North Carolina Medicaid Special Bulletin

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Attention:

Orthotic and Prosthetic Devices

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Introduction

Effective with date of service July 1, 2005, the N.C. Medicaid program will reimburse only Board-certified providers for orthotic and prosthetic devices. The orthotic and prosthetic fee schedule has been updated to accommodate the expansion of the service and now includes diabetic shoes, elastic support products, trusses, external breast prostheses, and ocular prostheses, as well as other new codes.

The fee schedule can be located on the Division of Medical Assistance (DMA) website at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

For information on provider certification requirements and lifetime expectancies and quantity limitations for orthotics and prosthetics, refer to the attachments to Clinical Coverage Policy #5B, Orthotics and Prosthetics on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

Clinical Coverage Policy for Orthotics and Prosthetics

1.0 Description of the Service

Orthotic and Prosthetic Devices

Orthotic and prosthetic devices are purchased for recipients when they are prescribed by the patient's treating physician, physician's assistant, or nurse practitioner and medical necessity is documented. An item is medically necessary if it is needed to maintain or improve a recipient's medical, physical or functional level. Orthotic and prosthetic devices purchased by Medicaid become the property of the Medicaid recipient.

Refer to the Orthotic and Prosthetic Devices Fee Schedule for a list of the equipment, supplies, and services covered by Medicaid. The fee schedules are available on the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/fee.htm.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions that would make them ineligible for services due to their eligibility category. Medicaid recipients under the age of 21 are eligible for orthotic and prosthetic devices, subject to the limitations listed in **Section 5.0, Requirements for and Limitation on Coverage and Attachment B, How a Recipient Obtains Orthotic and Prosthetic Devices, Step 3 (on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm)** . All services provided to a Medicaid for Pregnant Women (MPW) recipient (pink Medicaid identification card) must be pregnancy-related.

2.2 Special Provisions

For recipients under the age of 21, additional products, services or procedures may be requested even if they do not appear in the N.C. State Medicaid Plan or when coverage is limited for those over 21 years of age. Service limitations on scope, amount or frequency described in the coverage policy may not apply if the product, service or procedure is medically necessary.

3.0 When the Service is Covered

Orthotic and prosthetic devices are covered only when they are listed on the Orthotic and Prosthetic Devices Fee Schedule and the recipient meets the specific coverage requirements for the device. Refer to **Section 5.3, Documenting Medical Necessity.** In addition, the provider will only be reimbursed for orthotic and prosthetic devices when he is enrolled as an appropriate Board-certified provider for a specific device. See **Attachment F, Board Certification Requirements for Orthotic and Prosthetic Services** (on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm).

The fee schedules are available on the Division of Medical Assistance's website at http://www.dhhs.state.nc.us/dma/fee.htm.

Orthotic devices are covered if the recipient requires the item(s) for the correction or prevention of skeletal deformities, to support or align movable body parts, or to preserve or improve physical function. Prosthetic devices are covered as a replacement for all or part of the function of a permanently inoperative, absent, or malfunctioning body part. The recipient must require the prosthesis for mobility, daily care, and/or rehabilitation purposes. In addition, orthotic and prosthetic devices shall be:

1. Ordered by the treating physician, physician's assistant or nurse practitioner;
2. A reasonable and medically necessary part of the recipient's treatment plan;
3. Consistent with the recipient's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the recipient;
4. Furnished at a safe, efficacious, and cost-effective level; and
5. Of high quality for which replacement parts are available and obtainable.

Refer to **Section 5.3, Documenting Medical Necessity,** for specific coverage requirements.

4.0 When the Service is not Covered

Orthotic and prosthetic devices are not covered when the coverage policy requirements are not met.

Non-covered devices and supplies include, but are not limited to, all of the following:

1. Experimental or investigational devices;
2. Items for the recipient's comfort or convenience or for the convenience of the recipient's caregiver(s);
3. Devices and supplies for residents of nursing facilities;
4. Equipment or supplies covered by another agency; and
5. Equipment or supplies for patients receiving hospice care, as defined in **Section 7.2, Coordinating Care.**

Providers who have questions about whether a device is covered should call EDS Provider Services at 1-800-688-8888 or 919-851-8888. Recipients who have questions should call the Care Line at 1-800-662-7030.

5.0 Requirements for and Limitations on Coverage

5.1 Referral Authorizations for Carolina ACCESS Participants

A referral authorization must be obtained from the primary care physician before providing orthotic or prosthetic devices to a Carolina ACCESS participant. This referral authorization is required in addition to other requirements for the service, such as prior approval.

5.2 Prior Approval

Some orthotic and prosthetic devices require prior approval. Items that require prior approval are identified on the **Orthotic and Prosthetic Devices Fee Schedule** by an asterisk (*).

Prior approval is valid for the time period approved on the Certificate of Medical Necessity/Prior Approval (CMN/PA) form. If a physician, physician assistant or nurse practitioner decides that an item is needed for a different period of time, a new CMN/PA form must be submitted.

Refer to **Completing the Certificate of Medical Necessity/Prior Approval Form** on page 20 for general instructions on completing the CMN/PA form.

Refer to **Section 5.3, Documenting Medical Necessity**, for information on documenting medical necessity requirements for specific orthotic and prosthetic devices.

5.3 Documenting Medical Necessity

Medical necessity must be documented on the CMN/PA form regardless of any requirements for prior approval.

5.3.1 Therapeutic Shoes for Diabetics

A5500	**A5504**	**A5507**
A5501	**A5505**	**K0628**
A5503	**A5506**	**K0629**

Therapeutic shoes, inserts and/or modifications to therapeutic shoes are covered if the following criteria are met:

1. The patient has diabetes mellitus (ICD-9 diagnosis codes 250.00-250.93); and
2. The patient has one or more of the following conditions:
   a. Previous amputation of the other foot, or part of either foot, or
   b. History of previous foot ulceration of either foot, or
   c. History of pre-ulcerative calluses of either foot, or
   d. Peripheral neuropathy with evidence of callus formation of either foot, or
   e. Foot deformity of either foot, or
   f. Poor circulation in either foot; and
3. The certifying physician who is managing the patient's systemic diabetes condition has certified that indications (1) and (2) are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes.

Separate inserts may be covered and dispensed independently of diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed. This footwear must meet the definitions found in this policy for depth shoes or custom molded shoes. **See Section 5.3.8, Orthopedic Footwear.**

There is no separate payment for the fitting of the shoes, inserts or modifications or for the certification of need or prescription of the footwear.

5.3.2 Spinal Orthoses

K0630	**K0644**	**L0458**	**L0700**	**L0982**	**L1085**	**L1290**
K0631	**K0645**	**L0460**	**L0710**	**L0984**	**L1090**	**L1300**
K0632	**K0646**	**L0462**	**L0810**	**L0999**	**L1100**	**L1310**
K0633	**K0647**	**L0464**	**L0820**	**L1000**	**L1110**	**L1499**
K0634	**K0648**	**L0466**	**L0830**	**L1005**	**L1120**	**L1500**
K0635	**K0649**	**L0468**	**L0860**	**L1010**	**L1200**	**L1510**
K0636	**L0112**	**L0470**	**L0861**	**L1020**	**L1210**	**L1520**
K0637	**L0210**	**L0472**	**L0960**	**L1025**	**L1220**	**L4000**
K0638	**L0220**	**L0480**	**L0970**	**L1030**	**L1230**	
K0639	**L0430**	**L0482**	**L0972**	**L1040**	**L1240**	
K0640	**L0450**	**L0484**	**L0974**	**L1050**	**L1250**	
K0641	**L0452**	**L0486**	**L0976**	**L1060**	**L1260**	
K0642	**L0454**	**L0488**	**L0978**	**L1070**	**L1270**	
K0643	**L0456**	**L0490**	**L0980**	**L1080**	**L1280**	

A thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis is covered when it is ordered for one of the following indications:

1. To reduce pain by restricting mobility of the trunk; or
2. To facilitate healing following an injury to the spine or related soft tissues; or
3. To facilitate healing following a surgical procedure on the spine or related soft tissue; or
4. To otherwise support weak spinal muscles and/or a deformed spine.

5.3.3 Helmets

L0100 **L0110**

Helmets are provided when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living. These devices are not provided for use during sports-related activities.

