skin barrier; with flange (solid, flexible or accordion), with built-in convexity, any size, each | None | | **1 item = 1 skin barrier** |
| A4375 | Ostomy pouch, drainable, with faceplate attached, plastic, each | None | | **1 item = 1 pouch** |
| A4376 | Ostomy pouch, drainable, with faceplate attached, rubber, each | None | | 1 item = 1 pouch |
| A4377 | Ostomy pouch drainable, for use on faceplate, plastic, each | None | | 1 item = 1 pouch |
| A4378 | Ostomy pouch, drainable, for use on faceplate, rubber, each | None | | 1 item = 1 pouch |
| A4379 | Ostomy pouch, urinary, with faceplate attached, plastic, each | None | | 1 item = 1 pouch |
| A4380 | Ostomy pouch, urinary, with faceplate attached, rubber, each | None | | 1 item = 1 pouch |
| A4381 | Ostomy pouch, urinary, for use on faceplate, plastic, each | None | | 1 item = 1 pouch |
| A4382 | Ostomy pouch, urinary, for use on faceplate, heavy plastic, each | None | | 1 item = 1 pouch |
| A4383 | Ostomy pouch, urinary, for use on faceplate, rubber, each | None | | 1 item = 1 pouch |
| A4384 | Ostomy faceplate equivalent, silicone ring, each | None | | 1 item = 1 faceplate, silicone ring |
| A4385 | Ostomy skin barrier, solid 4x4 or equivalent, extended wear, without built-in convexity, each | None | | 1 item = 1 skin barrier |
| A4387 | Ostomy pouch, closed; with barrier attached, with built-in convexity (1 piece), each | None | | 1 item = 1 pouch |
| A4388 | Ostomy pouch, drainable, with extended wear barrier attached, (1 piece), each | None | | 1 item = 1 pouch |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A4389 | Ostomy pouch, drainable, with barrier attached, with built-in convexity (1 piece), each | None | | 1 item = 1 pouch |
| A4390 | Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each | None | | 1 item = 1 pouch |
| A4391 | Ostomy pouch, urinary, with extended wear barrier attached (1 piece), each | None | | 1 item = 1 pouch |
| A4392 | Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each | None | | 1 item = 1 pouch |
| A4393 | Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each | None | | 1 item = 1 pouch |
| A4394 | Ostomy deodorant, with or without lubricant, for use in ostomy pouch, per fluid ounce | None | | |
| A4395 | Ostomy deodorant for use in ostomy pouch, solid, per tablet | None | | 1 item = 1 tablet |
| A4396 | Ostomy belt with peristomal hernia support | None | | 1 item = 1 belt |
| A4397 | Irrigation supply, sleeve, each | None | | 1 item = 1 sleeve |
| A4398 | Ostomy irrigation supply; bag, each | None | | 1 item = 1 bag |
| A4399 | Ostomy irrigation supply; cone/catheter, with or without brush | None | | 1 item = cone/catheter and brush |
| A4400 | Ostomy irrigation set, each | None | | 1 item = 1 set |
| A4402 | Lubricant, per ounce | None | | 1 item = 1 ounce |
| A4404 | Adhesive rings (washers, wafers, discs, etc.), each | None | | 1 item = 1 ring |
| A4405 | Ostomy skin barrier, non-pectin based, paste, per ounce | None | 6/M | 1 item = 1 ounce |
| A4406 | Ostomy skin barrier, pectin based, paste, per ounce | None | 6/M | 1 item =1 ounce |
| A4407 | Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, 4 X 4 inches or smaller, each | None | 31/M | 1 item = 1 skin barrier |
| A4408 | Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, larger than 4 X 4 inches, each | None | 31/M | 1 item = 1 skin barrier |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A4409 | Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 X 4 inches or smaller, each | None | 31/M | 1 item = 1 skin barrier |
| A4410 | Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 X 4 inches, each | None | 60/M | 1 item = 1 skin barrier |
| A4411 | Ostomy skin barrier, solid 4X4 or equivalent, extended wear, with built-in convexity, each | None | 60/M | |
| A4412 | Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), without filter, each | None | 31/M | |
| A4413 | Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), with filter, each | None | 31/M | 1 item = 1 pouch |
| A4414 | Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 X 4 inches or smaller, each | None | 31/M | 1 item = 1 skin barrier |
| A4415 | Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4 X 4 inches, each | None | 31/M | 1 item = 1 skin barrier |
| A4416 | Ostomy pouch, closed, with barrier attached, with filter (1 piece), each | None | 50/M | 1 unit = 1 pouch |
| A4417 | Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter( 1 piece), each | None | 50/M | 1 unit = 1 pouch |
| A4418 | Ostomy pouch , closed, without barrier attached, with filter (1 piece), each | None | 50/M | 1 unit = 1 pouch |
| A4419 | Ostomy pouch, closed, for use on barrier with non-locking flange, with filter (2 piece), each | None | 60/M | 1 unit = 1 pouch |
| A4420 | Ostomy pouch, closed, for use on barrier with locking flange, (2 piece), each | None | 50/M | 1 unit = 1 pouch |
| A4421 | Miscellaneous ostomy supply not otherwise classified | None | | Charges greater than $23.73 must attach manufacturer's invoice, description & amounts. Claim must be submitted on paper. |
| A4422 | Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each | None | | 1 item = 1 packet |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A4423 | Ostomy pouch, closed, for use on barrier with locking flange, with filter (2 piece), each | None | 50/M | 1 unit = 1 pouch |
| A4424 | Ostomy pouch, drainable, with barrier attached, with filter (1 piece), each | None | 50/M | 1 unit = 1 pouch |
| A4425 | Ostomy pouch, drainable; for use on barrier with nonlocking flange, with filter (two (2) piece system), each | None | 50/M | 1 unit = 1 pouch |
| A4426 | Ostomy pouch, drainable, for use on barrier with locking flange (2 piece system), each | None | 50/M | 1 unit = 1 pouch |
| A4427 | Ostomy pouch, drainable, for use on barrier with locking flange with filter (2 piece system), each | None | 50/M | 1 unit = 1 pouch |
| A4428 | Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (1 piece), each | None | 50/M | 1 unit = 1 pouch |
| A4429 | Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each | None | 50/M | 1 unit = 1 pouch |
| A4430 | Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each | None | 50/M | 1 unit = 1 pouch |
| A4431 | Ostomy pouch, urinary, with barrier attached, with faucet-type tap with valve (1 piece), each | None | 50/M | 1 unit = 1 pouch |
| A4432 | Ostomy pouch, urinary, for use on barrier with non-locking flange, with faucet-type tap with valve (2 piece), each | None | 50/M | 1 unit = 1 pouch |
| A4433 | Ostomy pouch, urinary, for use on barrier with locking flange (2 piece), each | None | 50/M | 1 unit = 1 pouch |
| A4434 | Ostomy pouch, urinary, for use on barrier with locking flange, with faucet-type tap with valve (2 piece), each | None | 50/M | 1 unit = 1 pouch |
| A4435 | Ostomy pouch, drainable, high output, with extended wear barrier (one-piece system), with or without filter, each | None | 31/M | 1 unit per one (1) to two (2) days per site. This item should not be billed with barriers. |
| A5051 | Pouch, closed; with barrier attached (1 piece), each | None | | 1 item = 1 pouch |
| A5052 | Ostomy pouch, closed; without barrier attached (1 piece), each | None | | 1 item = 1 pouch |
| A5053 | Ostomy pouch, closed; for use on faceplate, each | None | | 1 item = 1 pouch |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A5054 | Ostomy pouch, closed; for use on barrier with flange, (2 piece) each | None | | 1 item = 1 pouch (2 piece system) each |
| A5055 | Stoma cap, each | None | | 1 item = 1 cap |
| A5056 | Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each | None | | New code effective 1/1/12. |
| A5057 | Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (1 piece), each | None | | New code effective 1/1/12. |
| A5061 | Ostomy pouch, drainable; with barrier attached (1 piece), each | None | | 1 item = 1 pouch |
| A5062 | Ostomy pouch, drainable; without barrier attached (1 piece), each | None | | 1 item = 1 pouch |
| A5063 | Ostomy pouch, drainable; for use on barrier with flange, (2 piece system), each | None | | 1 item = 1 pouch (2 piece system) each |
| A5071 | Ostomy pouch; urinary; with barrier attached (1 piece), each | None | | 1 item = 1 pouch |
| A5072 | Ostomy pouch, urinary; without barrier attached (1 piece), each | None | | 1 item = 1 pouch |
| A5073 | Ostomy pouch, urinary; for use on barrier with flange, per (2 piece), each | None | | 1 item = 1 pouch |
| A5081 | Stoma plug or seal, any type | None | | 1 item = 1 device |
| A5082 | Continent device, catheter for continent stoma, each | None | | 1 item = 1 catheter |
| A5083 | Continent device, stoma absorptive cover for continent stoma | None | | 1 item = 1 cover |
| A5093 | Ostomy accessory, convex insert, each | None | | 1 item = 1 insert |
| A5102 | Bedside drainage bottle, with or without tubing rigid or expandable, each | None | | 1 item = 1 bottle |
| A5105 | Urinary suspensory with leg bag, with or without tube, each | None | | 1 item = 1 suspensory |
| A5112 | Urinary drainage bag, leg or abdomen, latex, with or without tube, with straps, each | None | | 1 item = 1 bag |
| A5113 | Leg strap; latex, replacement only, per set | None | | 1 item = 1 pair |
| A5114 | Leg strap; foam or fabric, replacement only, per set | None | | 1 item = 1 set |
| A5120 | Skin barrier, wipes or swabs, each | None | | . |
| A5121 | Skin barrier, solid, 6x6 or equivalent, each | None | | 1 item = 1 skin barrier |
| A5122 | Skin barrier, solid, 8x8 or equivalent, each | None | | 1 item = 1 skin barrier |
| A5126 | Adhesive or non-adhesive disc or foam pad | None | | 1 item = 1 pad |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A5131 | Appliance cleaner, incontinence or ostomy appliance, per ounce | None | | 1 item = 1 ounce |
| A6250 | Skin sealants, protectants, moisturizers, ointments, any type, any size | None | | |
| | **Incontinence Products or Briefs** | | | |
| T4521 | Adult sized disposable incontinence product, brief/diaper, small, each | Con | 240/M | Diaper. COMBINATION LIMIT |
| T4522 | Adult sized disposable incontinence product, brief/diaper, medium, each | Con | 240/M | Diaper. COMBINATION LIMIT |
| T4523 | Adult sized disposable incontinence product, brief/diaper, large, each | Con | 240/M | Diaper. COMBINATION LIMIT |
| T4524 | Adult sized disposable incontinence product, brief/diaper, extra large, each | Con | 240/M | Diaper. COMBINATION LIMIT |
| T4525 | Adult sized disposable incontinence product, protective underwear/pull-on, small size, each | Con | 240/M | Pull-up. COMBINATION LIMIT |
| T4526 | Adult sized disposable incontinence product, protective underwear/pull-on, medium size, each | Con | 240/M | Pull-up. COMBINATION LIMIT |
| T4527 | Adult sized disposable incontinence product, protective underwear/pull-on, large size, each | Con | 240/M | Pull-up. COMBINATION LIMIT |
| T4528 | Adult sized disposable incontinence product, protective underwear/pull-on, extra large size, each | Con | 240/M | Pull-up. COMBINATION LIMIT |
| T4529 | Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each | Con | 240/M | Diaper. COMBINATION LIMIT |
| T4530 | Pediatric size disposable incontinence product brief/diaper, large size, each | Con | 240/M | Diaper. COMBINATION LIMIT |
| T4531 | Pediatric size disposable incontinence product, protective underwear/pull-on, small/medium size, each | Con | 240/M | Pull-up. COMBINATION LIMIT |
| T4532 | Pediatric sized disposable incontinence product, protective underwear/pull-on, large size, each | Con | 240/M | Pull-up. COMBINATION LIMIT |
| T4533 | Youth sized disposable incontinence product, brief/diaper, each | Con | 240/M | Diaper. COMBINATION LIMIT |
| T4534 | Youth sized disposable incontinence product, protective underwear/pull-on, each | Con | 240/M | Pull-up. COMBINATION LIMIT |
| T4535 | Disposable liner/shield/guard/pad/undergarment, for incontinence, each | Con | 240/M | Liner. COMBINATION LIMIT |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| T4543 | Adult sized disposable incontinence product, protective brief/diaper, above extra large, each | Con | 240/M | Brief. COMBINATION LIMIT |
| T4544 | Adult sized disposable incontinence product, protective underwear/pull-on, above extra large, each | Con | 240/M | Pull-Up. COMBINATION LIMIT |
| A4554 | Underpads, disposable, each | Con | 150/M | Chux. 1 item = 1 pad. Limit 150 per calendar month. Above 150 requires a PAR. |
| | **Syringes, needles & infusion supplies** | | | |
| A4206 | Syringe with needle, sterile, 1 cc, each | None | | Use for diabetic syringes. 1 item = 1 syringe. |
| A4207 | Syringe with needle, sterile, 2 cc, each | Yes | | 1 item = 1 syringe. Indicate medication administered, route of administration, dosage, frequency, and length of necessity on each prior authorization request. |
| A4208 | Syringe with needle, sterile, 3 cc, each | Yes | | 1 item = 1 syringe. Indicate medication administered, route of administration, dosage, frequency, and length of necessity on each prior authorization request. |
| A4209 | Syringe with needle, sterile, 5 cc up to 20 cc, each | Yes | | 1 item = 1 syringe. Indicate medication administered, route of administration, dosage, frequency, and length of necessity on each prior authorization request. |
| A4212 | Noncoring needle or stylet with or without catheter | None | | 1 item = 1 stylet. |
| A4213 | Syringe, sterile, 20 cc or greater, each | Yes | | 1 item = 1 syringe. Indicate medication administered, route of administration, dosage, frequency, and length of necessity on each prior authorization request. |
| A4215 | Needle (only), sterile, any size, each | None | | 1 item = 1 needle. Use for diabetic pen needles. Indicate frequency of administration. Do not use with B4220, A4206-A4209. |
| A4220 | Refill kit for implantable infusion pump | None | | |
| A4221 | Supplies for maintenance of drug infusion catheter, per week (list drug separately) | None | | |
| A4222 | Infusion supplies for external drug infusion pump, per cassette or bag (list drugs separately) | None | | |
| A4232 | Syringe with needle for external insulin pump, sterile, 3cc | Yes | | |
| S8490 | Insulin syringes (100 syringes, any size) | None | | |
| | **Urinary care** | | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A4310 | Insertion tray without drainage bag & without catheter (accessories only), each | None | | Includes: underpad/drape, povidone iodine, 10cc syringe, specimen container, sterile gloves, lubricant, and graduated collection basin. Do not bill included items separately. |
| A4311 | Insertion tray without drainage bag, with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.), per set | None | | 1 item = 1 set |
| A4312 | Insertion tray without drainage bag with indwelling catheter, Foley type, two-way, all silicone, per set | None | | 1 item = 1 set |
| A4314 | Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.), per set | None | | 1 item = 1 set |
| A4315 | Insertion tray with drainage bag with indwelling catheter, Foley type, two-way, all silicone, per set | None | | 1 item = 1 set |
| A4320 | Irrigation tray with bulb or piston syringe, each | None | | 1 item = 1 set |
| A4322 | Irrigation syringe, bulb or piston, each | None | | 1 item = 1 syringe |
| A4326 | Male external catheter with integral collection chamber, any type, each | None | 35/M | Inflatable, faceplate, etc.<br>1 item = 1 catheter |
| A4327 | Female external urinary collection device, metal cup, each | None | | 1 item = 1 cup |
| A4328 | Female external urinary collection device, pouch, each | None | | 1 item = 1 pouch |
| A4330 | Perianal fecal collection pouch with adhesive, each | None | | 1 item = 1 pouch |
| A4331 | Extension drainage tubing, any type, any length, with connector/adapter, for use with urinary leg bag or urostomy pouch, each | None | 15/M | 1 item = 1 extension drainage tubing |
| A4332 | Lubricant, individual sterile packet, each | None | 180/M | 1 item = 1 packet |
| A4333 | Urinary catheter anchoring device, adhesive skin attachment, each | None | 30/M | 1 item = 1 device |
| A4334 | Urinary catheter anchoring device, leg strap, each | None | 30/M | 1 item = 1 device |
| A4335 | Miscellaneous incontinence supply not otherwise classified | Yes | | No PAR required if used for urinary tubing, clamps, connectors, hand adapters. Billing must include description of urinary item. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A4336 | Incontinence supply, urethral insert, any type, each | None | 30/M | 1 item = 1 insert |
| A4338 | Indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.), each | None | 2/M | 1 item = 1 catheter |
| A4340 | Indwelling catheter, specialty type (coude, mushroom, wing, etc.), each | None | | 1 item = 1 catheter |
| A4344 | Indwelling catheter, Foley type, two-way, all silicone, each | None | | 1 item = 1 catheter |
| A4349 | Male external catheter, with or without adhesive, disposable, each | None | 35/M | |
| A4351 | Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each | None | 120/M | 1 item = 1 catheter |
| A4351-22 | Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each | None | 120/M | Use for Hydrophilic catheter. 1 item = 1 catheter |
| A4352 | Intermittent urinary catheter; Coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each | None | | 1 item = 1 catheter |
| A4352-22 | Intermittent urinary catheter; Coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each | None | | Use for Hydrophilic catheter. 1 item = 1 catheter |
| A4353 | Intermittent urinary catheter, with insertion supplies | Yes | 120/M | |
| A4353- 22 | Intermittent urinary catheter, with insertion supplies | Yes | 120/M | |
| A4354 | Insertion tray with drainage bag, without catheter, each | None | | 1 item = 1 tray & bag |
| A4356 | External urethral clamp or compression device (not to be used for catheter clamp), each | None | | 1 item = 1 clamp |
| A4357 | Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, per set | None | 2/M | 1 item = 1 set |
| A4358 | Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each | None | 2/M | 1 item = 1 bag |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A4360 | Disposable external urethral clamp or compression device, with pad and/or pouch, each | None | 31/M | |
| | **Miscellaneous** | | | |
| A4265 | Paraffin, per pound | Yes | | 1 item = 1 pound |
| A6410 | Eye Pad, sterile, each | None | | 1 item = 1 eye pad |
| A6411 | Eye Pad, non-sterile, each | None | | 1 item = 1 eye pad |
| A6412 | Eye patch, occlusive, each | None | | 1 item = 1 eye patch |
| E0235 | Paraffin bath unit, portable each | Yes | | 1 item = 1 unit |
| **ELASTIC SUPPORTS & STOCKINGS – GENERAL USE** | | | | |
| A4465 | Nonelastic binder for extremity | None | | |
| A4466 | Garment, belt, sleeve or other covering, elastic or similar stretchable material, any type, each | None | | |
| A4490 | Surgical stocking, above knee length, each | None | | 1 item = 1 stocking |
| A4495 | Surgical stocking, thigh length, each | None | | 1 item = 1 stocking |
| A4500 | Surgical stocking, below knee length, each | None | | 1 item = 1 stocking |
| A4510 | Surgical stocking, full length, each | None | | 1 item = 1 stocking |
| A6530 | Gradient compression stocking, below knee, 18-30 mmhg, each | None | | |
| A6531 | Gradient compression stocking, below knee, 30-40 mmhg, each | None | | |
| A6532 | Gradient compression stocking, below knee, 40-50 mmhg, each | None | | |
| A6533 | Gradient compression stocking, thigh length, 18-30 mmhg, each | None | | |
| A6534 | Gradient compression stocking, thigh length, 30-40 mmhg, each | None | | |
| A6535 | Gradient compression stocking, thigh length, 40-50 mmhg, each | None | | |
| A6536 | Gradient compression stocking, full length/chap style, 18-30 mmhg, each | None | | |
| A6537 | Gradient compression stocking, full length/chap style, 30-40 mmhg, each | None | | |
| A6538 | Gradient compression stocking, full length/chap style, 40-50 mmhg, each | None | | |
| A6539 | Gradient compression stocking, waist length, 18-30 mmhg, each | None | | |
| A6540 | Gradient compression stocking, waist length, 30-40 mmhg, each | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A6541 | Gradient compression stocking, waist length 40-50 mmhg, each | None | | |
| A6544 | Gradient compression stocking, garter belt | None | | |
| A6545 | Gradient compression wrap, non-elastic, below knee, 30-50 mm hg, each | None | | |
| A6549 | Gradient compression stocking/sleeve, not otherwise specified | None | | |
| **HEAT & COLD APPLICATION EQUIPMENT – GENERAL USE** | | | | |
| A9273 | Hot water bottle, ice cap or collar, heat and/or cold wrap, any type | Yes | | |
| E0200 | Heat lamp, without stand (table model), includes bulb or infrared element, each | Yes | | |
| E0215 | Electric heat pad, moist | Yes | | Benefit under very limited circumstances. |
| E0217 | Water circulating heat pad with pump | Yes | | |
| E0218 | Water circulating cold pad with pump | Yes | | |
| E0221 | Infrared heating pad system | Yes | | |
| E0236 | Pump for water circulating pad, each | Yes | | |
| E0249 | Pad for water circulating heat unit, for replacement only | Yes | | Purchase for member owned equipment only. |
| **MONITORING EQUIPMENT & SUPPLIES – GENERAL USE** | | | | |
| A4556 | Electrodes (e.g., apnea monitor), per pair | None | | 1 item = 1 pair. Note: Purchase for member owned equipment only. Must be provided by supplier for rented equipment. |
| A4557 | Lead wires or cables, per pair | None | | 1 item = 1 pair. Note: Purchase for member owned equipment only. Must be provided by supplier for rented equipment. |
| A4558 | Conductive gel or paste, for use with electrical device (e.g., tens, nmes), per oz | None | | 1 item = 1 tube of gel |
| A4660 | Sphygmomanometer/blood pressure apparatus with cuff and stethoscope | Yes | | |
| A4663 | Blood pressure cuff only | Yes | | 1 item = 1 cuff only |
| A4670 | Automatic blood pressure monitor | Yes | | Digital |
| E0607 | Home blood glucose monitor, each | None | | |
| E0619-RR | Apnea monitor, with recording feature | Yes | 1/M | Includes cardiac monitoring (belts included). 1 unit = 1 month Beyond 6 months requires Questionnaire #7. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0445<br>E0445-RR<br>E0445-KR | Oximeter device for measuring blood oxygen levels non-invasively | Yes | | Requires Questionnaire # 6<br>Purchase is required after a two (2) month rental period. Total reimbursement, including rental, shall not exceed the purchase price.<br>For members under 3 years of age only: Equipment may be rented by members for a period of up to 3 years or until age 3. However, for rental periods exceeding 2 months, purchase is required when the member reaches age 3.<br>Rental:<br>- RR 1 unit = 1 month<br>- KR 1 unit = 1 day – use only for overnight or 24-hour test period use. |
| E0610 | Pacemaker monitor, self-contained (checks battery depletion, includes audible & visual check systems), each | Yes | | |
| E0615 | Pacemaker monitor, self-contained, checks battery depletion & other pacemaker components, includes digital/visual check systems, each | Yes | | |
| K0606 | Automatic external defibrillator, with integrated electrocardiogram analysis, garment type | Yes | | |
| K0607 | Replacement battery for automated external defibrillator, garment type only, each | Yes | | |
| K0608 | Replacement garment for use with automated external defibrillator, each | Yes | | |
| K0609 | Replacement electrodes for use with automated external defibrillator, garment type only, each | Yes | | |
| S8270 | Enuresis alarm, using auditory buzzer and/or vibration device | Yes | | |
| S9001-KR | Home uterine monitor with or without associated nursing services | Yes | 31/D | Equipment only. Limited to 1 unit per day-no more than 31 days at a time. NAB without essential nursing services. Telephonic transmission & interpretation are not benefits. |
| **PHOTOTHERAPY – GENERAL USE** | | | | |
| E0202-KR | Phototherapy (bilirubin) light with photometer, per day | None | 31/M | 1 item = 1 day rental. Claims may be date spanned using the KR modifier for the rental period. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0691-KR | Ultraviolet light therapy system , includes bulbs/lamps, timer and eye protection; treatment area 2 square feet or less | Yes | 31/M | 1 item = 1 day rental |
| E0692-KR | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 foot panel | Yes | 31/M | 1 item = 1 day rental |
| E0693-KR | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 foot panel | Yes | 31/M | 1 item = 1 day rental |
| E0694-KR | Ultraviolet multidirectional light therapy system in 6 foot cabinet, includes bulbs/lamps, timer and eye protection | Yes | 31/M | 1 item = 1 day rental |
| **OXYGEN & RESPIRATORY CARE- GENERAL USE**<br>Respiratory care equipment requires a physician's prescription. The supplier must maintain a copy of the prescription and questionnaire #17 on file at all times. | | | | |
| | **Humidifiers** | | | |
| A4483 | Moisture exchanger, disposable, for use with invasive mechanical ventilation | Yes | 31/M | |
| A7046 | Water chamber for humidifier, used with positive airway pressure device, replacement, each | Yes | | 1 item = 1 bottle |
| E0500-RR | IPPB machine(s), all types, with built in nebulization, manual or automatic valves, internal or external power source (Manual valves external power source includes cylinder regulator built-in nebulization) | None | | 1 item = 1 month rental |
| E0550 | Humidifier, durable, for extensive supplemental humidification during IPPB treatment or oxygen delivery (e.g., Cascade) | None | | |
| E0555 | Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter | None | | |
| E0560 | Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery (e.g., Cascade Jr.) | None | | |
| E0561 | Humidifier, non-heated, used with positive airway pressure device | Yes | | Purchase for member owned equipment only. |
| E0562 | Humidifier, heated, used with positive airway pressure device | Yes | | One-time purchase per provider per member. |
| E1405 | Oxygen & water vapor enriching system with heated delivery | Yes | | |
| E1406 | Oxygen & water vapor enriching system without heated delivery | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| | **IPPB machines** | | | |
| | **Oxygen contents – All settings** | | | |
| E0441 | Stationary oxygen contents, gaseous, 1 month's supply = 1 unit | None | | 1 unit = 50 cubic ft<br>Use Modifier QE for <2 LPM - 95.00<br>Use no modifier for 2-4 LPM<br>Us Modifier QF for >4 to 6 LPM - 285.00<br>Use Modifier QG for > 6 LPM - 403.20<br>1 unit = 1M |
| E0442 | Stationary oxygen contents, liquid, 1 month's supply = 1 unit | None | | 1 unit = 10 lbs<br>Use Modifier QE for <2 LPM - 95.00<br>Use no modifier for 2-4 LPM<br>Use Modifier QF for >4 to 6 LPM - 285.00<br>Use Modifier QG for > 6 LPM - 403.20<br>1 unit = 1M |
| E0443 | Portable oxygen contents, gaseous, 1 month's supply = 1 unit | None | | Available only for Medicare crossover claims |
| E0444 | Portable oxygen contents, liquid, 1 month's supply = 1 unit | None | | Available only for Medicare crossover claims |
| S8120 | Oxygen contents, gaseous, 1 unit equals 1 cubic foot | None | | Available for ventilator members<br>Use Modifier TG<br>Available for use with members receiving more than 6LPM when approved by HCPF |
| S8121 | Oxygen contents, liquid, 1 unit equals 1 pound | None | | Available only for ventilator members<br>Use Modifier TG<br>Available for use with members receiving more than 6LPM when approved by HCPF |
| | **Oxygen systems: Colorado Medicaid-Only Member, POS- Home** | | | |
| E0425-RR | Stationary compressed gas system, purchase: includes regulator, flow meter, humidifier, cannula or mask, and tubing | None | | Providers must include RR modifier. |
| E0431-RR | Portable gaseous oxygen system, rental; includes portable container, regulator, flow meter, humidifier, cannula or mask, and tubing | None | | Provider must use RR modifier. |
| E0435-RR | Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing, and refill adapter | None | | Providers must include RR modifier. |
| E0440-RR | Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing | None | | Providers must include RR modifier. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| K0738-RR | Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing | None | | Providers must include RR modifier. |
