Article

Lower Limb Prostheses - Policy Article

A52496

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Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	States
CGS Administrators, LLC	DME MAC	17013 - DME MAC	J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin
CGS Administrators, LLC	DME MAC	18003 - DME MAC	J-C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi New Mexico North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas Virgin Islands Virginia West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	J-A	Connecticut Delaware District of Columbia Maine Maryland Massachusetts

Contractor Name	Contract Type	Contract Number	Jurisdiction	States
				New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Idaho Iowa Kansas Missouri - Entire State Montana Nebraska Nevada North Dakota Northern Mariana Islands Oregon South Dakota Utah Washington Wyoming

Article Information

General Information

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Article Title
Lower Limb Prostheses - Policy Article

Article Type
Article

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Article Guidance

Article Text
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. “reasonable and necessary”).

Lower limb prostheses are covered under the Medicare Artificial Legs, Arms and Eyes benefit (Social Security Act §1861(s)(9)). In order for a beneficiary's lower limb prosthesis to be eligible for reimbursement, the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition to meeting the benefit policy, there are specific statutory payment policy requirements, discussed below, that also must be met.

GENERAL:

A repair is a restoration of the prosthesis to correct problems due to wear or damage.

An adjustment is any modification to the prosthesis due to a change in the beneficiary's condition or to improve the function of the prosthesis.

The following items are included in the reimbursement for a prosthesis and, therefore, are not separately billable to Medicare under the prosthetic benefit:

- Evaluation of the residual limb and gait
- Fitting of the prosthesis
- Cost of base component parts and labor contained in HCPCS base codes
- Repairs due to normal wear or tear within 90 days of delivery
- 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 beneficiary's functional abilities.

Payment for Prostheses Provided During a Medicare Part A Covered Hospital Stay

Payment by Medicare Part A for a prosthesis provided to a beneficiary for use during a Medicare Part A covered hospital stay is eligible for inclusion in the payment for the hospital stay if the following criteria (1 and 2) are met:

1. The prosthesis is provided to a beneficiary during the inpatient hospital stay; and,
2. The beneficiary uses the prosthesis for reasonable and necessary inpatient treatment or rehabilitation.

In this situation, a claim must not be submitted to the DME MAC.

Payment by the DME MAC for a prosthesis delivered to a beneficiary, not for use during a Medicare Part A covered hospital stay, is eligible for DME MAC coverage if the following criteria (1 – 3) are met:

1. The prosthesis is reasonable and necessary for a beneficiary after discharge from a hospital; and,
2. The prosthesis is delivered to the beneficiary no more than two days prior to discharge to home; and,
3. The prosthesis is not used for inpatient treatment or rehabilitation.

Payment for Prostheses Provided During a Medicare Part A Covered Skilled Nursing Facility (SNF) Stay

Payment by Medicare Part A for a prosthesis provided to a beneficiary, described by codes L5000, L5010, L5020, L5400, L5410, L5420, L5430, L5450, L5460, L5987, L8400, L8410, L8417, L8420, L8430, L8440, L8460, L8470, and L8480, for use during a Medicare Part A covered SNF stay is eligible for inclusion in the payment for the SNF stay if the following criteria (1 and 2) are met:

1. The prosthesis is provided to a beneficiary during the SNF stay; and,
2. The beneficiary uses the prosthesis for reasonable and necessary treatment or rehabilitation.

In this situation, a claim must not be submitted to the DME MAC.

Claims (other than for the above HCPCS codes) for a lower limb prosthesis provided to a beneficiary during a Medicare Part A covered SNF stay (see below), and claims for any lower limb prosthesis provided to a beneficiary during a non-covered Medicare Part A SNF stay, are to be submitted to the DME MAC.

Payment by the DME MAC for a prosthesis delivered to a beneficiary during a Part A covered SNF stay is eligible for DME MAC coverage if:

1. The prosthesis is reasonable and necessary for a beneficiary's use during the Medicare Part A covered SNF stay; and,
2. The prosthetic components are classified as major category III codes under the SNFs consolidated billing.

ADJUSTMENTS, REPAIRS, AND COMPONENT REPLACEMENT:

Routine periodic servicing, such as testing, cleaning, and checking of the prosthesis is noncovered. Adjustments to a prosthesis required by wear or by a change in the beneficiary's condition are covered under the initial treating practitioner's order for the prosthesis for the life of the prosthesis.

Repairs to a prosthesis are covered when necessary to make the prosthesis functional. If the expense for repairs exceeds the estimated expense of purchasing another entire prosthesis, no payments can be made for the amount of the excess. Maintenance which may be necessitated by manufacturer's recommendations or the construction of the prosthesis and must be performed by the prosthetist is covered as a repair.

Replacement of a prosthesis or prosthetic component is covered if the treating practitioner orders a replacement device or part because of any of the following:

1. A change in the physiological condition of the beneficiary; or
2. Irreparable wear of the device or a part of the device; or
3. The condition of the device, or part of the device, requires repairs and the cost of such repairs would be more than 60% of the cost of a replacement device, or of the part being replaced.

Replacement of a prosthesis or prosthetic components required because of loss or irreparable damage may be reimbursed without a practitioner's order when it is determined that the prosthesis as originally ordered still fills the beneficiary's medical needs.

MISCELLANEOUS:

A prosthetic donning sleeve (L7600) will be denied as noncovered.

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO Final Rule 1713 (84 Fed. Reg Vol 217)

Final Rule 1713 (84 Fed. Reg Vol 217) requires a face-to-face encounter and a Written Order Prior to Delivery (WOPD) for specified HCPCS codes. CMS and the DME MACs provide a list of the specified codes, which is periodically updated. The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.

Claims for the specified items subject to Final Rule 1713 (84 Fed. Reg Vol 217) that do not meet the face-to-face encounter and WOPD requirements specified in the LCD-related Standard Documentation Requirements Article (A55426) will be denied as not reasonable and necessary.

If a supplier delivers an item prior to receipt of a WOPD, it will be denied as not reasonable and necessary. If the WOPD is not obtained prior to delivery, payment will not be made for that item even if a WOPD is subsequently obtained by the supplier. If a similar item is subsequently provided by an unrelated supplier who has obtained a WOPD, it will be eligible for coverage.

FUNCTIONAL LEVEL CHARACTERISTICS (based on CMS Health Technology Assessment: Lower Limb Prosthetic Workgroup Consensus Document, 2017)

Note: Not all traits listed for K levels must be realized by the patient in order to receive a K level assignment, but generally, documentation should demonstrate that equivalent activities can be achieved by the prosthetic user.

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.

a. The individual does not have sufficient cognitive ability to safely use a prosthesis with or without assistance.
b. The individual requires assistance from equipment or a caregiver in order to transfer and use of a prosthesis does not improve mobility or independence with transfers.
c. The individual is wheelchair dependent for mobility and use of a prosthesis does not improve transfer abilities.
d. The individual is bedridden and has no need or capacity to ambulate or transfer.

