

State of California
DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation

**NOTICE OF MODIFICATION TO TEXT OF
PROPOSED REGULATIONS
(Official Medical Fee Schedule and Medical Legal Fee Schedule)**

NOTICE IS HEREBY GIVEN pursuant to Labor Code Section 5307.1 and Government Code Section 11346.8(c) that the Administrative Director of the Division of Workers' Compensation proposes to modify the text of the proposed amendments to the text of the Official Medical Fee Schedule, (a document that is incorporated by reference into Title 8, California Code of Regulations, Section 9791.1) and Title 8, California Code of Regulations, Section 9791.1.

Sections 9791.1 concerns fees for medical treatment in workers' compensation cases.

AN IMPORTANT PROCEDURAL NOTE ABOUT THIS RULEMAKING:

The regulations relating to the Official Medical Fee Schedule ("OMFS") and the Medical-Legal Fee Schedule ("MLFS") are regulations that establish or fix rates, prices, or tariffs" within the meaning of Government Code Section 11340.9(g) and are therefore not subject to Chapter 3.5 of the Administrative Procedure Act relating to rulemaking (commencing at Government Code Section 11340.)

This rulemaking proceeding to amend the OMFS and MLFS are being conducted under the Administrative Director's rulemaking power under Labor Code Sections 5307.1, 5307.3, 5307.4, and 5307.6. This regulatory proceeding is subject to the procedural requirements of Labor Code Sections 5307.1 and 5307.4. This Notice was prepared to comply with the procedural requirements of Labor Code Section 5307.4 and for the convenience of the regulated public to assist the regulated public in analyzing and commenting on this non-APA rulemaking proceeding.

PRESENTATION OF WRITTEN COMMENTS AND DEADLINE FOR SUBMISSION OF WRITTEN COMMENTS

Members of the public are invited to present written comments regarding these proposed modifications. **Only comments directly concerning the proposed modifications to the text of the regulations will be considered and responded to in the Final Statement of Reasons.**

Written comments should be addressed to:

Marcela Reyes, Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142

The Division's contact person must receive all written comments concerning the proposed modifications to the regulations no later than 5:00 p.m. on Friday February 22, 2002. Written comments may be submitted by facsimile transmission (FAX), addressed to the contact person at (415) 703-4720. Written comments may also be sent electronically (via e-mail), using the following e-mail address: dwcrules@hq.dir.ca.gov .

AVAILABILITY OF TEXT OF REGULATIONS AND RULEMAKING FILE

Copies of the original text and modified text with modifications clearly indicated, and the entire rulemaking file, are currently available for public review during normal business hours of 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding legal holidays, at the offices of the Division of Workers' Compensation. The Division is located at 455 Golden Gate Avenue, 9th Floor, San Francisco, California.

Please contact the Division's regulations coordinator, Ms. Marcela Reyes at (415) 703-4600 to arrange to inspect the rulemaking file.

The specific modifications proposed include changes to portions of the text of the Official Medical Fee Schedule, (a document that is incorporated by reference into Title 8, California Code of Regulations, Section 9791.1) and Title 8, California Code of Regulations, Section 9791.1. A copy of the proposed modified text is attached to this Notice.

FORMAT OF PROPOSED MODIFICATIONS

Proposed Text Noticed for 45-Day Comment Period:

Deletions from the codified regulatory text are indicated by strike-through, thus: ~~deleted language~~.

Additions to the codified regulatory text are indicated by underlining, thus: underlined language.

Proposed Text Noticed for This 15-Day Comment Period on Modified Text:

Deletions from the amended regulatory text as proposed on July 28, 2000, are indicated by strike-through under-line, thus: ~~deleted language~~.

Additions to the regulatory text as proposed on July 28, 2000, are indicated by a double underline, thus: added language.

Modifications to the text of the OMFS itself are shown in the above formats with the addition of ***bold italic*** font.

SUMMARY OF PROPOSED CHANGES

1. MODIFICATIONS TO THE TEXT OF THE OFFICIAL MEDICAL FEE SCHEDULE

A. General Information and Instructions for Use Section - Services Covered-Page 1

The proposed language is being amended to allow a facility fee to be charged by any ambulatory surgical center that is certified to participate in the Medicare program under Title XIX (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act, or any accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4.

B. General Information and Instructions for Use Section - Supplies and Material - Page 4

The proposed language is being amended to clarify that the additional storage and handling charge permitted (20% of cost up to a maximum of cost plus \$15.00), may not exceed the provider's usual and customary charge for the item.

C. General Information and Instructions for Use Section - Dispensed Durable Medical Equipment - Page 4

The proposed language is being amended to clarify that the additional storage and handling charge permitted (50% of cost up to a maximum of cost plus \$25.00), may not exceed the provider's or retailer's usual and customary charge for the item.

D. General Information and Instructions for Use Section - Consultation Reports-Page 7

The proposed language stating that a consultation code may not be billed when care or any part of care has been transferred by the primary treating physician to another physician is being amended to improve its clarity.

E. Manipulative Treatment - Page 510

The Division is withdrawing, for further study and discussion during the next full revision of the OMFS, the proposed language deleting the statement that the Physical Medicine and Rehabilitation ground rules apply to osteopathic manipulative treatment codes.

F. Effective dates – Pages 1, 3, 4, 7, 8, 13, 82, 351, 394, 451, 498, 503, 505, 501 and 534 - 546

The effective date for each proposed amendment and/or adoption is being updated from */*/2001 to */*/2002. As explained in Section 2 below, in order to give the regulated public time to train their staff and implement the proposed amendments, the Division will ask the Office of Administrative Law for the adopted amendments to have an effective date of *thirty (30) days* after their filing with the Secretary of State. The Office of Administrative Law will fill in the

effective date of the regulations as adopted as *thirty (30) days* after the date on which the regulations as adopted were filed with the Secretary of State.

2. MODIFICATIONS TO SECTION 9791.1

Section 9791.1 incorporates the Official Medical Fee Schedule effective January 1, 1994 and as revised for services on or after January 1, 1996 into Title 8, California Code of Regulations. This section is being amended to set forth the effective date of the currently proposed amendments.

In order to give the regulated public time to train their staff and implement the proposed amendments, the Division will ask the Office of Administrative Law for the adopted amendments to have an effective date of *thirty (30) days* after their filing with the Secretary of State. The Office of Administrative Law will fill in the effective date as *thirty (30) days* after the date on which the amendments as adopted were filed with the Secretary of State.

The effective dates for the proposed amendments will be made available on the Division's website (http://www.dir.ca.gov/workers'_comp.html) as soon as their effective date is received from the Office of Administrative Law.

**Division of Workers' Compensation
Administrative Director - Administrative Rules
Title 8 California Code of Regulations
Chapter 4.5, Subchapter 1
Article 5.5, Article 5.6**

*** An important note about the effective date of the proposed amendments to the OMFS:**

In order to give the regulated public time to train their staff and implement the proposed amendments set forth below, the Division will ask the Office of Administrative Law for the proposed amendments to have an effective date of *thirty (30) days* after their filing with the Secretary of State. The Office of Administrative Law will fill in the effective date as *thirty (30) days* after the date on which the amendments as adopted are filed with the Secretary of State.

The effective dates for the proposed amendments set forth below will be made available on the Division's website (http://www.dir.ca.gov/workers'_comp.html) as soon as their effective date is received from the Office of Administrative Law.

FORMAT OF PROPOSED MODIFICATIONS

Proposed Text Noticed for Original 45-Day Comment Period:

Deletions from the codified regulatory text are indicated by strike-through, thus: ~~deleted language~~.

Additions to the codified regulatory text are indicated by underlining, thus: underlined language.

Proposed Text Noticed for This 15-Day Comment Period on Modified Text:

Deletions from the amended regulatory text as proposed on July 20, 2001, are indicated by strike-through under-line, thus: ~~deleted language~~.

Additions to the regulatory text as proposed on July 20, 2001, are indicated by a double underline, thus: added language.

Modifications to the text of the OMFS itself are shown in the above formats with the addition of *bold italic* font.

§9791.1 Medical Fee Schedule

The Official Medical Fee Schedule shall include the procedures, procedure numbers, descriptions, instructions, and unit values adopted by the Administrative Director, effective January 1, 1994; as revised for services on or after January 1, 1996; and as thereafter revised and adopted. The

Official California Workers' Compensation Medical Fee Schedule (Revised April 1, 1999, and as amended for dates of service on or after **/01 02) is hereby incorporated by reference. An order form for purchasing a copy of the Schedule can be obtained by contacting the Division of Workers' Compensation at the following address:

DIVISION OF WORKERS' COMPENSATION
(ATTENTION: OMFS ORDER)
P.O. BOX 420603
SAN FRANCISCO, CALIFORNIA 94142

The amendments to the OMFS for dates of service on or after **/01 02 may be obtained either by purchasing them from the Division or they may be downloaded at no charge from the Division's website at (<http://www.dir.ca.gov/workers' comp.html>).

Note: Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

GENERAL INFORMATION AND INSTRUCTIONS

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INTRODUCTION

AUTHORITY

Pursuant to the provisions of Labor Code Sections 4603.5 and 5307.1, the Administrative Director of the Division of Workers' Compensation has adopted the Official Medical Fee Schedule as the basis for billing and payment of medical services provided injured employees under the Workers' Compensation Laws of the State of California.