| | **Oxygen systems: Dually eligible Colorado Medicaid Member, POS- Home** | | | |
| E0424-RR | Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, & tubing | None | | Providers must include RR modifier. |
| E0434-RR | Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flow meter, refill adapter, contents gauge, cannula or mask, and tubing | None | | Provider must use RR modifier. |
| E0434-TT-RR | Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flow meter, refill adapter, contents gauge, cannula or mask, and tubing | None | | Providers must include both TT and RR modifier. Use for monthly rental of a portable liquid oxygen system to be filled through a centrally located/shared stationary reservoir, includes portable container, flow humidifier, cannula or mask, tubing & refill adaptor. |
| K0738-RR | Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing | None | | Providers must include RR modifier. |
| | **Oxygen systems: Colorado Medicaid-Only Member, POS-Nursing Facility** | | | |
| E0425-RR | Stationary compressed gas system, purchase: includes regulator, flow meter, humidifier, cannula or mask, and tubing | None | | Providers must include RR modifier. |
| E0430-RR | Portable gaseous oxygen system, purchase: includes regulator, flowmeter, humidifier, cannula or mask, and tubing | None | | Providers must include RR modifier. |
| E0435-RR | Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing, and refill adapter | None | | Providers must include RR modifier. |
| E0435-TT-RR | Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing, and refill adapter | None | | Providers must include both TT and RR modifier. Use for monthly rental of a portable liquid oxygen system to be filled through a centrally located/shared stationary reservoir, includes portable container, flow humidifier, cannula or mask, tubing & refill adaptor. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0440-RR | Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing | None | | Providers must include RR modifier. |
| E0440-TT-RR | Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing | None | | Providers must include both TT and RR modifier. Use for multiple member use of reservoir. Bill usual & customary charge divided by total number of **all** members utilizing reservoir. The total, unduplicated count of members (regardless of payment source) using the equipment during the month must be maintained in each member's file. |
| | **Oxygen systems: Dually eligible Medicare/Colorado Medicaid Member, POS-Nursing Facility** | | | |
| E0424-RR | Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, & tubing | None | | Providers must include RR modifier. |
| E0430-RR | Portable gaseous oxygen system, purchase: includes regulator, flowmeter, humidifier, cannula or mask, and tubing | None | | Providers must include RR modifier. |
| E0433-RR | Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge | None | | Providers must include RR modifier. |
| E0434-RR | Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flow meter, refill adapter, contents gauge, cannula or mask, and tubing | None | | Provider must use RR modifier. |
| E0434-TT-RR | Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flow meter, refill adapter, contents gauge, cannula or mask, and tubing | None | | Providers must include both TT and RR modifier. Use for monthly rental of a portable liquid oxygen system to be filled through a centrally located/shared stationary reservoir, includes portable container, flow humidifier, cannula or mask, tubing & refill adaptor. |
| E0439-RR | Stationary liquid oxygen system, rental; includes container, contents, regulator, flow meter, humidifier, nebulizer, cannula or mask, & tubing | None | | Providers must include RR modifier. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0439-TT-RR | Stationary liquid oxygen system, rental; includes container, contents, regulator, flow meter, humidifier, nebulizer, cannula or mask, & tubing | None | | Providers must include both TT and RR modifier. Use for multiple member use of reservoir. Bill usual & customary charge divided by total number of **all** members utilizing reservoir. The total, unduplicated count of members (regardless of payment source) using the equipment during the month must be maintained in each member's file. |
| | **Oxygen concentrators: Colorado Medicaid-Only Member and Medicare/Colorado Medicaid Dually Eligible Member, POS-Home** | | | |
| E1390-RR | Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate | None | | |
| E1391-RR | Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each | None | | |
| E1392-RR | Portable oxygen concentrator, rental | None | | |
| | **Oxygen concentrators: Colorado Medicaid-Only Member and Medicare/Colorado Medicaid Dually Eligible Member, POS-Nursing Facility** | | | |
| E1390-TT | Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate | None | | 1 item = 1 hour usage $167.67(or 729 units) per month maximum for concentrator/equipment. |
| E1391-TT | Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each | None | | 1 item = 1 hour usage<br>167.67 (or 729 units) per month maximum for concentrator/equipment. |
| E1392-TT | Portable oxygen concentrator, rental | None | | 1 item = 1 hour usage $167.67 (or 729 units) per month maximum for concentrator/equipment. |
| | **Ventilators, percussors, & respirators** | | | |
| A4604 | Tubing with integrated heating element for use with positive airway pressure device | Yes | | |
| A7020 | Interface for cough stimulating device, includes all components, replacement only | Yes | | |
| A7025 | High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each | Yes | | Requires Questionnaire #14. |
| A7026 | High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each | None | | Purchase for member owned equipment only. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A7027 | Combination oral/nasal mask, used with continuous positive airway pressure device, each | Yes | 6/Y | Purchase for member owned equipment only. |
| A7028 | Oral cushion for combination oral/nasal mask, replacement only, each | Yes | 6/Y | Purchase for member owned equipment only. |
| A7029 | Nasal pillows for combination oral/nasal mask, replacement only, pair | Yes | 6/Y | Purchase for member owned equipment only. |
| A7030 | Full face mask used with positive airway pressure device, each | Yes | 6/Y | Purchase for member owned equipment only. |
| A7031 | Face mask interface, replacement for full face mask, each | Yes | 6/Y | Purchase for member owned equipment only. |
| A7032 | Cushion for use on nasal mask interface, replacement only, each | Yes | 6/Y | Purchase for member owned equipment only. |
| A7033 | Pillow for use on nasal cannula type interface, replacement only, pair | Yes | 6/Y | Purchase for member owned equipment only. |
| A7034 | Nasal interface (mask or cannula type) used with positive airway pressure devise, with or without head strap | Yes | 6/Y | Purchase for member owned equipment only. |
| A7035 | Headgear used with positive airway pressure device | Yes | 6/Y | Purchase for member owned equipment only. |
| A7036 | Chinstrap used with positive airway pressure device | Yes | 6/Y | Purchase for member owned equipment only. |
| A7037 | Tubing used with positive airway pressure device | None | 12/Y | Purchase for member owned equipment only. |
| A7038 | Filter, disposable, used with positive airway pressure device | Yes | 1/Y | Purchase for member owned equipment only. |
| A7039 | Filter, non disposable, used with positive airway pressure device | Yes | 1/Y | Purchase for member owned equipment only. |
| A7044 | Oral interface used with positive airway pressure device, each | Yes | 6/Y | Purchase for member owned equipment only. |
| A7045 | Exhalation port with or without swivel used with accessories for positive airway devices, replacement only | Yes | 6/Y | Purchase for member owned equipment only. |
| A9280 | Alert or alarm device, not otherwise classified | Yes | | Purchase only for member owned equipment. |
| E0450-RR | Volume control ventilator, without pressure support mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube) | Yes | | LP-6, LP-10, PLV 100, PLV 102, Bear 33, PB2800, PB2801. PAR must include equipment description. 1 item = 1 month rental. |
| E0457 | Chest Shell (cuirass) | Yes | | Must be provided if equipment is rented. Purchase for member owned equipment only. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0459 | Chest wrap | Yes | | Must be provided if equipment is rented. Purchase for member owned equipment only. |
| E0460 | Negative pressure ventilator, portable or stationary | Yes | | |
| E0461-RR | Volume control ventilator, without pressure support mode, may include pressure control mode, used with non-invasive interface (e.g. mask) | Yes | 1/M | 1 item = 1 month rental |
| E0463 | Pressure support ventilator with volume control mode, may include pressure control mode, used with invasive interface (e.g. tracheostomy tube) | Yes | 1/M | Members may receive up to 2 units per month if a backup ventilator is required. |
| E0464 | Pressure support ventilator with volume control mode, may include pressure control mode, used with non-invasive interface (e.g. mask) | Yes | 1/M | Members may receive up to 2 units per month if a backup ventilator is required. |
| E0470 | Respiratory assist device, bi-level pressure capability, without back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) | Yes | | Requires sleep study with PAR. Rental includes mask & headgear. Use A7030 for mask purchase. Use A7035 for headgear purchase. Requires Questionnaire #8 for adults over 21 years of age. . |
| E0471 | Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) | Yes | | Requires sleep study with PAR. Requires Questionnaire #8 for adults over 21 years of age. |
| E0472 | Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device) | Yes | | Requires sleep study with PAR. Rental includes mask & headgear. Use A7030 for mask purchase. Use A7035 for headgear purchase. Requires Questionnaire #8 for adults over 21 years of age. |
| E0480 | Percussor, electric or pneumatic, home model | Yes | | |
| E0482 | Cough stimulating device, alternating positive and negative airway pressure | Yes | | |
| E0483 | High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest) each. | Yes | | Requires Questionnaire #14. |
| E0561 | Humidifier, non-heated, used with positive airway pressure device | Yes | | Purchase for member owned equipment only. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0562 | Humidifier, heated, used with positive airway pressure device | Yes | | One-time purchase per provider per member. |
| E0601 | Continuous positive airway pressure (CPAP) device | Yes | | Requires sleep study with PAR. Rental includes mask & headgear. Use A7030 for mask purchase. Use A7035 for headgear purchase. Rental period of 60-90 days must demonstrate 80% overall compliance with a nightly average of at least five (5) hours before a purchase request will be approved. Requires Questionnaire #8 for adults over 21 years of age. |
| E0606 | Postural drainage board | Yes | | |
| S8185 | Flutter device | Yes | | |
| S8186 | Swivel adapter | Yes | | |
| | **Oxygen concentrators: Colorado Medicaid-Only Member and Medicare/Colorado Medicaid Dually Eligible Member, POS-Home** | | | |
| E1390-RR | Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate | None | | |
| E1391-RR | Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each | None | | |
| E1392-RR | Portable oxygen concentrator, rental | None | | |
| | **Oxygen concentrators: Colorado Medicaid-Only Member and Medicare/Colorado Medicaid Dually Eligible Member, POS-Nursing Facility** | | | |
| E1390-TT | Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate | None | | 1 item = 1 hour usage $167.67(or 729 units) per month maximum for concentrator/equipment. |
| E1391-TT | Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each | None | | 1 item = 1 hour usage<br>167.67 (or 729 units) per month maximum for concentrator/equipment. |
| E1392-TT | Portable oxygen concentrator, rental | None | | 1 item = 1 hour usage $167.67 (or 729 units) per month maximum for concentrator/equipment. |
| **NEBULIZERS, VAPORIZERS, SUCTION** | | | | |
| A7000 | Canister, disposable, used with suction pump | None | | 1 unit = 1 canister |
| A7001 | Canister, non-disposable, used with suction pump | None | | 1 unit = 1 canister |
| A7002 | Tubing, used with suction pump | None | | 1 unit = 1 tubing |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A7003 | Administration set, with small volume nonfiltered pneumatic nebulizer, disposable | None | | |
| A7004 | Small volume non-filtered pneumatic nebulizer, disposable | None | | 1 unit = 1 nebulizer |
| A7005 | Administration set, with small volume nonfiltered pneumatic nebulizer, nondisposable | None | | |
| A7006 | Administration set, with small volume filtered pneumatic nebulizer | None | | |
| A7007 | Large volume nebulizer, disposable, unfilled, used with aerosol compressor | None | | 1 unit = 1 nebulizer |
| A7008 | Large volume nebulizer, disposable, pre-filled, used with aerosol compressor | None | | 1 unit = 1 nebulizer |
| A7009 | Reservoir bottle, non-disposable, used with large volume ultrasonic nebulizer | None | | 1 unit = 1 reservoir bottle |
| A7010 | Corrugated tubing, disposable, used with large volume nebulizer, 100 feet | None | | 1 unit = 100 feet |
| A7011 | Corrugated tubing, non-disposable, used with large volume nebulizer, 10 feet | None | | 1 unit = 10 feet |
| A7012 | Water collection device, used with large volume nebulizer | None | | 1 unit = 1 device |
| A7013 | Filter, disposable, used with aerosol compressor or ultrasonic generator | None | | 1 unit = 1 filter |
| A7014 | Filter, non-disposable, used with aerosol compressor or ultrasonic generator | None | | 1 unit = 1 filter |
| A7015 | Aerosol mask, used with DME nebulizer | None | | 1 unit = 1 mask |
| A7016 | Dome and mouthpiece, used with small volume ultrasonic nebulizer | None | | 1 unit = dome and mouthpiece |
| A7017 | Nebulizer, durable glass, or autoclavable plastic, bottle type, not used with oxygen | None | | 1 unit = 1 nebulizer |
| A7018 | Water, distilled, used with large volume nebulizer, 1000 ml | None | | 1 unit = 1,000 ml. |
| E0565 | Compressor, air power source for equipment which is not self-contained or cylinder driven | None | | |
| E0570 | Nebulizer with compressor | None | | |
| E0571 | Aerosol compressor, battery powered, for use with small volume nebulizer | None | | Deleted effective 1/1/2012. |
| E0572 | Aerosol compressor, adjustable pressure, light duty for intermittent use | None | | |
| E0574 | Ultrasonic electronic aerosol generator with small volume nebulizer | None | | |
| E0575 | Nebulizer, ultrasonic, large volume | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0580 | Nebulizer, durable glass or autoclavable plastic bottle type for use with regulator or flowmeter, each | None | | |
| E0585 | Nebulizer with compressor & heater | None | | |
| E0600 | Respiratory suction pump, home model, portable or stationary, electric | None | 1/M | 1 unit = 1 month. Capped rental item. Rental includes suction tubing. |
| E1372 | Immersion external heater for nebulizer | None | | |
| K0730 | Controlled dose inhalation drug delivery system | None | | |
| | **Respiratory care accessories, supplies & related services**<br>**Note**: All belts, leads, pads, & tubing are included in the rental price. Items may be purchased only for member-owned equipment. | | | |
| A4481 | Tracheostomy filter, any type, any size, each | None | | 1 item = 1 filter |
| A4605 | Tracheal suction catheter, closed system, each | None | | |
| A4606 | Oxygen probe for use with oximeter device, replacement | Yes | | 1 unit = 1 probe<br>Non-disposable |
| A4608 | Transtracheal oxygen catheter, each | None | | 1 item = 1 catheter |
| A4611 | Battery, heavy duty, replacement for patient owned ventilator, each | None | | |
| A4612 | Battery cables, replacement for patient owned ventilator, each | None | | |
| A4613 | Battery charger, replacement for patient owned ventilator, each | None | | |
| A4614 | Peak expiratory flow rate meter, hand held | None | | |
| A4615 | Cannula, nasal, each | None | | Must be provided with rental equipment. Purchase for member owned equipment only. |
| A4616 | Tubing (oxygen), per foot | None | | |
| A4617 | Mouthpiece, each | None | | |
| A4618 | Breathing circuits, each | None | | Must be provided with rental equipment. Purchase for member owned equipment only. |
| A4619 | Face tent, each | None | | |
| A4620 | Variable concentration mask, each | None | | |
| A4623 | Tracheostomy, inner cannula (replacement only), each | None | | |
| A4624 | Tracheal suction catheter, any type other than closed system, each | None | | 1 item = 1 catheter |
| A4625 | Tracheostomy care kit for new tracheostomy | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A4627 | Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler, each | None | | Includes aerochamber. |
| A4628 | Oropharyngeal suction catheter, each | None | | 1 item = 1 catheter |
| A4629 | Tracheostomy care kit for established tracheostomy | None | | 1 item = 1 kit.<br>Includes: soaking tray, gloves, instrument tray, folded towel, forceps, gauze sponges, cleaning brush, trach dressing, twill tape, pipe cleaners, cotton tip applicators, and hospital wrap. Do not bill included items separately. |
| A7501 | Tracheostoma valve, including diaphragm, each | None | | |
| A7502 | Replacement diaphragm/faceplate for tracheostoma valve, each | None | | |
| A7503 | Filter holder or filter cap, reusable, for use with tracheostoma heat and moisture exchange system, each | None | | |
| A7504 | Filter for use with tracheostoma heat and moisture exchange system, each | None | | |
| A7505 | Housing, reusable without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma valve, each | None | | |
| A7506 | Adhesive disc for use in a heat and moisture exchange system and/or with a tracheostoma valve, any type, each | None | | |
| A7507 | Filter holder and integrated filter without adhesive, for use in a tracheostoma heat and moisture exchange system, each | None | | |
| A7508 | Housing and integrated adhesive, for use in a tracheostoma heat and moisture exchange system and/or with a tracheostoma valve, each | None | | |
| A7509 | Filter holder and integrated filter housing, and adhesive, for use as a tracheostoma heat and moisture exchange system, each | None | | |
| A7520 | Tracheostomy,/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each | None | | 1 unit = 1 tube |
| A7521 | Tracheostomy,/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each | None | | 1 unit = 1 tube |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A7522 | Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each | None | | 1 unit = 1 tube |
| A7523 | Tracheostomy shower protector, each | None | | 1 unit = 1 protector |
| A7524 | Tracheostoma stent/stud/button, each | None | | 1 unit = 1 stent/stud/button |
| A7525 | Tracheostomy mask, each | None | | |
| A7526 | Tracheostomy tube collar/holder, each | None | | |
| A7527 | Tracheostomy/laryngectomy tube plug/stop, each | None | | |
| E0455 | Oxygen tent excluding croup or pediatric tents, each | None | | |
| E0755 | Electronic salivary reflex stimulator, intra oral/non-invasive, each | Yes | | |
| E1353 | Regulator, each | None | | Purchase for member owned equipment only. |
| E1354 | Oxygen accessory, wheeled cart for portable cylinder or portable concentrator, any type, replacement only, each | None | | Purchase for member owned equipment only. |
| E1355 | Stand/rack, each | None | | Purchase for member owned equipment only. |
| E1356 | Oxygen accessory, battery pack/cartridge for portable concentrator, any type, replacement only, each | None | | Purchase for member owned equipment only. |
| E1357 | Oxygen accessory, battery charger for portable concentrator, any type, replacement only, each | None | | Purchase for member owned equipment only. |
| E1358 | Oxygen accessory, DC power adapter for portable concentrator, any type, replacement only, each | None | | Purchase for member owned equipment only. |
| L8501 | Tracheostomy, speaking valve, each | None | | |
| S8100 | Holding chamber or spacer for use with an inhaler or nebulizer; without mask | None | | |
| S8101 | Holding chamber or spacer for use with an inhaler or nebulizer; with mask | None | | |
| S8189 | Tracheostomy supply, not otherwise classified | Yes | | Use for tracheostomy supplies when an appropriate code is not available. |
| S8210 | Mucus trap | None | | |
| S8301 | Infection control supplies, not otherwise specified | Yes | | Use for cleaning solutions for respiratory equipment. |
| S8999 | Resuscitation bag (For use by patient on artificial respiration during power failure or other catastrophic event) | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| **TENS OR NMES (TRANSCUTANEOUS OR NEUROMUSCULAR ELECTRICAL NERVE STIMULATOR) EQUIPMENT & SUPPLIES – GENERAL USE**<br>**Note**: TENS or NMES require 2-month trial rental before purchase. Requires Questionnaire #9. | | | | |
| A4595 | Electrical stimulator supplies, 2 lead, per month, (e.g., tens, nmes) | None | | Purchase for member owned equipment only. Use for 4 lead also. |
| A4630 | Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient | None | 4/Y | |
| E0720 | Transcutaneous Electrical Nerve Stimulation (TENS) device, two (2) lead, localized stimulation | Yes | | |
| E0720-KH | TENS, two (2) lead, localized stimulation, each | Yes | | Use for 1st month trial rental only. All TENS rental requires PAR. 1st month rental without PAR is not available. PAR is required for both months. 1 item = 1 month rental |
| E0720-KI | TENS, two (2) lead, localized stimulation, each | Yes | | Use for 2nd month trial rental only. All TENS rental requires PAR. 1st month rental without PAR is not available. PAR is required for both months. 1 item = 1 month rental |
| E0730 | Transcutaneous Electrical Nerve Stimulation (TENS) device, four (4) or more leads, for multiple nerve stimulation | Yes | | |
| E0730-KH | Transcutaneous electrical nerve stimulation device, four (4) or more leads, for multiple nerve stimulation | Yes | | Use for 1st month trial rental only. All TENS rental requires PAR. 1st month rental without PAR is not available. PAR is required for both months. 1 item = 1 month rental |
| E0730-KI | Transcutaneous electrical nerve stimulation device, four (4) or more leads, for multiple nerve stimulation | Yes | | Use for 2nd month trial rental only. All TENS rental requires PAR. 1st month rental without PAR is not available. PAR is required for both months. 1 item = 1 month rental |
| E0731 | Form fitting conductive garment for delivery of TENS or NMES with conducting fibers separated from the patient's skin by layers of fabric, each | Yes | | |
| E0744 | Neuromuscular stimulator for scoliosis, each | Yes | | |
| E0745 | Neuromuscular stimulator electronic shock unit, each | Yes | | |
| E0746 | Electromyography (EMG), biofeedback device | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0747 | Osteogenesis stimulator, electrical noninvasive, other than spinal applications | Yes | | |
| E0748 | Osteogenic stimulator, noninvasive, spinal applications | Yes | | |
| E0760 | Osteogenesis stimulator, low intensity ultrasound, non-invasive | Yes | | |
| E0762 | Transcutaneous electrical joint stimulation device system, includes all accessories | Yes | | |
| E0762-KH | Transcutaneous electrical joint stimulation device system, includes all accessories | Yes | | Use for 1st month trial rental only. 1st month rental without PAR is not available. PAR is required for both months.<br>1 item = 1 month rental |
| E0762-KI | Transcutaneous electrical joint stimulation device system, includes all accessories | Yes | | Use for 2nd month trial rental only. 2nd month rental without PAR is not available. PAR is required for both months.<br>1 item = 1 month rental |
| E0770-KH | Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified | Yes | | Use for 1st month trial rental only. 1st month rental without PAR is not available. PAR is required for both months.<br>1 item = 1 month rental |
| E0770-KI | Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified | Yes | | Use for 2nd month trial rental only. 2nd month rental without PAR is not available. PAR is required for both months.<br>1 item = 1 month rental |
| S8130 | Interferential current stimulator, 2 channel | Yes | | New code effective 1/1/12. |
| S8131 | Interferential current stimulator, 4 channel | Yes | | New code effective 1/1/12. |
| **TRAPEZE, TRACTION & FRACTURE FRAMES – GENERAL USE** | | | | |
| E0830 | Ambulatory traction device, all types, each | Yes | | |
| E0840 | Traction frame, attached to headboard, cervical traction | Yes | | |
| E0849 | Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible | Yes | | |
| E0850 | Traction stand, free standing, cervical traction | Yes | | |
| E0855 | Cervical traction equipment not requiring additional stand or frame | Yes | | |
| E0856 | Cervical traction device, cervical collar with inflatable air bladder | Yes | | |
| E0860 | Traction equipment, over door, cervical | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0870 | Traction frame, attached to footboard, extremity traction | Yes | | |
| E0880 | Traction stand, free standing, extremity traction | Yes | | |
| E0890 | Traction frame, attached to footboard, pelvic traction | Yes | | |
| E0900 | Traction stand, free standing, pelvic traction | Yes | | |
| E0910 | Trapeze bars (also known as "patient helper"), attached to bed, with grab bar | Yes | | |
| E0911 | Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar | Yes | | |
| E0912 | Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar | Yes | | |
| E0920 | Fracture frame, attached to bed, includes weights | Yes | | |
| E0930 | Fracture frame, free standing, includes weights | Yes | | |
| E0935-KR | Continuous passive motion exercise device for use on knee only | Yes | 7/W | Rental per day. First 14 days post-op maximum. |
| E0936 | Continuous passive motion exercise device for use other than knee | Yes | | |
| E0940 | Trapeze bar, free standing, complete with grab bar | Yes | | |
| E0941 | Traction device, gravity assisted, any type | Yes | | |
| E0942 | Cervical head harness or halter, each | Yes | | |
| E0944 | Pelvic belt, harness or boat, each | Yes | | |
| E0945 | Extremity belt or harness, each | Yes | | |
| E0946 | Fracture frame, dual, with cross bars, attached to bed | Yes | | Balken, 4-poster |
| E0947 | Fracture frame, attachments for complex pelvic traction | Yes | | |
| E0948 | Fracture frame, attachments for complex cervical traction | Yes | | |
| E1841-KR | Static progressive stretch shoulder device, with or without range of motion adjustability, includes all components and accessories | Yes | 31/M | Rental is per day. |
| **LYMPHEDEMA PUMPS & COMPRESSORS – SPECIALIZED USE** | | | | |
| A4600 | Sleeve for intermittent limb compression device, replacement only, each | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0650 | Pneumatic compressor, non-segmental home model | **Yes** | | |
| E0651 | Pneumatic compressor, segmental home model without calibrated gradient pressure | Yes | | |
| E0652 | Pneumatic compressor, segmental home model with calibrated gradient pressure | Yes | | |
| E0655 | Non-segmental pneumatic appliance for use with pneumatic compressor, half arm | Yes | | |
| E0656 | Segmental pneumatic appliance for use with pneumatic compressor, trunk | Yes | | |
| E0657 | Segmental pneumatic appliance for use with pneumatic compressor, chest | Yes | | |
| E0660 | Non-segmental pneumatic appliance for use with pneumatic compressor, full leg | Yes | | |
| E0665 | Non-segmental pneumatic appliance for use with pneumatic compressor, full arm | Yes | | |
| E0666 | Non-segmental pneumatic appliance for use with pneumatic compressor, half leg | Yes | | |
| E0667 | Segmental pneumatic appliance for use with pneumatic compressor, full leg | Yes | | |
| E0668 | Segmental pneumatic appliance for use with pneumatic compressor, full arm | Yes | | |