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.

a. The individual has sufficient cognitive ability to safely use a prosthesis with or without an assistive device and/or the assistance/supervision of one person.
b. The individual is capable of safe but limited ambulation within the home or on a similar flat surface like a home, with or without an assistive device and/or with or without the assistance/supervision of one person.
c. The individual requires the use of a wheelchair for most activities outside of their residence.
d. The individual is not capable of most of the functional activities designated in Level 2.

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

a. The individual can, with or without an assistive device (which may include one or two handrails) and/or with or without the assistance/supervision of one person:
    i. Perform the Level 1 tasks designated above
    ii. Ambulate on a flat, smooth surface (e.g., concrete, asphalt) such as might be found outside the home. (e.g., porch, deck, patio garage, driveway)
    iii. Negotiate a curb
    iv. Access public or private transportation
    v. Negotiate 1-2 stairs

vi. Negotiate a ramp built to ADA specifications.

b. The individual may require a wheelchair for distances that are beyond the perimeters of the yard/driveway, apartment building, etc.
c. The individual is only able to increase their generally observed speed of walking for short distances or with great effort.
d. The individual is generally not capable of accomplishing most of the tasks at Level 3 (or does so infrequently with great effort).

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

a. With or without an assistive device (which may include one or two handrails), the individual is independently capable (i.e. requires no personal assistance or supervision) of performing the Level 2 tasks above and can:
    i. Walk on terrain that varies in texture and level (e.g., grass, gravel, uneven concrete)
    ii. Negotiate 3-7 consecutive stairs
    iii. Walk up/down ramps built to ADA specifications
    iv. Open and close doors
    v. Ambulate through a crowded area (e.g., grocery store, big box store, restaurant)
    vi. Cross a controlled intersection within their community within the time limit provided (varies by location)
    vii. Access public or private transportation
    viii. Perform dual ambulation tasks (e.g. carry an item or meaningfully converse while ambulating)
b. The individual does not perform the activities of Level 4.

Level 4: Has the ability or potential for prosthetic ambulation that exceeds the basic ambulation skills, exhibiting high impact, stress or energy levels typical of the prosthetic demands of the child, active adult, or athlete.

With or without an assistive device (which may include one or two handrails), this individual is independently capable (i.e. requires no personal assistance or supervision) of performing high impact domestic, vocational or recreational activities such as:

a. Running
b. Repetitive stair climbing
c. Climbing of steep hills
d. Being a caregiver for another individual
e. Home maintenance (e.g. repairs, cleaning)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

In addition to policy specific documentation requirements, there are general documentation requirements that are applicable to all DMEPOS policies. These general requirements are located in the DOCUMENTATION REQUIREMENTS section of the LCD.

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this Policy Article under the Related Local Coverage Documents section for additional information regarding GENERAL

DOCUMENTATION REQUIREMENTS and the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS discussed below.

Based on Social Security Act §1834(h)(5), for purposes of determining the reasonableness and medical necessity of orthotics and prosthetics, documentation created by an orthotist or prosthetist shall be considered part of the individual's medical record to support documentation created by the treating practitioner.

When submitting a prosthetic claim, the billed code for knee, foot, ankle and hip (HCPCS codes L5610, L5611, L5613, L5614, L5615, L5616, L5710, L5711, L5712, L5714, L5716, L5718, L5722, L5724, L5726, L5728, L5780, L5810, L5811, L5812, L5814, L5816, L5818, L5822, L5824, L5826, L5828, L5830, L5840, L5841, L5848, L5856, L5857, L5858, L5859, L5930, L5961, L5970, L5971, L5972, L5973, L5974, L5975, L5976, L5978, L5979, L5980, L5981, L5982, L5984, L5985, L5986, L5987) components must be submitted with modifiers K0 - K4, indicating the expected beneficiary functional level. This expectation of functional ability information must be clearly documented and retained in the prosthetist's records. The simple entry of a K modifier in those records is not sufficient. There must be information about the beneficiary's history and current condition which supports the designation of the functional level by the prosthetist.

For L5610, L5613, L5614, L5615, L5722, L5724, L5726, L5728, L5780, L5814, L5822, L5824, L5826, L5828, L5830, L5840, L5841, L5848, L5856, L5857, L5858 for beneficiaries whose functional level is 2, the medical records must include all of the following:

1. Documentation of a clinical evaluation of the beneficiary's potential functional abilities by a treating practitioner or the prosthetist which designates a functional level of 2 (If completed by a prosthetist, the treating practitioner's medical records must support the functional level assigned); and,
2. Discussion of the beneficiary's overall medical health and the rationale for selection of a fluid, pneumatic, or electronic/microprocessor-control addition to a prosthetic knee system. Taking into consideration potential safety concerns of the advanced knee technology, the following must be included (at minimum):
    a. Which functional health outcomes (e.g., fall reduction, injury prevention, lower energy expenditure) are expected to be improved with the selected knee; and,
    b. Specifically which activities of daily living (e.g., transferring, climbing stairs, grocery shopping, housekeeping, working) are expected to be improved with the use of the selected knee; and,
3. Documentation to support that lower-level knee systems (e.g., knee systems which exclude use of fluid, pneumatic, or microprocessor) have been considered and ruled out, including the rationale for why a lower-level knee system would not be sufficient to meet the beneficiary's specific functional and medical needs.

Additionally, for an electronic/microprocessor-controlled knee system (L5856, L5857, or L5858 plus associated components) for beneficiaries whose functional level is 2, the medical record must also include:

1. Documentation that the electronic/microprocessor knee is indicated for functional level 2 and has integrated technology that allows the knee to detect when the user trips or stumbles and can automatically adjust to stabilize the knee unit (e.g., stumble recovery); and,
2. Documentation indicating the beneficiary is able to make use of a product that requires daily charging and has the capacity to understand and respond to error alerts and alarms indicating problems with the function of the unit.

For L5859, the medical records should describe the nature and extent of the comorbidity of the spine or the sound limb which is what is limiting this beneficiary to a household ambulator, and clearly document how this feature will enable the beneficiary to function as a community ambulator.

Refer to the Supplier Manual for more information on documentation requirements.

REPAIR/REPLACEMENT (BPM Ch 15, §120)

Adjustments and repairs of prostheses and prosthetic components are covered under the original order for the prosthetic device.