5.3.4 Cervical Orthoses

L0100	**L0120**	**L0140**	**L0160**	**L0172**	**L0180**	**L0200**
L0110	**L0130**	**L0150**	**L0170**	**L0174**	**L0190**	

A cervical orthosis is covered when it is ordered for one of the following indications:

1. To reduce pain by restricting mobility of the neck; or
2. To facilitate healing following an injury to the cervical spine or related soft tissues; or
3. To facilitate healing following a surgical procedure on the cervical spine or related soft tissue; or
4. To otherwise support weak cervical muscles and/or a deformed cervical spine.

5.3.5 Hip Orthoses

L1600	**L1630**	**L1652**	**L1685**	**L1700**	**L1730**
L1610	**L1640**	**L1660**	**L1686**	**L1710**	**L1750**
L1620	**L1650**	**L1680**	**L1690**	**L1720**	**L1755**

A hip orthosis is covered when it is ordered for one of the following indications:

1. To reduce pain by restricting mobility of the hip; or
2. To facilitate healing following an injury to the hip or related soft tissues; or
3. To facilitate healing following a surgical procedure on the hip or related soft tissue; or
4. To otherwise support weak hip muscles and/or a hip deformity.

5.3.6 Knee Orthoses

L1800	**L1825**	**L1834**	**L1844**	**L1850**	**L1870**
L1810	**L1830**	**L1836**	**L1845**	**L1855**	**L1880**
L1815	**L1831**	**L1840**	**L1846**	**L1858**	
L1820	**L1832**	**L1843**	**L1847**	**L1860**	

A knee orthosis is covered when it is ordered for one of the following indications:

1. To reduce pain by restricting mobility of the knee; or
2. To facilitate healing following an injury to the knee or related soft tissues; or
3. To facilitate healing following a surgical procedure on the knee or related soft tissue; or
4. To otherwise support weak knee muscles and/or a knee deformity.

These devices are not provided solely for use during sports-related activities.

5.3.7 Ankle-Foot/Knee-Ankle-Foot Orthoses

L1900	**L2005**	**L2126**	**L2265**	**L2415**	**L2628**	**L2850**	**L1990**
L1901	**L2010**	**L2128**	**L2270**	**L2425**	**L2630**	**L2860**	**L2000**
L1902	**L2020**	**L2132**	**L2275**	**L2430**	**L2640**	**L2999**	**L2114**
L1904	**L2030**	**L2134**	**L2280**	**L2492**	**L2650**	**L4010**	**L2116**
L1906	**L2035**	**L2136**	**L2300**	**L2500**	**L2660**	**L4020**	**L2250**
L1907	**L2036**	**L2180**	**L2310**	**L2510**	**L2670**	**L4030**	**L2260**
L1910	**L2037**	**L2182**	**L2320**	**L2520**	**L2680**	**L4040**	**L2397**
L1920	**L2038**	**L2184**	**L2330**	**L2525**	**L2750**	**L4045**	**L2405**
L1930	**L2039**	**L2186**	**L2335**	**L2526**	**L2755**	**L4050**	**L2624**
L1932	**L2040**	**L2188**	**L2340**	**L2530**	**L2760**	**L4055**	**L2627**
L1940	**L2050**	**L2190**	**L2350**	**L2540**	**L2768**	**L4060**	**L2830**
L1945	**L2060**	**L2192**	**L2360**	**L2550**	**L2770**	**L4070**	**L2840**
L1950	**L2070**	**L2200**	**L2370**	**L2570**	**L2780**	**L4080**	
L1951	**L2080**	**L2210**	**L2375**	**L2580**	**L2785**	**L4090**	
L1960	**L2090**	**L2220**	**L2380**	**L2600**	**L2795**	**L4100**	
L1970	**L2106**	**L2230**	**L2385**	**L2610**	**L2800**	**L4130**	
L1971	**L2108**	**L2232**	**L2390**	**L2620**	**L2810**		
L1980	**L2112**	**L2240**	**L2395**	**L2622**	**L2820**		

AFOs Not Used During Ambulation

A static AFO (L4396) is covered if either all of criteria 1-4 or criterion 5 is met:

1. Plantar flexion contracture of the ankle (ICD-9 diagnosis code 718.47) with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a non-fixed contracture); and
2. Reasonable expectation of the ability to correct the contracture; and

3. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and
4. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons.
5. The patient has plantar fasciitis (ICD-9 diagnosis code 728.71).

If a static AFO is used for the treatment of a plantar flexion contracture, the pre-treatment passive range of motion must be measured with a goniometer and documented in the medical record. There must be documentation of an appropriate stretching program carried out by professional staff or caregiver. A static AFO and replacement interface will be denied as not medically necessary if the contracture is fixed. A static AFO and replacement interface will be denied as not medically necessary for a patient with a foot drop but without an ankle flexion contracture. A component of a static AFO that is used to address positioning of the knee or hip will be denied as not medically necessary because the effectiveness of this type of component is not established.

If code L4396 is covered, a replacement interface (L4392) is covered as long as the patient continues to meet indications and other coverage rules for the splint. Coverage of a replacement interface is limited to a maximum of one (1) per 6 months. Additional interfaces will be denied as not medically necessary.

A foot drop splint/recumbent positioning device and replacement interface will be denied as not medically necessary in a patient with foot drop who is non-ambulatory because there are other more appropriate treatment modalities.

AFOs and KAFOs Used During Ambulation:
Ankle-foot orthoses (AFO) described by codes L1900-L1990, L2106-L2116, L4350, L4360, and L4386 are covered for ambulatory patients with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.

Knee-ankle-foot orthoses (KAFO) described by codes L2000-L2039, L2126-L2136, and L4370 are covered for ambulatory patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required.

If the basic coverage criteria for an AFO or KAFO are not met, the orthosis will be denied as not medically necessary. AFOs and KAFOs that are molded-to-patient-model, or custom-fabricated, are covered for ambulatory patients when the basic coverage criteria listed above and one of the following criteria are met:
1. The patient could not be fit with a prefabricated AFO, or
2. The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months), or
3. There is a need to control the knee, ankle or foot in more than one plane, or
4. The patient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury, or
5. The patient has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

L coded additions to AFOs and KAFOs (L2180-L2550, L2750-L2830) will be denied as not medically necessary if either the base orthosis is not medically necessary or the specific addition is not medically necessary.

5.3.8 Orthopedic Footwear

L3000	**L3100**	**L3211**	**L3251**	**L3334**	**L3455**	**L3570**
L3001	**L3140**	**L3212**	**L3252**	**L3340**	**L3460**	**L3580**
L3002	**L3150**	**L3213**	**L3253**	**L3350**	**L3465**	**L3590**
L3003	**L3160**	**L3214**	**L3254**	**L3360**	**L3470**	**L3595**
L3010	**L3170**	**L3215**	**L3255**	**L3370**	**L3480**	**L3600**
L3020	**L3201**	**L3216**	**L3257**	**L3380**	**L3485**	**L3610**
L3030	**L3202**	**L3217**	**L3260**	**L3390**	**L3500**	**L3620**
L3040	**L3203**	**L3219**	**L3265**	**L3400**	**L3510**	**L3630**
L3050	**L3204**	**L3221**	**L3300**	**L3410**	**L3520**	**L3640**
L3060	**L3206**	**L3222**	**L3310**	**L3420**	**L3530**	**L3649**
L3070	**L3207**	**L3224**	**L3320**	**L3430**	**L3540**	
L3080	**L3208**	**L3225**	**L3330**	**L3440**	**L3550**	
L3090	**L3209**	**L3250**	**L3332**	**L3450**	**L3560**	

Shoes which are incorporated into a brace must be billed by the same supplier billing for the brace.

Prosthetic shoes (L3250) are covered if they are an integral part of a prosthesis for patients with a partial foot amputation (ICD-9 diagnosis codes 755.31, 755.38, 755.39, 895.0-896.3). Claims for prosthetic shoes for other ICD-9 diagnosis codes will be denied as not medically necessary.

Shoes are denied as noncovered when they are put on over a partial foot prosthesis or other lower extremity prosthesis (L5010-L5600) which is attached to the residual limb by other mechanisms.

Orthopedic footwear will be covered for recipients ages birth through 20 years when deemed medically necessary by the prescribing physician regardless of the provision of a brace.