This revision to the Official Medical Fee Schedule sets forth changes to the procedures, procedure numbers, descriptions, instructions, ground rules and unit values adopted by the Administrative Director. The amendments to the Official Medical Fee Schedule contained in the 1998 revision are effective for services rendered on or after April 1, 1999.

Use this schedule for services rendered on or after April 1, 1999. You will need to consult the applicable prior schedule for services that were provided prior to April 1, 1999.

The text in this revision of the Official Medical Fee Schedule is formatted to identify its sources. Language from the American Medical Association's Current Procedural Terminology (CPT) is identified by non-italicized text (eg, "American Medical Association"). Relative values and California modifications to the CPT language are identified by italics (eg, "California Official Medical Fee Schedule"). Language which is new and changed in this revision is underlined (eg, "American Medical Association" identifies new text from the 1997 CPT and "Official Medical Fee Schedule" identifies new California language).

SERVICES COVERED

The Official Medical Fee Schedule applies to all covered medical services provided, referred or prescribed by physicians (as defined in Section 3209.3 of the Labor Code), regardless of the type of facility in which the medical services are performed, including clinic and hospital based physicians working on a contract basis. The Schedule shall not apply to inpatient medical services provided by employees of a health facility, medical-legal expenses authorized under Section 4621 of the Labor Code, and medical expenses payable pursuant to Section 9795 of the California Code of Regulations.

Nothing contained in this schedule shall preclude any hospital as defined in subdivisions (a), (b), or (f) of Section 1250 of the Health and Safety Code, or any surgical facility which is licensed under subdivision (b) of Section 1204 of the Health and Safety Code, or any ambulatory surgical center that is certified to participate in the Medicare program under Title XIX (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act, or any surgical clinic accredited by the Accreditation Association for Ambulatory Health Care (AAAHC) accrediting agency as approved by the Licensing

Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4, from charging and collecting a facility fee for the use of the emergency room or operating room of the facility. Outpatient procedures and services which are included in this fee schedule and which are provided in the emergency room or operating room of a hospital or in a freestanding outpatient surgery facility shall be reimbursed in accordance with this fee schedule.

No facility except those specified in the immediately preceding paragraph may charge or collect a facility fee for services provided on an outpatient basis

Hospital treatment rooms used by physicians for providing outpatient non-emergency follow-up services are not separately reimbursable as they are included in the value of the Evaluation and Management service codes.

CODES, MODIFIERS and SYMBOLS

The coding in this edition of the Official Medical Fee Schedule primarily uses the procedure codes, descriptors, and modifiers of the American Medical Association's Physicians' Current Procedural Terminology (CPT) 1997, copyright 1996, American Medical Association.

The Schedule also includes codes, descriptors, and modifiers that are unique to California, or California changes to CPT codes. Unique California codes, and CPT codes modified for California, are designated in the schedule by the symbol "∞".

Codes that have been revised since the last edition of the Schedule are designated by the symbol "®".

Codes that are new are designated by the symbol "Δ".

The "Orthotics and Prosthetics" section of the schedule uses the identifiers listed in Title 22, California Code of Regulations, Section 51051 and Section 51515.

FORMAT

The Official Medical Fee Schedule consists of seven major sections. Within each section are subsections with anatomic, procedural, condition, or descriptor subheadings.

The section numbers and their sequence are as follows:

EVALUATION and MANAGEMENT	99201 to 99499
ANESTHESIOLOGY	00100 to 01999
	99100 to 99140
SURGERY	10040 to 69979

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GENERAL INSTRUCTIONS

FEE COMPUTATION AND BILLING PROCEDURES

Except as otherwise provided in this Schedule, the fee amount is established by multiplying the listed unit value of the procedure by the applicable conversion factor set forth in Title 8, CCR Section 9792 (see Appendix B for the list of current conversion factors). The resultant fee establishes a reasonable maximum fee to be paid for the particular medical service provided (Labor Code Section 5307.1(a)).

A medical provider or a licensed health care facility may be paid by an employer or carrier fees in excess of those set forth in the Official Medical Fee Schedule, provided that the fee is: reasonable, accompanied by itemization, and justified by an explanation of extraordinary circumstances related to the unusual nature of the medical services rendered. In no event shall a physician charge in excess of his or her usual fee (Labor Code Section 5307.1(b)).

California law requires the employer (or insurer) to provide all medical care necessary to cure and relieve the effects of the employee's industrial or work related illness or injury. Accordingly, under no circumstances shall the employee be billed for the treatment for which the employee has filed a workers' compensation claim unless the medical provider has received written notice that the claim has been rejected (Labor Code Section 3751(b)).

Conversion factors to be applied to the unit values contained in the schedule are adjusted periodically after public hearings conducted by the Administrative Director, Division of Workers' Compensation. The conversion factors currently in use are included in appendix C of this schedule.

Total reimbursement for the professional and technical components of procedures shall not exceed the listed value for the total procedure.

Billings must include each provider's professional designation and, if applicable, the license or certification number of the person providing the service and shall be limited to services allowed by the provider's authorized scope of practice.

Practitioners who are not physicians as defined by California workers' compensation law, including orthotists; prosthetists; nurse practitioners; physician assistants; marriage, family and child counselors; and licensed clinical social workers, who are acting within the scope of their license, certification or education and who have received authorization from the payer to treat an injured worker, may be reimbursed in accordance with this Schedule.

Nonphysicians billing under this fee schedule shall use the appropriate modifier. (See the appropriate specialty section for nonphysician modifiers).

Claims administrators shall make determinations regarding authorization for payment of medical bills in accordance with all relevant statutes and regulations, including but not limited to Labor Code Sections 4600 and 4062; Title 8, California Code of Regulations Section 9792.6; and this Official Medical Fee Schedule.

CONFIRMATION OF VERBAL AUTHORIZATION FOR PAYMENT

This policy applies only to those services listed in the Official Medical Fee Schedule which require prior authorization or to services for which the provider voluntarily seeks confirmation of authorization.

When verbal authorization for payment is given for this purpose, the claims administrator shall provide to the provider (1) a confirmation number that the provider shall place on the bill when billing for the service, or (2) a written confirmation of the verbal authorization. Confirmation shall be placed in the mail to the provider by the claims administrator within five working days of the verbal authorization.

When authorization is given either verbally or through a written authorization, the claims administrator is obligated to pay for the services authorized in accordance with the Official Medical Fee Schedule or other contractual payment arrangements previously agreed.

In the event the claims administrator subsequently determines that authorization for payment should be terminated, the claims administrator shall notify the provider in writing of this change.

SUPPLIES AND MATERIALS

Supplies and/or materials normally necessary to perform the service are not separately reimbursable. Supplies and materials provided over and above those usually included with the office or other services rendered may be charged for separately.

Examples of supplies that are usually not separately reimbursable include:
applied hot or cold packs
eye patches
injections or debridement trays
steristrips

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medical opinion on the necessity or appropriateness of previously recommended medical treatment or a surgical procedure. A confirmatory consultation (CPT codes 99271-99275) may also be charged by the consulting physician.

- A report by a consulting physician, where consultation was requested on one or more medical issues by a party, the Administrative Director, or the Workers' Compensation Appeals Board. Reports included under this section are those reports that are admissible and reimbursable in accordance with Labor Code Section 4064(c). An office consultation (CPT codes 99241-99245) may also be charged by the consulting physician.
- A report by the treating physician, where medical information other than that required to be reported under the treatment report section above was requested by a party, the Administrative Director, or the Workers' Compensation Appeals Board. An office consultation (CPT codes 99241-99245) may also be charged by the treating physician in this circumstance.
- A report by a consulting physician where the claim does not meet the criteria of a "contested claim" as set forth in 8 CCR § 9793(b).
- A consultation code may not be billed when care or any part of care has been clearly transferred from by the primary treating physician to the consulting another physician. (See definition of Referral under the Evaluation and Management Section page 11.)

PROLONGED SERVICE CODES

Where appropriate, a treating or consulting physician may be paid for service which extends beyond the usual service time for a particular Evaluation and Management code. The prolonged service codes are of two types in the outpatient setting: direct (face-to-face) patient contact (CPT codes 99354 and 99355), and without direct (face-to-face) patient contact (CPT code 99358).

Where the physician is required to spend at least 30 minutes or more of direct (face-to-face) time in addition to the time set forth in the appropriate CPT code (eg, at least 90 minutes in an office consultation under CPT code 99244), then CPT codes 99354 and, where appropriate, 99355 may be charged in addition to the basic charge for the appropriate Evaluation and Management code.

Where the physician is required to spend 15 or more minutes before and/or after direct (face-to-face) patient contact in reviewing extensive records, tests or in communication with other professionals, the CPT code 99358 may be charged in addition to

the basic charge for the appropriate Evaluation and Management code.

CPT code 99358 may also be used where the physician is required to spend 15 or more minutes reviewing records or tests, a job analysis, an evaluation of ergonomic status, work limitations, or work capacity when there is no direct (face-to-face) contact; however, in this case, the physician is not entitled to charge an Evaluation and Management code. For example, if subsequent to an examination of the employee, a consulting physician is asked to prepare a supplemental report based on a review of additional medical records, and the physician spends 15 minutes in this review, CPT code 99358 may be charged along with CPT code 99080 for a report, but no Evaluation and Management code may be charged.