Medicare payment may be made for the replacement of prosthetic devices which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if a treating practitioner determines that the replacement device, or replacement part of such a device, is reasonable and necessary. Claims involving the replacement of a prosthesis or major component (foot, ankle, knee, socket) must be supported by a new treating practitioner's order and documentation supporting the reason for the replacement. The reason for replacement must be documented by the treating practitioner, either on the order or in the medical record, and must fall under one of the following:

1. A change in the physiological condition of the patient resulting in the need for a replacement. Examples include but are not limited to, changes in beneficiary weight, changes in the residual limb, beneficiary functional need changes; or,

2. An irreparable change in the condition of the device, or in a part of the device resulting in the need for a replacement; or,

3. The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

The prosthetist must retain documentation of the prosthesis or prosthetic component replaced, the reason for replacement, and a description of the labor involved irrespective of the time since the prosthesis was provided to the beneficiary. This information must be available upon request. It is recognized that there are situations where the reason for replacement includes but is not limited to: changes in the residual limb; functional need changes; or irreparable damage or wear/tear due to excessive beneficiary weight or prosthetic demands of very active amputees.

CONTINUED MEDICAL NEED

For all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered, therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. Once initial medical need is established, unless continued coverage requirements are specified in the LCD, ongoing need for the lower limb prosthesis is assumed to be met. There is no requirement for further documentation of continued medical need as long as the beneficiary continues to meet the Artificial Legs, Arms and Eyes benefit.

MODIFIERS

GA, GY, GZ, KX, LT, and RT MODIFIERS:

Suppliers must add the KX modifier to claim lines billed for lower limb prosthetics only if all of the coverage criteria in the “Coverage Indications, Limitations, and/or Medical Necessity” section in the related LCD have been met and evidence of such is retained in the supplier’s files and available to the DME MAC upon request.

If all of the criteria in the “Coverage Indications, Limitations, and/or Medical Necessity” section of the related LCD have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.

Prosthetic donning sleeves (L7600) are statutorily non-covered and must be billed with a GY modifier.

Claim lines billed without a KX, GA, GY, or GZ modifier will be rejected as missing information.

The right (RT) and left (LT) modifiers must be used with prosthesis codes. Effective for claims with dates of service (DOS) on or after 3/1/2019, when the same code for prostheses, sockets, or components for bilateral amputees are billed on the same date of service bill each item on two separate claim lines using the RT and LT modifiers and 1 unit of service (UOS) on each claim line. Do not use the RTLT modifier on the same claim line and billed with 2 UOS. Claim lines billed without the RT and/or LT modifiers, or with RTLT on the same claim line and 2 UOS, will be rejected as incorrect coding.

CODING GUIDELINES

Prosthetic devices (such as sockets, inserts, and applicable additions [e.g., light weight material]) that are custom fabricated for the individual beneficiary are not solely restricted to standard methods of fabrication (e.g., wet lamination and prepreg composite) and can include alternative fabrication methods (e.g., additive manufacturing). Correct coding of custom fabricated items includes compliance with the HCPCS long description of the individual HCPCS code, along with any other published coding guidelines.

Code L5999 (LOWER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED) must not be used to bill for any features or functions included in the socket or addition codes. Use of L5999 is incorrect coding (unbundling).

REPAIR AND LABOR CODING

Code L7510 is used to bill for any "minor" materials (i.e., those without specific HCPCS codes) used to achieve the adjustment and/or repair.

Code L7520 is used to bill for labor associated with adjustments and repairs that either do not involve replacement parts or that involve replacement parts billed with code L7510. Code L7520 must not be billed for labor time involved in the replacement of parts that are billed with a specific HCPCS code. Labor is included in the allowance for those codes.

One unit of service of code L7520 represents 15 minutes of labor time. Documentation must exist in the supplier's records indicating the specific adjustment and/or repair performed and the time involved. The time reported for L7520 must only be for actual repair time. Time performing the following services (not all-inclusive) must not be billed using code L7520:

- Evaluation to determine the need for a repair or adjustment or follow-up assessment
- Evaluation of problems regarding the fit or function of the prosthesis
- General beneficiary education or gait instruction
- Programming of electronic componentry

SUSPENSION

Code L5671 includes both the part of the suspension locking mechanism that is integrated into the prosthesis socket and the pin(s), lanyard, or other component which is attached to the socket insert. L5671 does not include the socket insert itself. The socket inserts used in conjunction with a suspension locking mechanism are billed with codes L5673, L5681, or L5683, as appropriate. These codes include socket inserts with adapter for attaching the pin or lanyard of the locking mechanism.

Codes L5681 and L5683 are for use only with the initial issue of a custom fabricated socket insert. Additional inserts (either custom fabricated or prefabricated) provided at the time of initial issue or replacement socket inserts are coded L5673 and L5679, whichever is applicable.

Codes L5647 and L5652 describe a modification to a prosthetic socket that incorporates a suction valve in the design. The items described by these codes are not components of a suspension locking mechanism (L5671). Valve component must be installed as singular product separate from other suspension products like L5671.

L5657 describes a complete device that is an addition to a lower limb prosthesis. The primary function of the insert is volume management for the prosthetic limb. L5657 is a manual or automated adjustable air, fluid, gel or equal socket insert. The predicate product is the Ethnocare Overlay.

L5781 describes a complete device that is an addition to a lower limb prosthesis. The primary function of the vacuum pump is to suspend the prosthetic limb. Additionally, products coded L5781 provide residual limb volume management and moisture evacuation. The pump mechanism evacuates air and accumulated moisture between the limb and socket walls. The pump mechanism can be actuated by either external power and/or mechanical system(s).

L5782 describes a complete device that is an addition to a lower limb prosthesis. The primary function of the vacuum pump is to suspend the prosthetic limb. It also provides residual limb volume management and moisture evacuation. The pump mechanism evacuates air and accumulated moisture between the limb and socket walls. The pump mechanism can be actuated by either external power and/or mechanical system(s). Products described by this code would have components built to withstand higher prosthetic limb forces than L5781.

Code L7700 (GASKET OR SEAL, FOR USE WITH PROSTHETIC SOCKET INSERT, ANY TYPE, EACH) describes a stand-alone (i.e., not integrated into or a part of a prosthetic socket insert) sealing ring that is added to a socket insert to assist in providing or maintaining negative pressure for socket suspension. The ring creates a seal against the outer surface of the insert and against the inner wall of the socket. L7700 is not intended for use with mechanical socket suspensions such as a pin-lock system. It may be made of any suitable material. L7700 may be used with upper or lower extremity sockets. Unit of service (UOS) is 1 (one) item. This code is not to be used to bill for gaskets, seals, or other sealing materials that are included as part of an

insert. Integrated seals are included in the code for the insert. Separate billing of integrated gaskets or seals as L7700 is unbundling.

PROSTHETIC SYSTEMS

Prosthetic system codes should not be used when billing a replacement socket for an existing prosthesis.

Immediate Post Op

L5400, L5410, L5420, and L5430 describe weight bearing rigid dressings that are immediate post-surgical or early fitting, which include the alignable system, suspension system and one cast change.

L5450 and L5460 describe non-weight bearing rigid dressings that are immediate post-surgical or early fitting.