| E0669 | Segmental pneumatic appliance for use with pneumatic compressor, half leg | Yes | | |
| E0671 | Segmental gradient pressure pneumatic appliance, full leg | Yes | | |
| E0670 | Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk | Yes | 1/Y | For use with pneumatic compression device only when medical conditions exist that prevent the use of other appliances. |
| E0672 | Segmental gradient pressure pneumatic appliance, full arm | Yes | | |
| E0673 | Segmental gradient pressure pneumatic appliance, half leg | Yes | | |
| E0675 | Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral) | Yes | | |
| E0676 | Intermittent limb compression device (includes all accessories), not otherwise specified | Yes | | |
| S8420 | Gradient pressure aid (sleeve and glove combination), custom made | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| S8421 | Gradient pressure aid (sleeve and glove combination), ready made | Yes | | |
| S8422 | Gradient pressure aid (sleeve), custom made, medium weight | Yes | | |
| S8423 | Gradient pressure aid (sleeve), custom made, heavy weight | Yes | | |
| S8424 | Gradient pressure aid (sleeve), ready made | Yes | | |
| S8425 | Gradient pressure aid (glove), custom made, medium weight | Yes | | |
| S8426 | Gradient pressure aid (glove), custom made, heavy weight | Yes | | |
| S8427 | Gradient pressure aid (glove), ready made | Yes | | |
| S8428 | Gradient pressure aid (gauntlet), ready made | Yes | | |
| S8429 | Gradient pressure exterior wrap | Yes | | |
| S8430 | Padding for compression bandage, roll | Yes | | |
| S8431 | Compression bandage, roll | Yes | | |
| **WOUND THERAPY EQUIPMENT** | | | | |
| E2402-KR | Negative pressure wound therapy electrical pump, stationary or portable | Yes | | Price includes equipment & all supplies. 1 unit = one (1) day rental<br>Requires Questionnaire #12. |
| A9272 | Wound suction, disposable, includes dressing, all accessories and components, any type, each | Con | | |
| **REHABILITATION EQUIPMENT – SPECIALIZED USE** | | | | |
| A8000 | Helmet, protective, soft, prefabricated, includes all components and accessories | Yes | | |
| A8001 | Helmet, protective, hard, prefabricated, includes all components and accessories | Yes | | |
| A8002 | Helmet, protective, soft, custom fabricated, includes all components and accessories | Yes | | |
| A8003 | Helmet, protective, hard, custom fabricated, includes all components and accessories | Yes | | |
| A8004 | Soft interface for helmet, replacement only | Yes | | |
| E1700 | Jaw motion rehabilitation system | Yes | | |
| E1701 | Replacement cushions for jaw motion rehabilitation system, package of 6 | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E1702 | Replacement measuring scales for jaw motion rehabilitation system, package of 200 | Yes | | |
| **ORAL & ENTERAL NUTRITION, FORMULAS, EQUIPMENT & SUPPLIES – SPECIALIZED USE** | | | | |
| | **Enteral formulas** | | | |
| B4100 | Food thickener, administered orally, per ounce | Yes | | 1 unit = 1 ounce<br>Use modifier BO. |
| B4102 | Enteral formula, for adults, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit | Yes | | |
| B4103 | Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit | Yes | | |
| B4104 | Additive for enteral formula (e.g. fiber) | Yes | | |
| B4149 | Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit | Yes | | |
| B4150 | Enteral formula; nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | Yes | | For oral administration use modifier -BO. |
| B4152 | Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber administered through an enteral feeding tube, 100 calories = 1 unit | Yes | | For oral administration use modifier -BO. |
| B4153 | Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | Yes | | For oral administration use modifier -BO. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| B4154 | Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | Yes | | For oral administration use modifier -BO. |
| B4155 | Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (E.G. glucose polymers), proteins/amino acids (e.g. glutamine, arginine), fat (e.g. medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories = 1 unit | Yes | | For oral administration use modifier -BO. |
| B4157 | Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | Yes | | |
| B4158 | Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories= 1 unit | Yes | | |
| B4159 | Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories=1 unit | Yes | | |
| B4160 | Enteral formula, for pediatrics, nutritionally complete calorically dense(equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| B4161 | Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit | Yes | | |
| B4162 | Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | Yes | | |
| B4164 | Parenteral nutrition solution, carbohydrates (dextrose), 50% or less (500 ml = 1 unit) - home mix | Yes | | **This item must be provided by the pharmacy using a valid NDC.** |
| B4168 | Parenteral nutrition solution, amino acid, 3.5%, (500 ml = 1 unit) - home mix | Yes | | **This item must be provided by the pharmacy using a valid NDC.** |
| B4172 | Parenteral nutrition solution, amino acid, 5.5% through 7%, (500 ml = 1 unit) - home mix | Yes | | **This item must be provided by the pharmacy using a valid NDC.** |
| B4176 | Parenteral nutrition solution, amino acid, 7% through 8.5%, (500 ml = 1 unit) - home mix | Yes | | **This item must be provided by the pharmacy using a valid NDC.** |
| B4178 | Parenteral nutrition solution, amino acid, greater than 8.5% (500 ml = 1 unit) - home mix | Yes | | **This item must be provided by the pharmacy using a valid NDC.** |
| B4180 | Parenteral nutrition solution, carbohydrates (dextrose), greater than 50% (500 ml = 1 unit) - home mix | Yes | | **This item must be provided by the pharmacy using a valid NDC.** |
| B4185 | Parenteral nutrition solution, per 10 grams lipids | Yes | | **This item must be provided by the pharmacy using a valid NDC.** |
| B4189 | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 grams of protein - premix | Yes | | **This item must be provided by the pharmacy using a valid NDC.** |
| B4193 | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 grams of protein - premix | Yes | | **This item must be provided by the pharmacy using a valid NDC.** |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| B4197 | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, 74 to 100 grams of protein - premix | Yes | | **This item must be provided by the pharmacy using a valid NDC.** |
| B4199 | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, over 100 grams of protein - premix | Yes | | **This item must be provided by the pharmacy using a valid NDC.** |
| B4216 | Parenteral nutrition, additives (vitamins, trace elements, heparin, electrolytes) - home mix, per day | Yes | | **This item must be provided by the pharmacy using a valid NDC.** |
| B5000 | Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal - amirosyn rf, nephramine, renamine - premix | Yes | | **This item must be provided by the pharmacy using a valid NDC.** |
| B5100 | Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic - freamine hbc, hepatamine - premix | Yes | | **This item must be provided by the pharmacy using a valid NDC.** |
| B5200 | Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress - branch chain amino acids - premix | Yes | | **This item must be provided by the pharmacy using a valid NDC.** |
| S9433 | Medical food nutritionally complete, administered orally, providing 100% of nutritional intake | Yes | | |
| | **Enteral equipment & supplies**<br>See the feeding tube/changes and modifications in descriptions, and quantities specific to skin level devices. Quantities exceeding the allowed amount will require additional supporting documentation | | | |
| A5200 | Percutaneous catheter/tube anchoring device, adhesive skin attachment | None | | 1 unit = 1 device |
| B4034 | Enteral feeding supply kit: Syringe fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| B4035 | Enteral feeding supply kit: Pump fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape | Yes | | |
| B4036 | Enteral feeding supply kit: Gravity fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape | Yes | | |
| B4081 | Nasogastric tubing with stylet, each | Yes | | |
| B4082 | Nasogastric tubing without stylet, each | Yes | | |
| B4083 | Stomach tube, Levine type, each | Yes | | |
| B4087 | Gastrostomy/jejunostomy tube, standard, any material, any type, each | Yes | 1/M | |
| B4088 | Gastrostomy/jejunostomy tube, low-profile, any material, any type, each | Yes | 1/M | |
| B9000-RR | Enteral nutrition infusion pump, without alarm, each | Yes | | Rental: 1 item = 1 day. Supplies may not be billed separately. All supplies must be provided with the pump for each day the equipment is rented. |
| B9002-RR | Enteral nutrition infusion pump, with alarm, each | Yes | | Rental: 1 item = 1 day. Supplies may not be billed separately. All supplies must be provided with the pump for each day the equipment is rented. |
| E0776 | IV pole | Yes | | Total reimbursement, including rental, shall not exceed the purchase price. |
| E2000 | Gastric suction pump, home model, portable or stationary, electric | Yes | | |
| S8265 | Haberman feeder for cleft lip/palate | None | | Use this code also for glass bottle, nipple, membrane, disc or collar replacements. Must be billed on a paper claim. Bill one (1) line for multiple components. Describe individual components and units of each item in comment section of the claim. |
| B9998 | Miscellaneous enteral supplies not otherwise classified. (Extension sets [not included in feeding kit code] 24 hour use-one (1) time use only as stated by manufacturer). | Yes | | Include description & quantities on PAR. For rental, must submit manufacturer's invoice with PAR. Rental based on percentage of invoice & rate will be determined at the time of PAR approval. PAR copy must be submitted with claim. Do not use for items included in supply kits. Quantity Allowed: 30 per month |
| | **Breast feeding equipment & supplies** | | | |
| E0602 | Breast Pump, manual, any type | None | | Includes kit and all supplies. Only available for use with premature infants and infants in critical care. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E0603-KR | Breast Pump, electric (AC and/or DC), any type | Yes | 1<br>31/M | Includes breast pump and all supplies. Purchase is available only for use with premature infants and infants in critical care, and only during period of anticipated infant hospitalization of 54 days or more. Rental is available only for periods of infant hospitalization anticipated to be less than 54 days. When renting: 1 unit = 1 day. Submit under mom's ID. |
| A4281 | Tubing for breast pump, replacement | None | | Purchase for member owned equipment only. |
| A4282 | Adapter for breast pump, replacement | Yes | | Purchase for member owned equipment only. |
| A4283 | Cap for breast pump bottle, replacement | Yes | | Purchase for member owned equipment only. |
| A4284 | Breast shield and splash protector for use with breast pump, replacement | Yes | | Purchase for member owned equipment only. |
| A4286 | Locking ring for breast pump, replacement | Yes | | Purchase for member owned equipment only. |
| T2101 | Human breast milk processing, storage and distribution only | Yes | | |
| **HOME IV THERAPY – SPECIALIZED USE** | | | | |
| | **Enteral formulas** | | | |
| | ***Parenteral equipment & supplies*** | | | |
| A4305 | Disposable Drug Delivery System, flow rate of 50 ml or greater per hour | Yes | | 1 item = 1 system |
| A4306 | Disposable drug delivery system, flow rate of less than 50 ml per hour | Yes | | 1 item = 1 system |
| B4220 | Parenteral nutrition supply kit: Premix, including gloves, wipes, alcohol, acetone, povidone iodine scrub, ointment, swab sticks, sponges, Heparin flush, tape, caps, syringes, needles, ketodiastic & destruclip, per day | Yes | 31/M | 1 item = 1 day's supplies which includes all or part of the listed items. Do not bill included items separately. May be used utilized for total parenteral nutrition (TPN), the administration of antibiotics, and the maintenance of electrolyte balances or hydration |
| B4224 | Parenteral nutrition administration kit, includes luer lok & microfilter, pump cassettes, clamps, extension sets & connectors, per day | Yes | | 1 item = 1 day's supplies which includes all or part of the listed items. Do not bill included items separately. May be used utilized for total parenteral nutrition (TPN), the administration of antibiotics, and the maintenance of electrolyte balances or hydration |
| B9004-RR | Parenteral nutrition infusion pump, portable | Yes | 1/M | 1 unit = 1 month rental |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| B9006-RR | Parenteral nutrition infusion pump, stationary | Yes | | 1 unit = 1 month rental |
| B9999 | Miscellaneous Parenteral supplies not otherwise classified | Yes | | Include description & quantity on PAR. Do not use for items included in kits. Submit paper claim with manufactures invoice attached. |
| E0779-KR | Ambulatory infusion pump, mechanical, reusable, for infusion 8 hours or greater | Yes | | 1 item = 1 day<br>8 hours or greater. Prior authorization must substantiate the necessity for the use of an ambulatory pump. |
| E0780-KR | Ambulatory infusion pump, mechanical, reusable, for infusion less than 8 hours. | Yes | | 1 item = 1 pump<br>Less than 8 hours. Prior authorization must substantiate the necessity for the use of an ambulatory pump. |
| E0781 | Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administration equipment, worn by patient | Yes | 1<br>1/M | 1 unit = 1 month rental |
| E0791 | Parenteral infusion pump, stationary, single or multi channel | Yes | 1<br>1/M | 1 unit = 1 month rental |
| K0455 | Infusion pump used for uninterrupted parenteral administration of medication, (e.g. epoprostenol or treprostinol) | Yes | 1<br>1/M | 1 item = 1 system<br>1 item = 1 month rental |
| K0552 | Supplies for external drug infusion pump, syringe type cartridge, sterile, each | Yes | 31/M | 1 unit = 1 cartridge |
| K0601 | Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each | None | | For member owned equipment only. |
| K0602 | Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each | None | | For member owned equipment only. |
| K0603 | Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each | None | | For member owned equipment only. |
| K0604 | Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each | None | | For member owned equipment only. |
| K0605 | Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each | None | | For member owned equipment only. |
| S5035 | Home infusion therapy, routine service of infusion device (e.g. pump maintenance) | Yes | | For member owned equipment only.<br>Cannot be billed with K0739 or K0739-MS.<br>Do not use for skilled nursing visits for initial or subsequent pump set-ups.<br>1 unit = 15 minutes |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| S5036 | Home infusion therapy, repair of infusion device (e.g. pump repair) | Yes | | For member owned equipment only. Cannot be billed with k0739 or K0739-MS. Do not use for skilled nursing visits for initial or subsequent pump set-ups. |
| S5520 | Home infusion therapy, all supplies (including catheter) necessary for a peripherally inserted central venous catheter (PICC) line insertion | Yes | | Use for insertion supplies only. |
| S5521 | Home infusion therapy, all supplies (including catheter) necessary for a midline catheter insertion | Yes | | Use for insertion supplies only. |
| **PROSTHETICS & ORTHOTICS** | | | | |
| A4280 | Adhesive skin support attachment for use with external breast prosthesis, each | None | | 1 unit = 1 attachment |
| | **Diabetic shoes, fitting, and modifications** | | | |
| A5500 | For diabetics only, fitting (including follow-up) custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe | None | 2/Y | |
| A5501 | For diabetics only, fitting (including follow-up) custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), per shoe | None | 2/Y | |
| A5503 | For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with roller or rigid rocker bottom, per shoe | None | | |
| A5504 | For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with wedge(s), per shoe | None | | |
| A5505 | For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with metatarsal bar, per shoe | None | | |
| A5506 | For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with off-set heel(s), per shoe | None | | |
| A5507 | For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf. Depth-inlay shoe or custom molded shoe, per shoe | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| A5508 | For diabetics only, deluxe feature of off-the-shelf depth-inlay shoe or custom molded shoe, per shoe | None | | |
| A5510 | For diabetics only, direct formed, compression molded to patient's foot without external heat source, multiple density insert(s), prefabricated, per shoe | None | | |
| A5512 | For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum or ¼ inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each | None | | |
| A5513 | For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each | None | | |
| | **Orthotic Devices – Spinal** | | | |
| | ***Cervical*** | | | |
| L0112 | Cranial cervical orthosis, congenital torticollis type, with or without soft interface material, adjustable range of motion joint, custom fabricated | Yes | | |
| L0113 | Cranial cervical orthosis, toricollis type, with or without joint, with or without soft interface material, prefabricated, includes fitting and adjustment | Yes | | |
| L0120 | Cervical, flexible, nonadjustable (foam collar) | None | | |
| L0130 | Cervical, flexible, thermoplastic collar, molded to patient | Yes | | |
| L0140 | Cervical, semi-rigid, adjustable (plastic collar) | Yes | | |
| L0150 | Cervical, semi-rigid, adjustable molded chin cup (plastic collar with mandibular/occipital piece) | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L0160 | Cervical, semi-rigid, wire frame occipital/mandibular support | Yes | | |
| L0170 | Cervical, collar, molded to patient model | Yes | | |
| L0172 | Cervical, collar, semi-rigid thermoplastic foam, two (2) piece | Yes | | |
| L0174 | Cervical, collar, semi-rigid, thermoplastic foam, two (2) piece, prefabricated, off-the-shelf | Yes | | |
| S1040 | Cranial remolding orthosis, pediatric, rigid, with soft interface material, custom fabricated, includes fitting and adjustment(s) | Yes | | |
| | ***Multiple post collar*** | | | |
| L0180 | Cervical, multiple post collar occipital/mandibular supports, adjustable | Yes | | |
| L0190 | Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars (Somi, Guilford, Taylor types) | Yes | | |
| L0200 | Cervical, multiple post collar, occipital/ mandibular supports, adjustable cervical bars, and thoracic extension | Yes | | |
| | ***Thoracic*** | | | |
| L0220 | Thoracic rib belt, custom fabricated | Yes | | |
| | ***Thoracic-Lumbar-Sacral Orthosis (TLSO)Flexible*** | | | |
| L0450 | TLSO, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, off-the-shelf | None | | |
| L0452 | TLSO, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, custom fabricated | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L0454 | TLSO flexible, provides trunk support, extends from sacrococcygeal junction to above T-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated item that has been trimmed, bent, molder, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L0455 | TLSO, flexible, provides trunk support, extends from sacrococcygeal junction to above t-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, off-the-shelf | None | | |
| L0456 | TLSO, flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L0457 | TLSO, flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated, off-the-shelf | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L0458 | TLSO, triplanar control, modular segmented spinal system, two (2) rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment | None | | |
| L0460 | TLSO, triplanar control, modular segmented spinal system, two (2) rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L0462 | TLSO, triplanar control, modular segmented spinal system, three (3) rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L0464 | TLSO, triplanar control, modular segmented spinal system, four (4) rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment | None | | |
| L0466 | TLSO, sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, includes fitting and shaping the frame, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L0467 | TLSO, sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated, off-the-shelf | None | | |
| L0468 | TLSO, sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal, and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, includes fitting and shaping the frame, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L0469 | TLSO, sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated, off-the-shelf | None | | |
| L0470 | TLSO, triplanar control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding extends from sacrococcygeal junction to scapula, lateral strength provided by pelvic, thoracic, and lateral frame pieces, rotational strength provided by subclavicular extensions, restricts gross trunk motion in sagittal, coronal, and transverse planes, provides intracavitary pressure to reduce load on the intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment | None | | |
| L0472 | TLSO, triplanar control, hyperextension, rigid anterior and lateral frame extends from symphysis pubis to sternal notch with two (2) anterior components (one (1) pubic and one (1) sternal), posterior and lateral pads with straps and closures, limits spinal flexion, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment | None | | |
| L0480 | TLSO, triplanar control, one (1) piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L0482 | TLSO, triplanar control, one (1) piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated | None | | |
| L0484 | TLSO, triplanar control, two (2) piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated | None | | |
| L0486 | TLSO, triplanar control, two (2) piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated | None | | |
| L0488 | TLSO, triplanar control, one (1) piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, prefabricated, includes fitting and adjustment | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L0490 | TLSO, sagittal-coronal control, one (1) piece rigid plastic shell, with overlapping reinforced anterior, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates at or before the T-9 vertebra, anterior extends from symphysis pubis to xiphoid, anterior opening, restricts gross trunk motion in sagittal and coronal planes, prefabricated, includes fitting and adjustment | None | | |
| L0491 | TLSO, sagittal-coronal control, modular segmented spinal system, two (2) rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment | None | | |
| L0492 | TLSO, sagittal-coronal control, modular segmented spinal system, three (3) rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closure, includes straps and closures, prefabricated, includes fitting and adjustment | None | | |
| | **Lumbar-Sacral Orthosis (LSO)** | | | |
| L0625 | Lumbar orthosis, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, off-the-shelf | None | | Support is not for obstetrical or obesity diagnosis. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L0626 | Lumbar orthosis, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L0627 | Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L0628 | Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf | None | | Support is not for obstetrical or obesity diagnosis. |
| L0629 | Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated, includes fitting and adjustment | None | | Support is not for obstetrical or obesity diagnosis. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L0630 | Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L0631 | Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L0632 | Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated | None | | |
| L0633 | Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L0634 | Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated | None | | |
| L0635 | Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panel(s), lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, prefabricated, includes fitting and adjustment | None | | |
| L0636 | Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panel(s), lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, custom fabricated | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L0637 | Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L0638 | Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated | None | | |
| L0639 | Lumbar-sacral orthosis, sagittal-coronal control, rigid shell (s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xiphoid, produces intracavitary pressure to reduce load on intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L0640 | Lumbar-sacral orthosis, sagittal-coronal control, rigid shell (s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xiphoid, produces intracavitary pressure to reduce load on intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated | None | | |
| L0641 | Lumbar orthosis, sagittal control, with rigid posterior panel(s), posterior extends from l-1 to below l-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf | None | | |
| L0642 | Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from l-1 to below l-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf | None | | |
| L0643 | Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf | None | | |
| L0648 | Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L0649 | Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf | None | | |
| L0650 | Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf | None | | |
| L0651 | Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated, off-the-shelf | None | | |
| | **Sacroiliac Flexible** | | | |
| L0621 | Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, off-the-shelf | None | | |
| L0622 | Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated. | None | | |
| | ***Semi-Rigid*** | | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L0623 | Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, off-the-shelf | None | | |
| L0624 | Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated | None | | |
| | **Cervical-Thoracic-Lumbar-Sacral Orthosis (CTLSO)** | | | |
| | ***Anterior-posterior-lateral control*** | | | |
| L0700 | CTLSO, anterior-posterior-lateral control, molded to patient model (Minerva type) | None | | |
| L0710 | CTLSO, anterior-posterior-lateral control, molded to patient model, with interface material (Minerva type) | None | | |
| | ***Halo procedure*** | | | |
| L0810 | Halo procedure, cervical halo incorporated into jacket vest | None | | |
| L0820 | Halo procedure, cervical halo incorporated into plaster body jacket | None | | |
| L0830 | Halo procedure, cervical halo incorporated into Milwaukee type orthosis | None | | |
| L0861 | Addition to halo procedure, replacement liner/interface material | None | | |
| | ***Additions to Spinal Orthosis*** | | | |
| L0970 | TLSO, corset front | None | | |
| L0972 | LSO, corset front | None | | |
| L0974 | TLSO, full corset | None | | |
| L0976 | LSO, full corset | None | | |
| L0978 | Axillary crutch extension | None | | |
| L0980 | Peroneal straps, off-the-shelf, pair | None | | |
| L0982 | Stocking supporter grips, prefabricated, off-the-shelf, set of four (4) | None | | |
| L0984 | Protective body sock, prefabricated, off-the-shelf, each | None | | |
| L0999 | Addition to spinal orthosis, NOS | None | | |
| | **Orthotic Devices - Scoliosis Procedure** | | | |
| | ***Cervical-thoracic-lumbar-sacral orthosis (CTLSO) (Milwaukee)*** | | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L1000 | CTLSO (Milwaukee), inclusive of furnishing initial orthosis, including model | None | | |
| L1001 | Cervical thoracic lumbar sacral orthosis, immobilizer, infant size, prefabricated, includes fitting and adjustment | None | | |