5.3.9 Upper Limb Orthoses

L3650	**L3740**	**L3840**	**L3908**	**L3924**	**L3948**	**L3969**
L3651	**L3760**	**L3845**	**L3909**	**L3926**	**L3950**	**L3970**
L3652	**L3762**	**L3850**	**L3910**	**L3928**	**L3952**	**L3972**
L3660	**L3800**	**L3855**	**L3911**	**L3930**	**L3954**	**L3974**
L3670	**L3805**	**L3860**	**L3912**	**L3932**	**L3956**	**L3980**
L3675	**L3507**	**L3890**	**L3914**	**L3934**	**L3960**	**L3982**
L3677	**L3810**	**L3900**	**L3916**	**L3936**	**L3962**	**L3984**
L3700	**L3815**	**L3901**	**L3917**	**L3938**	**L3963**	**L3985**
L3701	**L3820**	**L3902**	**L3918**	**L3940**	**L3964**	**L3986**
L3710	**L3825**	**L3904**	**L3820**	**L3942**	**L3965**	**L3995**
L3720	**L3830**	**L3906**	**L3922**	**L3944**	**L3966**	**L3999**
L3730	**L3835**	**L3907**	**L3923**	**L3946**	**L3968**	

An upper limb orthosis is covered when it is ordered for one of the following indications:

1. To reduce pain by restricting mobility of the joint(s); or
2. To facilitate healing following an injury to the joint(s) or related soft tissues; or
3. To facilitate healing following a surgical procedure on the joint(s) or related soft tissue; or

4. To otherwise support weak skeletal muscles and/or musculo-skeletal deformities.

5.3.10 Lower Limb Prostheses

L5000	**L5460**	**L5628**	**L5658**	**L5697**	**L5810**	**L5970**
L5010	**L5500**	**L5629**	**L5661**	**L5698**	**L5811**	**L5972**
L5020	**L5505**	**L5630**	**L5665**	**L5699**	**L5812**	**L5974**
L5050	**L5510**	**L5631**	**L5666**	**L5700**	**L5814**	**L5975**
L5060	**L5520**	**L5632**	**L5668**	**L5701**	**L5816**	**L5976**
L5100	**L5530**	**L5634**	**L5670**	**L5702**	**L5818**	**L5978**
L5105	**L5535**	**L5636**	**L5671**	**L5704**	**L5822**	**L5979**
L5150	**L5540**	**L5637**	**L5672**	**L5705**	**L5824**	**L5980**
L5160	**L5560**	**L5638**	**L5673**	**L5706**	**L5826**	**L5981**
L5200	**L5570**	**L5639**	**L5676**	**L5707**	**L5828**	**L5982**
L5210	**L5580**	**L5640**	**L5677**	**L5610**	**L5830**	**L5984**
L5220	**L5585**	**L5642**	**L5678**	**L5611**	**L5840**	**L5985**
L5230	**L5590**	**L5643**	**L5679**	**L5612**	**L5845**	**L5986**
L5250	**L5595**	**L5644**	**L5680**	**L5614**	**L5848**	**L5987**
L5270	**L5600**	**L5645**	**L5681**	**L5616**	**L5850**	**L5988**
L5280	**L5610**	**L5646**	**L5682**	**L5618**	**L5855**	**L5990**
L5301	**L5611**	**L5647**	**L5683**	**L5622**	**L5910**	**L5995**
L5311	**L5613**	**L5648**	**L5684**	**L5624**	**L5920**	**L5999**
L5321	**L5614**	**L5649**	**L5685**	**L5626**	**L5925**	
L5331	**L5616**	**L5650**	**L5686**	**L5628**	**L5930**	
L5341	**L5617**	**L5651**	**L5688**	**L5780**	**L5940**	
L5400	**L5618**	**L5652**	**L5690**	**L5781**	**L5950**	
L5410	**L5620**	**L5653**	**L5692**	**L5782**	**L5960**	
L5420	**L5622**	**L5654**	**L5694**	**L5785**	**L5968**	
L5430	**L5624**	**L5655**	**L5695**	**L5799**	**L5962**	
L5450	**L5626**	**L5656**	**L5696**	**L5795**	**L5966**	

A lower limb prosthesis is covered when the patient:

1. Will reach or maintain a defined functional state within a reasonable period of time; **and**
2. Is motivated to ambulate.

A determination of the medical necessity for certain components/additions to the prosthesis is based on the patient's potential functional abilities.
Potential functional ability is based on the reasonable expectations of the prosthetist and treating physician, considering factors including, but not limited to:

1. The patient's past history (including prior prosthetic use if applicable); and
2. The patient's current condition including the status of the residual limb and the nature of other medical problems; and
3. The patient's desire to ambulate.

Clinical assessments of patient rehabilitation potential must be based on the following classification levels:

Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

Level 1: Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.

Level 2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.

Level 3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete. The records must document the patient's current functional capabilities and his/her expected functional potential, including an explanation for the difference, if that is the case.

Accessories (e.g., stump stockings for the residual limb, harness, including replacements) are also covered when these appliances aid in or are essential to the effective use of the artificial limb.

The following items are included in the reimbursement for a prosthesis and, therefore, are not separately billable to Medicaid as they are included in the established reimbursement rate for the devices:

1. Evaluation of the residual limb and gait.
2. Fitting of the prosthesis.
3. Cost of base component parts and labor contained in HCPCS base codes.
4. Repairs due to normal wear or tear within 90 days of delivery
5. Adjustments of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments are not necessitated by changes in the residual limb or the patient's functional abilities.

5.3.11 Upper Limb Prostheses

L6000	**L6380**	**L6610**	**L6647**	**L6692**	**L6755**	**L6845**
L6010	**L6382**	**L6615**	**L6650**	**L6693**	**L6765**	**L6850**
L6020	**L6384**	**L6616**	**L6655**	**L6694**	**L6770**	**L6855**
L6050	**L6386**	**L6620**	**L6660**	**L6695**	**L6775**	**L6860**
L6055	**L6388**	**L6623**	**L6665**	**L6696**	**L6780**	**L6865**
L6100	**L6400**	**L6625**	**L6670**	**L6697**	**L6790**	**L6867**
L6110	**L6450**	**L6628**	**L6672**	**L6698**	**L6795**	**L6868**
L6120	**L6500**	**L6629**	**L6675**	**L6700**	**L6800**	**L6870**
L6130	**L6550**	**L6630**	**L6676**	**L6705**	**L6805**	**L6872**
L6200	**L6570**	**L6632**	**L6680**	**L6710**	**L6806**	**L6873**
L6205	**L6580**	**L6635**	**L6682**	**L6715**	**L6807**	**L6875**
L6250	**L6582**	**L6637**	**L6684**	**L6720**	**L6808**	**L6880**
L6300	**L6584**	**L6638**	**L6686**	**L6725**	**L6809**	**L6890**
L6310	**L6586**	**L6640**	**L6687**	**L6730**	**L6810**	**L6900**
L6320	**L6588**	**L6641**	**L6688**	**L6735**	**L6825**	**L6905**
L6350	**L6590**	**L6642**	**L6689**	**L6740**	**L6830**	**L6910**
L6360	**L6600**	**L6645**	**L6690**	**L6745**	**L6835**	**L6915**

L6370 L6605 L6646 L6691 L6750 L6840 L7499

An upper limb prosthetic device is covered when it replaces all or part of the function of a permanently inoperative, absent, or malfunctioning part of the upper limb. The recipient must require the prosthesis for activities of daily living and/or rehabilitation purposes. His treating physician, physician assistant or nurse practitioner must document that he is motivated to utilize the device prescribed. The physician, physician assistant, or nurse practitioner must sign a written rehabilitation plan incorporating goals he expects the recipient to achieve.

Accessories (e.g., stump stockings for the residual limb, harness, including replacements) are also covered when these appliances aid in or are essential to the effective use of the artificial limb.

The following items are included in the reimbursement for a prosthesis and, therefore, are not separately billable to Medicaid as they are included in the established reimbursement rate for the device:

1. Evaluation of the residual limb and activities of daily living.
2. Fitting of the prosthesis.
3. Cost of base component parts and labor contained in the HCPCS base code.
4. Repairs due to normal wear or tear within 90 days of delivery.
5. Adjustments of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments are not necessitated by changes in the residual limb or the patient's functional abilities.