Preparatory

L5510, L5520, L5530, L5535, L5540, L5560, L5570, L5580, L5585, L5590, L5595, and L5600 describe preparatory prosthetic limb systems.

L5510 and L5560 include a molded plaster socket, a pylon, and a SACH Foot.

L5520 and L5570 include a direct formed thermoplastic patient socket, a pylon, and a SACH foot.

L5530, L5580, and L5595 include a molded thermoplastic prosthetic socket, a pylon, and a SACH foot.

L5535 and L5585 include an adjustable open-end prosthetic socket and a SACH foot.

L5540, L5590, and L5600 include a molded laminated prosthetic socket, a pylon, and a SACH foot.

Initial

L5500 and L5505 describe prosthetic systems which are used during the initial stages of prosthetic limb use. Both codes include a direct formed plaster socket, a pylon, and a SACH foot.

Exoskeletal

L5100, L5105, L5150, L5160, L5200, L5250, L5270, and L5280 describe exoskeleton prosthetic limb systems.

L5100 includes a molded prosthetic socket and a SACH foot.

L5105 includes a plastic molded socket, external knee joints, thigh lacer, and a SACH foot.

L5150 and L5160 include a knee disarticulation molded prosthetic socket, external knee joints, and a SACH foot.

L5200, L5250, L5270, and L5280 include a molded prosthetic socket, exoskeletal single axis knee-shin system, and a SACH foot.

Endoskeletal

L5301, L5312, L5321, L5331, and L5341 describe endoskeletal prosthetic systems.

L5301 includes a molded prosthetic socket and a SACH Foot.

L5312, L5321, L5331, and L5341 include a molded prosthetic socket, an endoskeletal single axis knee-shin system, and a SACH foot.

PROSTHETIC CONNECTORS

L5991 describes a complete endoskeletal product that is used as an osseointegrated external limb prosthetic connection device. The product provides a standard connection between an osseointegrated implantable limb component and endoskeletal prosthetic components. L5991 describes a complete device, and the use of additional codes would be considered incorrect coding (unbundling). The predicate product is the Axor II osseointegrated external prosthetic connection device manufactured by Integrum, S.E.

SOCKETS

Codes L5940, L5950, and L5960 for ultra-light materials may only be used when materials such as carbon fiber, fiberglass, Kevlar, or other advanced composite lamination materials are used in the fabrication of a socket for an endoskeletal prosthesis. They are not used for ultralight materials used in other components of a prosthesis – e.g., knee/shin system, pylon, ankle, foot. For codes L5940, L5950, and L5960, the unit of service is per limb.

L5783 describes a complete mechanical product used as an addition to current lower extremity prosthetic base socket and socket replacement codes. This system is a kit of components (reel, cable, or similar) incorporated into a custom-fabricated socket. The beneficiary can manually adjust their socket volume throughout the day, decrease or increase. HCPCS code may include the lamination kit. The predicate product is the RevoFit manufactured by Click Medical.

Replacements

L5700, L5701, L5702, and L5703 describe prosthetic socket replacements.

L5700 includes a below the knee molded prosthetic socket replacement.

L5701 includes an above the knee or knee disarticulation molded prosthetic socket replacement with an attachment plate.

L5702 includes a hip disarticulation molded prosthetic socket replacement and a hip joint.

L5703 includes a symes molded prosthetic socket replacement.

The use of the prosthetic system codes with a replacement socket is incorrect coding (unbundling).

PROTECTIVE COVERS

Lower limb prosthetic covers (L5704, L5705, L5706, and L5707) are complete products and afford shape, protection and waterproofing for normal daily usage of the prosthesis. They offer sufficient protection and weatherproofing for beneficiaries who require lower limb prosthetics.

Protective outer surface covering systems (L5962, L5964, and L5966) are specialized covers intended to be worn over an existing prosthesis. They are used by a beneficiary who has special needs for protection

against unusually harsh environmental situations where it is necessary to protect the lower limb prosthesis beyond the level of protection that is afforded by L5704, L5705, L5706, and L5707. They are not for cosmetic or convenience reasons, or for everyday usage in a typical environment. Protective outer surface coverings are different from the covering that is already reimbursed as part of L5704, L5705, L5706, and L5707.

FOOT COVERS

Foot covers are included in the codes for a prosthetic foot component and are not separately payable.

KNEES

With the exception of items described by specific HCPCS codes, there should be no separate billing and there is no separate payment for a component or feature of a microprocessor controlled knee, including but not limited to real time gait analysis, continuous gait assessment, or electronically controlled static stance regulator.

Addition codes for exoskeletal knee-shin systems (L5614, L5710, L5711, L5712, L5714, L5716, L5718, L5722, L5724, L5726, L5728, and L5780) are considered an upgrade to the knee-shin system. The beneficiary may qualify for an upgraded knee-shin system depending on their assigned K-level modifier (K0-K4) and any additional coverage criteria that must be met, as referenced in the LCD. These HCPCS codes can fully describe a complete prosthetic knee-shin system commonly referred to as a “base knee code.” A single addition code can fully describe a complete knee-shin system and thus the use of two codes from the list would be considered incorrect coding (unbundling).

Addition codes for endoskeletal knee-shin systems (L5610, L5611, L5613, L5615, L5616, L5810, L5811, L5812, L5814, L5816, L5818, L5822, L5824, L5826, L5827, L5828, L5830, L5840, and L5841) are considered an upgrade to the knee-shin system. The beneficiary may qualify for an upgraded knee-shin system based on their assigned K-Level modifier (K0-K4) and any additional coverage criteria that must be met, as referenced in the LCD. These HCPCS codes can fully describe a complete prosthetic knee-shin system commonly referred to as a “base knee code.” A single addition code can fully describe a complete knee-shin system and thus the use of two codes (L5610, L5611, L5613, L5615, L5616, L5810, L5811, L5812, L5814, L5816, L5818, L5822, L5824, L5826, L5827, L5828, L5830, L5840, and L5841) would be considered incorrect coding (unbundling).

L5925, L5930, L5845, L5848, L5850, L5856, L5857, L5858, and L5859 are additional features and/or functions that do not describe a complete endoskeletal knee-shin system and must be used in combination with an L-code for a knee-shin system (L5610, L5611, L5613, L5615, L5616, L5810, L5811, L5812, L5814, L5816, L5818, L5822, L5824, L5826, L5827, L5828, L5830, L5840, and L5841). The use of additional feature L-codes may also depend on the assigned K-Level modifier (K0-K4) and any additional coverage criteria that must be met, as referenced in the LCD.

L5827 describes an endoskeletal product that is used as an addition to a knee shin system. It is an upgrade to a system found in the base limb codes such as L5321. This HCPCS code can fully describe a complete prosthetic knee-shin system commonly referred to as a “base” knee code. Included features in the code are described by L5845 and L5848. The product uses an electro-mechanical system to provide basic swing and stance phase control. Use of L5999 to describe features or functions not specifically designated by an L-code would be considered incorrect coding (unbundling). The use of additional feature L-codes may also depend on the assigned K-Level modifier (K0-K4) and any additional coverage criteria that must be met, as

referenced in the LCD. The predicate product is the Ossur Power Knee. Full coding of the Power Knee product is L5827, L5856, and L5859.