| L1005 | Tension based scoliosis orthosis and accessory pads, includes fitting and adjustment | None | | |
| L1010 | Addition to CTLSO or scoliosis orthosis, axilla sling | None | | |
| L1020 | Addition to CTLSO or scoliosis orthosis, kyphosis pad | None | | |
| L1025 | Addition to CTLSO or scoliosis orthosis, kyphosis pad, floating | None | | |
| L1030 | Addition to CTLSO or scoliosis orthosis, lumbar bolster pad | None | | |
| L1040 | Addition to CTLSO or scoliosis orthosis, lumbar or lumbar rib pad | None | | |
| L1050 | Addition to CTLSO or scoliosis orthosis, sternal pad | None | | |
| L1060 | Additions to CTLSO or scoliosis orthosis, thoracic pad | None | | |
| L1070 | Addition to CTLSO or scoliosis orthosis, trapezius sling | None | | |
| L1080 | Addition to CTLSO or scoliosis orthosis, outrigger | None | | |
| L1085 | Addition to CTLSO or scoliosis orthosis, outrigger, bilateral with vertical extensions | None | | |
| L1090 | Addition to CTLSO or scoliosis orthosis, lumbar sling | None | | |
| L1100 | Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather | None | | |
| L1110 | Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather, molded to patient model | None | | |
| L1120 | Addition to CTLSO or scoliosis orthosis, cover for upright, each | None | | |
| | ***Thoracic-lumbar-sacral orthosis (TLSO) (low profile)*** | | | |
| L1200 | TLSO, inclusive of furnishing initial orthosis only | None | | |
| L1210 | Addition to TLSO, (low profile), lateral thoracic extension | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L1220 | Addition to TLSO, (low profile), anterior thoracic extension | None | | |
| L1230 | Addition to TLSO, (low profile), Milwaukee type superstructure | None | | |
| L1240 | Addition to TLSO, (low profile), lumbar derotation pad | None | 1/D | |
| L1250 | Addition to TLSO, (low profile), anterior ASIS pad | None | | |
| L1260 | Addition to TLSO, (low profile), anterior thoracic derotation pad | None | | |
| L1270 | Addition to TLSO, (low profile), abdominal pad | None | | |
| L1280 | Addition to TLSO, (low profile), rib gusset (elastic), each | None | | |
| L1290 | Addition to TLSO, (low profile), lateral trochanteric pad | None | | |
| | ***Other scoliosis procedures*** | | | |
| L1300 | Other scoliosis procedure, body jacket molded to patient model | None | | |
| L1310 | Other scoliosis procedure, postoperative body jacket | None | | |
| L1499 | Spinal orthosis, not otherwise specified | None | | |
| | ***Thoracic-hip-knee-ankle orthosis (THKAO)*** | | | |
| L1500 | THKAO, mobility frame (Newington, Parapodium types) | Yes | | Code deleted 12/31/2011. |
| L1510 | THKAO, standing frame, with or without tray and accessories | Yes | | Code deleted 12/31/2011. |
| L1520 | THKAO, swivel walker | Yes | | Code deleted 12/31/2011. |
| | **Orthotic Devices - Lower Limb** | | | |
| | ***Hip orthosis (HO) - Flexible*** | | | |
| L1600 | HO, abduction control of hip joints, flexible, Frejka type with cover, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L1610 | HO, abduction control of hip joints, flexible, (Frejka cover only), prefabricated, includes fitting and adjustment | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L1620 | HO abduction control of hip joints, flexible, (Pavlik harness), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L1630 | HO abduction control of hip joints, semi-flexible (Von Rosen type), custom fabricated | None | | |
| L1640 | HO, abduction control of hip joints, static, pelvic band or spreader bar, thigh cuffs, custom fabricated | None | | |
| L1650 | HO, abduction control of hip joints, static, adjustable (Iifted type), prefabricated, includes fitting and adjustment | None | | |
| L1652 | Hip orthosis, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, includes fitting and adjustment, any type | None | | |
| L1660 | HO abduction control of hip joints, static, plastic, prefabricated, includes fitting and adjustment | None | | |
| L1680 | HO abduction control of hip joints, dynamic, pelvic control, adjustable hip motion control, thigh cuffs (Rancho hip action type), custom fabricated | None | | |
| L1685 | HO abduction control of hip joint, postoperative hip abduction type, custom fabricated | None | | |
| L1686 | HO abduction control of hip joint, postoperative hip abduction type, prefabricated, includes fitting and adjustment | None | | |
| L1690 | Combination, bilateral, lumbo-sacral, hip, femur orthosis providing adduction and internal rotation control, prefabricated, includes fitting and adjustment | None | | |
| | ***Legg perthes*** | | | |
| L1700 | Legg Perthes orthosis, (Toronto type), custom fabricated | None | | |
| L1710 | Legg Perthes orthosis, (Newington type), custom fabricated | None | | |
| L1720 | Legg Perthes orthosis, trilateral, (Tachdijan type), custom fabricated | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L1730 | Legg Perthes orthosis, (Scottish Rite type), custom fabricated | None | | |
| L1755 | Legg Perthes orthosis, (Patten bottom type), custom fabricated | None | | |
| | ***Knee Orthosis (KO)*** | | | |
| E1810 | Dynamic adjustable knee extension/ flexion device, includes soft interface material | None | | |
| E1811 | Static progressive stretch knee device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories | None | | |
| E1812 | Dynamic knee, extension/flexion device with active resistance control | None | | |
| L1810 | KO, elastic with joints, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L1812 | Knee orthosis, elastic with joints, prefabricated, off-the-shelf | None | | |
| L1820 | Knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment | None | | |
| L1830 | KO, immobilizer, canvas longitudinal, prefabricated, off-the-shelf | None | | |
| L1831 | Knee orthosis, locking knee joint(s), positional orthosis, prefabricated, includes fitting and adjustment | None | | |
| L1832 | Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L1833 | Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf | None | | |
| L1834 | KO, without knee joint, rigid, custom fabricated | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L1836 | KO, rigid, without joint(s), includes soft interface material, prefabricated, off-the-shelf | None | | |
| L1840 | KO, derotation, medial-lateral, anterior cruciate ligament, custom fabricated | None | | |
| L1843 | Knee orthosis, 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 item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L1844 | Knee orthosis, 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, custom fabricated | None | | |
| L1845 | Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L1846 | Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, custom fabricated | None | | |
| L1847 | KO, double upright with adjustable joint, with inflatable air chamber(s), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L1848 | Knee orthosis, double upright with adjustable joint, with inflatable air support chamber(s), prefabricated, off-the-shelf | None | | |
| L1850 | KO, Swedish type, prefabricated off-the-shelf | None | | |
| L1860 | KO, modification of supracondylar prosthetic socket, custom fabricated (SK) | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| | ***Ankle-Foot Orthosis (AFO)*** | | | |
| A9283 | Foot pressure off loading/supportive device, any type, each | None | | |
| E1815 | Dynamic adjustable ankle extension/flexion, includes soft interface material | None | | |
| E1816 | Static progressive stretch ankle device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories | None | | |
| L1900 | AFO, spring wire, dorsiflexion assist calf band, custom fabricated | None | | |
| L1902 | AFO, ankle gauntlet, prefabricated, off-the-shelf | None | | |
| L1904 | Ankle orthosis, ankle gauntlet, custom fabricated | None | | |
| L1906 | AFO, multi-ligamentous ankle support, prefabricated, off-the-shelf | None | | |
| L1907 | Ankle orthosis, supramalleolar with straps, with or without interface/pads, custom fabricated | None | | |
| L1910 | AFO, posterior, single bar, clasp attachment to shoe counter, prefabricated, includes fitting and adjustment | None | | |
| L1920 | AFO, single upright with static or adjustable stop (Phelps or Peristein type), custom fabricated | None | | |
| L1930 | AFO, plastic or other material, prefabricated, includes fitting and adjustment | None | | |
| L1932 | AFO, rigid anterior tibial section, total carbon fiber or equal material, prefabricated, includes fitting and adjustment | None | | |
| L1940 | AFO, plastic or other material, custom fabricated | None | | |
| L1945 | AFO, molded to patient model, plastic, rigid anterior tibial section (floor reaction), custom fabricated | None | | |
| L1950 | AFO, spiral, (Institute of Rehabilitative Medicine type), plastic, custom fabricated | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L1951 | AFO, spiral, (Institute of Rehabilitative Medicine type), plastic or other material, prefabricated, includes fitting and adjustment | None | | |
| L1960 | AFO, posterior solid ankle, plastic, custom fabricated | None | | |
| L1970 | AFO, plastic, with ankle joint, custom fabricated | None | | |
| L1971 | AFO, plastic or other material with ankle joint, prefabricated, includes fitting and adjustment | None | | |
| L1980 | AFO, single upright free plantar dorsiflexion, solid stirrup, calf band/cuff (single bar "BK" orthosis), custom fabricated | None | | |
| L1990 | AFO, double upright free plantar dorsiflexion, solid stirrup, calf band/cuff (double bar "BK" orthosis), custom fabricated | None | | |
| | ***Knee-Ankle-Foot Orthosis (KAFO) - or Any Combination*** | | | |
| L2000 | KAFO, single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar "AK" orthosis), custom fabricated | None | | |
| L2005 | Knee-ankle-foot orthosis, any material, single or double upright, stance control, automatic lock and swing phase release, any type activation, includes ankle joint, any type, custom fabricated | None | | |
| L2010 | KAFO, single upright, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar "AK" orthosis), without knee joint, custom fabricated | None | | |
| L2020 | KAFO, double upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar "AK" orthosis), custom fabricated | None | | |
| L2030 | KAFO, double upright, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar "AK" orthosis), without knee joint, custom fabricated | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L2034 | Knee ankle foot orthosis, full plastic, single upright, with or without free motion knee, medial lateral rotation control, with or without free motion ankle, custom fabricated | None | | |
| L2035 | Knee ankle foot orthosis, full plastic, static, (pediatric size), without free motion ankle, prefabricated, includes fitting and adjustment | None | | |
| L2036 | Knee ankle foot orthosis, full plastic, double upright, with or without free motion knee, with or without free motion ankle, custom fabricated | None | | |
| L2037 | Knee ankle foot orthosis, full plastic, single upright, with or without free motion knee, with or without free motion ankle, custom fabricated | None | | |
| L2038 | Knee ankle foot orthosis, full plastic, with or without free motion knee, multi-axis ankle, custom fabricated | None | | |
| | ***Torsion Control: Hip-Knee-Ankle-Foot Orthosis (HKAFO)*** | | | |
| L2040 | HKAFO, torsion control, bilateral rotation straps, pelvic band/belt, custom fabricated | None | | |
| L2050 | HKAFO, torsion control, bilateral torsion cables, hip joint, pelvic band/belt, custom fabricated | None | | |
| L2060 | HKAFO, torsion control, bilateral torsion cables, ball bearing hip joint, pelvic band/belt, custom fabricated | None | | |
| L2070 | HKAFO, torsion control, unilateral rotation straps, pelvic band/belt, custom fabricated | None | | |
| L2080 | HKAFO, torsion control, unilateral torsion cable, hip joint, pelvic band/belt, custom fabricated | None | | |
| L2090 | HKAFO, torsion control, unilateral torsion cable, ball bearing hip joint, pelvic band/belt, custom fabricated | None | | |
| | ***Fracture orthosis*** | | | |
| L2106 | AFO, fracture orthosis, tibial fracture cast orthosis, thermoplastic type casting material, custom fabricated | None | | |
| L2108 | AFO, fracture orthosis, tibial fracture cast orthosis, custom fabricated | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L2112 | AFO, fracture orthosis, tibial fracture orthosis, soft, prefabricated, includes fitting and adjustment | None | | |
| L2114 | AFO, fracture orthosis, tibial fracture orthosis, semi-rigid, prefabricated, includes fitting and adjustment | None | | |
| L2116 | AFO, fracture orthosis, tibial fracture orthosis, rigid, prefabricated, includes fitting and adjustment | None | | |
| L2126 | KAFO, fracture orthosis, femoral fracture cast orthosis, thermoplastic type casting material, custom fabricated | None | | |
| L2128 | KAFO, fracture orthosis, femoral fracture cast orthosis, custom fabricated | None | | |
| L2132 | KAFO, fracture orthosis, femoral fracture cast orthosis, soft, prefabricated, includes fitting and adjustment | None | | |
| L2134 | KAFO, fracture orthosis, femoral fracture cast orthosis, semi-rigid, prefabricated, includes fitting and adjustment | None | | |
| L2136 | KAFO, fracture orthosis, femoral fracture cast orthosis, rigid, prefabricated, includes fitting and adjustment | None | | |
| | ***Additions to fracture orthosis*** | | | |
| L2180 | Addition to lower extremity fracture orthosis, plastic shoe insert with ankle joints | None | | |
| L2182 | Additions to lower extremity fracture orthosis, drop lock knee joint | None | | |
| L2184 | Addition to lower extremity fracture orthosis, limited motion knee joint | None | | |
| L2186 | Addition to lower extremity fracture orthosis, adjustable motion knee joint, Lerman type | None | | |
| L2188 | Addition to lower extremity fracture orthosis, quadrilateral brim | None | | |
| L2190 | Addition to lower extremity fracture orthosis, waist belt | None | | |
| L2192 | Addition to lower extremity fracture orthosis, hip joint, pelvic band, thigh flange, and pelvic belt | None | | |
| | ***Additions to lower extremity orthosis: Shoe-Ankle-Shin-Knee*** | | | |
| L2200 | Addition to lower extremity, limited ankle motion, each joint | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L2210 | Addition to lower extremity, dorsiflexion assist (plantar flexion resist), each joint | None | | |
| L2220 | Addition to lower extremity, dorsiflexion and plantar flexion assist/resist, each joint | None | | |
| L2230 | Addition to lower extremity, split flat caliper stirrups and plate attachment | None | | |
| L2232 | Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only | None | | |
| L2240 | Addition to lower extremity, round caliper and plate attachment | None | | |
| L2250 | Addition to lower extremity, foot plate, molded to patient model, stirrup attached | None | | |
| L2260 | Addition to lower extremity, reinforced solid stirrup (Scott-Craig type) | None | | |
| L2265 | Addition lower extremity, long tongue stirrup | None | | |
| L2270 | Addition to lower extremity, varus/valgus correction ("T") strap, padded/lined or malleolus pad | None | | |
| L2275 | Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined | None | 2/D | Maximum number of items are indicated for each extremity. |
| L2280 | Addition to lower extremity, molded inner boot | None | | |
| L2300 | Addition to lower extremity, abduction bar (bilateral hip involvement), jointed, adjustable | None | | |
| L2310 | Addition to lower extremity, abduction bar, straight | None | | |
| L2320 | Addition to lower extremity, non-molded lacer, for custom fabricated orthosis only | None | | |
| L2330 | Addition to lower extremity, lacer molded to member patient, for custom fabricated orthosis only | None | | |
| L2335 | Addition to lower extremity, anterior swing band | None | | |
| L2340 | Addition to lower extremity, pretibial shell, molded to patient model | None | | |
| L2350 | Addition to lower extremity, prosthetic type, (BK) socket, molded to patient model, (used for "PTB," "AFO" orthoses) | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L2360 | Addition to lower extremity, extended steel shank | None | | |
| L2370 | Addition to lower extremity, Patten bottom | None | | |
| L2375 | Addition to lower extremity, torsion control, ankle joint and half solid stirrup | None | | |
| L2380 | Addition to lower extremity, torsion control, straight knee joint, each joint | None | | |
| L2385 | Addition to lower extremity, straight knee joint, heavy duty, each joint | None | | |
| L2387 | Addition to lower extremity, polycentric knee joint, for custom fabricated knee ankle foot orthosis, each joint | None | | |
| L2390 | Addition to lower extremity, offset knee joint, each joint | None | | |
| L2395 | Addition to lower extremity, offset knee joint, heavy duty, each joint | None | | |
| L2397 | Addition to lower extremity orthosis, suspension sleeve | None | | |
| | ***Additions to straight knee or offset knee joints*** | | | |
| L2405 | Addition to knee joint, drop lock, each | None | | |
| L2415 | Addition to knee lock with integrated release mechanism (bail, cable or equal), any material, each joint | None | | |
| L2425 | Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint | None | | |
| L2430 | Addition to knee joint, ratchet lock for active and progressive knee extension, each joint | None | | |
| L2492 | Addition to knee joint, lift loop for drop lock ring | None | | |
| | ***Additions: Thigh/weight bearing – Gluteal/Ischial weight bearing*** | | | |
| L2500 | Addition to lower extremity, thigh/weight bearing, gluteal/ischial weight bearing, ring | None | | |
| L2510 | Addition to lower extremity, thigh/weight bearing, quadri-lateral brim, molded to patient model | None | | |
| L2520 | Addition to lower extremity, thigh/weight bearing, quadri-lateral brim, custom fitted | None | | |
| L2525 | Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim molded to patient model | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L2526 | Addition lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim, custom fitted | None | | |
| L2530 | Addition to lower extremity, thigh/weight bearing, lacer, non-molded | None | | |
| L2540 | Addition to lower extremity, thigh/weight bearing, lacer, molded to patient model | None | | |
| L2550 | Addition to lower extremity, thigh/weight bearing, high roll cuff | None | | |
| | ***Additions: Pelvic and thoracic control*** | | | |
| L2570 | Addition to lower extremity, pelvic control, hip joint, Clevis type, two (2) position joint, each | None | | |
| L2580 | Addition to lower extremity, pelvic control, pelvic sling | None | | |
| L2600 | Addition to lower extremity, pelvic control, hip joint, Clevis type, or thrust bearing, free, each | None | | |
| L2610 | Addition to lower extremity, pelvic control, hip joint, Clevis or thrust bearing, lock, each | None | | |
| L2620 | Addition to lower extremity, pelvic control, hip joint, heavy-duty, each | None | | |
| L2622 | Addition to lower extremity, pelvic control, hip joint, adjustable flexion, each | None | | |
| L2624 | Addition to lower extremity, pelvic control, hip joint, adjustable flexion, extension, abduction control, each | None | | |
| L2627 | Addition to lower extremity, pelvic control, plastic, molded to patient model, reciprocating hip joint and cables | None | | |
| L2628 | Addition to lower extremity, pelvic control, metal frame, reciprocating hip joint and cables | None | | |
| L2630 | Addition to lower extremity, pelvic control, band and belt, unilateral | None | | |
| L2640 | Addition to lower extremity, pelvic control, band and belt, bilateral | None | | |
| L2650 | Addition to lower extremity, pelvic and thoracic control, gluteal pad, each | None | | |
| L2660 | Addition to lower extremity, thoracic control, thoracic band | None | | |
| L2670 | Addition to lower extremity, thoracic control, paraspinal uprights | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L2680 | Addition to lower extremity, thoracic control, lateral support uprights | None | | |
| | ***Additions: General*** | | | |
| E1830 | Dynamic adjustable toe extension/flexion device, includes soft interface material | None | | |
| E1831 | Static progressive stretch toe device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories | None | | |
| K0672 | Addition to lower extremity orthosis, removable soft interface, all components, replacement only, each | None | | |
| L2750 | Addition to lower extremity orthosis, plating chrome or nickel, per bar | None | | |
| L2755 | Addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, per segment, for custom fabricated orthosis only | None | | |
| L2760 | Addition to lower extremity orthosis, extension, per extension, per bar (for lineal adjustment for growth) | None | | |
| L2768 | Orthotic side bar disconnect device, per bar | None | | |
| L2780 | Addition to lower extremity orthosis, non-corrosive finish, per bar | None | | |
| L2785 | Addition to lower extremity orthosis, drop lock retainer, each | None | | |
| L2795 | Addition to lower extremity orthosis, knee control, full kneecap | None | | |
| L2800 | Addition to lower extremity orthosis, knee control, knee cap, medial or lateral pull, for use with custom fabricated orthosis only | None | | |
| L2810 | Addition to lower extremity orthosis, knee control, condylar pad | None | | |
| L2820 | Addition to lower extremity orthosis, soft interface for molded plastic, below knee section | None | | |
| L2830 | Addition to lower extremity orthosis soft interface for molded plastic, above knee section | None | | |
| L2840 | Addition to lower extremity orthosis, tibial length sock, fracture or equal, each | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L2850 | Addition to lower extremity orthosis, femoral length sock, fracture or equal, each | None | | |
| L2861 | Addition to lower extremity joint, knee or ankle, concentric adjustable torsion style mechanism for custom fabricated orthotics only, each | None | | |
| L2999 | Lower extremity orthoses, NOS | None | | |
| | **Orthopedic Shoes** | | | |
| | ***Inserts*** | | | |
| L3000 | Foot insert, removable, molded to patient model, "UCB" type, Berkeley shell, each | Yes | 4/Y | |
| L3001 | Foot insert, removable, molded to patient model, Spenco, each | Yes | 2/Y | |
| L3002 | Foot insert, removable, molded to patient model, Plastazote or equal, each | Yes | 2/Y | |
| L3003 | Foot insert, removable, molded to patient model, silicone gel, each | Yes | 2/Y | |
| L3010 | Foot insert, removable, molded to patient model, longitudinal arch support, each | Yes | 2/Y | |
| L3020 | Foot insert, removable, molded to patient model, longitudinal/metatarsal support, each | Yes | 2/Y | |
| L3030 | Foot insert, removable, formed to patient foot, each | Yes | 2/Y | |
| L3031 | Foot, insert/plate, removable, addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, each | Yes | 2/Y | |
| L3040 | Foot, arch support, removable, pre-molded, longitudinal, each | Yes | 2/Y | |
| L3050 | Foot, arch support, removable, pre-molded, metatarsal, each | Yes | 2/Y | |
| L3060 | Foot, arch support, removable, pre-molded, longitudinal/metatarsal, each | Yes | | |
| | ***Arch support, non-removable, attached to shoe*** | | | |
| L3070 | Foot, arch support, non-removable, attached to shoe, longitudinal, each | Yes | | |
| L3080 | Foot, arch support, non-removable attached to shoe, metatarsal, each | Yes | | |
| L3090 | Foot, arch support, non-removable attached to shoe, longitudinal/metatarsal, each | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L3100 | Hallus-valgus night dynamic splint, prefabricated, off-the-shelf | Yes | | |
| | ***Abduction and rotation bars*** | | | |
| L3140 | Foot, abduction rotation bar, including shoes | Yes | | |
| L3150 | Foot, abduction rotation bar, without shoes | Yes | | |
| L3160 | Foot, adjustable shoe-styled positioning device | Yes | | |
| L3170 | Foot, plastic, silicone or equal, heel stabilizer, prefabricated, off-the-shelf, each | Yes | | |
| | ***Orthopedic footwear*** | | | |
| L3201 | Orthopedic shoe, oxford with supinator or pronator, Infant | None | | |
| L3202 | Orthopedic shoe, oxford with supinator or pronator, Child | None | | |
| L3203 | Orthopedic shoe, oxford with supinator or pronator, Junior | None | | |
| L3204 | Orthopedic shoe, high top with supinator or pronator, Infant | None | | |
| L3206 | Orthopedic shoe, high top with supinator or pronator, Child | None | | |
| L3207 | Orthopedic shoe, high top with supinator or pronator, Junior | None | | |
| L3208 | Surgical boot, each, infant | None | | |
| L3209 | Surgical boot, each, child | None | | |
| L3211 | Surgical boot, each, junior | None | | |
| L3212 | Benesch boot, pair, infant | None | | |
| L3213 | Benesch boot, pair, child | None | | |
| L3214 | Benesch boot, pair, junior | None | | |
| L3215 | Orthopedic footwear, ladies shoe, oxford, each | Yes | | |
| L3216 | Orthopedic footwear, ladies shoe, depth inlay, each | Yes | | |
| L3217 | Orthopedic footwear, ladies shoe, hightop, depth inlay, each | Yes | | |
| L3219 | Orthopedic footwear, men's shoe, oxford, each | Yes | | |
| L3221 | Orthopedic footwear, men's shoe, depth inlay, each | Yes | | |
| L3222 | Orthopedic footwear, men's shoe, hightop, depth inlay, each | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L3224 | Orthopedic footwear woman's shoe, oxford, used as an integral part of a brace (orthosis) | Yes | | |
| L3225 | Orthopedic footwear man's shoe, oxford, used as an integral part of a brace (orthosis) | Yes | | |
| L3230 | Orthopedic footwear, custom shoe, depth inlay, each | Yes | | |
| L3250 | Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each | Yes | | |
| L3251 | Foot, shoe molded to patient model, silicone shoe, each | Yes | | |
| L3252 | Foot, shoe molded to patient model, Plastazote (or similar), custom fabricated, each | Yes | | |
| L3253 | Foot, molded shoe Plastozote (or similar), custom fitted, each | Yes | | |
| L3254 | Nonstandard size or width | Yes | | |
| L3255 | Nonstandard size or length | Yes | | |
| L3257 | Orthopedic footwear, additional charge for split size | Yes | 1 | Updated per NCCI requirements. 1 unit per foot is allowed and must be billed with the appropriate LT/RT modifier on separate lines. |
| L3260 | Surgical boot/shoe, each | Yes | | |
| L3265 | Plastazote sandal, each | Yes | | |
| | ***Shoe modification - lifts*** | | | |
| L3300 | Lift, elevation, heel, tapered to metatarsals, per inch | Yes | | |
| L3310 | Lift, elevation, heel and sole, neoprene, per inch | Yes | | |
| L3320 | Lift, elevation, heel and sole, cork, per inch | Yes | | |
| L3330 | Lift, elevation, metal extension (skate) | Yes | | |
| L3332 | Lift, elevation, inside shoe, tapered, up to one-half inch | Yes | | |
| L3334 | Lift, elevation, heel, per inch | Yes | | |
| | ***Shoe modification - wedges*** | | | |
| L3340 | Heel wedge, SACH | Yes | | |
| L3350 | Heel wedge | Yes | | |
| L3360 | Sole wedge, outside sole | Yes | | |
| L3370 | Sole wedge, between sole | Yes | | |
| L3380 | Clubfoot wedge | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L3390 | Outflare wedge | Yes | | |
| L3400 | Metatarsal bar wedge, rocker | Yes | | |
| L3410 | Metatarsal bar wedge, between sole | Yes | | |
| L3420 | Full sole and heel wedge, between sole | Yes | | |
| | ***Shoe modifications - heels*** | | | |
| L3430 | Heel, counter, plastic reinforced | Yes | | |
| L3440 | Heel, counter, leather reinforced | Yes | | |
| L3450 | Heel, SACH cushion type | Yes | | |
| L3455 | Heel, new leather, standard | Yes | | |
| L3460 | Heel, new rubber, standard | Yes | | |
| L3465 | Heel, Thomas with wedge | Yes | | |
| L3470 | Heel, Thomas extended to ball | Yes | | |
| L3480 | Heel, pad and depression for spur | Yes | | |
| L3485 | Heel, pad, removable for spur | Yes | | |
| | ***Miscellaneous shoe additions*** | | | |
| L3500 | Orthopedic shoe addition, insole, leather | Yes | | |
| L3510 | Orthopedic shoe addition, insole, rubber | Yes | | |
| L3520 | Orthopedic shoe addition, insole, felt covered with leather | Yes | | |
| L3530 | Orthopedic shoe addition, sole, half | Yes | | |
| L3540 | Orthopedic shoe addition, sole, full | Yes | | |