5.3.12 Elastic Supports

L8100	**L8130**	**L8160**	**L8190**	**L8210**	**L8239**
L8110	**L8140**	**L8170**	**L8195**	**L8220**	
L8120	**L8150**	**L8180**	**L8200**	**L8230**	

Elastic supports are covered when they are ordered for one of the following indications:

1. Severe or incapacitating vascular problems, such as
   a. acute thrombophlebitis, or
   b. massive venous stasis, or
   c. pulmonary embolism.
2. Venous insufficiency.
3. Varicose veins.
4. Edema of lower extremities.
5. Edema of pregnancy.
6. Lymphedema.

5.3.13 Trusses

L8300 L8310 L8320 L8330

Trusses are covered when a hernia is reducible with the application of a truss.

5.3.14 Orthotic and Prosthetic-Related Supplies

L8400	**L8417**	**L8435**	**L8465**	**L8485**
L8410	**L8420**	**L8440**	**L8470**	**L8499**
L8415	**L8430**	**L8460**	**L8480**	

Orthotic and prosthetic-related supplies are covered when the device with which it is used is covered and they are necessary for the function of the orthotic or prosthetic device.

5.3.15 External Breast Prostheses

A4280	**L8001**	**L8010**	**L8020**
L8000	**L8002**	**L8015**	**L8030**

A breast prosthesis is covered for a patient who has had a mastectomy, ICD-9-CM diagnosis codes V45.71, 174.0-174.9 or 233.0.

An external breast prosthesis garment, with mastectomy form (L8015) is covered for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis.

5.3.16 Ocular Prosthesis

V2623 **V2624** **V2625** **V2626** **V2627** **V2628**

An eye prosthesis is covered for a patient with absence or shrinkage of an eye due to birth defect, trauma or surgical removal.

Polishing and resurfacing (V2624) is covered on a twice per year basis.

Replacement is covered every five (5) years with exceptions allowed when documentation supports medical necessity for more frequent replacement.

One enlargement (V2625) or reduction (V2626) of the prosthesis is covered.

Scleral cover shell (V2627) is covered if it is ordered by the physician, physician assistant or nurse practitioner as an artificial support to a shrunken and sightless eye or as a barrier in the treatment of severe dry eye.

5.4 Amount of Service

The amount of service is limited to that which is medically necessary as determined by Medicaid policies. See **Attachment D: Lifetime Expectancies and Quantity Limitations for Orthotic and Prosthetic Devices** for specific limitations (on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm**).**

5.5 Orthotic and Prosthetic Limitations

Medicaid may place appropriate limits, based on medical necessity criteria, on orthotic and prosthetic items and supplies. When the prescribing physician, physician's assistant or nurse practitioner orders equipment or supplies beyond these limits, the provider must seek authorization for payment for these items from DMA. The orthotic and prosthetic provider must send a written request to DMA, along with a letter of medical necessity from the prescribing physician, physician's assistant or nurse practitioner. Consideration will be given to the request and a written decision will be returned to the provider. Recipients will be notified in writing if the request is denied.

Refer to **Attachment D: Lifetime Expectancies and Quantity Limitations for Orthotic and Prosthetic Devices** for a listing of the established lifetime expectancies

and quantity limitations for orthotic and prosthetic supplies (on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm).

5.6 Delivery of Service

Providers must dispense orthotic and prosthetic items as quickly as possible due to the medical necessity identified for an item. However, providers who deliver an item requiring prior approval before approval has been received, do so at their own risk.

Refer to **How a Recipient Obtains Orthotic and Prosthetic Devices and Supplies** (on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm) for an outline of the basic steps to follow for a recipient to obtain orthotic and prosthetic devices.

5.7 Servicing and Repairing Orthotic and Prosthetic Devices

L4205 L4210 L7510 L7520

Providers are responsible for replacement or repair of equipment or any part thereof that is found to be non-functional because of faulty material or workmanship within the guarantee of the manufacturer without charge to the recipient or to Medicaid.

Service and repairs must be handled under any warranty coverage an item may have.

If there is no warranty, providers may request prior approval to perform the needed service and repairs by sending a completed CMN/PA form with a repair estimate to the address listed on the form. The estimate must show a breakdown of charges for parts, the number of hours of labor and the hourly labor rate. No charge is allowed for pick-up or delivery of the item or for the assembly of Medicaid-reimbursed parts. The following information must be entered in block 24 of the CMN/PA form:

1. The description and HCPCS code of the item being serviced or repaired;
2. The age of the item;
3. The number of times it has been previously repaired; and
4. The current replacement cost.

If emergency repairs are needed to ensure the continued mobility or support of the recipient, providers may request approval by calling 1-800-688-6696 or 1-919-851-8888 between 8:00 a.m. and 4:30 p.m., Monday through Friday, except holidays. Providers must be prepared to provide the information required on the CMN/PA form for service or repair of a purchased item. The completed CMN/PA form must be received within 10 workdays of the phone approval or the prior approval will be voided.

Refer to **Completing the Certificate of Medical Necessity/Prior Approval Form** on page 18 for instructions on completing the CMN/PA form.

Note: Medicaid does not cover maintenance or service contracts.

5.8 Replacing Orthotic and Prosthetic Devices

When repairing an item that is no longer cost-effective and the item is out of warranty, Medicaid will consider replacing the item. The anticipated life expectancies for some of the major categories of orthotic and prosthetic devices are listed below:

1. Helmets are expected to last at least 6 months.
2. Most orthotic devices are expected to last at least 6 months for children (ages birth through 20 years).

3. Certain orthotic devices that include fabrics and/or elastic materials are expected to last shorter periods of time.
4. Scoliosis orthotic devices are expected to last at least 6 months.
5. Most upper limb and lower limb prosthetics are expected to last at least one year for children (ages birth through 20 years).
6. Certain prosthetic devices that include fabric and/or soft materials are expected to last shorter periods of time.
7. Diabetic shoes and orthopedic footwear are expected to last at least 6 months for children (ages birth through 20 years).

Providers must refer to **Attachment D: Lifetime Expectancies and Quantity Limitations for Orthotic and Prosthetic Devices** for specific information for individual devices and supplies (on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm).

Note: When requesting prior approval for the replacement of an item before its usual life expectancy has ended, explain on the CMN/PA form why the replacement is needed.

Specific documentation, in addition to the prescription and CMN/PA form, is required in the following situations:

1. In cases of equipment loss or damage beyond repair, a letter from the social worker, case manager, child service coordinator, treating physical or occupational therapist explaining the circumstances.
2. In cases of theft, a copy of the police report or a letter from the appropriate person with knowledge of the occurrence, such as the school principal, social worker, etc.
3. In cases of equipment destruction by fire, a copy of the fire report.

Refer to **Completing the Certificate of Medical Necessity/Prior Approval Form** on page 18 for instructions on completing the CMN/PA form.

6.0 Providers Eligible to Bill for the Service

6.1 Provider Qualifications

Providers must be enrolled with DMA and meet all of the following conditions to qualify for participation with Medicaid as an Orthotics and Prosthetics supplier:

1. Providers must be Board certified by one of the following entities:
   a. American Board for Certification in Orthotics and Prosthetics
   b. Board for Orthotist/Prosthetist Certification
   c. Board for Certification in Pedorthics
   d. National Examining Board of Ocularists, Inc., and
2. Providers cannot accept prescriptions for Medicaid-covered equipment from any physician, physician assistant or nurse practitioner or practitioner who has an ownership interest in their agency, and
3. Providers must be enrolled and participate in Medicare as a Orthotics and Prosthetics supplier, and
4. The providing agency must be located within the boundaries of North Carolina or in an adjoining state from which North Carolina recipients living on the border can use the agency as a general practice, and
5. Providers must have a North Carolina Board of Pharmacy permit, and
6. Providers must be either:

a. A business entity authorized to conduct business in the state or in the locality where the business site is located. Proof of authorization shall include a certificate of assumed name, certificate of authority, certificate of good standing, license, permit or privilege license; or

b. A Medicaid-enrolled home health agency, a state agency, a local health department, a local lead agency for the Community Alternatives Program for Disabled Adults, a local lead agency for the Community Alternatives Program for the Mentally Retarded/Developmentally Disabled or an agency that provides case management for the Community Alternatives Program for Children.