L5845 describes an endoskeletal product that is used as an addition to L-code Knee-Shin Systems for lower limb prosthesis construction. The product provides shock absorption during the initial stance phase of gait. It is designed to simulate the eccentric contraction of the quadriceps to reduce trauma on the residual limb. The predicate product is the Stance Flexion Feature, Adjustable manufactured by Endolite North America.

L5848 refers to a feature of an endoskeletal knee component which is incorporated into the entire knee-shin system. The Hydraulic Stance Extension Dampening Feature restricts the prosthetic knee joint's extension moment during the transition of mid to late stance phase of gait. The predicate products are the Otto Bock 3R60, 3C98 and 3C88 Hydraulic Knees.

L5856 refers to a feature of an endoskeletal knee component which is incorporated into the entire knee-shin system. The microprocessor componentry with sensors, any type, provide automated adjustment for controlling the swing and stance phase of gait. This feature would be discernable from schematic drawings and user manual documentation. The documentation would provide details for all of the adjustments for the dynamic properties of this sub-system within the knee component. Adjustments could factor user characteristics such as the activity level, body weight, or gait preferences, among others. This adjustment feature is energized by an on-board rechargeable battery source. The code would include any external components needed to access the microprocessor for modification of the settings.

L5857 refers to a feature of an endoskeletal knee component which is incorporated into the entire knee-shin system. The microprocessor componentry with sensors, any type, provide automated adjustment for controlling the swing phase of gait. The documentation would provide details for all of the adjustments for the dynamic properties of this sub-system within the knee component. Adjustments could factor user characteristics such as the activity level, body weight, or gait preferences, among others. This adjustment feature is energized by an on-board rechargeable battery source. The code would include any external components needed to access the microprocessor for modification of the settings.

L5858 refers to a feature of an endoskeletal knee component which is incorporated into the entire knee-shin system. The microprocessor componentry with sensors, any type, provide automated adjustment for controlling the stance phase of gait. The documentation would provide details for all of the adjustments for the dynamic properties of this sub-system within the knee component. Adjustments could factor user characteristics such as the activity level, body weight, or gait preferences, among others. This adjustment feature is energized by an on-board rechargeable battery source. The code would include any external components needed to access the microprocessor for modification of the settings.

L5926 describes an endoskeletal above the knee positioning device that allows 360 degrees of rotation and locks the endoskeletal prosthetic knee and foot system in a neutral position for ambulation. The predicate product is the Ottobock 4R57 Rotation Adapter.

ANKLE AND LOWER EXTREMITY MOTION UNITS

Codes L5968, L5982, L5984, L5985, L5986 and L5988 describe separate products which provide either a single motion or a combination of motions generally attributed to functional movement of the lower limb during ambulation. The use of these codes can be used to fully describe additional features or functions not found in the prosthetic foot system (L5969, L5970, L5971, L5972, L5973, L5974, L5975, L5976, L5978, L5979 L5980, L5981 and L5987).

L5968 describes a product that is used as an addition to L-code foot systems for lower limb prosthesis construction. The product provides multiaxial motion in the coronal and sagittal plane from articulating components. At transition of stance phase to swing phase, the product will increase the ankle's dorsiflexion angle and maintain it throughout swing phase. The product provides an accommodation of changing heel heights without the user's input. The predicate product is the Rincoe R-Hab Ankle manufactured by R.G. Rincoe & Associates, Inc.

L5982 describes an exoskeletal device that allows adjustable amount of vertical twisting motion between the foot and pelvis during ambulation. Motion of this product is separate from any similar incidental prosthetic foot/ankle motions.

L5984 describes an endoskeletal device that allows an adjustable, or non-adjustable, amount of vertical twisting motion between the foot and pelvis during ambulation. Motion of this product is separate from any similar incidental prosthetic foot/ankle motions.

L5985 describes an endoskeletal pylon device that provides simulated multiaxial ankle motion through a dynamic vertical shank separate from any similar incidental prosthetic foot motions. The predicate product is The Seattle Ankle manufactured by Seattle Medical Systems Group.

L5986 describes a product that is used as an addition to L-code foot systems for lower limb prosthesis construction. The product provides multiaxial motion in all three planes of motion, sagittal, coronal, and transverse. This code does not describe the multiaxial motion achieved from the inherent flexibility of the prosthetic keel or a split keel/heel prosthetic foot design. The predicate product is a device that was manufactured by Medical Center Prosthetic, which is represented in the coding narrative by "MCP."

Use of L5968, L5982, L5984 or L5986 is based on the beneficiary's K-level modifier (K0-K4), as referenced in the LCD.

L5988 describes an endoskeletal pylon device that allows vertical shock reduction between the foot and pelvis during ambulation. The vertical shock reducing pylon feature of L5988 is a separate function from other products which use a piston/telescoping mechanism such as products described by L5781 or L5782. The predicate product is the Total Shock that was manufactured by Century XXII International, Inc.

FEET

Addition codes for lower extremity prostheses, L5970, L5971, L5972, L5974, L5975, L5976, L5978, L5979, L5980, L5981, L5987 are considered an upgrade to the SACH foot. The beneficiary may qualify for an upgraded prosthetic foot based on their assigned K-level modifier (K0-K4) and any additional coverage criteria that must be met, as referenced in the LCD. A single addition code (L5970, L5971, L5972, L5974, L5975, L5976, L5978, L5979, L5980, L5981, L5987) can fully describe a complete foot and thus the use of more than one code would be considered incorrect coding (unbundling).

L5968, L5982, L5984, L5985, L5986, L5988, L5990 are additional features and/or functions that do not describe a complete prosthetic foot and may be used in combination with L5970, L5971, L5972, L5974, L5975, L5976, L5978, L5979, L5980, L5981, and L5987. The use of additional feature L-codes may also depend on the assigned K-Level modifier (K0-K4) and any additional coverage criteria that must be met, as referenced in the LCD.

L5980 describes a product that can be used for either endoskeletal or exoskeletal lower limb construction. The Flex Foot has an energy storing J-shaped keel design. Heel component is attached onto the J-shaped

keel section. The Flex Foot System's J-shaped keel design extends proximally as a monolithic composite shank. Shank height is determined and modified by supplier to utilize the dynamics of the composite shank. L5980 includes foot cover.

L5981 describes a product that can be used for either endoskeletal or exoskeletal lower limb construction. The Flex Walk has an energy storing J-shaped keel design. Heel component is attached to the J-shaped keel section. The Flex Walk J-shaped keel design proximally terminates at a nonadjustable fixed height determined and modified by the prosthetic foot manufacturer. L5981 includes foot cover.