DIETARY SUPPLEMENTS

Dietary supplements such as minerals and vitamins shall not be reimbursable unless a specific dietary deficiency has been clinically established in the injured employee as a result of the industrial injury or illness.

PROCEDURES WITHOUT UNIT VALUES ("BY REPORT")

Unit values are not shown for some procedures listed in the Schedule. Fees for such procedures need to be justified by report, although a detailed clinical record is not necessary.

By Report (BR): Procedures coded BR (By Report) are services which are unusual or variable.

An unlisted service or one that is rarely provided, unusual or variable may require a report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service. Additional items which may be included are:

- complexity of symptoms;
- final diagnosis;
- pertinent physical findings;
- diagnostic and therapeutic procedures;
- concurrent problems;
- follow-up care.

In some instances, the values of BR procedures may be determined using the value assigned to a comparable procedure. The comparable procedure should reflect the same amount of time, complexity, expertise, etc., as required for the procedure performed.

SEPARATE PROCEDURES

Some of the listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate reimbursement. When however, such a procedure is

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performed independent of and is not immediately related to other services, it may be listed as a "separate procedure." Thus, when a procedure is performed alone for a specific purpose it may be considered to be a separate procedure.

STARRED PROCEDURES

The star "*" is used to identify certain surgical procedures. A description of this reporting mechanism is found in the Surgery ground rules.

SPECIAL SERVICES AND REPORTS

The procedures with code numbers 99000 through 99090 provide the reporting physician or health care provider with the means of identifying the completion of special reports and services that are an adjunct to the basic services rendered. The specific number assigned indicates the special circumstances under which a basic procedure is performed. Charges for services generally provided as an adjunct to common medical services should be billed only when circumstances clearly warrant an additional charge over and above the scheduled charges for the basic services.

CHART NOTES

Requests for chart notes shall be in writing and shall be separately reimbursable at \$10.00 for up to the first 15 pages. Pages in excess of 15 shall be reimbursable at \$0.25 per page. Chart note requests shall be made only by the claims administrator. Code 99086 is used to bill for chart notes "By Report", using these guidelines.

DUPLICATE REPORTS

A primary treating physician has fulfilled his or her reporting duties by sending one copy of a required report to the claims administrator or to a person designated by the claims administrator to be the recipient of the required report. Requests for duplicate reports related to billings shall be in writing. Duplicate reports shall be separately reimbursable. Where the payer requests an additional copy of the reports, the payer shall reimburse for the duplicate report at \$10.00 for up to the first 15 pages. Pages in excess of 15 pages shall be reimbursed at \$0.25 per page. Charges for duplicate reports shall be billed using code 99087. Requests for duplicate reports shall be made only by the claims administrator.

MISSED APPOINTMENTS

Code 99049 may be used to indicate missed appointments on a By-Report (BR) basis. This code is designed for communication purposes only. It does not imply that compensation is necessarily owed.

This code applies to both treatment and consultation appointments. For Medical-Legal missed appointments use the appropriate code from the Medical-Legal Fee Schedule - CCR 9795 (see Appendix C).

MODIFIERS

A modifier provides the means by which the reporting physician or health care provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. The judicious application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of a report that:

- A service or procedure has both a professional and technical component.
- A service or procedure was performed by more than one physician and/or in more than one location.
- A service or procedure has been increased or reduced.
- Only part of service was performed.
- An adjunctive service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.
- Unusual events occurred.

A listing of modifiers pertinent to Evaluation and Management, Anesthesia, Surgery, Radiology, Pathology, and Medicine is located in the Ground Rules of each section. A complete listing of modifiers is found in Appendix A.

GLOBAL SERVICE PROFESSIONAL COMPONENT AND TECHNICAL COMPONENT REIMBURSEMENT

Certain procedures are a combination of both a physician (professional) and a technical component. The listed values are total values that include both the professional and technical components. Total reimbursement for the professional and technical components combined shall not exceed the listed value for the total procedure, regardless of the site(s) where services are rendered. When both the professional and technical components of such procedures are performed by the same provider, a global service has been rendered. When the professional or technical component of a procedure is billed separately it shall be valued according to the percent of the total value indicated in the "PC/TC" column of the fee schedule. When reporting a procedure for which there is a professional/technical component split listed in this schedule use the modifier which appropriately describes the service rendered (i.e., '-26', '-27').

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EVALUATION AND MANAGEMENT

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case management codes.

The final component, Time, is discussed in detail *in this section*.

The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are **not** included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT codes are available *should be* reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (i.e., professional component) with preparation of *either* a separate distinctly identifiable signed written report *or* a separate distinctly identifiable section of an overall report (i.e. PR-2, PR-3, Narrative Report or Doctor's First Report of Injury) may also be reported separately, using the appropriate CPT code with the modifier -26 appended.

Nature Of Presenting Problem

A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for the encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

- **Minimal**--A problem that may not require the presence of the physician, but service is provided under the physician's supervision.
- **Self-limited or Minor**--A problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status OR has a good prognosis with management/compliance.
- **Low severity**--A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.
- **Moderate severity**--A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.
- **High severity**--A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

Past History

A review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about:

- prior major illnesses and injuries;
- prior operations;
- prior hospitalizations;
- current medications;
- allergies (e.g., drug, food);
- age appropriate immunization status;
- age appropriate feeding/dietary status.

Social History

An age appropriate review of past and current activities that includes significant information about:

- marital status and/or living arrangements;
- current employment;
- occupational history;
- use of drugs, alcohol, and tobacco;
- level of education;
- sexual history;
- other relevant social factors.

System Review (Review of Systems)

An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. For the purposes of CPT the following elements of a system review have been identified:

- Constitutional symptoms (fever, weight loss, etc.)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

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ANESTHESIA

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Anesthetist (CRNA) and is involved in medical direction of the patient, including pre- and post-operative evaluation and care, but is not personally administering the anesthesia, the reimbursement for the supervising physician shall be for the basic value of the procedure plus one unit per hour or fraction thereof for the duration of the anesthesia. In order to be reimbursable the anesthesiologist shall remain within visual and auditory range of the operating rooms under medical direction and shall extend medical direction to no more than two rooms. Medical direction excludes simultaneous administration of anesthesia by the anesthesiologist. Total reimbursement to the nurse anesthetist and the supervising anesthesiologist shall not exceed the listed value of this service if performed by an anesthesiologist. Identify by adding modifier -48 to the appropriate anesthesia procedure code and anesthesia time code.

of extreme age, under one year and over seventy. 1

99116 Anesthesia complicated by utilization of total body hypothermia. 5

99135 Anesthesia complicated by utilization of controlled hypotension. 5

99140 Anesthesia complicated by emergency conditions (specify). 2

These services are reimbursed using the Anesthesia Conversion Factor.

An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part. Use 99140.

@-51 Multiple Procedures

~~When multiple procedures are performed on the same day or at the same session, the major procedure or service is reported as listed. The secondary additional, or lesser procedure(s) or service(s) may be identified by adding modifier -51 to the secondary procedure or service code(s).~~

∞ - 75 Concurrent Care, Services Rendered by More Than One Physician:

When the patient's condition requires the additional services of more than one physician, each physician may identify his or her services by adding the modifier -75 to the basic service performed.

11. QUALIFYING CIRCUMSTANCES

(More Than One May Be Selected.)

Many anesthesia services are provided under particularly difficult circumstances depending on factors such as extraordinary condition of patient, notable operative conditions or the unusual risk factors. This section includes a list of important qualifying circumstances that significantly impact on the character of the anesthesia service provided. These procedures would not be reported alone but would be reported as additional procedure numbers qualifying an anesthesia procedure or service. *These modifying units may be added to the basic unit value.*

CPT

RVs

99100 Anesthesia for patient

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Radiology and Nuclear Medicine

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are reviewed in conjunction with a visit, consultation, record review, or other evaluation, no separate charge is warranted for the review by the medical practitioner or other medical personnel. Neither the professional component value modifier '-26' nor the radiologic consultation code (76140) is reimbursable under this circumstance. The review of diagnostic tests is included in the Evaluation and Management codes.

X-ray Consultation: Code 76140 is reimbursable only when the advice or expert opinion of a physician is requested regarding a specific diagnostic problem. Value at 100% of the listed value of the Professional Component of the x-ray study for which the consultation is made. Code 76140 is not reimbursable for routine confirmatory readings of x-ray films.

When radiology films or scans are duplicated for medical purposes, reimburse using code(s) 76175 and/or 76176, at \$5.00 per x-ray and \$10.00 per scan sheet as appropriate. Requests for duplication of films and scans shall be in writing.

9. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier code, which is reported by a two-digit number placed after the usual procedure number from which it is separated by a hyphen. If more than one modifier is used, place the Multiple Modifiers code '-99' immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Modifiers commonly used in **Radiology (including Nuclear Medicine and Diagnostic Ultrasound)** are listed below.

Modifier - 29 for global procedures (those procedures where one provider is responsible for both the professional and technical component) has been deleted. If a provider is billing for a global service, no modifier is necessary.