| L3550 | Orthopedic shoe addition, toe tap, standard | Yes | | |
| L3560 | Orthopedic shoe addition, toe tap, horseshoe | Yes | | |
| L3570 | Orthopedic shoe addition, special extension to instep (leather with eyelets) | Yes | | |
| L3580 | Orthopedic shoe addition, convert instep to Velcro closure | Yes | | |
| L3590 | Orthopedic shoe addition, convert firm shoe counter to soft counter | Yes | | |
| L3595 | Orthopedic shoe addition, March bar | Yes | | |
| | ***Transfer or replacement*** | | | |
| L3600 | Transfer of an orthosis from one (1) shoe to another, caliper plate, existing | Yes | | |
| L3610 | Transfer of an orthosis from one (1) shoe to another, caliper plate, new | Yes | | |
| L3620 | Transfer of an orthosis from one (1) shoe to another, solid stirrup, existing | Yes | | |
| L3630 | Transfer of an orthosis from one (1) shoe to another, solid stirrup, new | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L3640 | Transfer of an orthosis from one (1) shoe to another, Dennis Browne splint (Riveton), both shoes | Yes | | |
| L3649 | Orthopedic shoe, modification, additional or transfer, NOS | Yes | | |
| | **Orthotic Devices – Upper Limb** | | | |
| | ***Shoulder Orthosis (SO)*** | | | |
| L3650 | SO, figure of eight design abduction re-strainer, prefabricated, off-the-shelf | None | | |
| L3660 | SO, figure of eight design abduction restrainer, canvas and webbing, prefabricated, off-the-shelf | None | | |
| L3670 | SO, acromi/calvicular (canvas and webbing type), prefabricated, off-the-shelf | None | | |
| L3671 | Shoulder orthosis, shoulder joint design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |
| L3674 | SO, abduction positioning (airplane design), thoracic component and support bar, with or without nontorsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |
| L3675 | SO, vest type abduction restrainer, canvas webbing type or equal, prefabricated, off-the-shelf | None | | |
| L3677 | SO, shoulder joint design, without joints, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L3678 | Shoulder orthosis, shoulder joint design, without joints, may include soft interface, straps, prefabricated, off-the-shelf | None | | |
| | ***Elbow Orthosis (EO)*** | | | |
| E1800 | Dynamic adjustable elbow extension/flexion device, includes soft interface material | None | | |
| E1801 | Static progressive stretch elbow device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E1802 | Dynamic adjustable forearm pronation/supination device, includes soft interface material | None | | |
| E1818 | Static progressive stretch forearm pronation/supination device with or without range of motion adjustment, includes all components and accessories | None | | |
| L3702 | Elbow orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |
| L3710 | EO, elastic with metal joints, prefabricated, off-the-shelf | None | | |
| L3720 | EO, double upright with forearm/arm cuffs, free motion custom fabricated | None | | |
| L3730 | EO, double upright with forearm/arm cuffs, extension/flexion assist, custom fabricated | None | | |
| L3740 | EO, double upright with forearm/arm cuffs, adjustable position lock with active control, custom fabricated | None | | |
| L3760 | EO with adjustable position locking joint(s), prefabricated, includes fitting and adjustments, any type | None | | |
| L3762 | EO, rigid, without joints, includes soft interface material, prefabricated, off-the-shelf | None | | |
| | ***Elbow-Wrist-Hand Orthosis*** | | | |
| L3763 | Elbow wrist hand orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |
| L3764 | Elbow wrist hand orthosis, includes one (1) or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |
| | ***Elbow-Wrist-Hand-Finger Orthosis*** | | | |
| L3765 | Elbow wrist hand finger orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L3766 | Elbow wrist hand finger orthosis, includes one (1) or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |
| | ***Wrist-Hand-Finger Orthosis (WHFO)*** | | | |
| L3806 | WHFO, includes one (1) or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, custom fabricated, includes fitting and adjustment | None | | |
| L3807 | WHFO, without joint(s), prefabricated, item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L3808 | WHFO, rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment | None | | |
| L3809 | Wrist hand finger orthosis, without joint(s), prefabricated, off-the-shelf, any type | None | | |
| | ***Additions - general*** | | | |
| L3891 | Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism for custom fabricated orthotics only, each | None | | |
| | ***Dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension*** | | | |
| E1805 | Dynamic adjustable wrist extension/flexion device, includes soft interface material | None | | |
| E1806 | Static progressive stretch wrist device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories | None | | |
| E1825 | Dynamic adjustable finger extension/flexion device, includes soft interface material | None | | |
| L3900 | WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven, custom fabricated | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L3901 | WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, cable driven, custom fabricated | None | | |
| | ***External power*** | | | |
| L3904 | WHFO, external powered, electric, custom fabricated | None | | |
| | ***Other WHFOs – Custom fitted*** | | | |
| L3905 | Wrist hand orthosis, includes one (1) or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |
| L3906 | Wrist hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |
| L3908 | WHO, wrist extension control cock-up, non-molded, prefabricated, off-the-shelf | None | | |
| L3912 | HFO, flexion glove with elastic finger control, prefabricated, off-the-shelf | None | | |
| L3913 | Hand finger orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |
| L3915 | WHFO, includes one (1) or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L3616 | Wrist hand orthosis, includes one (1) or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, off-the-shelf | None | | |
| L3917 | Hand orthosis, metacarpal fracture orthosis, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L3918 | Hand orthosis, metacarpal fracture orthosis, prefabricated, off-the-shelf | None | | |
| L3919 | Hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | . |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L3921 | Hand finger orthosis, includes one (1) or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | . |
| L3923 | Hand finger orthosis, without joints, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L3924 | Hand finger orthosis, without joints, may include soft interface, straps, prefabricated, off-the-shelf | None | | |
| L3925 | FO, proximal interphalangeal (PIP)/distal interphalangeal (DIP), non-torsion joint/spring, extension/flexion, may include soft interface material, prefabricated, off-the-shelf | None | | |
| L3927 | FO, proximal interphalangeal (PIP)/distal interphalangeal (DIP), without joint/spring, extension/flexion (e.g. static or ring type), may include soft interface material, prefabricated, off-the-shelf | None | | |
| L3929 | HFO, includes one (1) or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L3930 | Hand finger orthosis, includes one (1) or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, off-the-shelf | None | | |
| L3931 | WHFO, includes one (1) or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment | None | | |
| L3933 | Finger orthosis, without joints, may include soft interface, custom fabricated, includes fitting and adjustment | None | | . |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L3935 | Finger orthosis, non-torsion joint, may include soft interface, custom fabricated, includes fitting and adjustment | None | | . |
| L3956 | Addition of joint to upper extremity orthosis, any material; per joint | None | | |
| | ***Shoulder-Elbow-Wrist-Hand Orthosis (SEWHO)*** | | | |
| L3960 | SEWHO, abduction positioning, airplane design prefabricated, includes fitting and adjustment | None | | |
| L3961 | Shoulder elbow wrist hand orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |
| L3962 | SEWHO, abduction positioning, Erb's palsy design, prefabricated, includes fitting and adjustment | None | | |
| L3964 | SEO, mobile arm support attached to wheelchair, balanced, adjustable, prefabricated, includes fitting and adjustment | None | | Code deleted 12/31/2011.<br>See code E2626. |
| L3965 | SEO, mobile arm support attached to wheelchair, balanced, adjustable Rancho type, prefabricated, includes fitting and adjustment | None | | Code deleted 12/31/2011.<br>See code E2627. |
| L3966 | SEO, mobile arm support attached to wheelchair, balanced, reclining, prefabricated, includes fitting and adjustment | None | | Code deleted 12/31/2011.<br>See code E2628. |
| L3967 | Shoulder elbow wrist hand orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |
| L3968 | SEO, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints), prefabricated, includes fitting and adjustment | None | | Code deleted 12/31/2011.<br>See code E2629. |
| L3969 | SEO, mobile arm support, mono-suspension arm and hand support, overhead elbow forearm hand sling support, yoke type arm suspension support, prefabricated, includes fitting and adjustment | None | | Code deleted 12/31/2011.<br>See code E2630. |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L3970 | SEO, addition to mobile arm support, elevating proximal arm | None | | Code deleted 12/31/2011.<br>See code E2631. |
| L3971 | Shoulder elbow wrist hand orthosis, shoulder cap design, includes one (1) or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |
| L3972 | SEO, addition to mobile arm support, offset or lateral rocker arm with elastic balance control | None | | Code deleted 12/31/2011.<br>See code E2632. |
| L3973 | Shoulder elbow wrist hand orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one (1) or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |
| L3974 | SEO, addition to mobile arm support, supinator | None | | Code deleted 12/31/2011. |
| L3975 | Shoulder elbow wrist hand finger orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |
| L3976 | 121BShoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |
| L3977 | Shoulder elbow wrist hand finger orthosis, shoulder cap design, includes one (1) or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |
| L3978 | 131BShoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one (1) or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | None | | |
| | ***Fracture orthosis*** | | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L3980 | Upper extremity fracture orthosis, humeral, prefabricated, includes fitting and adjustment | None | | |
| L3982 | Upper extremity fracture orthosis, radius/ulna, prefabricated, includes fitting and adjustment | None | | |
| L3984 | Upper extremity fracture orthosis, wrist, prefabricated, includes fitting and adjustment | None | | |
| L3995 | Addition to upper extremity orthosis, sock, fracture or equal, each | None | | |
| L3999 | Upper limb orthosis, NOS | None | | |
| | ***Specific repair*** | | | |
| E1820 | Replacement soft interface material, dynamic adjustable extension/flexion device | None | | |
| E1821 | Replacement soft interface material/cuffs for bi-directional static progressive stretch device | None | | |
| L4000 | Replace girdle for spinal orthosis (CTLSO or SO) | None | | |
| L4002 | Replacement strap, any orthosis, includes all components, any length, any type | None | | |
| L4010 | Replace trilateral socket brim | None | | |
| L4020 | Replace quadrilateral socket brim, molded to patient model | None | | |
| L4030 | Replace quadrilateral socket brim, custom fitted | None | | |
| L4040 | Replace molded thigh lacer, for custom fabricated orthosis only | None | | |
| L4045 | Replace non-molded thigh lacer, for custom fabricated orthosis only | None | | |
| L4050 | Replace molded calf lacer, for custom fabricated orthosis only | None | | |
| L4055 | Replace non-molded calf lacer, for custom fabricated orthosis only | None | | |
| L4060 | Replace high roll cuff | None | | |
| L4070 | Replace proximal and distal upright for KAFO | None | | |
| L4080 | Replace metal bands KAFO, proximal thigh | None | | |
| L4090 | Replace metal bands KAFO-AFO, calf or distal thigh | None | | |
| L4100 | Replace leather cuff KAFO, proximal thigh | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L4110 | Replace leather cuff KAFO-AFO, calf or distal thigh | None | | |
| L4130 | Replace pretibial shell | None | | |
| | ***Repairs*** | | | |
| L4205 | Repair of orthotic device, labor component, per 15 minutes | None | | |
| L4210 | Repair of orthotic device, repair or replace minor parts | None | | |
| L4350 | Ankle control orthosis, stirrup style, rigid, includes any type interface (e.g. pneumatic, gel), prefabricated, off-the-shelf | None | | |
| L4360 | Walking boot, pneumatic and/or vacuum, with or without joints, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L4361 | Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, off-the-shelf | None | | |
| L4370 | Pneumatic full leg splint, prefabricated, off-the-shelf | None | | |
| L4380 | Pneumatic knee splint, prefabricated, includes fitting and adjustment | None | | Code deleted 12/31/2011.<br>See code L4370-L3470 |
| L4386 | Walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L4387 | Walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated, off-the-shelf | None | | |
| L4392 | Replacement soft interface material, static AFO | None | | |
| L4394 | Replace soft interface material, foot drop splint | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L4396 | Static or dynamic ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual w/ expertise | None | | |
| L4398 | Foot drop splint recumbent positioning device, prefabricated, off-the-shelf | None | | |
| L4631 | Ankle foot orthosis, walking boot type, varus/valgus correction, rocker bottom, anterior tibial shell, soft interface, custom arch support, plastic or other material, includes straps and closures, custom fabricated | None | | |
| | **Prosthetic Procedures L5000-L9999** | | | |
| | **Lower limb** | | | |
| | ***Partial foot*** | | | |
| L5000 | Partial foot, shoe insert with longitudinal arch, toe filler | None | | |
| L5010 | Partial foot, molded socket, ankle height, with toe filler | None | | |
| L5020 | Partial foot, molded socket, tibial tubercle height, with toe filler | None | | |
| | ***Ankle*** | | | |
| L5050 | Ankle, Symes, molded socket, SACH foot | None | | |
| L5060 | Ankle, Symes, metal frame, molded leather socket, articulated ankle/foot | None | | |
| | ***Below knee*** | | | |
| L5100 | Below knee, molded socket, shin, SACH foot | None | | |
| L5105 | Below knee, plastic socket, joints and thigh lacer, SACH foot | None | | |
| | ***Knee disarticulation*** | | | |
| L5150 | Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot | None | | |
| L5160 | Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin, SACH foot | None | | |
| | ***Above knee*** | | | |
| L5200 | Above knee, molded socket, single axis constant friction knee, shin, SACH foot | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L5210 | Above knee, short prosthesis, no knee joint ("stubbies"), with foot blocks, no ankle joints, each | None | | |
| L5220 | Above knee, short prosthesis, no knee joint (stubbies), with articulated ankle/foot, dynamically aligned, each | None | | |
| L5230 | Above knee, for proximal femoral focal deficiency, constant friction knee, shin, SACH foot | None | | |
| | ***Hip disarticulation*** | | | |
| L5250 | Hip disarticulation, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot | None | | |
| L5270 | Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin SACH foot | None | | |
| | ***Hemipelvectomy*** | | | |
| L5280 | Hemipelvectomy, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot | None | | |
| L5301 | Below knee, molded socket, shin, SACH foot, endoskeletal system | None | | |
| L5312 | Knee disarticulation (or through knee), molded socket, single axis knee, pylon, SACH foot, endoskeletal system | Yes | | New code effective 1/1/12. |
| L5321 | Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee | None | | |
| L5331 | Hip disarticulation, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot | None | | |
| L5341 | Hemipelvectomy, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot | None | | |
| | ***Immediate post surgical or early fitting procedures*** | | | |
| L5400 | Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, and one (1) cast change, below knee | None | | |
| L5410 | Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, blow knee, each additional cast change and realignment | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L5420 | Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension and one (1) cast change "AK" or knee disarticulation | None | | |
| L5430 | Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, "AK" or knee disarticulation, each additional cast change and realignment | None | | |
| L5450 | Immediate post surgical or early fitting, application of non weight-bearing rigid dressing, below knee | None | | |
| L5460 | Immediate post surgical or early fitting, application of non weight-bearing rigid dressing, above knee | None | | |
| | ***Initial prosthesis*** | | | |
| L5500 | Initial, below knee "PTB" type socket, non-alignable system, pylon, no cover, Sach foot, plaster socket, direct formed | None | | |
| L5505 | Initial, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, sach foot plaster socket, direct formed | None | | |
| | ***Preparatory prosthesis*** | | | |
| L5510 | Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, molded to model | None | | |
| L5520 | Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed | None | | |
| L5530 | Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model | None | | |
| L5535 | Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, prefabricated, adjustable open end socket | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L5540 | Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, sach foot, laminated socket, molded to model | None | | |
| L5560 | Preparatory, above knee-knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, molded to model | None | | |
| L5570 | Preparatory, above knee-knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed | None | | |
| L5580 | Preparatory, above knee-knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model | None | | |
| L5585 | Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, prefabricated adjustable open end socket | None | | |
| L5590 | Preparatory, above knee-knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model | None | | |
| L5595 | Preparatory, hip disarticulation – hemipelvectomy, pylon, no cover, sach foot, thermoplastic or equal, molded to patient model | None | | |
| L5600 | Preparatory, hip disarticulation – hemipelvectomy, pylon, no cover, SACH foot, laminated socket, molded to patient model | None | | |
| | ***Additions: Lower extremity*** | | | |
| L5610 | Addition to lower extremity, endoskeletal system, above knee, hydracadence system | None | | |
| L5611 | Addition to lower extremity, endoskeletal system, above knee – knee disarticulation, 4-bar linkage, with friction swing phase control | None | | |
| L5613 | Addition to lower extremity, endoskeletal system, above knee – knee disarticulation, 4-bar linkage, with hydraulic swing phase control | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L5614 | Addition to lower extremity, endoskeletal system, above knee – knee disarticulation, 4-bar linkage, with pneumatic swing phase control | None | | |
| L5616 | Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control | None | | |
| L5617 | Addition to lower extremity, quick change self-aligning unit, above or below knee, each | None | | |
| | ***Additions: Test sockets*** | | | |
| L5618 | Addition to lower extremity, test socket, Symes | None | | |
| L5620 | Addition to lower extremity, test socket, below knee | None | | |
| L5622 | Addition to lower extremity, test socket, knee disarticulation | None | | |
| L5624 | Addition to lower extremity, test socket, above knee | None | | |
| L5626 | Addition to lower extremity, test socket, hip disarticulation | None | | |
| L5628 | Addition to lower extremity, test socket, hemipelvectomy | None | | |
| L5629 | Addition to lower extremity, below knee, acrylic socket | None | | |
| | ***Additions: Socket variations*** | | | |
| L5630 | Addition to lower extremity, Symes type, expandable wall socket | None | | |
| L5631 | Addition to lower extremity, above knee or knee disarticulation, acrylic socket | None | | |
| L5632 | Addition to lower extremity, Symes type, "PTB" brim design socket | None | | |
| L5634 | Addition to lower extremity, Symes type, posterior opening (Canadian) socket | None | | |
| L5636 | Addition to lower extremity, Symes type, medial opening socket | None | | |
| L5637 | Addition to lower extremity, below knee, total contact | None | | |
| L5638 | Addition to lower extremity, below knee, leather socket | None | | |
| L5639 | Addition to lower extremity, below knee, wood socket | None | | |
| L5640 | Addition to lower extremity, knee disarticulation, leather socket | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L5642 | Addition to lower extremity, above knee, leather socket | None | | |
| L5643 | Addition to lower extremity, hip disarticulation, flexible inner socket, external frame | None | | |
| L5644 | Addition to lower extremity, above knee, wood socket | None | | |
| L5645 | Addition to lower extremity, below knee, flexible inner socket, external frame | None | | |
| L5646 | Addition to lower extremity, below knee, air, fluid, gel or equal, cushion socket | None | | |
| L5647 | Addition to lower extremity, below knee, suction socket | None | | |
| L5648 | Addition to lower extremity, above knee, air, fluid, gel or equal, cushion socket | None | | |
| L5649 | Addition to lower extremity, ischial containment/narrow M-L socket | None | | |
| L5650 | Addition to lower extremity, total contact, above knee or knee disarticulation socket | None | | |
| L5651 | Addition to lower extremity, above knee, flexible inner socket, external frame | None | | |
| L5652 | Addition to lower extremity, suction suspension, above knee or knee disarticulation socket | None | | |
| L5653 | Addition to lower extremity, knee disarticulation, expandable wall socket | None | | |
| | ***Additions: Socket insert and suspension*** | | | |
| L5654 | Addition to lower extremity, socket insert, Symes (Kemblo, Pelite, Aliplast, Plastazote or equal) | None | | |
| L5655 | Addition to lower extremity, socket insert, below knee (Kemblo, Pelite, Aliplast, Plastazote or equal) | None | | |
| L5656 | Addition to lower extremity, socket insert, knee disarticulation (Kemblo, Pelite, Aliplast, Plastazote or equal) | None | | |
| L5658 | Addition to lower extremity, socket insert, above knee (Kemblo, Pelite, Aliplast, Plastazote or equal) | None | | |
| L5661 | Addition to lower extremity, socket insert, multidurometer, Symes | None | | |
| L5665 | Addition to lower extremity, socket insert, multidurometer, below knee | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L5666 | Addition to lower extremity, below knee, cuff suspension | None | | |
| L5668 | Addition to lower extremity, below knee, molded distal cushion | None | | |
| L5670 | Addition to lower extremity, below knee, molded supracondylar suspension ("PTS" or similar) | None | | |
| L5671 | Addition to lower extremity, below knee/above knee suspension locking mechanism (shuttle, lanyard or equal), excludes socket insert | None | | |
| L5672 | Addition to lower extremity, below knee, removable medial brim suspension | None | | |
| L5673 | Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or elastomeric or equal, for use with locking mechanism | None | | |
| L5676 | Addition to lower extremity, below knee, knee joints single axis, pair | None | | |
| L5677 | Addition to lower extremity, below knee, knee joints, polycentric, pair | None | | |
| L5678 | Addition to lower extremity, below knee joint covers, pair | None | | |
| L5679 | Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism | None | | |
| L5680 | Addition to lower extremity, below knee, thigh lacer, non-molded | None | | |
| L5681 | Addition to lower extremity, below knee / above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial use code L5673 or L5679) | None | | |
| L5682 | Addition to lower extremity, below knee, thigh lacer, gluteal/ischial, molded | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L5683 | Addition to lower extremity, below knee / above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial use code L5673 or L5679) | None | | |
| L5684 | Addition to lower extremity, below knee, fork strap | None | | |
| L5685 | Addition to lower extremity prosthesis, below knee, suspension/sealing sleeve, with or without valve, any material, each | None | | |
| L5686 | Addition to lower extremity, below knee, back check (extension control) | None | | |
| L5688 | Addition to lower extremity, below knee, waist belt, webbing | None | | |
| L5690 | Addition to lower extremity, below knee, waist belt, padded and lined | None | | |
| L5692 | Addition to lower extremity, above knee, pelvic control belt, light | None | | |
| L5694 | Addition to lower extremity, above knee, pelvic control belt, padded and lined | None | | |
| L5695 | Addition to lower extremity, above knee, pelvic control, sleeve suspension, neoprene or equal, each | None | | |
| L5696 | Addition to lower extremity, above knee or knee disarticulation, pelvic joint | None | | |
| L5697 | Addition to lower extremity, above knee or knee disarticulation, pelvic band | None | | |
| L5698 | Addition to lower extremity, above knee or knee disarticulation, Silesian bandage | None | | |
| L5699 | All lower extremity prostheses, shoulder harness | None | | |
| | ***Replacements*** | | | |
| L5700 | Replacement, socket, below knee, molded to patient model | None | | |
| L5701 | Replacement, socket, above knee/knee disarticulation, including attachment plate, molded to patient model | None | | |
| L5702 | Replacement, socket, hip disarticulation, including hip joint, molded to patient model | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L5703 | Ankle, Symes, molded to patient model, socket without solid ankle cushion heel (SACH) foot, replacement only | None | | |
| L5704 | Custom shaped protective cover, below knee | None | | |
| L5705 | Custom shaped protective cover, above knee | None | | |
| L5706 | Custom shaped protective cover, knee disarticulation | None | | |
| L5707 | Custom shaped protective cover, hip disarticulation | None | | |
| | ***Additions: Exoskeletal knee-shin system*** | | | |
| L5710 | Addition, exoskeletal knee-shin system, single axis, manual lock | None | | |
| L5711 | Addition, exoskeletal knee-shin system, single axis, manual lock, ultra-light material | None | | |
| L5712 | Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee) | None | | |
| L5714 | Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control | None | | |
| L5716 | Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock | None | | |
| L5718 | Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control | None | | |
| L5722 | Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control | None | | |
| L5724 | Addition, exoskeletal knee-shin system, single axis, fluid swing phase control | None | | |
| L5726 | Addition, exoskeletal knee-shin system, single axis, external joints, fluid swing phase control | None | | |
| L5728 | Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control | None | | |
| L5780 | Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L5781 | Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system | None | | |
| L5782 | Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy duty | None | | |
| | ***Component modification*** | | | |
| L5785 | Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal) | None | | |
| L5790 | Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal) | None | | |
| L5795 | Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal) | None | | |