L5987 describes a product that can be used for either endoskeletal or exoskeletal lower limb construction. All components are integrated as a single product, i.e. not an assembly of separate products or components. The product has an energy storing J-shaped keel design. Heel component is attached onto the J-shaped keel section. Vertical loading pylon allows controlled motion for shock absorption. This code does not describe vertical loading or shock absorption achieved from the inherent flexibility of the J-shaped keel section. L5987 includes foot cover.

PARTIAL FOOT AND TOE FILLER INSERTS

Codes L5000, L5010, and L5020 describe products that are necessary for standing balance and toe off support in beneficiaries who are missing the forefoot or digits including the hallux (great toe) and who require the rigidity and support offered by these products, in order to achieve or maintain an effective gait.

L5000 describes a shoe insert with a rigid longitudinal arch support that also incorporates material accommodating the void left by the missing digit(s) or forefoot. Additional soft material is added where contact is made with the residual limb or toes. These inserts are designed to provide standing balance and toe off support for improved gait. L5000 is inclusive of variations in materials or combinations such as differing stiffnesses or Shore value.

L5010 describes a partial foot device including a molded socket for the residual limb with a proximal height terminating at the ankle or extending proximally as needed to achieve appropriate support and function. L5010 is inclusive of a rigid longitudinal arch support that also incorporates material accommodating the void left by the missing digit(s) or forefoot. Additional soft material is added where contact is made with the residual limb or toes. L5010 devices are designed to provide standing balance and toe off support for improved gait. All closures are included, any type. L5010 is inclusive of variations in materials or combinations such as differing stiffnesses or Shore value.

L5020 describes a partial foot device including a molded socket for the residual limb with a proximal height terminating at or near the tibial tubercle to achieve appropriate support and function. L5020 is inclusive of a rigid longitudinal arch support that also incorporates material accommodating the void left by the missing digit(s) or forefoot. Additional soft material is added where contact is made with the residual limb or toes. L5020 devices are designed to provide standing balance and toe off support for improved gait. All closures are included, any type. L5020 is inclusive of variations in materials or combinations such as differing stiffnesses or Shore value.

MICROPROCESSOR ANKLE FOOT SYSTEMS

With the exception of items described by specific HCPCS codes, there should be no separate billing and there is no separate payment for a component or feature of a microprocessor controlled foot, including but not

limited to real time gait analysis, continuous gait assessment, or electronically controlled static stance regulator.

L5973 describes an endoskeletal device with integrated energy storage and release foot and microprocessor ankle system. The integrated microprocessor is programmable along with sensors to optimize plantar and dorsiflexion angles for stance and swing phase. L5973 includes foot cover, power source(s) and charger.

A microprocessor ankle-foot system with power assist (BiOM Ankle-Foot System by iWalk, Inc) is coded as the combination of L5969 (ADDITION, ENDOSKELETAL ANKLE-FOOT OR ANKLE SYSTEM, POWER ASSIST, INCLUDES ANY TYPE MOTOR(S)) and L5973 (ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL, INCLUDES POWER SOURCE).

Coding Batteries and Chargers Concurrently With a Powered Base Item

Powered base items are those that contain the power source (battery). At the time that a base item is billed, all necessary batteries and/or battery chargers are considered as included in the payment for the powered base item. There is no separate payment for batteries (L7360, L7364, and L7367) and/or battery chargers (L7362, L7366, and L7368) billed concurrently with a powered base item.

Payments for items listed in Column II are included in the payment for each Column I code. Claims for Column II items billed with the provision of a Column I item will be denied as unbundling.

Column I	Column II
Base codes with battery, charger and/or power included	Batteries
L5781	L7360
L5782	L7364
L5856	L7367
L5857	
L5858	
L5859	Chargers
L5973	L7362
	L7366
	L7368

Suppliers should contact the DME PDAC contractor for guidance on the correct coding of these items.

CODING VERIFICATION REVIEW

The only products which may be billed using the following list of HCPCS codes are those for which a written coding verification review (CVR) has been made by the Pricing, Data Analysis, and Coding (PDAC) contractor and subsequently published on the Product Classification List (PCL). Information concerning the documentation that must be submitted to the PDAC for a CVR can be found on the PDAC web site or by contacting the PDAC. A PCL with products which have received a coding verification can be found on the PDAC web site. The effective date of the CVR is included for each code.

Effective for claims with dates of service on or after January 1, 2014:
L5969

Effective for claims with dates of service on or after January 1, 2021:
L5856, L5857, L5858, L5973, L5980, L5987

If a product is billed to Medicare using a HCPCS code that requires written CVR, but the product is not on the PCL for that particular HCPCS code, then the claim line will be denied as incorrect coding.

Coding Information

CPT/HCPCS Codes

N/A

ICD-10-CM Codes that Support Medical Necessity

N/A

ICD-10-CM Codes that DO NOT Support Medical Necessity

N/A

ICD-10-PCS Codes

N/A

Additional ICD-10 Information

N/A

Bill Type Codes

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

N/A

Revenue Codes

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

Revision History Information

Revision History Date	Revision History Number	Revision History Explanation
10/01/2025	R19	Revision Effective Date: 10/01/2025 CODING GUIDELINES: Added: HCPCS code L5657 coding guideline information Added: “HCPCS code may include the lamination kit.” to HCPCS code L5783 coding guideline information *10/23/2025: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
04/01/2025	R18	Revision Effective Date: 04/01/2025 CODING GUIDELINES: Added: “Prosthetic devices (such as sockets, inserts, and applicable additions [e.g., light weight material]) that are custom fabricated for the individual beneficiary are not solely restricted to standard methods of fabrication (e.g., wet lamination and prepreg composite) and can include alternative fabrication methods (e.g., additive manufacturing). Correct coding of custom fabricated items includes compliance with the HCPCS long description of the individual HCPCS code, along with any other published coding guidelines.” as clarification *09/18/2025: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*