Ⓢ-22 Unusual Procedural Services:

When the service(s) provided is greater than that usually required for the listed procedure, it is identified by adding modifier '-22' to the usual procedure number. *Documentation is required.*

Note: Modifier '-22' may be utilized with computerized tomography numbers when additional slices are required or a more detailed examination is necessary.

Ⓢ-26 Professional Component:

Certain procedures are a combination of a physician

component and a technical component. When the physician component is reported separately, the service is identified by adding the modifier '-26' to the usual procedure number.

∞-27 Technical component:

Under certain circumstances, a charge may be made for the technical component alone (see definition of technical component under Radiology and Pathology sections, General Information and Ground Rules). Identify the technical component charge by adding modifier '-27' to the usual procedure code, and value in accordance with the ground rules for the section.

Δ-30 Consultation Service During Medical-legal

Evaluation:

Services or procedures performed by a consultant in the context of a medical-legal evaluation are identified by adding the modifier '-30' to the basic service or procedure code.

Ⓢ-32 Mandated Services:

Services related to mandated consultation and/or related services (eg, PRO, 3rd party payer) is identified by adding the modifier '-32' to the basic procedure.

Δ-51 Multiple Procedures:

When multiple procedures, other than Evaluation and Management Services, are performed on the same day or at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) are identified by appending the modifier '-51' to the additional procedure or service code(s).

Note: This modifier should not be appended to designated "add-on" codes (eg, 22612, 22614).

-52 Reduced Services:

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '-52' signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

Note: Modifier '-52' may be utilized with computerized tomography numbers for a limited study or a follow-up study.

∞ - California Code/Revision; Δ - New Code; Ⓢ - Revised Code; **BR** - By report

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to provide the service. Additional items which may be included are:

- complexity of symptoms;
- final diagnosis;
- pertinent physical findings;
- diagnostic and therapeutic procedures;
- concurrent problems;
- follow-up care.

In some instances, the values of BR procedures may be determined using the value assigned to a comparable procedure. The comparable procedure should reflect the same amount of time, complexity, expertise, etc., as required for the procedure performed.

6. SPECIFIC BILLING INSTRUCTIONS: GLOBAL SERVICE, PROFESSIONAL COMPONENT AND TECHNICAL COMPONENT REIMBURSEMENT

The relativities listed in this section include recording of the specimen, performance of the test, and reporting of the result. They do not include specimen collection, transfer, or individual patient administrative services. (For reporting collection and handling, see the 99000 series.)

Certain procedures are a combination of both a physician (professional) and a technical component. The listed values are total values that include both the professional and technical components. Total reimbursement for the professional and technical components combined shall not exceed the listed value for the total procedure, regardless of the site(s) where services are rendered. When both the professional and technical components of such procedures are performed by the same provider, a global service has been rendered. When the professional or technical component of a procedure is billed separately it shall be valued according to the percent of the total value indicated in the "PC/TC" column of the fee schedule. When reporting a procedure for which there is a professional/technical component split listed in this schedule use the modifier which appropriate describes the service rendered (i.e., '-26', '-27').

The listed values apply to physicians, physician-owned laboratories, commercial laboratories, and hospital laboratories.

Global Service: *Certain procedures are a combination of both a physician (professional) and a technical component. When both the professional and technical components of such procedures are performed by the same provider, a global service has been rendered.*

Professional Component: *The professional component represents the value of the professional pathology services or of the physician. This includes examination of the patient, when indicated, performance and/or supervision of the procedure, interpretation and written report of the laboratory procedure, and consultation with the referring physician. (Report using modifier '-26'.)*

Technical Component: *The technical component includes the charges for personnel, materials, space, equipment, and other facilities. (Report using modifier '-27'.)*

The column designated PC/TC indicates the percent of the global fee (RV) for the technical and professional components of the procedure.

7. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier code. The modifier is reported by a two digit number placed after the usual procedure number from which it is separated by a hyphen. If more than one modifier is used, place the "Multiple Modifiers" code '-99' immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Modifiers commonly used in **Pathology and Laboratory** are as follows:

Modifier - 29 for global procedures (those procedures where one provider is responsible for both the professional and technical component) has been deleted. If a provider is billing for a global service, no modifier is necessary.

®-22 Unusual Procedural Services

When the service(s) provided is greater than that usually required for the listed procedure, it is identified by adding the modifier '-22' to the usual procedure number. *Documentation is required.*

®-26 Professional Component

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service is identified by adding the modifier '-26' to the usual procedure number.

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5. UNLISTED SERVICE OR PROCEDURE

A service or procedure may be provided that is not listed in this edition of *this Schedule*. When reporting such a service, the appropriate "Unlisted Procedure" code may be used to indicate the service, identifying it By Report as discussed in *Item 6 below*. The "Unlisted Procedures" and accompanying codes for **Medicine** are as follows:

<u>90749</u>	<u>Unlisted Immunization procedure</u>
<u>90799</u>	<u>Unlisted therapeutic or diagnostic injection</u>
<u>90899</u>	<u>Unlisted psychiatric service or procedure</u>
<u>90915</u>	<u>Unlisted biofeedback procedure</u>
<u>90999</u>	<u>Unlisted dialysis procedure, inpatient or outpatient</u>
<u>91299</u>	<u>Unlisted diagnostic gastroenterology procedure</u>
<u>92499</u>	<u>Unlisted ophthalmological service or procedure</u>
<u>92599</u>	<u>Unlisted otorhinolaryngological service or procedure</u>
<u>93799</u>	<u>Unlisted cardiovascular service or procedure</u>
<u>94799</u>	<u>Unlisted pulmonary service or procedure</u>
<u>95199</u>	<u>Unlisted allergy/clinical immunologic service or procedure</u>
<u>95999</u>	<u>Unlisted neurological or neuromuscular diagnostic procedure</u>
<u>96549</u>	<u>Unlisted chemotherapy procedure</u>
<u>96999</u>	<u>Unlisted special dermatological service or procedure</u>
<u>97039</u>	<u>Unlisted physical medicine modality</u>
<u>97139</u>	<u>Unlisted physical medicine therapeutic procedure</u>
<u>97799</u>	<u>Unlisted physical medicine service or procedure</u>
<u>99199</u>	<u>Unlisted special service or report</u>

6. PROCEDURES WITHOUT UNIT VALUE ("BY REPORT")

Unit values are not shown for some procedures listed in the Schedule. Fees for such procedures need to be justified by report, although a detailed clinical record is not necessary.

By Report (BR): Procedures coded BR (By Report) are services which are unusual or variable.

An unlisted service or one that is rarely provided, unusual or variable may require a report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service. Additional items which may be included are:

- complexity of symptoms;
- final diagnosis;
- pertinent physical findings;
- diagnostic and therapeutic procedures;
- concurrent problems;
- follow-up care.

In some instances, the values of BR procedures may be determined using the value assigned to a comparable procedure. The comparable procedure should reflect the same amount of time, complexity, expertise, etc., as required for the procedure performed.

7. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code. The modifier is reported by a two digit number placed after the usual procedure number from which it is separated by a hyphen. If more than one modifier is used, place the Multiple Modifiers code '-99' immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Modifiers commonly used in Medicine are listed below.

Modifier - 29 for global procedures (those procedures where one provider is responsible for both the professional and technical component) has been deleted. If a provider is billing for a global service, no modifier is necessary.

®-22 Unusual Procedural Services

When the service(s) provided is greater than that usually required for the listed procedure, it is identified by adding the modifier '-22' to the usual procedure number. *Documentation is required.*

®-25 **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure or Other Service**
The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated

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CPT CODE	Rel Value	Descriptor	CPT CODE	Rel Value	Descriptor
		(For development of cognitive skills, see <u>97799</u>)	® 96111	21.8	<u>extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, eg, Bayley Scales of Infant Development) with interpretation and report, per hour</u>
		<u>Marriage, family and child counselors and licensed clinical social workers billing under this fee schedule shall use modifier '- 88'. (See item 7, "Modifiers", in the Medicine Section.)</u>			
96100	17.1	Psychological testing (includes psycho-diagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, eg, WAIS-R, Rorschach, MMPI) with interpretation and report, per hour	96115	22.8	80/20 Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report, per hour
96105	35.9	100/0 Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	96117	17.1	Neuropsychological testing battery (eg, Halstead-Reitan, Luria, WAIS-R) with interpretation and report, per hour
® 96110	19.6	80/20 Developmental testing; <u>limited: Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report</u>			CHEMOTHERAPY ADMINISTRATION Procedures 96400-96549 are independent of the patient's visit. <u>If significant separately identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported in addition to 96400-96549.</u>

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reimbursed at 100% of listed value)

Additional time codes are not subject to the multiple procedures calculation (97145, 97221, 97241, 97501, 97521, 97531, 97541, 97631).