Note: Providers must be enrolled to provide the specific device/HCPCS code they provide in order to be reimbursed for the device. See **Attachment F: Board Certification Requirements for Orthotic and Prosthetic Services** (on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm).

Note: Providers must be enrolled and meet the provider qualifications on the date that service is provided.

6.2 Federal Laws

Providers must comply with the following requirements in addition to the laws specifically pertaining to Medicaid:

1. **Title VI of the Civil Rights Act of 1964** which states that "no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation under any program or activity receiving federal financial assistance."
2. **Section 504 of the Rehabilitation Act of 1973**, as amended, which states that "no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."
3. The **Americans with Disabilities Act of 1990** which prohibits exclusion from participation in or denial of services because the agency's facilities are not accessible to individuals with a disability.

6.3 Seeking Other Sources of Payment

Providers must take all reasonable measures to determine the legal liabilities of third parties, including Medicare and private insurance, to pay for services. If third party liability is established, providers must bill the third party before billing Medicaid. Refer to the **Basic Medicaid Billing Guide** on DMA's website at http://www.dhhs.state.nc.us/dma/medbillcaguide.htm for additional information.

6.4 Accepting Payment

Providers must accept Medicaid payment according to the rules and regulations for reimbursement promulgated by the Secretary of the Department of Health and Human Services and the State of North Carolina, and established under the N.C. Medicaid program. This includes accepting Medicaid payment as payment in full.

6.5 Billing the Recipient

When a non-covered service is requested by a recipient, the provider must inform the recipient either orally or in writing that the requested service is not covered under the Medicaid program and will, therefore, be the financial responsibility of the recipient. This must be done prior to providing the service.

A provider may refuse to accept a Medicaid recipient and bill the recipient as private pay **only** if the provider informs the recipient, either orally or in writing, that the service will not be billed to Medicaid and that the recipient will be responsible for payment.

6.6 Verifying Recipient Eligibility

Providers are responsible for verifying Medicaid eligibility when a recipient presents for services.

6.7 Disclosing Ownership Information

Providers must disclose ownership and control information, and information about the provider agency's owners or employees that have been convicted of criminal offenses against Medicare, Medicaid, and the Title XX services program.

7.0 Additional Requirements

7.1 Record Keeping

Records and documentation relating to the delivery of a Medicaid-reimbursed service must be kept for five years from the date of service. The provider must furnish any information that the U.S. Department of Health and Human Services and its agents, DMA and its agents or the State Medicaid Fraud Control Unit requests regarding payments received for providing Medicaid services.

Providers must keep the following documentation of their services:

1. The prescription for the item signed by the physician, physician assistant or nurse practitioner specifying the order as much as possible (e.g., number being ordered, frequency to be used, duration of prescription, etc.).
2. The original CMN/PA form for orthotic and prosthetic devices.
3. A full description of all item(s) supplied to a recipient.
4. The dates the items were supplied – the delivery date for purchased items or the delivery and pickup dates for rental items, including signed pick-up and delivery slips.
5. A full description of any service or repairs, including details of parts and labor, applicable warranty information, and the date of the service or repair. If the item is removed from the recipient's home for service or repair, record the date of removal and the date of return.

Note: All recipient information, including the recipient's Medicaid status, must be kept confidential. Provide this information only to those who are authorized to receive it.

7.2 Coordinating Care

Coordinate services to ensure appropriate recipient care while avoiding duplication or overlap.

7.2.1 Community Alternatives Programs (CAP/AIDS, CAP/C, CAP/DA and CAPMR/DD)

Providers must notify the CAP case manager of all items they anticipate providing to a recipient who participates in a CAP program. The CAP case manager must be aware of all services being provided to a recipient to coordinate care and keep the cost of care within the CAP limit. CAP participants have a two-letter CAP indicator in the CAP block of the Medicaid identification card.

7.2.2 Home Health Services

Because home health agencies may also provide supplies, the provider must coordinate the provision of orthotic and prosthetic devices and related supplies with any home health agencies serving the recipient to ensure that supply items being provided by the home health agency are not being duplicated.

If orthotic or prosthetic devices are being provided to a home health recipient, the home health agency staff may be involved in helping the recipient to learn how to use the equipment and may be monitoring its use. Be sure that the recipient and/or caregiver understands:

1. how to care for the orthotic and prosthetic devices and related supplies
2. the responsibilities of the recipient/caregiver and the providing agency

Note: The provider must give the recipient/caregiver written instructions that include provisions for emergency situations and a phone number for contacting their agency 24 hours per day.

7.2.3 Hospice

If an orthotic or prosthetic provider is requested to provide a device for a Hospice recipient, determine if the device is related to the terminal illness. Providers may not bill Medicaid for orthotic or prosthetic devices or supplies related to the terminal illness.

Refer to **Section 8.0, Billing Guidelines**, for payment restrictions related to Hospice care.

Refer to **How a Recipient Obtains Orthotic and Prosthetic Devices**, on page 20 for step-by-step instructions on how a recipient receives orthotic and prosthetic devices.

8.0 Billing Guidelines

8.1 Payment Rates

Providers must bill their usual and customary charges. Payment is calculated based on the lower of the provider's billed charge or the maximum amount allowed by Medicaid.

Payment for all items includes delivery to the recipient's home as well as any required fitting or assembly.

Note: Medicaid does not pay separately for travel time, shipping costs, delivery, fitting or assembly of orthotic and prosthetic devices. Medicaid's fees include these services.

8.2 Diagnosis Codes That Support Medical Necessity:

Providers must bill the ICD-9-CM diagnosis code(s) to the highest level of specificity that supports medical necessity.

8.3 Payment Restrictions

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs.

Medicaid payment is restricted in relation to the following services:

Hospice: A recipient receiving Hospice services through Medicaid or Medicare cannot receive orthotic and prosthetic coverage for items related to the

treatment of the terminal illness. A recipient who meets the requirements of both services may choose which service to receive.

Refer to **Section 7.2, Coordinating Care**, for additional information.

Note: Participation in a Medicaid Managed Care program or CAP may also affect coverage.

8.4 Dually Eligible Recipients

Effective with **date of service September 6, 2004**, claims filed to **Medicare will be crossed over automatically** to Medicaid for payment if a Medicare Crossover Request form is on file with Medicaid for that provider and Medicare and Medicaid have matching data for the recipient. It is the provider's responsibility to check the Medicaid Remittance and Status Report to verify that the claim was crossed over from Medicare. Providers may verify that their Medicare provider number is cross-referenced to their Medicaid provider number by contacting EDS Provider Services at 1-800-688-6696 or 919-851-8888. If your Medicare provider number is not cross-referenced to your Medicaid provider number, you must complete and submit the Medicare Crossover Request form (available from DMA's website at http://www.dhhs.state.nc.us/dma/forms.html) and submit it by fax or mail to the fax number or address listed on the form. Claims will pay to the Medicaid provider number indicated on the claim filed to Medicare. If no Medicaid provider number is on the claim filed to Medicare, claims will pay to the Medicaid provider number indicated on the Medicare Crossover Request form.

Note: If you have more than one Medicaid provider number, you should indicate on the Medicare claim the Medicaid provider number for which you want to receive payment. Refer to Medicaid Special Bulletin, "Medicare Part B Effective September 6, 2004", August 2004 for details regarding crossover claims for recipient with both Medicaid and Medicare eligibility.

8.5 Units of Service

Medicaid pays for services in specific units that measure the amount of service provided to the recipient.

For orthotics and prosthetics, the units of service are:

1. **Purchased Equipment:** The unit of service is **1** for each item provided.

2. **Service and Repair:** The unit of service is **1** for each approved service or repair unit, in 15 minute increments.

8.6 Filing Claims

Orthotic and prosthetic providers file claims using the CMS-1500 claim form.

Refer to **Completing a Claim for Orthotic and Prosthetic Services** on page 23 for additional information.

8.7 Procedure Codes

Refer to the **Orthotic and Prosthetic Devices Fee Schedule** for a list of orthotic and prosthetic devices and related supplies covered by Medicaid. The fee schedules are available on DMA's website at http://www.dhhs.state.nc.us/dma/fee/fee.htm.

Completing the Certificate of Medical Necessity/Prior Approval Form

The Certificate of Medical Necessity/Prior Approval (CMN/PA) form is completed according to the following instructions. All blocks **must** be completed unless they are listed as optional. An example of a completed form follows the instructions.