Revision History Date	Revision History Number	Revision History Explanation
04/01/2025	R17	Revision Effective Date: 04/01/2025 CODING GUIDELINES: Revised: Coding guidelines for HCPCS codes L5671 and L5647, as clarification Removed: Coding guideline for the Infinite Socket, as clarification Revised: “Addition codes for endoskeletal knee-shin systems (L5610, L5611, L5613, L5615, L5616, L5810, L5811, L5812, L5814, L5816, L5818, L5822, L5824, L5826, L5828, L5830, L5840, and L5841) are considered an upgrade to the knee-shin system.” to “Addition codes for endoskeletal knee-shin systems (L5610, L5611, L5613, L5615, L5616, L5810, L5811, L5812, L5814, L5816, L5818, L5822, L5824, L5826, L5827, L5828, L5830, L5840, and L5841) are considered an upgrade to the knee-shin system.” Revised: “A single addition code can fully describe a complete knee-shin system and thus the use of two codes (L5610, L5611, L5613, L5615, L5616, L5810, L5811, L5812, L5814, L5816, L5818, L5822, L5824, L5826, L5828, L5830, L5840, and L5841) would be considered incorrect coding (unbundling).” to “A single addition code can fully describe a complete knee-shin system and thus the use of two codes (L5610, L5611, L5613, L5615, L5616, L5810, L5811, L5812, L5814, L5816, L5818, L5822, L5824, L5826, L5827, L5828, L5830, L5840, and L5841) would be considered incorrect coding (unbundling).” Revised: “L5925, L5930, L5845, L5848, L5850, L5856, L5857, L5858, and L5859 are additional features and/or functions that do not describe a complete endoskeletal knee-shin system and must be used in combination with an L-code for a knee-shin system (L5610, L5611, L5613, L5615, L5616, L5810, L5811, L5812, L5814, L5816, L5818, L5822, L5824, L5826, L5828, L5830, L5840, and L5841).” to “L5925, L5930, L5845, L5848, L5850, L5856, L5857, L5858, and L5859 are additional features and/or functions that do not describe a complete endoskeletal knee-shin system and must be used in combination with an L-code for a knee-shin system (L5610, L5611, L5613, L5615, L5616, L5810, L5811, L5812, L5814, L5816, L5818, L5822, L5824, L5826, L5827, L5828, L5830, L5840, and L5841).” Added: Coding guideline for HCPCS code L5827 *04/03/2025: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*

Revision History Date	Revision History Number	Revision History Explanation
09/01/2024	R16	Revision Effective Date: 09/01/2024 FUNCTIONAL LEVEL CHARACTERISTICS: Added: Section header and functional level characteristics information POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Added: Information which specifies that orthotist and prosthetist records are considered part of the medical record to support documentation created by the treating practitioner Added: L5615 and L5841 to the HCPCS codes referenced in regard to claims for knee, foot, ankle, and hip components Added: Information that must be included in the medical records for certain HCPCS codes (L5610, L5613, L5614, L5615, L5722, L5724, L5726, L5728, L5780, L5814, L5822, L5824, L5826, L5828, L5830, L5840, L5841, L5848, L5856, L5857, L5858) for beneficiaries whose functional level is 2 MODIFIERS: Revised “LT and RT MODIFIERS:” to “GA, GY, GZ, KX, LT, and RT MODIFIERS:” Added: Information which pertains to inclusion of the KX, GA, GY, or GZ modifier on claims Added: GY modifier usage when billing for a prosthetic donning sleeve (L7600) Removed: “(refer to the CODING GUIDELINES section for additional information)” in regard to RT and LT modifiers Added: RT and LT modifier information (relocated from the CODING GUIDELINES section) CODING GUIDELINES: Revised: The layout and content located within “PROSTHETIC SYSTEMS,” including addition of “Immediate Post Op” with relevant information, “Preparatory” with relevant information, “Initial” with relevant information, “Exoskeletal” with relevant information, and “Endoskeletal” with relevant information Added: “Prosthetic system codes should not be used when billing a replacement socket for an existing prosthesis.” Removed: “L5301, L5540, L5321, L5590 should not be used when billing a replacement socket for an existing prosthesis.” Removed: “The use of L5301, L5540, L5321, L5590 with a replacement socket is incorrect coding (unbundling).” Added: “Replacements” with relevant information Added: “The use of the prosthetic system codes with a replacement socket is incorrect coding (unbundling).” Revised: “The beneficiary may qualify for an upgraded knee-shin system depending on their assigned K-level modifier (K0-K4), as referenced in the

Revision History Date	Revision History Number	Revision History Explanation
		LCD." to "The beneficiary may qualify for an upgraded knee-shin system depending on their assigned K-level modifier (K0-K4) and any additional coverage criteria that must be met, as referenced in the LCD." Revised: HCPCS codes referenced as addition codes for endoskeletal knee-shin systems that are considered an upgrade to the knee-shin system, to include L5615 and L5841 Revised: "The beneficiary may qualify for an upgraded knee-shin system based on their assigned K-Level modifier (K0-K4), as referenced in the LCD." to "The beneficiary may qualify for an upgraded knee-shin system based on their assigned K-Level modifier (K0-K4) and any additional coverage criteria that must be met, as referenced in the LCD." Revised: HCPCS codes referenced as single addition codes that can fully describe complete knee-shin systems and for which the use of two codes would be considered incorrect coding, to include L5615 and L5841 Revised: "L5925, L5930, L5845, L5848, L5850, L5856, L5857, L5858, L5859 are additional features and/or functions that do not describe a complete endoskeletal knee-shin system and must be used in combination with an L-code for a knee-shin system (L5610, L5611, L5613, L5616, L5810, L5811, L5812, L5814, L5816, L5818, L5822, L5824, L5826, L5828, L5830, L5840)." to "L5925, L5930, L5845, L5848, L5850, L5856, L5857, L5858, and L5859 are additional features and/or functions that do not describe a complete endoskeletal knee-shin system and must be used in combination with an L-code for a knee-shin system (L5610, L5611, L5613, L5615, L5616, L5810, L5811, L5812, L5814, L5816, L5818, L5822, L5824, L5826, L5828, L5830, L5840, and L5841)." Revised "The use of additional feature L-codes may also depend on the assigned K-Level modifier (K0-K4), as referenced in the LCD." and "The use of additional feature L-codes may also depend on the assigned K-Level modifier (K0-K4) as referenced in the LCD." to "The use of additional feature L-codes may also depend on the assigned K-Level modifier (K0-K4) and any additional coverage criteria that must be met, as referenced in the LCD." Revised: "The beneficiary may qualify for an upgraded prosthetic foot based on their assigned K-level modifier (K0-K4) as referenced in the LCD." to "The beneficiary may qualify for an upgraded prosthetic foot based on their assigned K-level modifier (K0-K4) and any additional coverage criteria that must be met, as referenced in the LCD." Removed: RT and LT modifier information *07/18/2024: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*

Revision History Date	Revision History Number	Revision History Explanation
04/01/2024	R15	Revision Effective Date: 04/01/2024 CODING GUIDELINES: Added: HCPCS code L5783 coding guideline information *05/02/2024: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
01/01/2024	R14	Revision Effective Date: 01/01/2024 CODING GUIDELINES: Added: HCPCS code L5926 coding guideline information *12/28/2023: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
10/01/2023	R13	Revision Effective Date: 10/01/2023 CODING GUIDELINES: Added: “PROSTHETIC CONNECTORS” Added: HCPCS code L5991 coding guideline information Added: “L5614” to the HCPCS codes listed in reference to addition codes for exoskeletal knee-shin systems Added: HCPCS code L5845 coding guideline information Added: HCPCS code L5848 coding guideline information Revised: HCPCS code L5982 coding guideline information, to include “Motion of this product is separate from any similar incidental prosthetic foot/ankle motions." Revised: HCPCS code L5984 coding guideline information, to include “Motion of this product is separate from any similar incidental prosthetic foot/ankle motions." *12/14/2023: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
03/21/2023	R12	Revision Effective Date: 03/21/2023 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Revised: Language pertaining to payment of a prosthesis when provided in a Part A covered hospital stay and Part A covered skilled nursing