Physical therapist Assessment and Evaluation codes and test and measurement procedures are not included in the multiple procedures calculation or in the "no more than four in one visit." Additional time procedures (97145, 97721, 97241, 97501, 97521, 97531, 97541, 97631) shall not be included in multiple procedures and modalities calculation for reimbursement, but they are included in the "no more than four in one visit" ground rule. Codes 97660, 97670, 97690-97752 and 98770-98778 are reimbursable only once in a 30-day period of time and may not be combined with another procedure code which provides similar data unless prior authorization is received.

f. The reimbursement for follow-up evaluation and management services for the routine reassessment of an established patient is included in the value of the treatment codes in the Physical Medicine Section of the schedule. Follow-up Evaluation and Management services for the re-examination of an established patient may be reimbursed in addition to physical medicine, manipulation, starred procedures and acupuncture only when any of the following applies:

- There is a definite measurable change in the patient's condition requiring a significant change in the treatment plan
- The patient fails to respond to treatment requiring a change in the treatment plan
- The patient's condition becomes permanent and stationary, or the patient is ready for discharge
- It is medically necessary to provide evaluation services over and above those normally provided during the therapeutic services and included in the reimbursement for physical medicine treatment (Documentation may be required)
- It is necessary to provide evaluation services to meet the reporting requirements set forth in Title 8, California Code of Regulations Section 9785 **(f)**.

g. Values for Physical Medicine codes and acupuncture codes include routine follow-up assessment for evaluation and management purposes and the value of an office visit. When an Evaluation and Management service, test and measurement service (codes 97660, 97670, 97690, 97700-97752, 98770-98778), or Physical therapist Assessment and Evaluation service is provided on the same day by the same licensed medical provider of service, 2.4 units of value using the Medicine conversion factor shall be deducted from the combined value of the treatment codes to account for the follow-up assessment for evaluation and management purposes and the office visit inherent in the treatment codes. This applies when the physician is the same provider giving physical medicine service or when the physical therapist is employed by a physician. When physical therapy is provided at a separate facility or when the physical therapy department has separate and distinct overhead costs of getting the patient in and out of the office, the full value for both codes shall be allowed.

h. Test and Measurement codes (97700-97752) shall not be reimbursed when billed with an Evaluation and Management (E/M) code or a Physical therapist Assessment and Evaluation (A/E) code unless justified by documentation.

i. Treatment using computer-assisted equipment is reimbursable under 97110 for less than 30 minutes. For treatments of 30 minutes or more, use 97620.

j. Patients who have progressed from individual exercise programs requiring a one-to-one interaction with the provider to an individualized exercise program supervised by the provider within a treatment facility, should be billed using 97630. Although some time may still be spent with the provider on a one-to-one basis, it is less than 50% of the visit. The group size is limited to a ratio of five patients to one provider.

k. Patient education programs (97650) must be clearly defined in terms of numbers of sessions and number of participants in the group. The sessions must be spaced over time.

2. WORK HARDENING

Work Hardening (97545) is a highly structured, goal-oriented, individualized treatment program designed to return the person to work. Work Hardening programs,

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CPT CODE	Rel Value	Descriptor	CPT CODE	Rel Value	Descriptor
PHYSICAL MEDICINE			PROCEDURES		
		(For muscle testing, range of joint motion, electromyography, see 95831 et seq)			(Physician or therapist is required to be in constant attendance)
		(For biofeedback training by EMG, see 90900)			(Except where otherwise specified, for additional procedure time beyond initial 30 minutes, use code 97145)
		(For transcutaneous nerve stimulation (TNS), see 64550. <i>This code should only be used by physicians.</i>)	97110	5.4	Physical medicine treatment to one area, initial 30 minutes, each visit; therapeutic exercises
		<u>(The appropriate physical medicine code for the use of a transcutaneous electrical nerve stimulator (TENS unit) is 97014.)</u>	97112	5.4	neuromuscular reeducation
			97114	5.4	functional activities
			97116	4.4	gait training
			97118	3.8	electrical stimulation (manual)
			97120	4.9	iontophoresis
			97122	3.3	traction, manual
97010	<u>0.0</u>	Physical medicine treatment to one area; hot or cold packs	97124	3.6	massage
97012	3.0	traction, mechanical	97126	3.3	contrast baths
97014	3.0	electrical stimulation (unattended)	97128	3.4	ultrasound
97016	3.0	vasopneumatic devices	97139	BR	unlisted procedure (specify)
97018	3.0	paraffin bath	97145	2.2	Physical medicine treatment to one area, each additional 15 minutes
97020	3.0	microwave	97220	6.0	Hubbard tank; initial 30 minutes, each visit
97022	3.0	whirlpool	97221	2.9	each additional 15 minutes, up to one hour
97024	3.0	diathermy	97240	8.2	Pool therapy or Hubbard tank with therapeutic exercises; initial 30 minutes, each visit
97026	3.0	infrared			
97028	3.0	ultraviolet			
97039	BR	unlisted modality (specify)			

∞ - California Code/Revision; Δ - New Code; @ - Revised Code; BR - By report

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Manipulative Treatment

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**OSTEOPATHIC
MANIPULATIVE TREATMENT**

Codes 98925-98929 may be used only by licensed Doctors of Osteopathy (D.O.s) and licensed Doctors of Medicine (M.D.s)

~~Note: also see Physical Medicine and Rehabilitation ground rules which apply to osteopathic manipulative treatment codes.~~

Note: also see Physical Medicine and Rehabilitation ground rules which apply to osteopathic manipulative treatment codes.

Osteopathic manipulative treatment is a form of manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques.

Evaluation and Management services may be reported separately if, and only if, the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure

Body regions referred to are: head region; cervical region; thoracic region; lumbar region, sacral region; pelvic region; lower extremities; upper extremities; rib cage region; abdomen and viscera region.

98925 6.2 Osteopathic manipulative treatment (OMT) one to two body regions involved

98926 9.3 three to four body regions involved

98927 11.0 five to six body regions involved

98928 12.8 seven to eight body regions involved

98929 13.9 nine to ten body regions involved

Prosthetics Maximum Reimbursement Rates

Code	Descriptor	Amount	Code	Descriptor	Amount
(1) ENDOSKELETAL - MODULAR					
Partial Foot					
L5000	Shoe insert with longitudinal arch, toe filler	\$ 501.00	L5210	Short prosthesis, no knee joint ("Stubbies"), with foot blocks, no ankle joints, each	\$ 2,467.00
L5010	Molded socket, ankle height, with toe filler	\$ 1,124.00	L5220	Short prostehsis, no knee joint ("Stubbies"), with articulated ankle/foot, dynamically aligned, each	\$ 3,064.00
L5020	Molded socket, tibial tubercle height, with toe filler	\$ 2,202.00	L5230	Constant friction knee, shin, SACH	\$ 4,266.00
Ankle			Hip Disarticulation		
L5050	Symes, molded socket, SACH foot	\$ 2,219.00	L5250	Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot	\$ 5,764.00
L5060	Symes, metal frame, molded leather socket, articulated ankle/foot	\$ 3,069.00	L5270	Tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin, SACH foot	\$ 5,713.00
Below Knee			Hemipelvectomy		
X8814	Bock	Preauthorize	L5280	Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot	\$ 5,656.00
X8816	Hosmer	Preauthorize	Endoskeletal - (Ultralight Weight Fixed System)		
X8818	United States Manufacturing Company (U.S.M.C.)	Preauthorize	L5300	Below knee, molded socket, SACH foot, endoskeletal system, including soft cover and finishing	\$ 3,048.00
L5100	Molded socket, shin, SACH foot	\$ 2,240.00	L5310	Knee disarticulation (or through knee), molded socket, SACH foot endoskeletal system, including soft cover and finishing	\$ 4,110.00
L5105	Plastic socket, joints and thigh lacer, SACH foot	\$ 3,859.00	L5320	Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee, including soft cover and finishing	\$ 4,682.00
Knee Disarticulation			L5330	Hip disarticulation, Canadian type; molded socket, endoskeletal system, hip joint, single axis knee, SACH foot, including soft cover and finishing	\$ 6,027.00
L5150	Molded socket, external knee joints, shin, SACH foot	\$ 3,901.00	L5340	Hemipelvectomy, Canadian type; molded socket, endoskeletal system, hip joint, single axis knee, SACH foot, including soft cover and finishing	\$ 6,988.00
L5160	Molded socket, bent knee configuration, external knee joints, shin, SACH foot	\$ 4,243.00			
Above Knee					
X8820	Bock	Preauthorize			
X8822	Hosmer	Preauthorize			
X8824	U.S.M.C.	Preauthorize			
L5200	Molded socket, single axis constant friction knee, shin, SACH foot	\$ 3,344.00			