| | ***Additions: Endoskeletal knee-shin system*** | | | |
| L5810 | Addition, endoskeletal knee-shin system, single axis, manual lock | None | | |
| L5811 | Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material | None | | |
| L5812 | Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee) | None | | |
| L5814 | Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock | None | | |
| L5816 | Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock | None | | |
| L5818 | Addition, endoskeletal knee-shin system, polycentric, friction swing and stance phase control | None | | |
| L5822 | Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control | None | | |
| L5824 | Addition, endoskeletal knee-shin system, single axis, fluid swing phase control | None | | |
| L5826 | Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame | None | | |
| L5828 | Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L5830 | Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control | None | | |
| L5840 | Addition, endoskeletal knee-shin system, 4-bar linkage or multiaxial, pneumatic swing phase control | None | | |
| L5845 | Addition, endoskeletal knee-shin system, stance flexion feature, adjustable | None | | |
| L5848 | Addition to endoskeletal, knee-shin system, fluid stance extension, dampening feature, with or without adjustability | None | | |
| L5850 | Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist | None | | |
| L5855 | Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist | None | | |
| L5856 | Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type | None | | |
| L5857 | Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing phase only, includes electronic sensor(s), any type | None | | |
| L5858 | Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type | None | | |
| L5910 | Addition, endoskeletal system, below knee, alignable system | None | | |
| L5920 | Addition, endoskeletal system, above knee or hip disarticulation, alignable system | None | | |
| L5925 | Addition, endoskeletal system, above knee, knee disarticulation or hip disarticulation, manual lock | None | | |
| L5930 | Addition, endoskeletal system, high activity knee control frame | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L5940 | Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal) | None | | |
| L5950 | Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal) | None | | |
| L5960 | Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal) | None | | |
| L5961 | Addition, endoskeletal system, polycentric hip joint, pneumatic or hydraulic control, rotation control, with or without flexion and/or extension control | None | | |
| L5962 | Addition, endoskeletal system, below knee, flexible protective outer surface covering system | None | | |
| L5964 | Addition, endoskeletal system, above knee, flexible protective outer surface covering system | None | | |
| L5966 | Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system | None | | |
| L5968 | Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature | None | | |
| L5970 | All lower extremity prostheses, foot, external keel, SACH foot | None | | |
| L5971 | All lower extremity prosthesis, solid ankle cushion hell (SACH) foot, replacement only | None | | |
| L5972 | All lower extremity prostheses, foot, flexible keel | None | | |
| L5973 | Endoskeletal ankle foot system, microprocessor controlled feature, dorsiflexion and/or plantar flexion control, includes power source | None | | |
| L5974 | All lower extremity prostheses, foot, single axis ankle/foot | None | | |
| L5975 | All lower extremity prosthesis, foot, combination single axis ankle and flexible keel foot | None | | |
| L5976 | All lower extremity prostheses, energy storing foot (Seattle Carbon Copy II or equal) | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L5978 | All lower extremity prostheses, foot, multi-axial ankle/foot | None | | |
| L5979 | All lower extremity prostheses, multi-axial ankle, dynamic response foot, one (1) piece system | None | | |
| L5980 | All lower extremity prostheses, flex-foot system | None | | |
| L5981 | All lower extremity prostheses, flex-walk system or equal | None | | |
| L5982 | All exoskeletal lower extremity prostheses, axial rotation unit | None | | |
| L5984 | All endoskeletal lower extremity prostheses, axial rotation unit, with or without adjustability | None | | |
| L5985 | All endoskeletal lower extremity prostheses, dynamic prosthetic pylon | None | | |
| L5986 | All lower extremity prostheses, multi-axial rotation unit ("MCP" or equal) | None | | |
| L5987 | All lower extremity prostheses, shank foot system with vertical loading pylon | None | | |
| L5988 | Addition to lower limb prosthesis, vertical shock reducing pylon feature | None | | |
| L5990 | Addition to lower extremity prosthesis, user adjustable heel height | None | | |
| L5999 | Lower extremity prosthesis not otherwise specified | None | | Per CMS guidelines, real time gait assessment and other tasks shall not be billed under L5999. |
| | **Upper Limb**<br>The procedures in L6000-L6599 are considered as "base" or "basic procedures" and may be modified by listing procedures from the "addition" sections. The base procedures include only standard friction wrist and control cable system unless otherwise specified | | | |
| | ***Partial hand*** | | | |
| L6000 | Partial hand, thumb remaining | None | | |
| L6010 | Partial hand, little and/or ring finger remaining | None | | |
| L6020 | Partial hand, no finger remaining | None | | |
| L6025 | Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two (2) batteries, charger, myoelectric control of terminal device | None | | Code deleted 12/29/2014. |
| | ***Wrist disarticulation*** | | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L6050 | Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad | None | | |
| L6055 | Wrist disarticulation molded socket with expandable interface, flexible elbow hinges, triceps pad | None | | |
| | ***Below elbow*** | | | |
| L6100 | Below elbow, molded socket, flexible elbow hinge, triceps pad | None | | |
| L6110 | Below elbow, molded socket, (Muenster or Northwestern suspension types) | None | | |
| L6120 | Below elbow, molded double wall split socket, step-up hinges, half cuff | None | | |
| L6130 | Below elbow, molded double wall split socket, stump activated locking hinge, half cuff | None | | |
| | ***Elbow disarticulation*** | | | |
| L6200 | Elbow disarticulation, molded socket, outside locking hinge, forearm | None | | |
| L6205 | Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm | None | | |
| | ***Above elbow*** | | | |
| E1840 | Dynamic adjustable shoulder flexion/abduction/rotation device, includes soft interface material | None | | |
| L6250 | Above elbow molded double wall socket, internal locking elbow, forearm | None | | |
| | ***Shoulder disarticulation*** | | | |
| L6300 | Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm | None | | |
| L6310 | Shoulder disarticulation, passive restoration (complete prosthesis) | None | | |
| L6320 | Shoulder disarticulation, passive restoration (shoulder cap only) | None | | |
| | ***Interscapular thoracic*** | | | |
| L6350 | Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm | None | | |
| L6360 | Interscapular thoracic, passive restoration (complete prosthesis) | None | | |
| L6370 | Interscapular thoracic, passive restoration (shoulder cap only) | None | | |
| | **Immediate and early post surgical procedures** | | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L6380 | Immediate post surgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one (1) cast change, wrist disarticulation or below elbow | None | | |
| L6382 | Immediate post surgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one (1) cast change, elbow disarticulation or above elbow | None | | |
| L6384 | Immediate post surgical or early fitting, application of initial rigid dressing including fitting, alignment and suspension of components, and one (1) cast change, shoulder disarticulation or interscapular thoracic | None | | |
| L6386 | Immediate post surgical or early fitting, each additional cast change and realignment | None | | |
| L6388 | Immediate post surgical or early fitting, application of rigid dressing only | None | | |
| | ***Endoskeletal: Below elbow*** | | | |
| L6400 | Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping | None | | |
| | ***Endoskeletal: Elbow disarticulation*** | | | |
| L6450 | Elbow disarticulation, molded socket, endoskeletal system including soft prosthetic tissue shaping | None | | |
| | ***Endoskeletal: Above elbow*** | | | |
| L6500 | Above elbow, molded socket, endoskeletal system including soft prosthetic tissue shaping | None | | |
| | ***Endoskeletal: Shoulder disarticulation*** | | | |
| L6550 | Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping | None | | |
| | ***Endoskeletal: Interscapular thoracic*** | | | |
| L6570 | Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L6580 | Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, "USMC" or equal pylon, no cover, molded to patient model | None | | |
| L6582 | Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, "USMC" or equal pylon, no cover, direct formed | None | | |
| L6584 | Preparatory, wrist disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, "USMC" or equal pylon, no cover, molded to patient model | None | | |
| L6586 | Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, "USMC" or equal pylon, no cover, direct formed | None | | |
| L6588 | Preparatory, shoulder disarticulation or interscapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, "USMC" or equal pylon, no cover, molded to patient model | None | | |
| L6590 | Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, "USMC" or equal pylon, no cover, direct formed | None | | |
| | ***Additions: Upper limb***<br>The following procedures/modifications/components may be added to other base procedures. The items in this section should reflect the additional complexity of each modification procedure, in addition to the base procedure, at the time of the original order. | | | |
| L6600 | Upper extremity additions, polycentric hinge, pair | None | | |
| L6605 | Upper extremity additions, single pivot hinge, pair | None | | |
| L6610 | Upper extremity additions, flexible metal hinge, pair | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L6611 | Addition to upper extremity prosthesis, external powered, additional switch, any type | None | | |
| L6615 | Upper extremity addition, disconnect locking wrist unit | None | | |
| L6616 | Upper extremity addition, additional disconnect insert for locking wrist unit, each | None | | |
| L6620 | Upper extremity addition, flexion-friction wrist unit, with or without friction | None | | |
| L6621 | Upper extremity prosthesis addition, flexion/extension wrist with or without friction, for use with external powered terminal device | None | | |
| L6623 | Upper extremity addition, spring assisted rotational wrist unit with latch release | None | | |
| L6624 | Upper extremity addition, flexion/extension and rotation wrist unit | None | | |
| L6625 | Upper extremity addition, rotation wrist unit with cable lock | None | | |
| L6628 | Upper extremity addition, quick disconnect hook adapter, Otto Bock or equal | None | | |
| L6629 | Upper extremity addition, quick disconnect lamination collar with coupling piece, Otto Bock or equal | None | | |
| L6630 | Upper extremity addition, stainless steel, any wrist | None | | |
| L6632 | Upper extremity addition, latex suspension sleeve, each | None | | |
| L6635 | Upper extremity addition, life assist for elbow | None | | |
| L6637 | Upper extremity addition, nudge control elbow lock | None | | |
| L6638 | Upper extremity addition to prosthesis, electric locking feature, only for use with manually powered elbow | None | | |
| L6640 | Upper extremity additions, shoulder abduction joint, pair | None | | |
| L6641 | Upper extremity addition, excursion amplifier, pulley type | None | | |
| L6642 | Upper extremity addition, excursion amplifier, lever type | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L6645 | Upper extremity addition, shoulder flexion-abduction joint, each | None | | |
| L6646 | Upper extremity addition, shoulder joint, multi-positional locking, flexion, adjustable abduction friction control, for use with body powered or external powered system | None | | |
| L6647 | Upper extremity addition, shoulder lock mechanism, body powered actuator | None | | |
| L6648 | Upper extremity addition, shoulder lock mechanism, external powered actuator | None | | |
| L6650 | Upper extremity addition, shoulder universal joint, each | None | | |
| L6655 | Upper extremity addition, standard control cable, extra | None | | |
| L6660 | Upper extremity addition, heavy duty control cable | None | | |
| L6665 | Upper extremity addition, Teflon, or equal, cable lining | None | | |
| L6670 | Upper extremity addition, hook to hand, cable adapter | None | | |
| L6672 | Upper extremity addition, harness, chest or shoulder, saddle type | None | | |
| L6675 | Upper extremity addition, harness, (e.g. figure of eight type), single cable design | None | | |
| L6676 | Upper extremity addition, harness, (e.g. figure of eight type), dual cable design | None | | |
| L6677 | Upper extremity addition, harness, triple control, simultaneous operation of terminal device and elbow | None | | |
| L6680 | Upper extremity addition, test socket, wrist disarticulation or below elbow | None | | |
| L6682 | Upper extremity addition, test socket, elbow disarticulation or above elbow | None | | |
| L6684 | Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic | None | | |
| L6686 | Upper extremity addition, suction socket | None | | |
| L6687 | Upper extremity addition, frame type socket, below elbow or wrist disarticulation | None | | |
| L6688 | Upper extremity addition, frame type socket, above elbow or elbow disarticulation | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L6689 | Upper extremity addition, frame type socket, shoulder disarticulation | None | | |
| L6690 | Upper extremity addition, frame type socket, interscapular-thoracic | None | | |
| L6691 | Upper extremity addition, removable insert, each | None | | |
| L6692 | Upper extremity addition, silicone gel insert or equal, each | None | | |
| L6693 | Upper extremity addition, locking elbow, forearm counter balance | None | | |
| L6694 | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism | None | | |
| L6695 | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism | None | | |
| L6696 | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695) | None | | |
| L6697 | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695) | None | | |
| L6698 | Addition to upper extremity prosthesis, below elbow/above elbow, lock mechanism, excludes socket insert | None | | |
| | **Terminal Devices** | | | |
| L6703 | Terminal device, passive hand/mitt, any material, any size | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L6704 | Terminal device, sport/recreation/work attachment, any material, any size | Yes | | |
| L6706 | Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined | None | | |
| L6707 | Terminal device, hook, mechanical, voluntary closing, any material, any sized, lined or unlined | None | | |
| L6708 | Terminal device, hand, mechanical, voluntary opening, any material, any size | None | | |
| L6709 | Terminal device, hand, mechanical, voluntary closing, any material, any size | None | | |
| L6711 | Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined, pediatric | None | | |
| L6712 | Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined, pediatric | None | | |
| L6713 | Terminal device, hand, mechanical, voluntary opening, any material, any size, pediatric | None | | |
| L6714 | Terminal device, hand, mechanical, voluntary closing, any material, any size, pediatric | None | | |
| L6715 | Terminal device, multiple articulating digit, includes motor(s), initial issue or replacement | Yes | | New code effective 1/1/12. |
| L6721 | Terminal device, hook or hand, heavy duty, mechanical, voluntary opening, any material, any size, lined or unlined | None | | |
| L6722 | Terminal device, hook or hand, heavy duty, mechanical, voluntary closing, any material, any size, lined or unlined | None | | |
| L6805 | Addition to terminal device, modifier wrist unit | None | | |
| L6810 | Addition to terminal device, precision pinch device | None | | |
| L6880 | Electric hand, switch or myolelectric controlled, independently articulating digits, any grasp pattern or combination of grasp patterns, includes motor(s) | Yes | | New code effective 1/1/12. |
| L6881 | Automatic grasp feature, addition to upper limb electric prosthetic terminal device | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L6882 | Microprocessor control feature, addition to upper limb prosthetic terminal device | Yes | | |
| | ***Replacement sockets*** | | | |
| L6883 | Replacement socket, below elbow/wrist disarticulation, molded to patient model, for use with or without external power | None | | |
| L6884 | Replacement socket, above elbow/elbow disarticulation, molded to patient model, for use with or without external power | None | | |
| L6885 | Replacement socket, shoulder disarticulation/interscapular thoracic, molded to patient model, for use with or without external power | None | | |
| | ***Gloves for above hands*** | | | |
| L6890 | Addition to upper extremity prosthesis, glove for terminal device, any material, prefabricated, includes fitting and adjustment | Yes | | |
| L6895 | Addition to upper extremity prosthesis, glove for terminal device, any material, custom fabricated | Yes | | |
| | ***Hand restoration*** | | | |
| L6900 | Hand restoration (casts, shading and measurements included), partial hand, with glove, thumb or one (1) finger remaining | Yes | | |
| L6905 | Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining | Yes | | |
| L6910 | Hand restoration (casts, shading and measurements included), partial hand, with glove, no fingers remaining | Yes | | |
| L6915 | Hand restoration (shading and measurements included), replacement glove for above | Yes | | |
| | **External Power** | | | |
| | ***Base devices*** | | | |
| L6920 | Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two (2) batteries and one (1) charger, switch control of terminal device | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L6925 | Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two (2) batteries and one (1) charger, myoelectronic control of terminal device | None | | |
| L6930 | Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two (2) batteries and one (1) charger, switch control of terminal device | None | | |
| L6935 | Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two (2) batteries and one (1) charger, myoelectronic control of terminal device | None | | |
| L6940 | Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal switch, cables, two (2) batteries and one (1) charger, switch control of terminal device | None | | |
| L6945 | Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal electrodes, cables, two (2) batteries and one (1) charger, myoelectronic control of terminal device | None | | |
| L6950 | Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal switch, cables, two (2) batteries and one (1) charger, switch control of terminal device | None | | |
| L6955 | Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal electrodes, cables, two (2) batteries and one charger, myoelectronic control of terminal device | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L6960 | Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two (2) batteries and one (1) charger, switch control of terminal device | None | | |
| L6965 | Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two (2) batteries and one (1) charger, myoelectronic control of terminal device | None | | |
| L6970 | Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two (2) batteries and one (1) charger, switch control of terminal device | None | | |
| L6975 | Intercapsular thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two (2) batteries and one (1) charger, myoelectronic control of terminal device | None | | |
| L7007 | Electric hand, switch or myoelectric, controlled, adult | None | | |
| L7008 | Electric hand, switch or myoelectric, controlled, pediatric | None | | |
| L7009 | Electric hook, switch or myoelectric controlled, adult | None | | |
| L7040 | Prehensile actuator, switch controlled | None | | |
| L7045 | Electronic hook, switch or myoelectric controlled, pediatric | None | | |
| | ***Elbow*** | | | |
| L7170 | Electronic elbow, Hosmer or equal, switch controlled | None | | |
| L7180 | Electronic elbow, microprocessor sequential control of elbow and terminal device | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L7181 | Electronic elbow, microprocessor simultaneous control of elbow and terminal device | None | | |
| L7185 | Electronic elbow, adolescent, Variety Village or equal, switch controlled | None | | |
| L7186 | Electronic elbow, child, Variety Village or equal, switch controlled | None | | |
| L7190 | Electronic elbow, adolescent, Variety Village or equal, myoelectronically controlled | None | | |
| L7191 | Electronic elbow, child, Variety Village or equal, myoelectronically controlled | None | | |
| L7260 | Electronic wrist rotator, Otto Bock or equal | None | | Code deleted 12/29/2014. |
| L7261 | Electronic wrist rotator, for Utah arm | None | | Code deleted 12/29/2014. |
| L7266 | Servo control, Steeper or equal | None | | Code deleted 12/31/2011. |
| L7272 | Analogue control, UNB or equal | None | | Code deleted 12/31/2011. |
| L7274 | Proportional control 6-12 volt, Liberty, Utah or equal | None | | Code deleted 12/31/2011. |
| | ***Battery components*** | | | |
| L7360 | Six (6) volt battery, each | None | | |
| L7362 | Battery charger, six (6) volt, each | None | | |
| L7364 | 12 volt battery, each | None | | |
| L7366 | Battery charger, 12 volt, each | None | | |
| L7367 | Lithium ion battery, replacement | None | | |
| L7368 | Lithium ion battery charger, replacement only | None | | |
| | ***Addition to upper extremity prosthesis*** | | | |
| L7400 | Addition to upper extremity prosthesis, below elbow/wrist disarticulation, ultralight material (titanium, carbon fiber or equal) | None | | |
| L7401 | Addition to upper extremity prosthesis, above elbow disarticulation, ultralight material (titanium, carbon fiber or equal) | None | | |
| L7402 | Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, ultralight material (titanium, carbon fiber or equal) | None | | |
| L7403 | Addition to upper extremity prosthesis, below elbow/wrist disarticulation, acrylic material | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L7404 | Addition to upper extremity prosthesis, above elbow disarticulation, acrylic material | None | | |
| L7405 | Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, acrylic material | None | | |
| L7499 | Upper extremity prosthesis, NOS | None | | |
| | ***Repairs*** | | | |
| L7500 | Repair of prosthetic device, hourly rate (excludes V5335<br>Repair of oral or laryngeal prosthesis or artificial larynx) | None | | Code deleted 12/31/2011.<br>See code L7520. |
| L7510 | Repair of prosthetic device, repair or replace minor parts | None | | |
| L7520 | Repair prosthetic device, labor component, per 15 minutes | None | | |
| | ***Prostheses*** | | | |
| L8000 | Breast prosthesis, mastectomy bra | None | | |
| L8001 | Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral, any size, any type | None | | |
| L8002 | Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral, any size, any type | None | | |
| L8010 | Breast prosthesis, mastectomy sleeve | None | | |
| L8015 | External breast prosthesis garment, with mastectomy form, post-mastectomy | None | | |
| L8020 | Breast prosthesis, mastectomy form | None | | |
| L8030 | Breast prosthesis, silicone or equal, without integral adhesive | Yes | | |
| L8031 | Breast prosthesis, silicone or equal, with integral adhesive | Yes | | |
| L8032 | Nipple prosthesis, reusable, any type, each | Yes | | |
| L8035 | Custom breast prosthesis, post mastectomy, molded to patient model | None | | |
| L8039 | Breast prosthesis, NOS | Yes | | |
| L8040 | Nasal prosthesis, provided by a non-physician | Yes | | |
| L8041 | Midfacial prosthesis, provided by a non-physician | Yes | | |
| L8042 | Orbital prosthesis, provided by a non-physician | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L8043 | Upper facial prosthesis, provided by a non-physician | Yes | | |
| L8044 | Hemi-facial prosthesis, provided by a non-physician | Yes | | |
| L8045 | Auricular prosthesis, provided by a non-physician | Yes | | |
| L8046 | Partial facial prosthesis, provided by a non-physician | Yes | | |
| L8047 | Nasal septal prosthesis, provided by a non-physician | Yes | | |
| L8048 | Unspecified maxillofacial prosthesis, by report, provided by a non-physician | Yes | | |
| L8049 | Repair or modification of maxillofacial prosthesis, labor component, 15 minute increments, provided by a non-physician | Yes | | |
| L8499 | Unlisted procedure for miscellaneous prosthetic services | Yes | | |
| | ***Trusses*** | | | |
| L8300 | Truss, single with standard pad | None | | |
| L8310 | Truss, double with standard pads | None | | |
| L8320 | Truss, addition to standard pads, water pad | None | | |
| L8330 | Truss, addition to standard pads, scrotal pad | None | | |
| | ***Prosthetic socks*** | | | |
| L7600 | Prosthetic donning sleeve, any material, each | None | | |
| L8400 | Prosthetic sheath, below knee, each | None | | |
| L8410 | Prosthetic sheath, above knee, each | None | | |
| L8415 | Prosthetic sheath upper limb each | None | | |
| L8417 | Prosthetic sheath/sock, including a gel cushion layer, below knee or above knee, each | None | | |
| L8420 | Prosthetic sock, multiple ply, below knee, each | None | | |
| L8430 | Prosthetic sock, multiple ply, above knee, each | None | | |
| L8435 | Prosthetic sock, multiple ply, upper limb, each | None | | |
| L8440 | Prosthetic shrinker, below knee, each | None | | |
| L8460 | Prosthetic shrinker, above knee, each | None | | |
| L8465 | Prosthetic shrinker, upper limb, each | None | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| L8470 | Prosthetic sock, single ply, fitting, below knee, each | None | | |
| L8480 | Prosthetic sock, single ply, fitting, above knee, each | None | | |
| L8485 | Prosthetic sock, single ply, fitting, upper limb, each | None | | |
| | **Prosthetic Implants** | | | |
| | ***Integumentary system*** | | | |
| L8500 | Artificial larynx, any type | None | | |
| L8501 | Tracheostomy speaking valve | None | | |
| L8505 | Artificial larynx replacement battery/accessory, any type | Yes | | |
| L8507 | Tracheo-esophageal voice prosthesis, patient inserted, any type, each | Yes | | |
| L8509 | Tracheo-esophageal voice prosthesis, inserted by a licensed health care provider, any type | Yes | | |
| L8510 | Voice amplifier | Yes | | |
| L8511 | Insert for indwelling tracheoesophageal prosthesis, with or without valve, replacement only, each | None | | |
| L8512 | Gelatin capsules or equivalent, for use with tracheoesophageal voice prosthesis, replacement only, per 10 | None | | |
| L8513 | Cleaning device used with tracheoesophageal voice prosthesis, pipet, brush, or equal, replacement only, each | None | | |
| L8514 | Tracheoesophageal puncture dilator, replacement only, each | None | | |
| L8515 | Gelatin capsule application device for use with tracheoesophageal voice prosthesis, each | None | 31/M | |
| | ***Head: Skull, facial bones, and temporomandibular joint*** | | | |
| L8610 | Ocular implant | Yes | | |
| L8619 | Cochlear implant external speech processor and controller, integrated system, replacement | None | | |
| | **Alternative and Augmentative Communication Devices (AACDs)**<br>Refer to the Department website for full coverage guidelines and limitations:<br>colorado.gov/hcpf → For Our Stakeholders → Committees, Boards, and Collaboration → Benefits Collaborative→ Approved Benefit Coverage Standards | | | |
| A4601 | Lithium ion battery for non-prosthetic use, replacement | Yes | | |