1.	**Patient's Last Name, First, Middle**	Enter the patient's last name, first name, and middle name as it appears on the patient's Medicaid ID card.
2.	**Birth Date (MM/DD/YYYY)**	Enter the month, day, and year of the patient's date of birth.
3.	**Sex**	Enter an F or M to indicate the patient's sex.
4.	**Medicare Number**	Enter the patient's Medicare number – nine digits and a letter. Enter **N/A** if the patient is not on Medicare.
5.	**Medicaid Number**	Enter the patient's Medicaid number – nine digits and a letter.
6.	**Patient's Address and Telephone Number**	(Optional entry) Enter the patient's street address, city, state and zip code – and phone number with the area code.
7.	**Provider Number/Attending Number**	Enter the supplier's Medicaid provider number – this is a seven-digit number. For orthotic and prosthetic devices the Board Certified attending number must also be provided.
8.	**Provider Name, Address and Telephone Number**	Enter the supplier's name, street address, city, state and zip code – and phone number with the area code.
9.	**Prescribing Physician Name, Address and Telephone Number**	Enter the prescribing physician's name, street address, city, state and zip code – and phone number with the area code.
10.	**Provider Number**	(Optional entry) Enter the physician's Medicaid provider number – this is a seven-digit number.
11.	**ICD-9-CM, Principal Diagnosis, and Date**	Enter the description of the principal diagnosis and the date of onset. Entering the ICD-9-CM code is optional unless coverage of the device is restricted to specific codes. (The code is needed on the claim; therefore, it is helpful to obtain it from the physician when completing the CMN/PA.)
12.	**ICD-9-CM, Other Pertinent Diagnoses and Date**	Enter the description of the secondary or pertinent diagnosis(es), and the date(s) of onset. Entering the ICD-9-CM code(s) is optional.
13.	**CPT-4, Surgical Procedure**	If a surgical procedure is related to the need for DME, enter the name of the procedure and the date it was performed. Entering the CPT-4 code is optional.
14 - 23:		For the items 14 through 23, check the applicable blocks to justify the need for the requested item(s). Write additional information as needed for justification. Enter **N/A** if not applicable to the patient and the item being provided. The patient's height and weight is required.
24.	**Patient's status will be monitored by physician while equipment is provided**	Check this block if the item requires the physician to provide instructions to the recipient and monitor the patient's status during the period that the equipment is being used. This block must be checked for percussors, (E0480), glucose monitors (E0607), apnea monitors (E0608), external insulin pumps (E0784), ultra violet lights (W4006), isolettes (W4007), photo therapy units (E0202) and passive motion exercise device (E0935).

25.	**Provide objective information to substantiate medical necessity of equipment**	Provide additional information to justify the need for the item(s) or special features. See Appendix F for requirements for selected items, including apnea monitors, bi-level therapy, CPAP, external insulin pumps, oxygen and oxygen equipment, portable pulse oximeters, preasure reducing support surfaces, TENS units, therapeutic ventilators and wheelchairs.
26.		Enter information for each item requested **EXT:** Check if requesting an extension of a previous prior approval. **PRIOR APPROVAL NO.:** Leave blank. **FROM DATE** and **TO DATE:** **Customized Equipment, Prosthetics and Orthotics:** Enter the date of the physician's prescription in the FROM block. Enter a date six months after the FROM date in the TO block. **Other Purchased Equipment and DME-Related Supplies:** Enter the date the item is expected to be delivered to the patient in the from FROM box. Enter a date six months after the FROM date in the TO box. **Rental Equipment:** Enter the anticipated beginning of the rental period in the FROM block. Enter the expected and of the rental period in the TO block. **Service and Repairs:** Enter the expected date that the item is to be serviced or repaired in the FROM block. Enter a date three months after the FROM date in the TO block. **EDS Use Only:** Leave blank. **R – N - U:** Check **R** for rental, Check **N** for a new purchase or **U** for a used purchase. **HCPCS CODE:** Enter the HCPCS code for the item. Enter RT for right side or LT for left side for appropriate orthotic and prosthetic codes. **EQUIPMENT DESCRIPTION** Enter the description that corresponds to the HCPCS code for each item requested. *REMEMBER: Rentals are billed as type of service E on the claim form.*
27.	**Provider Signature/Board Certified Practitioner Signature** and **Date**	An authorized representative of the supplier signs and dates the form to show acceptance of the order and agreement to provide the requested items. A signature stamp is acceptable – stamp all three pages. For items on the Orthotic and Prosthetic Fee Schedule, the certified staff member authorized to provide the item must sign and date the form to indicate that their level of expertise is appropriate for the device and that the appropriate device will be provided.
28.	**Physician, Physician Assistant, or Nurse Practitioner Signature** and **Date**	The physician, physician assistant , or nurse practitioner signs and dates the form to verify the accuracy of the information on the form, the medical necessity for the requested item(s) and, if applicable, the agreement to provide instruction and supervision to the recipient. ***NOTE:*** *Signature stamps are* **NOT** *acceptable for the physician, physician assistant, or nurse practitioner signature.*
29.	**Return Address**	Enter your company name and the mailing address that you want the form returned. You may handwrite, type or stamp the information on the form.

*** DO NOT LEAVE ANY BLOCKS BLANK**

CERTIFICATE OF MEDICAL NECESSITY AND PRIOR APPROVAL FORM FOR DURABLE MEDICAL EQUIPMENT AND ORTHOTIC AND PROSTHETIC DEVICES

North Carolina Division of Medical Assistance - Medicaid Program

1. Patient's Last Name	First	Middle	2. Birth Date (MM/DD/YYYY)	3. Sex	4. Medicare Number
Recipient	Jane	D.	01-05-1999	F	N/A

5. Medicaid Number	6. Patient's Address	Telephone Number
999-99-9999 T	123 Any Street Any Town, NC 12345	919 987-6543

7. Provider Number/Attending Number	8. Provider Name	Address	Telephone Number
7700319 / 7799007	ACME Orthotics & Prosthetics	1 Main Street Any Town, NC 12345	919 123-4567

9. Prescribing Physician Name	Address	Telephone Number	10. Provider Number
Dr. Joe Provider	23 Any Street Any Town, NC 12345	919 246-1357	8999999

11. ICD-9-CM	Principal Diagnosis	Date	12. ICD-9-CM	Other Pertinent Diagnoses	Date
754.51	Talipes Equinovarus	2/10/05		Infantile Cerebral Palsy	3/99
13. CPT-4	Surgical Procedure	Date			
276.85	Heelcord Lengthening	4/15/05	343.9		

MEDICAL AND FUNCTIONAL STATUS

14. **CONDITION :** (X) Stable ( ) Unstable Height: 3'4" Weight: 48 lbs.

15. **PROGNOSIS:** ( ) Terminal ( ) Poor ( ) Guarded ( ) Fair (X) Good ( ) Excellent

16. **PATIENT :** ( ) Requires positioning not feasible in ordinary bed ( ) Unattended for long periods of time ( ) Lives alone (N/A)

17. **EQUIPMENT :** ( ) Necessary to retard deterioration of condition (X) Necessary for function: specify Ambulation ( ) Length of need _____ days/months/years

18. **MENTAL :** (X) Oriented ( ) Forgetful ( ) Disoriented ( ) Agitated ( ) Comatose ( ) Depressed ( ) Lethargic ( ) Infant ( ) Other : specify _____

19. **NEUROLOGICAL :** Muscle Tone : ( ) Normal (X) Increased ( ) Decreased ( ) Fluctuating
Sensation : (X) Normal ( ) Abnormal : specify _____

20. **RESPIRATORY :** (X) Normal : ( ) SOB on Minimal Exertion ( ) Tracheostomy
( ) O2: Flow Rate: _____ Frequency: _____ Test Date: _____ Results: _____

21. **SKIN :** (X) Normal ( ) Other : specify _____ ( ) Decubiti : specify _____

22. **AMBULATORY :** ( ) Complete bedrest -- or -- (X) Up as tolerated
( ) Transfers bed-chair : ( ) Independently ( ) Wheelchair use: Confined ( ) Yes ( ) No (X) Walks: ( ) Unassisted
( ) With assistance Hours / day _____ (X) With assistive device : specify walker

23. Can place of residence physically accommodate equipment being requested? (X) Yes ( ) No ( ) max distance walked: _____

24. Patient's status will be monitored by physician while equipment is provided. (X) Yes ( ) No

25. Provide objective information to substantiate medical necessity of equipment: AFO is necessary for patient function and completion of ADLs within her home.