Revision History Date	Revision History Number	Revision History Explanation
		facility (SNF) stay Added: “The prosthesis is reasonable and necessary for a beneficiary’s use during the Medicare Part A covered SNF stay” as a criterion for payment of a prosthesis delivered to a beneficiary during a Part A covered SNF stay when eligible for DME MAC coverage and payment Added: “The prosthetic components are classified as major category III codes under the SNFs consolidated billing” as a criterion for payment of a prosthesis delivered to a beneficiary during a Part A covered SNF stay when eligible for DME MAC coverage and payment *01/26/2023: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
08/01/2020	R11	Revision Effective Date: 08/01/2020 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Revised: “beneficiary to be eligible” to “beneficiary’s lower limb prosthesis to be eligible” in regard to eligibility for reimbursement CONTINUED MEDICAL NEED: Added: Section header and continued medical need language MODIFIERS: Added: Section Header and “RT and LT MODIFIERS:” Added: Statement regarding use of RT and LT, with reference to CODING GUIDELINES section for additional information CODING GUIDELINES: Added: L5781, L5782, L5985, L5988, L5000, L5010, and L5020 coding guidelines Revised: “ANKLES” to “ANKLE AND LOWER EXTREMITY MOTION UNITS” Revised: Statement pertaining to products that provide single motion or combination of motions, to include HCPCS codes L5985 and L5988 and to note “functional movement of lower limb during ambulation” Added: “manufactured by R.G. Rincoe & Associates, Inc.” to L5968 coding guideline predicate product information Added: “PARTIAL FOOT AND TOE FILLER INSERTS” Removed: “MODIFIERS” CODING VERIFICATION REVIEW: Revised: Location of coding verification review information *05/26/2022: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*

Revision History Date	Revision History Number	Revision History Explanation
08/01/2020	R10	Revision Effective Date: 08/01/2020 REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217): Removed: “The link will be located here once it is available.” Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list *04/14/2022: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
08/01/2020	R9	Revision Effective Date: 08/01/2020 CODING GUIDELINES: Removed: Trademark symbols Removed: “etc.” from the not all-inclusive list of other components of a prosthesis Revised: Infinite Socket TT-S information, to include addition HCPCS code L5637 Revised: Coding guidelines for HCPCS codes L5968 and L5986 CODING VERIFICATION REVIEW: Added: “(PCL)” after reference to “Product Classification List” Added: Incorrect coding denial language for products billed using HCPCS that require written coding verification review *03/18/2021: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
08/01/2020	R8	Revision Effective Date: 08/01/2020 CODING GUIDELINES: Added: Coding guidelines for HCPCS codes L5856, L5857, L5858, L5980, L5981, and L5987 CODING VERIFICATION REVIEW: Added: Section header for information related to PDAC coding verification review Revised: PDAC coding verification review information for HCPCS code L5969, to include effective for DOS on or after 01/01/2014 Added: PDAC coding verification review information for HCPCS codes L5856, L5857, L5858, L5973, L5980, and L5987, effective for DOS on or after 01/01/2021

Revision History Date	Revision History Number	Revision History Explanation
		06/25/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.
01/01/2020	R7	Revision Effective Date: 01/01/2020 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Revised: Format of HCPCS codes referenced, from code 'spans' to individually-listed HCPCS Revised: "physician's" to "treating practitioner's" Revised: "physician" to "practitioner" REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217): Added: Section and related information based on Final Rule 1713 POLICY SPECIFIC DOCUMENTATION REQUIRMENTS: Revised: Format of HCPCS code references, from code 'spans' to individually-listed HCPCS Revised: "ordering physician" to "treating practitioner" Revised: "physician's" to "treating practitioner's" CODING GUIDELINES: Revised: Section to include sub-headers for organization of coding guidelines and related information Added: Information related to prosthetic systems, sockets, and Infinite Socket information Revised: Format of HCPCS code references, from code 'spans' to individually-listed HCPCS Added: Coding guidelines and related information for Knees, Ankles, Feet, and Microprocessor Ankle Foot Systems ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY: Revised: Section header "ICD-10 Codes that are Covered" updated to "ICD-10 Codes that Support Medical Necessity" ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY: Revised: Section header "ICD-10 Codes that are Not Covered" updated to "ICD-10 Codes that DO NOT Support Medical Necessity" *03/12/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
03/01/2019	R6	Revision Effective Date: 03/01/2019 CODING GUIDELINES:

Revision History Date	Revision History Number	Revision History Explanation
		Removed: L8505 from list of batteries billed concurrently with powered base, due to technical correction Removed: L8505 from Column II of rebundling table, due to technical correction *02/21/2019: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
03/01/2019	R5	Revision Effective Date: 03/01/2019 CODING GUIDELINES: Revised: RT and LT modifier billing instructions *02/07/2019: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
01/01/2018	R4	Revision Effective Date: 01/01/2018 CODING GUIDELINES: Revised: "liner" to "insert" for continuity of terms Added: Coding guidelines for prosthetic covers (L5704-L5707) and Protective outer surface covering systems (L5962, L5964, and L5966) Added: Bundling table for Coding Batteries and Chargers Concurrently With a Powered Base Item *04/12/2018: At this time 21st Century Cures Act applies to new and revised LCDs that restrict coverage, which require comment and notice. This revision is to an article that is not a local coverage determination.*
01/01/2018	R3	Revision Effective Date: 01/01/2018 CODING GUIDELINES: Added: Coding guidelines and bundling information for L7700 *12/21/2017: At this time 21st Century Cures Act applies to new and revised LCDs that restrict coverage, which require comment and notice. This revision is to an article that is not a local coverage determination.*

Revision History Date	Revision History Number	Revision History Explanation
01/01/2017	R2	Revision Effective Date: 01/01/2017 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Updated: codes included in SNF payment due to clerical error POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Added: Modifier instructions and Repair/Replacement language RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements Language Article
07/01/2016	R1	Effective July 1, 2016 oversight for DME MAC Articles is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the Articles.

Associated Documents

Related Local Coverage Documents

Articles

A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs

LCDs

L33787 - Lower Limb Prostheses

Related National Coverage Documents

NCDs

N/A

Statutory Requirements URLs

N/A

Rules and Regulations URLs

N/A

CMS Manual Explanations URLs

N/A

Other URLs

N/A

Public Versions

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Keywords

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