| Code | Description | PAR | Unit Limits<br>Y=Year<br>M=Month<br>W=Week<br>D=Day | Comments |
|---|---|---|---|---|
| E1399-AV | Tablet computer for use as a communication device | Yes | | Device must be under full manufacturer warranty at the time of delivery to the member.<br>Max reimbursement = $600 |
| E1902 | Communication board, non-electronic augmentative or alternative communication device | Yes | | |
| E2500 | Speech generating device, digitalized speech, using pre-recorded messages, less than or equal to 8 minutes recording time | Yes | | |
| E2502 | Speech generating device, digitalized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time | Yes | | |
| E2504 | Speech generating device, digitalized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time | Yes | | |
| E2506 | Speech generating device, digitalized speech, using pre-recorded messages, greater than 40 minutes recording time | Yes | | |
| E2508 | Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device | Yes | | |
| E2510 | Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access | Yes | | |
| E2511 | Speech generating software program, for personal computer or personal digital assistant | Yes | | |
| E2512 | Accessory for speech generating device, mounting system | Yes | | |
| E2599 | Accessory for speech generating device, not otherwise classified | Yes | | |
| L9900 | Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code | Yes | | |

**The following codes are pure CRT codes. Only qualified CRT suppliers may bill for these codes.**

For the purpose of the below chart only, please note the following definitions:

**New:**

- Purchase of a chair or equipment type not previously owned.
- Replacement of equipment after the three year mark for pediatrics and five years for adults.

**Mod (Modification):**

- A change or alteration to a member owned piece of equipment. I.E. A different seating system to be placed on an existing base.

**Repair:**

- Repair or replacement of a part due to damage and/or normal wear and tear. Replacement item is a duplicate of the original.