Prosthetics Maximum Reimbursement Rates

Code	Descriptor	Amount	Code	Descriptor	Amount
Immediate and Early Post Surgical Procedures			L5530	"PTB" type socket, "U.S.M.C." or equal pylon, no cover, SACH foot, thermoplastic or equal, molded to model	\$ 1,919.00
L5400	Application of initial rigid dressing, including fitting, alignment, suspension, and one cast change, below knee	\$ 1,322.00	L5535	"PTB" type socket, "U.S.M.C." or equal prefabricated, adjustable open end socket	\$ 1,884.00
L5410	Application of initial rigid dressing, including fitting, alignment and suspension, below knee, each additional cast change and realignment	\$ 349.00	L5540	"PTB" type socket, "U.S.M.C." or equal pylon, no cover, SACH foot, laminated socket, molded to model	\$ 2,010.00
L5420	Application of initial rigid dressing, including fitting, alignment and suspension and one cast change "AK" or knee disarticulation	\$ 1,689.00	Preparatory Prosthesis - Above Knee		
L5430	Application of initial rigid dressing, including fitting, alignment and suspension, "AK" or knee disarticulation, each additional cast change and realignment	\$ 471.00	L5560	Knee disarticulation, ischial level socket, "U.S.M.C." or equal pylon, no cover, SACH foot, plaster socket, molded to model	\$ 1,959.00
L5450	Application of non-weight bearing rigid dressing, below knee	\$ 340.00	L5570	Knee disarticulation, ischial level socket, "U.S.M.C." or equal pylon, no cover, SACH foot, thermoplastic or equal, direct formed	\$ 2,148.00
L5460	Application of non-weight bearing rigid dressing, above knee	\$ 455.00	L5580	Knee disarticulation, ischial level socket, "U.S.M.C." or equal pylon, no cover, SACH foot, thermoplastic or equal, molded to model	\$ 2,607.00
Initial Prosthesis			L5585	Knee disarticulation, ischial level socket, "U.S.M.C." or equal pylon, no cover, SACH foot, prefabricated adjustable open end socket	\$ 2,309.00
L5500	Below knee "PTB" type socket, "U.S.M.C." or equal pylon, no cover, SACH foot, plaster socket, direct formed	\$ 1,421.00	L5590	Knee disarticulation ischial level socket, "U.S.M.C." or equal pylon, no cover, SACH foot, laminated socket, molded to model	\$ 2,671.00
L5505	Above knee - knee disarticulation, ischial level socket, "U.S.M.C." or equal pylon, no cover, SACH foot plaster socket, direct formed	\$ 1,933.00	L5595	Hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, thermoplastic or equal, molded to patient model	\$ 4,473.00
Preparatory Prosthesis - Below Knee			L5600	Hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, laminated socket, molded to patient model	\$4,490.00
L5510	"PTB", type socket, "U.S.M.C." or equal pylon, no cover, SACH foot, plaster socket, molded to model	\$ 1,466.00	Additions - Above Knee		
L5520	"PTB" type socket, "U.S.M.C." or equal pylon, no cover, SACH foot, thermoplastic or equal, direct formed	\$ 1,597.00	L5610	Hydracadence system	\$ 2,042.00

Prosthetics Maximum Reimbursement Rates

Code	Descriptor	Amount
L5613	Knee disarticulation, OHC 4-bar linkage, with hydraulic swing phase control	\$ 2,723.00
L5616	Universal multiplex system, friction swing phase control	\$ 1,176.00
Additions - Test Sockets		
L5618	Symes	\$ 241.00
L5620	Below knee	\$ 244.00
L5622	Knee disarticulation	\$ 316.00
L5624	Above knee	\$ 347.00
L5626	Hip disarticulation	\$ 456.00
L5628	Hemipelvectomy	\$ 403.00
X8840	Prosthetic socket quadrilateral, adjustable	Preauthorize
L5629	Below knee, acrylic socket	\$ 265.00
Additions - Socket Variations		
L5630	Symes type, expandable wall socket	\$ 460.00
L5631	Above knee or knee disarticulation, acrylic socket	\$ 367.00
L5632	Symes type, "PTB" brim design socket	\$ 197.00
L5634	Symes type, Posterior opening (Canadian) socket	\$ 338.00
L5636	Symes type, medial opening socket	\$ 213.00
L5637	Below knee, total contact	\$ 320.00
L5638	Below knee, leather socket	\$ 541.00
L5639	Below knee, wood socket	\$ 1,246.00
L5640	Knee disarticulation, leather socket	\$ 647.00
L5642	Above knee, leather socket	\$ 517.00
L5643	Hip disarticulation, flexible inner socket, external frame	\$ 1,297.00

Code	Descriptor	Amount
L5644	Above knee, wood socket	\$ 493.00
L5645	Below knee, flexible inner socket, external frame	\$ 753.00
L5646	Below knee, air cushion socket	\$ 457.00
L5647	Below knee suction socket	\$ 884.00
L5648	Above knee, air cushion socket	\$ 549.00
L5649	Ischial containment/narrow M-L socket	\$ 1,597.00
L5650	Total contact, above knee or knee disarticulation socket	\$ 543.00
L5651	Above knee, flexible inner socket, external frame	\$ 1,001.00
L5652	Suction suspension, above knee or knee disarticulation socket	\$ 364.00
L5653	Knee disarticulation, expandable wall socket	\$ 543.00
Additions - Socket Inserts		
L5654	Symes, (Kemblo, Pelite, Aliplast, Plastazote or equal)	\$ 340.00
L5655	Below knee (Kemblo, Pelite, Aliplast, Plastazote or equal)	\$ 295.00
L5656	Knee disarticulation (Kemblo, Pelite, Aliplast, Plastazote or equal)	\$ 413.00
L5658	Above knee (Kemblo, Pelite, Aliplast, Plastazote or equal)	\$ 314.00
L5660	Symes, silicone gel or equal	\$ 610.00
L5661	Multi-durometer Symes	\$ 627.00
L5662	Below knee, silicone gel or equal	\$ 516.00
L5663	Knee disarticulation, silicone gel or equal	\$ 756.00
L5664	Above knee, silicone gel or equal	\$ 659.00
L5665	Multi-durometer, below knee	\$ 569.00
Additions - Suspension - Below Knee		
L5666	Cuff suspension	\$ 78.00

Prosthetics Maximum Reimbursement Rates

Code	Descriptor	Amount	Code	Descriptor	Amount
L5668	Molded distal cushion	\$ 113.00	L5699	Shoulder harness for all lower extremity prostheses	\$ 208.00
L5670	Molded supracondylar suspension ("PTS" or similar)	\$ 302.00		Exoskeletal Additions - Knee - Shin System	
L5672	Removable medial brim suspension	\$ 263.00	L5710	Single axis, manual lock	\$ 400.00
L5674	Latex sleeve suspension or equal, each	\$ 71.00	L5711	Single axis, manual lock, ultra-light material	\$ 581.00
L5675	Latex sleeve suspension or equal, heavy duty, each	\$ 97.00	L5712	Single axis, friction swing and stance phase control (safety knee)	\$ 479.00
L5676	Knee joints, single axis, pair	\$ 403.00	L5714	Single axis, variable friction swing phase control	\$ 416.00
L5677	Knee joints, polycentric, pair	\$ 548.00	L5716	Polycentric, mechanical stance phase lock	\$ 810.00
L5678	Joint covers, pair	\$ 45.00	L5718	Polycentric, friction swing and stance phase control	\$ 1,012.00
L5680	Thigh lacer, non-molded	\$ 266.00	L5722	Single axis, pneumatic swing, friction stance phase control	\$ 904.00
L5682	Thigh lacer, gluteal/ischial, molded	\$ 695.00	L5724	Single axis, fluid swing phase control	\$ 1,607.00
L5684	Fork strap	\$ 54.00	L5726	Single axis, external joints fluid swing phase control	\$ 1,644.00
L5686	Back check (extension control)	\$ 52.00	L5728	Single axis, fluid swing and stance phase control	\$ 2,644.00
L5688	Waist belt, webbing	\$ 68.00	L5780	Single axis, pneumatic/hydra pneumatic swing phase control	\$ 1,272.00
L5690	Waist belt, padded and lined	\$ 109.00	X8834	Dyna-plex hydrolic knee	Preauthorize
X8826	Soft cosmetic leg cover	Preauthorize	X8836	Hydra-pneumatic with lock	Preauthorize
X8828	Realistic leg cover	Preauthorize	X8838	Pneumatic knee	Preauthorize
X8830	Trouser protector	Preauthorize	L5785	Below knee, ultra-light material (titanium, carbon fiber or equal)	\$ 458.00
	Additions - Suspension - Above Knee		L5790	Above knee, ultra-light material (titanium, carbon fiber or equal)	\$ 737.00
L5692	Pelvic control belt, light	\$ 148.00	L5795	Hip disarticulation, ultra-light material (titanium, carbon fiber or equal)	\$ 930.00
L5694	Pelvic control belt, padded and lined	\$ 202.00			
L5695	Pelvic control, sleeve suspension, Neoprene or equal, each	\$ 182.00			
L5696	Pelvic joint	\$ 206.00			
X8832	Pelvic joint cover	Preauthorize			
L5697	Pelvic band	\$ 90.00			
L5698	Silesian bandage	\$ 115.00			