26. ITEM NO.	EXT	SERVICE REVIEW NO. (EDS USE ONLY)	FROM DATE	TO DATE	EDS Use Only	R	N	U	HCPCS CODE	EQUIPMENT DESCRIPTION
1			07/02/05	01/01/06			X		L1960LT	AFO, posterior, solid ankle
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

27. A Provider / BC Practitioner 7/5/05
Provider Signature/Board Certified Practitioner — Date

28. A. Doctor 7/11/05
Physician, Physician Assistant, Nurse Practitioner Signature — Date

29. Return Address
Acme Orthotics & Prosthetics
1 Main Street
Any Town, NC 12345

Return to: EDS/PA
P.O. Box 31188
Raleigh, NC 27622

30. Approval constitutes medical approval for services only. Eligibility for care in the month in which services are provided should be verified from patient's Medicaid card.

How a Recipient Obtains Orthotic and Prosthetic Devices

The following steps outline how a recipient receives orthotic and prosthetic devices. The steps are in the order that they are usually accomplished.

Note: These procedures do not apply when Medicare is the primary payer. Providers are responsible for knowing when an item provided to a Medicare-Medicaid recipient should be billed to Medicare first. The fee schedule indicates the items that must always be billed to Medicare for dually-eligible recipients. For other Medicare/Medicaid covered items billed to Medicaid for a dually-eligible recipient, the provider must maintain documentation to support a decision to bill Medicaid as primary.

Step 1 Receive Physician's Prescription

A physician, physician assistant or nurse practitioner who has personally examined the recipient writes a prescription for the needed orthotic or prosthetic device. The prescription is given to the orthotic and prosthetic provider.

Step 2 Complete Documentation of Need

Fill out the appropriate form to document the need for the requested orthotic and prosthetic devices.

- For all orthotic and prosthetic devices, complete each item on the Certificate of Medical Necessity/Prior Approval (CMN/PA) form, unless the instructions indicate that a block is optional. Include any additional documentation required to document medical necessity.

  Send the CMN/PA to the prescribing physician, physician assistant or nurse practitioner for completion of the items requiring the physician's knowledge and expertise. Also, ask the physician, physician assistant or nurse practitioner to sign and date the form.

- For orthotic and prosthetic devices not on the Orthotic and Prosthetic Fee Schedule for recipients from birth through 20 years of age, complete:
  - items 1, 2, 5, 7, and 26 on the CMN/PA form; **and**
  - the Children's Special Health Services Form (DHHS 3056) "Authorization Request/Approval." Providers may obtain the form and instructions for completing the form from Children's Special Health Services (CSHS) by calling Special Needs Hotline at 800-737-3028 or Purchase of Medical Care Services Provider Relations at 919-855-3651.

Refer to **Completing the Certificate of Medical Necessity/Prior Approval Form**, on page 18 for a sample of and instructions for completing the CMN/PA form.

Step 3 Verify Medicaid Eligibility

Verify Medicaid eligibility according to the guidelines in **Section 2.0, Eligible Recipients**. When checking the color of the recipient's Medicaid identification card, remember the following:

Blue: The recipient may be considered for orthotic and prosthetic devices.

Pink: Covers only pregnancy-related services. Orthotic and prosthetic devices must be related to the pregnancy in order to be covered.

Buff: Not eligible for orthotic and prosthetic devices. (Medicaid will pay a percentage of the Medicare co-payments when Medicare covers an orthotic and prosthetic device.)

Note: Check all other key information on the card such as eligibility dates, insurance information, and other important items. If the card shows that a recipient participates in a Medicaid Managed Care program, CAP or Hospice, coverage may be affected.

Refer to **Section 7.2 Coordinating Care**, for additional information.

Step 4 Assess Appropriateness

Although the recipient's physician, physician assistant or nurse practitioner is responsible for prescribing orthotic and prosthetic devices, providers should review the available information to see if an item appears appropriate. Key points are:

- **Does the recipient have a medical necessity for the item?** Look at whether the item is a necessity or a convenience for the recipient or his caregivers. For example, a recipient may want orthopedic footwear. However, regular footwear meets the recipient's needs.
- **Is the item appropriate for the recipient's situation?** Check to ensure that the recipient or his caregiver can appropriately and safely apply the orthotic or prosthetic device.
- **Has Medicaid previously furnished this item to the recipient?** If Medicaid has previously purchased the same equipment for a recipient, refer to **Section 5.8, Replacing Orthotics and Prosthetics**, for information about replacement.

Step 5 Resolve Questions and Concerns

- Resolve any questions or concerns you have about an orthotic or prosthetic device before you provide it. If anything ordered by the physician, physician assistant or nurse practitioner appears inappropriate or a potential source of problems, contact the physician, physician assistant or nurse practitioner.

Step 6 Request Prior Approval

If a device requires prior approval, submit the request as follows:

- For orthotic and prosthetic devices listed on the Orthotic and Prosthetic Fee Schedule for which prior approval is required (as indicated by an asterisk on the fee schedule), send the completed three-part CMN/PA form to the address listed on the form.
  - **Approved Requests:** The form will show a PA number for each item and the time period for which it is approved. The dates of service that you bill must be within the approved period. Refer to **Completing a Claim for Orthotic and Prosthetic Services**, on page 26 for additional instructions about completing item **24A** on the CMS-1500 claim form.
  - **Denied Requests:** If the recipient wants a denied request reconsidered, he may appeal to the DMA Hearing Office.

- For devices not listed on the Orthotic and Prosthetic Fee Schedule **for recipients birth through 20 years of age**, send the CMN/PA form with items 1, 2, 5, 7, and 26 completed, and the CSHS Authorization Request/Approval form (DHHS 3056) to the Purchase of Medical Care Services at the address listed on the form. Include the following documentation with the form:
  - A letter of medical necessity signed by a physician, physician assistant or nurse practitioner and/or a physical or occupational therapist who is treating the child.
  - An itemized list of components with costs and a verification of the catalog price.
  - The accompanying HCPCS code for each item.

  CSHS will notify you of its decision.

  - **Approved Requests:** The form will show a PA number for each item and the time period for which it is approved. The dates of service that you bill must be within the approved period. Refer to **Completing a Claim for Orthotic and Prosthetic Services** on page 24 for additional instructions about completing item **24A** on the CMS-1500 claim form.
  - **Denied Requests:** If the recipient wants a denied request reconsidered, he may appeal to the DMA Hearing Office.

Note: Prior approval authorizes payment of an orthotic or prosthetic device only if the person is Medicaid-eligible. It does not ensure that the recipient is on Medicaid nor waive other prerequisites to payment such as billing third party payers. You must verify Medicaid eligibility and meet other reimbursement responsibilities.

Completing a Claim for Orthotic or Prosthetic Services

Refer to the following information for completing a CMS-1500 claim form for orthotic or prosthetic services.

Block #/Description	Instruction
1.	Place an **X** in the MEDICAID block.
1a. Insured's ID Number	Enter the recipient's Medicaid ID number (nine digits and the alpha suffix) from the recipient's Medicaid ID card.
2. Recipient's Name	Enter the recipient's last name, first name and middle initial from the Medicaid ID card.
3. Recipient's Birth Date/Sex	Enter eight numbers to show the recipient's date of birth - MMDDYYYY. The birth date is on the Medicaid ID card. ***EXAMPLE:*** *November 14, 1949 is* **11141949**. Place an **X** in the appropriate block to show the recipient's sex.
4. Insured's Name.	Leave blank
5. Recipient's Address	Enter the recipient's street address, including the city, state and zip code. The information is on the Medicaid ID card. Entering the telephone number is optional.
6. – 8.	Leave blank.
9. Other Insurer's Name	Enter applicable private insurer's name or the appropriate Medicare override statement if you know that Medicare will not cover the billed item, using the EXACT wording shown below: *This is a Medicare non-covered service.* *Service does not meet Medicare criteria.* *Medicare benefits are exhausted.* ***REMEMBER:*** *You must have documentation to support the use of any of these statements.*
9a. – 9d.	Enter applicable insurance information.
10. Is Recipient's Condition…?	Place an **X** in the appropriate block for each question.
11. – 14.	Optional.
15. – 16.	Leave blank.
17., 17a., and 18.	Optional.
19. Reserved for Local Use	If the claim is for a Carolina ACCESS participant, enter the primary care provider's referring number – otherwise leave blank.
20. Outside Lab…	Leave blank.
21. Diagnosis or Nature of Illness	Enter the ICD-9-CM code(s) to describe the primary diagnosis related to the service. You may also enter related secondary diagnoses. Entering written descriptions is optional.
22. Medicaid Resubmission Code	Leave blank.
23. Prior Authorization Number	Leave blank.