**Con:**

- Specialty eval is only required when the member is switching from or adding to a standard drive control (Joystick, any type) and/or attendant control.

| Pure CRT | Description | PAR | Unit Limits | Comments | Specialty Eval | | |
|---|---|---|---|---|---|---|---|
| | | | Y=Year M=Month W=Week D=Day | | New | Mod | Repair |
| E0637 | Combination sit to stand/table system, any size including pediatric, with seat lift feature, with or without wheels | Yes | | | No | No | No |
| E0638 | Standing frame/table system, one (1) position (e.g. upright, supine or prone stander), any size including pediatric, with or without wheels | Yes | | | No | No | No |
| E0641 | Standing frame/table system, multi-position (e.g. three-way stander), any size including pediatric, with or without wheels | Yes | | | No | No | No |
| E0642 | Standing frame/table system, mobile ( dynamic stander), any size including pediatric | Yes | | | No | No | No |
| E0986 | Manual wheelchair accessory, push activated power assist, each | Yes | | | No | No | No |
| E1002 | Wheelchair accessory, power seating system, tilt only | Yes | | Requires Questionnaire #15 | Yes | Yes | No |
| E1003 | Wheelchair accessory, power seating system, recline only, without shear reduction | Yes | | Requires Questionnaire #15 | Yes | Yes | No |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| E1004 | Wheelchair accessory, power seating system, recline only, with mechanical shear reduction | Yes | | Requires Questionnaire #15 | Yes | Yes | No |
| E1005 | Wheelchair accessory, power seating system, recline only, with power shear reduction | Yes | | Requires Questionnaire #15 | Yes | Yes | No |
| E1006 | Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction | Yes | | Requires Questionnaire #15 | Yes | Yes | No |
| E1007 | Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction | Yes | | Requires Questionnaire #15 | Yes | Yes | No |
| E1008 | Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction | Yes | | Requires Questionnaire #15 | Yes | Yes | No |
| E1009 | Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each | Yes | | | Yes | Yes | No |
| E1010 | Wheelchair accessory, addition to power seating system, power leg elevation system, including pushrod and leg rest, each | Yes | | | Yes | Yes | No |
| E1011 | Modification to pediatric size wheelchair width adjustment package (not to be dispensed with initial chair) | Yes | | For modification of existing wheelchair only | No | No | No |
| E1014 | Reclining back, addition to pediatric size wheelchair | Yes | | Requires Questionnaire #15 | No | No | No |
| E1037 | Transport chair, pediatric size | Yes | | | No | No | No |
| E1161 | Manual adult size wheelchair, includes tilt-in-space | Yes | | | Yes | No | No |
| E1220 | Wheelchair, specially sized or constructed (indicate brand name, model number, if any, and justification) | Yes | | | Yes | No | No |
| E1228 | Special back height for wheelchair | Yes | | | No | No | No |
| E1229 | Wheelchair, pediatric size, not otherwise specified | Yes | | | Yes | No | No |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| E1231 | Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system | Yes | | | Yes | No | No |
| E1232 | Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system | Yes | | | Yes | No | No |
| E1233 | Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system | Yes | | | Yes | No | No |
| E1234 | Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system | Yes | | | Yes | No | No |
| E1235 | Wheelchair, pediatric size, rigid, adjustable, with seating system | Yes | | | Yes | No | No |
| E1236 | Wheelchair, pediatric size, folding, adjustable, with seating system | Yes | | | Yes | No | No |
| E1237 | Wheelchair, pediatric size, rigid, adjustable, without seating system | Yes | | | Yes | No | No |
| E1238 | Wheelchair, pediatric size, folding, adjustable, without seating system | Yes | | | Yes | No | No |
| E1239 | Power wheelchair, pediatric size, not otherwise specified | Yes | | | Yes | No | No |
| E2209 | Accessory, arm trough, with or without hand support, each | Yes | | 1 item = 1 arm trough | No | No | No |
| E2291 | Back, planar, for pediatric size wheelchair including fixed attaching hardware | Yes | | | No | No | No |
| E2292 | Seat, planar, for pediatric size wheelchair including fixed attached hardware | Yes | | | No | No | No |
| E2293 | Back, contoured, for pediatric size wheelchair including fixed attaching hardware | Yes | | | No | No | No |
| E2294 | Seat, contoured, for pediatric size wheelchair including fixed attaching hardware | Yes | | | No | No | No |
| E2295 | Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features | Yes | | | Yes | No | No |
| E2300 | Wheelchair accessory, power seat elevation, system, any type | Yes | | | Yes | Yes | No |
| E2301 | Wheelchair accessory, power standing system, any type | Yes | | | Yes | Yes | No |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| E2310 | Power wheelchair accessory, electronic connection between wheelchair controller and two (2) or more power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware | Yes | | | Yes | No | No |
| E2311 | Power wheelchair accessory, electronic connection between wheelchair controller and one (1) power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware | Yes | | | Yes | No | No |
| E2312 | Power wheelchair accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including fixed mounting hardware | Yes | | | Yes | No | No |
| E2313 | Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each | Yes | | | Yes | No | No |
| E2321 | Power wheelchair accessory, hand control interface, remote joysticks, non-proportional, including all related electronics, mechanical stop switch, and fixed mounting hardware | Yes | | | Yes | No | No |
| E2322 | Power wheelchair accessory, hand control interface, multiple mechanical switches, non-proportional, including all related electronics, mechanical stop switch, and fixed mounting hardware | Yes | | | Yes | No | No |
| E2323 | Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated | Yes | | | Yes | No | No |
| E2324 | Power wheelchair accessory, chin cup for chin control interface | Yes | | | No | No | No |
| E2325 | Power wheelchair accessory, sip and puff interface, non-proportional, including all related electronics, mechanical stop switch, and manual swing away mounting hardware | Yes | | | Yes | Yes | No |
| E2326 | Power wheelchair accessory, breath tube kit for sip and puff interface | Yes | | | No | No | No |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| E2327 | Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and | Yes | | | Yes | Con | No |
| E2328 | Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware | Yes | | | Yes | Con | No |
| E2329 | Power wheelchair accessory, head control interface, contact switch mechanism, non-proportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware | Yes | | | Yes | Con | No |
| E2330 | Power wheelchair accessory, head control interface, proximity switch mechanism, non-proportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware | Yes | | | Yes | Con | No |
| E2331 | Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware | Yes | | | Yes | Yes | No |
| E2351 | Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface | Yes | | | No | No | No |
| E2373 | Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware | Yes | | | Yes | No | No |
| E2374 | Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only | Con | 1 per 3 Y | PAR required for more than 1 per 3 fiscal years | No | No | No |
| E2376 | Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only | Con | 1 per Y | Over 1 unit requires PAR | No | No | No |
| E2377 | Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue | Yes | | | No | No | No |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| E2609 | Custom fabricated wheelchair seat cushion, any size | Yes | | Identify specific brand/name of cushion requested on prior authorization request | Yes | Yes | No |
| E2610 | Wheelchair seat cushion, powered | Yes | | Identify specific brand/name of cushion requested on prior authorization request | Yes | Yes | No |
| E2617 | Custom fabricated wheelchair back cushion, any size, including any type mounting hardware | Yes | | Identify specific brand/name of cushion requested on prior authorization request | Yes | Yes | No |
| E8000 | Gait trainer, pediatric size, posterior support, includes all accessories and components | Yes | | Use for adults also | No | No | No |
| E8001 | Gait trainer, pediatric size, upright support, includes all accessories and components | Yes | | Use for adults also | No | No | No |
| E8002 | Gait trainer, pediatric size, anterior support, includes all accessories and components | Yes | | Use for adults also | No | No | No |
| K0005 | Ultra lightweight wheelchair | Yes | | | Yes | No | No |
| K0835 | Power wheelchair, group 2 standard, single power option, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | Yes | | | Yes | No | No |
| K0836 | Power wheelchair, group 2 standard, single power option, captains chair. Patient weight capacity up to and including 300 pounds | Yes | | | Yes | No | No |
| K0837 | Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | Yes | | | Yes | No | No |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| K0838 | Power wheelchair, group 2 heavy duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds | Yes | | | Yes | No | No |
| K0839 | Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds | Yes | | | Yes | No | No |
| K0840 | Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more | Yes | | | Yes | No | No |
| K0841 | Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to including 300 pounds | Yes | | | Yes | No | No |
| K0842 | Power wheelchair, group 2 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds | Yes | | | Yes | No | No |
| K0843 | Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | Yes | | | Yes | No | No |
| K0848 | Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds | Yes | | | Yes | No | No |
| K0849 | Power wheelchair, group 3 standard, captains chair, patient weight capacity up to and including 300 pounds | Yes | | | Yes | No | No |
| K0850 | Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds | Yes | | | Yes | No | No |
| K0851 | Power wheelchair, group 3 heavy duty, captains chair, patient weight capacity 301 to 450 pounds | Yes | | | Yes | No | No |
| K0852 | Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds | Yes | | | Yes | No | No |
| K0853 | Power wheelchair, group 3 very heavy duty, captains chair, patient weight capacity, 451 to 600 pounds | Yes | | | Yes | No | No |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| K0854 | Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more | Yes | | | Yes | No | No |
| K0855 | Power wheelchair, group 3 extra heavy duty, captains chair, patient weight capacity 601 pounds or more | Yes | | | Yes | No | No |
| K0856 | Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | Yes | | | Yes | No | No |
| K0857 | Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds | Yes | | | Yes | No | No |
| K0858 | Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | Yes | | | Yes | No | No |
| K0859 | Power wheelchair, group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds | Yes | | | Yes | No | No |
| K0860 | Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back. Patient weight capacity 451 to 600 pounds | Yes | | | Yes | No | No |
| K0861 | Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to including 300 pounds | Yes | | | Yes | No | No |
| K0862 | Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | Yes | | | Yes | No | No |
| K0863 | Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds | Yes | | | Yes | No | No |
| K0864 | Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more | Yes | | | Yes | No | No |
| K0868 | Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds | Yes | | | Yes | No | No |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| K0869 | Power wheelchair, group 4 standard, captains chair, patient weight capacity up to and including 300 pounds | Yes | | | Yes | No | No |
| K0870 | Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds | Yes | | | Yes | No | No |
| K0871 | Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds | Yes | | | Yes | No | No |
| K0877 | Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to including 300 pounds | Yes | | | Yes | No | No |
| K0878 | Power wheelchair, group 4 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds | Yes | | | Yes | No | No |
| K0879 | Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | Yes | | | Yes | No | No |
| K0880 | Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds | Yes | | | Yes | No | No |
| K0884 | Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | Yes | | | Yes | No | No |
| K0885 | Power wheelchair, group 4 standard, multiple power option, captains chair weight capacity up to and including 300 pounds | Yes | | | Yes | No | No |
| K0886 | Power wheelchair, group 4 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | Yes | | | Yes | No | No |
| K0890 | Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds | Yes | | | Yes | No | No |
| K0891 | Power wheelchair, group 5 pediatric, multiple power option, sling/solid | Yes | | | Yes | No | No |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | seat/back, patient weight capacity up to and including 125 pounds | | | | | | |
| K0898 | Power wheelchair, not otherwise classified | Yes | | | Yes | No | No |

**Mixed CRT Codes**: The following HCPCs codes contain a mix of CRT items and standard mobility and accessory items. These codes can be used in conjunction with pure CRT codes or as a non CRT DME code.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| E0950 | E0951 | E0952 | E0955 | E0956 | E0957 | E0958 | E0960 | E0967 | E0978 |
| E0990 | E1015 | E1016 | E1028 | E1029 | E1030 | E2205 | E2208 | E2231 | E2368 |
| E2369 | E2370 | E2605 | E2606 | E2607 | E2608 | E2613 | E2614 | E2615 | E2616 |
| E2620 | E2621 | E2624 | E2625 | K0004 | K0009 | K0040 | K0108 | K0669 | E1399 |

# Supply (Wound Care) CMS 1500 Claim Example

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

3. PATIENT'S BIRTH DATE MM 10 DD 16 YY 45 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? YES NO PLACE (State)

c. OTHER ACCIDENT? YES NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 1/1/15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 4540X B. 27800 C. 6829X D. 7823X

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| | 24. A. DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | | | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 01 | 01 | 15 | 01 | 01 | 15 | 12 | | A4452 | UB | GY | | ABC | 7 73 | 160 | | NPI | 12345678 0123456789 |
| 2 | 01 | 01 | 15 | 01 | 01 | 15 | 12 | | A4927 | GY | | | ABC | 25 08 | 2 | | NPI | 12345678 0123456789 |
| 3 | 01 | 01 | 15 | 01 | 01 | 15 | 12 | | A6216 | GY | | | ABC | 36 00 | 400 | | NPI | 12345678 0123456789 |
| 4 | 01 | 01 | 15 | 01 | 01 | 15 | 12 | | A6260 | UB | GY | | ABC | 11 00 | 2 | | NPI | 12345678 0123456789 |
| 5 | 01 | 01 | 15 | 01 | 01 | 15 | 12 | | A6440 | UB | GY | | ABC | 43 33 | 160 | | NPI | 12345678 0123456789 |
| 6 | 01 | 01 | 15 | 01 | 01 | 15 | 12 | | A6454 | UB | GY | | ABC | 83 33 | 200 | | NPI | 12345678 0123456789 |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 206 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature DATE 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

ABC Dialysis Clinic
100 Any Street
Any City

a. 1234567890 b. 04567890

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

# DME (Wheelchair) CMS 1500 Claim Example

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): D444444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

3. PATIENT'S BIRTH DATE MM 10 DD 16 YY 45 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 1/1/15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 06 DD 01 YY 14 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): Jazzy 10WD40SXW

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9

A. 72402 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| | 24. A. DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | | | | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 01 | 01 | 15 | 01 | 01 | 15 | 12 | | K0003 | NU | | | | A | 779 70 | 1 | | NPI | 12345678 0123456789 |
| 2 | | | | | | | | | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 779 70

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature DATE 1/1/15

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH# ( )

ABC Dialysis Clinic
100 Any Street
Any City

a. 1234567890 b. 04567890

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

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# *DME and Supplies Revisions Log*

| Revision Date | Section | Pages/ Action | Made by |
|---|---|---|---|
| *Created 06/2011* | *All due to creation of separation from combined Colorado 1500 billing manual* | *All* | *rd, ad, vr* |
| *08/30/2011* | *Changed wording from authorizing agent to authorizing agency.*<br>*Deleted "immediate system assignment of a PAR number, faster… "to expedited PAR processing."* | *16,21*<br>*6* | *cc* |
| *12/01/2011* | *Added -General Billing Information*<br>*-Column Instructions for HCPCs Code Table*<br>*-HCPCs*<br>*-Link to Questionnaires*<br>*Removed Questionnaires* | *8*<br>*11-13*<br>*34-257*<br>*7*<br>*257-277* | *cc* |
| *02/06/2012* | *-Incorporated HCPCS into billing manual.*<br>*-Changed billing manual name to Durable Medical Equipment and Supplies Provider Reference Manual*<br>*-Clarified benefit information throughout manual.*<br>*-Included ColoradoPAR Program where necessary*<br>*-Added new codes to HCPCS*<br>*-Removed pricing column in HCPCS*<br>*-Revised HCPCS column instructions*<br>*-Added unit limits to those codes that had limits in MMIS*<br>*-Added clarifying comments to the comments column* | *All* | *cc*<br>*ad* |
| *05/04/2012* | *Formatted and generated TOC* | *All* | *jg* |
| *06/22/2012* | *-Revised Wheelchair Purchase guideline-* "Eligible members may receive one primary wheelchair with one backup wheelchair. Members are eligible for wheelchair replacement every five years.<br>*-Revised PAR submission language with prescribing authority*<br>*- Removed 20% added at the current per rule*<br>*-Removed modifier -55, KJ, LL*<br>*-PAR instructional reference table, field 26 revised to reflect prescribing authority*<br>*-A4353-22 comment matches A4352-22 comment*<br>*-A4357, A4358 unit limit 2/M*<br>*-B4152, removed unit limit 950/M*<br>*-Added HCPCS page index* | *3*<br>*6*<br>*12*<br>*14*<br>*15*<br>*77*<br>*77*<br>*96*<br>*1-12* | *cc* |

| Revision Date | Section | Pages/ Action | Made by |
|---|---|---|---|
| *07/12/2012* | *Correct field number for Member Sex to 5* | *18* | *jg* |
| *09/14/2012* | *Corrected field numbers in Paper Claim Reference Table* | *24-27* | *jg* |
| *05/08/2013* | *2013 HCPCS additions*<br>• *A4435*<br>• *E0670*<br>• *E2378*<br>*Changes made to "Wheelchair Equipment Repair (Manual & Motorized) Section*<br>*Updated unit limits for the following codes:*<br>• *NCCI MUEs: E0463, E0464, B4087, B4088, E0202, E0600, L1240, L2275*<br>• *Other: A7027, A7028, A7029, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045*<br>*Updated Coverage Comments:*<br>• *E0562*<br>• *E0601* | <br>*78*<br>*90*<br>*62* | *as* |
| *05/08/2013* | *Condensed electronic billing information and referred to CO-1500 General Manual*<br>*Changed Website to website* | *9*<br>*All* | *cc* |
| *05/10/2013* | *Reformatted*<br>*Updated TOC*<br>*Updated Index* | *All*<br>*ii-iv* | *jg* |
| *06/14/2013* | *Included E0445-RR information per existing rental/purchase requirements.* | *78* | *as* |
| *06/19/2013* | *Fixed table breaks* | *All* | *cc* |
| *7/15/2013* | *Updated unit limits/coverage comments:*<br>• *NCCI MUEs: B4087, B4088, E0463, E0464, E0600* | | *as* |
| *08/15/2013* | *Updated PAR Submission*<br>*Updated Wheelchair claim example* | *8*<br>*168* | *cc* |
| *08/16/2013* | *Edited and Reformatted*<br>*Updated* Supply *(Wound Care) Claim Example*<br>*Updated TOC*<br>*Updated Index* | *Throughout*<br>*159*<br>*i-iv*<br>*161-172* | *jg* |
| *10/01/2013* | *Added AACD information and E1399-AV code/comments*<br>*Omitted "although not a requirement." On Medicaid/WIC benefits paragraph for enteral formula.* | *4*<br>*3* | *as* |

| Revision Date | Section | Pages/ Action | Made by |
|---|---|---|---|
| *01/24/2014* | *Add TW modifier instructions beginning 4/1/14*<br>*Added "If repair is for secondary/backup wheelchair, the PAR and claim must contain TW modifier*<br>*Added TW to list of acceptable modifier*<br>*Added comments to the following codes: A4245, E0445, E0445-RR, B9002-RR, E0776, L3257, L5999* | *5*<br>*5*<br>*10*<br>*63, 80, 100, 131, 151* | *as* |
| *01/27/2014* | *Added 2014 HCPCS: L0455, L0457, L0467, L0469, L0641, L0642, L0643, L0648, L0649, L0650, L0651, L1812, L1833, L1848, L3678, L3809, L3916, L3918, L3924, L3930, L4361, L4387, Q0507, Q0508, Q0509, T4544*<br>*Changed the descriptions for the following procedure codes: A5081, A9272, E0601, E2300, E2301, L0174, L0450, L0454, L0456, L0460, L0466, L0468, L0621, L0623, L0625, L0626, L0627, L0628, L0630, L0631, L0633, L0637, L0639, L0980, L0982, L0984, L1600, L1610, L1620, L1810, L1830, L1832, L1836, L1843, L1845, L1847, L1850, L1902, L1904, L1906, L1907, L3100, L3170, L3650, L3660, L3670, L3675, L3677, L3710, L3762, L3807, L3908, L3912, L3915, L3917, L3923, L3925, L3927, L3929, L4350, L4360, L4370, L4386, L4396, L4398, L5668, T4543* | *106-139*<br>*Throughout* | *cc* |
| *01/29/2014* | *Reformatted*<br>*Updated TOC*<br>*Updated Index* | *Throughout*<br>*i-iv*<br>*173-188* | *jg* |
| *04/01/2014* | *Minor description update to E0601 code* | *90* | *mm* |
| *05/14/2014* | *Updated Billing Manual for removal of the Primary Care Physician Program* | *Throughout* | *mm* |
| *06/05/2014* | *Updated language for codes:*<br>E0445<br>E0445-RR<br>E0445-KR<br>Included language regarding rental requirements | *83* | *mm* |
| *06/05/2014* | *Updated manual to revise references to 'member.' Member has been updated to 'member' (Except in the Paper Claim and PAR Reference tables* | *Throughout* | *Mm* |
| *7/18/14* | Replaced all CO 1500 references with CMS 1500 | *Throughout* | *ZS* |
| *7/18/14* | Replaced the paper claim reference table to reflect the CMS 1500 | | *ZS* |
| *08/08/2014* | Updated all web links to reflect the new website | *Throughout* | *Mm* |
| *8/08/2014* | Updated all references from Client to Member per new standards | *Throughout* | *mm* |

| Revision Date | Section | Pages/ Action | Made by |
|---|---|---|---|
| *12/22/2014* | Added existing unit limits for A4326, A4331-A4334, A4336, A4349, A4351, A4353, A4360, A4405-A4420, A4423-A4434, A6441-A6457; corrected typos. | *Throughout* | *tl* |
| *12/22/2014* | Added a CRT sections | *5-6,8-10,170-177* | *em* |
| *12/22/2014* | Updated page references | *Throughout* | *em* |
| *12/29/2014* | Added comment to codes L7260 and L7261 as "deleted codes" | *157* | *mc* |
| *12/29/2014* | *Added 2015 HCPCS: A4602, A7048, A9606, K0901, K0902, L3981, L6026, L7259, L8696.* | *28-29* | *mc* |
| *12/29/2014* | *Formatting and TOC updates* | *throughout* | *bl* |
| *3/3/2015* | *Noted that ventilators do not convert to purchase.*<br>*Added: PA 'none' to L7259, comment to code A4618 to include in rental, reimbursement cap to E1399-AV.*<br>*Inserted specialty eval grid to CRT code list.* | *2*<br>*38, 94, 178*<br>*179 - 188* | *Cs* |
| *3/4/15* | *Changed font to Tahoma, verified formatting and publications standards, and changed client/s and patient/s to member/s except for CMS 1500 section.* | *Throughout* | *Jh* |
| *3/6/15* | *Reverted member back to patient in the HCPCS code table in the description field as that is a CMS defined field.* | *Throughout HCPCS Code Table* | *JH* |

**Note:** In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above, are the page numbers on which the updates/changes occur.