Prosthetics Maximum Reimbursement Rates

Code	Descriptor	Amount	Code	Descriptor	Amount
	Endoskeletal Additions - Knee - Shin System		L5974	All lower extremity prostheses, foot, single axis ankle/foot	\$ 259.00
L5810	Single axis, manual lock	\$ 541.00	L5976	All lower extremity prostheses, energy storing foot (Seattle Carbon Copy II or equal)	\$ 623.00
L5811	Single axis, manual lock, ultra-light material	\$ 811.00	L5978	All lower extremity prostheses, foot, multiaxial ankle/foot (Greissinger or equal)	\$ 325.00
L5812	Single axis, friction swing and stance phase control (safety knee)	\$ 628.00	L5980	All lower extremity prostheses, flex.foot system	\$ 3,516.00
L5816	Polycentric, mechanical stance phase lock	\$ 945.00	L5982	All exoskeletal lower extremity prostheses, axial rotation unit	\$ 643.00
L5818	Polycentric, friction swing and stance phase control	\$ 1,067.00	L5984	All endoskeletal lower extremity prostheses, axial rotation unit	\$ 633.00
L5822	Single axis, pneumatic swing, friction stance phase control	\$ 1,419.00	L5986	All lower extremity prostheses, multi-axial rotation unit ("MCP" or equal)	\$ 704.00
L5824	Single axis, fluid swing phase control	\$ 1,704.00	L5999	Unlisted procedures for lower extremity prostheses	Preauthorize
L5828	Single axis, fluid swing and stance phase control	\$ 3,048.00		(2) UPPER LIMB PROSTHESES	
L5830	Single axis, pneumatic/swing phase control	\$ 2,108.00		Partial Hand	
L5850	Above knee or hip disarticulation, knee extension assist	\$ 107.00	L6000	Robin-Aids, thumb remaining (or equal)	\$ 1,476.00
L5910	Below knee, alignable system	\$ 302.00	L6010	Robin-Aids, little and/or ring finger remaining (or equal)	\$ 1,643.00
L5920	Above knee, or hip disarticulation, alignable system	\$ 443.00	L6020	Robin-Aids, no finger remaining (or equal)	\$ 1,532.00
L5940	Below knee, ultra-light material (titanium, carbon fiber or equal)	\$ 445.00		Wrist Disarticulation	
L5950	Above knee, ultra-light material (titanium, carbon fiber or equal)	\$ 649.00	L6050	Molded socket, flexible elbow hinges, triceps pad	\$ 2,104.00
L5960	Hip disarticulation, ultra-light material (titanium, carbon fiber or equal)	\$ 804.00	L6055	Molded socket with expandable interface, flexible elbow hinges, triceps pad	\$ 2,698.00
	Miscellaneous			Elbow	
L5970	All lower extremity prostheses, foot, external keel, SACH foot	\$ 213.00	L6100	Below elbow, molded socket, flexible elbow hinge, triceps pad	\$ 1,751.00
L5972	All lower extremity prostheses, flexible keel foot (Safe, Sten, Bock Dynamic or equal)	\$ 392.00			

Prosthetics Maximum Reimbursement Rates

Code	Descriptor	Amount	Code	Descriptor	Amount
L6110	Below elbow, molded socket, (Muenster or Northwestern suspension types)	\$ 2,267.00	L6382	Application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, elbow or disarticulation or above elbow	\$ 1,356.00
L6120	Below elbow, molded double wall split socket, step-up hinges, half cuff	\$ 2,574.00	L6384	Application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, shoulder disarticulation or interscapular thoracic	\$ 1,758.00
L6130	Below elbow, molded double wall split socket, stump activated locking hinge, half cuff	\$ 2,876.00	L6386	Each additional cast change and realignment	\$ 447.00
L6200	Elbow disarticulation, molded socket, outside locking hinge forearm	\$ 3,031.00	L6388	Application of rigid dressing only	\$ 456.00
L6205	Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm	\$ 3,700.00		Endoskeletal - Elbow or Shoulder Area	
L6250	Above elbow, molded double wall socket, internal locking elbow, forearm	\$ 2,983.00	L6400	Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping	\$ 2,578.00
	Shoulder		L6450	Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping	\$ 3,142.00
L6300	Molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm	\$ 4,139.00	L6500	Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping	\$ 2,857.00
L6310	Passive restoration (complete prosthesis)	\$ 3,371.00	L6550	Should disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping	\$ 4,236.00
L6320	Passive restoration (shoulder cap only)	\$ 1,899.00		Endoskeletal - Interscapular Thoracic	
	Interscapular Thoracic		L6570	Molded socket, endoskeletal system, including soft prosthetic tissue shaping	\$ 4,862.00
L6350	Molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm	\$ 4,319.00	L6580	Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, bowden cable control, "U.S.M.C." or equal pylon, no cover, molded to patient model	\$ 1,489.00
L6360	Passive restoration (complete prosthesis)	\$ 3,539.00			
L6370	Passive restoration (shoulder cap only)	\$ 2,257.00			
	Immediate and Early Surgical Procedures				
L6380	Application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, wrist disarticulation or below elbow	\$ 1,078.00			

Prosthetics Maximum Reimbursement Rates

Code	Descriptor	Amount	Code	Descriptor	Amount
L6582	Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, bowden cable control, "U.S.M.C." or equal pylon, no cover, direct formed	\$ 1,147.00	X8848	OW-75N oval friction wrist (child)	Preauthorize
L6584	Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, "U.S.M.C." or equal pylon, no cover, molded to patient model	\$ 1,862.00	L6615	Disconnect locking wrist unit	\$ 153.00
L6586	Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure or eight harness, fair lead cable control, "U.S.M.C." or equal pylon, no cover, direct formed	\$ 1,584.00	L6616	Additional disconnect insert for locking wrist unit, each	\$ 55.00
L6588	Preparatory, shoulder disarticulation or interscapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, "U.S.M.C." or equal pylon, no cover, molded to patient model	\$ 2,694.00	L6620	Flexion-friction wrist unit	\$ 319.00
L6590	Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, "U.S.M.C." or equal pylon, no cover, direct formed	\$ 2,367.00	L6623	Spring assisted rotational wrist unit with latch release	\$ 535.00
	Upper Extremity Additions		L6625	Rotation wrist unit with cable lock	\$ 591.00
L6589	Fair lead cable control	Preauthorize	L6628	Upquick disconnect hook adapter, Otto Bock or equal	\$ 400.00
L6600	Polycentric hinge, pair	\$ 209.00	L6629	Quick disconnect lamination collar with coupling piece, Otto Bock or equal	\$ 146.00
L6605	Single pivot hinge, pair	\$ 206.00	L6630	Stainless steel, any wrist	\$ 180.00
L6610	Flexible metal hinge, pair	\$ 185.00	L6632	Latex suspension sleeve, each	\$ 55.00
X8842	WD-400 quick change wrist	Preauthorize	L6635	Lift assist for elbow	\$ 196.00
X8844	WE-500S wrist	Preauthorize	L6637	Nudge control elbow lock	\$ 358.00
X8846	OW-100N oval friction wrist	Preauthorize	L6640	Shoulder abduction joint, pair	\$ 234.00
			L6641	Excursion amplifier, pulley type	\$ 168.00
			L6642	Excursion amplifier, lever type	\$ 218.00
			L6645	Shoulder flexion-abduction joint, each	\$ 355.00
			L6650	Shoulder universal joint, each	\$ 376.00
			L6655	Standard control cable, extra	\$ 84.00
			L6660	Heavy duty control cable	\$ 102.00
			L6665	Teflon, or equal, cable lining	\$ 42.00
			L6670	Hook to hand, cable adapter	\$ 54.00
			L6672	Harness, chest or shoulder, saddle type	\$ 188.00
			L6675	Harness, figure of ("8") eight type, for single control	\$ 128.00
			L6676	Harness, figure of ("8") eight type for dual control	\$ 135.00

Prosthetics Maximum Reimbursement Rates

Code	Descriptor	Amount	Code	Descriptor	Amount
L6680	Test socket, wrist disarticulation or below elbow	\$ 258.00	L6775	Dorrance, or equal, Model #555	\$ 417.00
L6682	Test socket, elbow disarticulation or above elbow	\$ 257.00	L6780	Dorrance, or equal, Model #SS555	\$ 497.00
L6684	Test socket, shoulder disarticulation or interscapular thoracic	\$ 388.00	L6790	ACCU hook, or equal	\$ 377.00
L6686	Suction socket	\$ 656.00	L6795	Hook-2 load, or equal	\$ 1,375.00
L6687	Frame type socket, below elbow or wrist disarticulation	\$ 487.00	L6800	Hook-APRL VC, or equal	\$ 1,126.00
L6688	Frame type socket, above elbow or elbow disarticulation	\$ 527.00	L6805	Modifier wrist flexion unit	\$ 353.00
L6689	Frame type socket, shoulder disarticulation	\$ 601.00	L6806	TRS gnp, VC	\$ 1,464.00
L6690	Frame type socket, interscapular-thoracic	\$ 696.00	L6807	TRS adept, child	\$ 1,077.00
L6691	Removable insert, each	\$ 383.00	L6808	TRS adept, infant, VC	\$ 951.00
L6692	Silicone gel insert or equal, each	\$ 622.00	L6809	TRS Super Sport, passive	\$ 334.00
Terminal Devices - Hooks			Terminal Devices - Hand		
L6700	Dorrance, or equal, Model #3	\$ 577.00	L6810	Pincher tool, Otto Bock or equal	\$ 182.00
L6705	Dorrance, or equal, Model #5	\$ 339.00	L6825	Dorrance, VO	\$ 1,147.00
L6710	Dorrance, or equal, Model #5X	\$ 331.00	L6830	APRL, VC	\$ 1,505.00
L6715	Dorrance, or equal, Model #5XA	\$ 356.00	L6835	Sierra, VO	\$ 1,311.00
L6720	Dorrance, or equal, Model #6	\$ 944.00	L6840	Becker Imperial	\$ 911.00
L6725	Dorrance, or equal, Model #7	\$ 431.00	L6845	Becker Lock Grip	\$ 828.00
L6730	Dorrance, or equal, Model #7LO	\$ 710.00	L6850	Becker Plylite	\$ 751.00
L6735	Dorrance, or equal, Model #8	\$ 317.00	X8852	Becker Plylite hand with opening thumb	Preauthorize
L6740	Dorrance, or equal, Model #8X	\$ 432.00	L6855	Robin-Aids, VO	\$ 963.00
L6745	Dorrance, or equal, Model #88X	\$ 387.00	L6860	Robin-Aids, VO Soft	\$ 717.00
L6750	Dorrance, or equal, Model #10P	\$ 391.00	L6865	Passive hand	\$ 300.00
L6755	Dorrance, or equal, Model #10X	\$ 390.00	X8854	Passive hand, Otto Bock system	Preauthorize
L6765	Dorrance, or equal, Model #12P	\$ 380.00	X8856	Cosmetic hand, wrist disarticulation (flexible socket, passive hand and glove)	Preauthorize
L6770	Dorrance, or equal, Model #99X	\$ 358.00	X8858	Cosmetic hand, BE amputation (plastic socket, passive hand and glove, less harness)	Preauthorize
			L6867	Detroit infant hand (mechanical)	\$ 933.00