Note: Blocks 24A through 24K are where you provide the details about what you are billing. There are several lines for listing services. Each line is called a "detail." When completing these blocks:

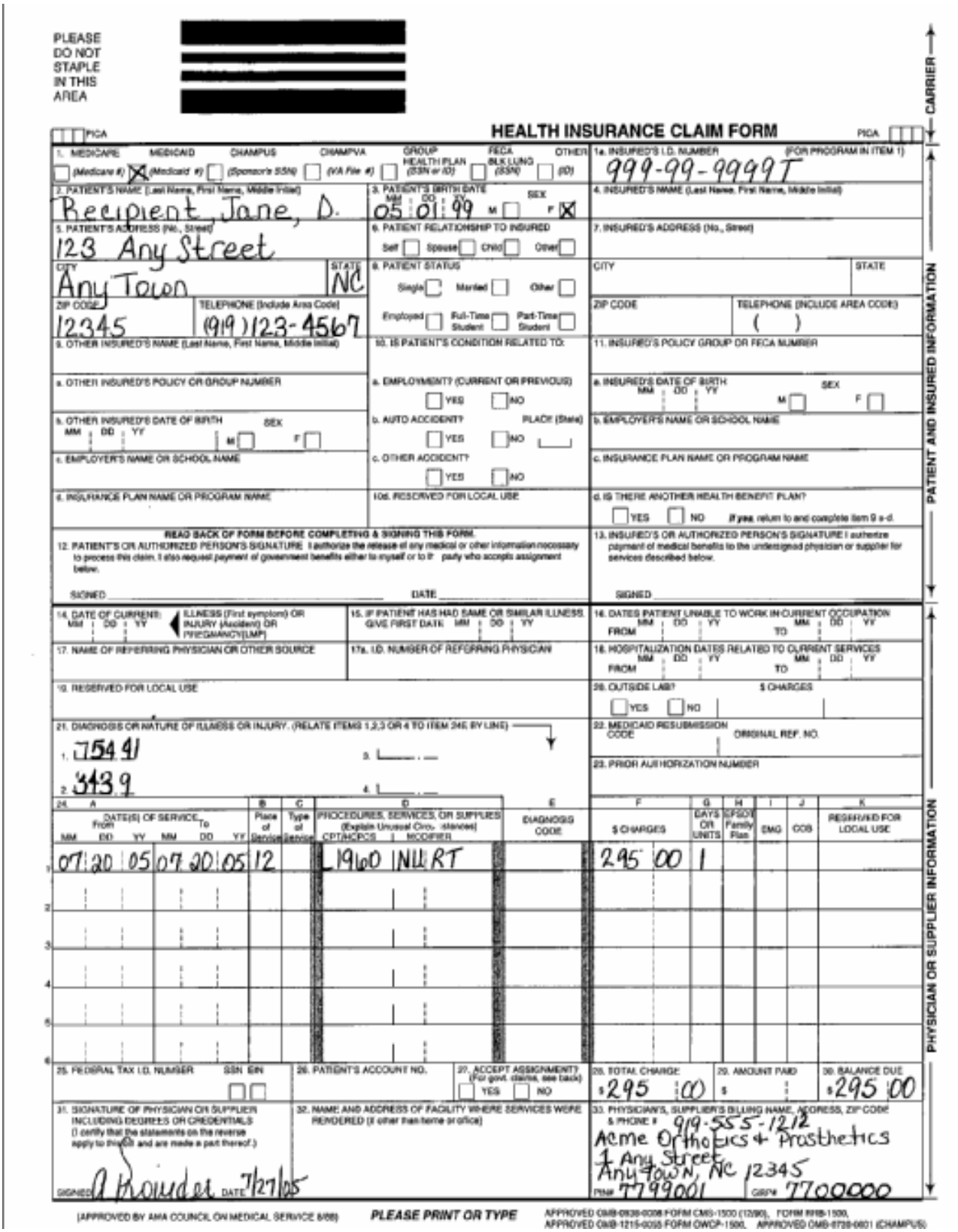
- Use one line for each HCPCS code that you bill on a given date.
- If you provide more than one unit of the same item on one day, include all the items on the same line. For example, if you provide 2 ankle-foot orthotics on May 1, include both on one line. Enter 2 units in 24G for that date of service.
- Include only dates of service for which the recipient is eligible for Medicaid.

Block #/Description	Instruction
24a. Date(s) of Service, From/To	Your entry depends upon the services: **Prosthetics and Orthotics:** You may enter either the date of the physician's prescription or the date of delivery to the recipient's home as the date of service. Place the date in the **FROM** block. Enter the same date in the **TO** block. **Service and Repairs:** Enter the date that the item is serviced or repaired in the recipient's home as the date of service. If the item is removed from the recipient's home for service or repairs, enter the date that it is returned. Place the date in the **FROM** block. Enter the same date in the **TO** block.
24b. Place of Service	Enter **12** to show the items are provided at the recipient' residence.
24c. Type of Services	Leave blank.
24d. Procedures, Services…	Enter the appropriate HCPCS code and modifier: **NU** for new purchase. Indicate **RT** for right side or **LT** for left side, if appropriate to the HCPCS code.
24e. Diagnosis Code	Leave blank.
24f. Charges	Enter the total charge for the items on the line.
24g. Days or Units	Enter the number of units as follows: **Prosthetics and Orthotics:** Enter the number of units provided on the date of service. **Service and Repair:** Enter **1 unit for each 15-minute increment** being billed.
24h. – 24i.	Leave blank.
24j. – 24k.	Optional.
25. Federal Tax ID Number	Optional
26. Recipient's Account No.	Optional. You may enter your agency's record or account number for the recipient. The entry may be any combination of numbers and letters up to a total of nine characters. If you enter a number, it will appear on your RA. This will assist in reconciling your accounts.
27. Accept Assignment	Leave blank.
28. Total Charge	Enter the sum of the charges listed in Item **24F**.
29. Amount Paid	Enter the total amount received from third party payment sources.
30. Balance Due	Subtract the amount in Item **29** from the amount in Item **28** and enter the result here.
31. Signature of Physician or Supplier…	Leave blank if there is a signature on file with Medicaid. Otherwise, an authorized representative of your agency must sign and date the claim in this block. A written signature stamp is acceptable.

Block #/Description	Instruction
32. Name and Address of Facility...	Optional.
33. Physician's/ Supplier's Billing Name...	Enter your agency's name, address, including ZIP code, and phone number. The name and address must be EXACTLY as shown on your Medicaid orthotic and prosthetic participation agreement.
PIN#	Enter your seven-digit Medicaid Board-certified orthotic and prosthetic provider attending number.
GRP#	Enter your seven-digit Medicaid orthotic and prosthetic or DME provider number.

Remember: When submitting a claim for manually priced items an invoice must also be attached to the claim.

Example of Claim Form for Orthotics and Prosthetics



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) X MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999-99-9999T

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane, D.

3. PATIENT'S BIRTH DATE: 05 01 99 SEX: M F X

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

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: Any Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

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 NO If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

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 _____ DATE _____

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 7545 1

2. 343 9

3. _____

4. _____

22. MEDICAID 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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circ. Modifier) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 20 05	07 20 05	12		L1960	NU RT		295 00	1				
2												
3												
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE: $295 00

29. AMOUNT PAID: $

30. BALANCE DUE: $295 00

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 A Provider DATE 7/27/05

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 919-555-1212

Acme Orthotics & Prosthetics
1 Any Street
Any Town, NC 12345

PIN# 7799001 GRP# 7700000

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM HHB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Mark T. Benton, Interim Director
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier
Executive Director
EDS