Prosthetics Maximum Reimbursement Rates

Code	Descriptor	Amount
L6868	Passive infant hand, (Steeper, Hosmer or Equal)	\$ 216.00
L6870	Child mitt	\$ 222.00
L6872	NYU child hand	\$ 872.00
L6873	Mechanical infant hand, Steeper or equal	\$ 390.00
L6875	Bock, VC	\$ 793.00
L6880	Bock, VO	\$ 514.00
L6890	Glove for above hands, production glove	\$ 189.00
L6895	Glove for above hands, custom glove	\$ 466.00
X8860	Kingsley cosmetic glove (sized to APRL hand)	Preauthorize
X8862	APRL cuff (as cover for forearm lengthener when changing from APRL hook to APRL hand)	Preauthorize
X8864	Forearm lengthener (aluminum 1/2-20 thread)	Preauthorize
X8866	Cosmetic hook fairing	Preauthorize
X8868	Child's mitt glove	Preauthorize
X8870	Custom glove, cosmetic without zipper	Preauthorize
X8872	Myoelectric, below elbow, rotation wrist (Bock or equal) includes MYO testing procedures	Preauthorize
Hand Restoration		
(Casts, shading and measurements included)		
L6900	Partial hand, with glove, thumb or one finger remaining	\$ 1,672.00
L6905	Partial hand, with glove, multiple fingers remaining	\$ 1,631.00
L6910	Partial hand, with glove, no fingers remaining	\$ 1,589.00
L6915	Replacement glove for above (does not include cast)	\$ 673.00

Code	Descriptor	Amount
External Power - Base Devices		
L6920	Wrist disarticulation, self-suspended inner socket, removable forearm shell, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device	\$ 6,212.00
L6925	Wrist disarticulation, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	\$ 7,089.00
L6930	Below elbow, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	\$ 5,782.00
L6935	Below elbow, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	\$ 6,715.00
L6940	Elbow disarticulation, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	\$ 7,318.00
L6945	Elbow disarticulation, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger myoelectronic control of terminal device	\$ 8,504.00
L6950	Above elbow, molded inner socket, removable humeral shell internal locking elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger switch control of terminal device	\$ 8,309.00

Prosthetics Maximum Reimbursement Rates

Code	Descriptor	Amount	Code	Descriptor	Amount
L6955	Above elbow, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal electrodes, cables two batteries and one charger, myoelectronic control of terminal device	\$ 9,951.00	L7025	Electronic hand, Otto Bock or equal, myoelectronically controlled	\$ 2,861.00
L6960	Shoulder disarticulation, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch two batteries and one charger, cables, switch control of terminal device	\$10,646.00	L7030	Electronic hand, System Teknik, Variety Village or equal, myoelectronically controlled	\$ 4,880.00
L6965	Shoulder disarticulation, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, switch control of terminal device	\$12,361.00	L7035	Electronic greifer, Otto Bock or equal, myoelectronically controlled	\$ 2,930.00
L6970	Interscapular-thoracic, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	\$13,091.00	L7040	Prehensile actuator, Hosmer or equal, switch controlled	\$ 2,349.00
L6975	Interscapular-thoracic, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	\$15,480.00	L7045	Electronic hook, child, Michigan or equal, switch controlled	\$ 1,347.00
External Power - Terminal Devices			Electronic Elbows		
L7010	Electronic hand, Otto Bock, Steeper or equal, switch controlled	\$ 3,043.00	L7160	Boston or equal, switch controlled	\$12,899.00
L7015	Electronic hand, System Teknik, Variety Village or equal, switch controlled	\$ 4,836.00	L7165	Boston or equal, myoelectronically controlled	\$14,707.00
L7020	Electronic greifer, Otto Bock or equal, switch controlled	\$ 2,855.00	L7170	Hosmer or equal, switch controlled	\$ 4,885.00
			L7180	Utah or equal, myoelectronically controlled	\$30,185.00
			L7185	Adolescent, Variety Village or equal, switch controlled	\$ 4,988.00
			L7186	Child, Variety Village or equal, switch controlled	\$ 7,370.00
			L7190	Adolescent, Variety Village or equal, myoelectronically controlled	\$ 6,533.00
			L7191	Child, Variety Village or equal, myoelectronically controlled	\$ 7,701.00
			Control Modules and Battery Components		
			L7260	Electronic wrist rotator, Otto Bock or equal	\$ 2,074.00
			L7261	Electronic wrist rotator, for Utah arm	\$ 3,767.00
			L7266	Servo control, Steeper or equal	\$ 825.00
			L7272	Analogue control, UNB or equal	\$ 1,764.00

Prosthetics Maximum Reimbursement Rates

Code	Descriptor	Amount
L7274	Proportional control, 12 volt, Utah or equal	\$ 5,264.00
L7360	Six volt battery, Otto Bock or equal, each	\$ 203.00
L7362	Battery charger, six volt, Otto Bock or equal	\$ 216.00
L7364	Twelve volt battery, Utah or equal, each	\$ 396.00
L7366	Battery charger, twelve volt, Utah or equal	\$ 512.00
L7499	Unlisted procedures for upper extremity prosthesis	Preauthorize
(3) BREAST PROSTHESES		
**L8000	Mastectomy bra	\$ 41.00
*L8010	Mastectomy sleeve	\$ 51.00
L8020	Mastectomy form	\$ 175.00
L8030	Silicone or equal	\$ 319.00
**X8800	Camp Tru-Life all sizes	Preauthorize
**X8802	Stryker size 1,2,3	Preauthorize
**X8804	Stryker size 4,5,6,7	Preauthorize
**X8806	Stryker size 8,9,10	Preauthorize
**X8808	Airway companion size 1-7	Preauthorize
**X8810	Airway companion size 8-10	Preauthorize
**X8812	Airway companion size 12-16	Preauthorize
(4) GENERAL ITEMS		
Elastic Stockings		
*L8100	Below knee, medium weight, each	Preauthorize
*L8110	Below knee, heavy weight, each	Preauthorize
*L8120	Below knee, surgical weight, (Linton type or equal), each	Preauthorize
*L8130	Above knee, medium weight, each	Preauthorize
*L8140	Above knee, heavy weight, each	Preauthorize

Code	Descriptor	Amount
*L8150	Above knee, surgical weight, (Linton type or equal), each	Preauthorize
*L8160	Full length, medium weight, each	Preauthorize
*L8170	Full length, heavy weight, each	Preauthorize
*L8180	Full length, heavy surgical weight (Linton type or equal), each	Preauthorize
*L8190	Leotards, medium weight, each	Preauthorize
*L8200	Leotards, surgical weight (Linton type), each	Preauthorize
L8210	Custom made	Preauthorize
L8220	Lymphedema	Preauthorize
*L8230	Garter belt	Preauthorize
*X9034	Jobst and related burn garment	Preauthorize
Prosthetic Socks		
L8400	Prosthetic sheath, below knee, each	\$ 18.00
L8410	Prosthetic sheath, above knee, each	\$ 23.00
L8415	Prosthetic sheath, upper limb, each	\$ 20.00
*L8420	Prosthetic sock, wool, below knee, each	\$ 22.00
*L8430	Prosthetic sock, wool, above knee, each	\$ 24.00
L8435	Prosthetic sock, wool, upper limb, each	\$ 22.00
*L8440	Prosthetic shrinker, below knee, each	\$ 47.00
*L8460	Prosthetic shrinker, above knee, each	\$ 75.00
L8465	Prosthetic shrinker, upper limb, each	\$ 41.00
L8470	Stump sock, single ply, fitting, below knee, each	\$ 8.00
L8480	Stump sock, single ply, fitting, above knee, each	\$ 9.00

Prosthetics Maximum Reimbursement Rates

Code	Descriptor	Amount	Code	Descriptor	Amount
*X8874	Arm sox all sizes, each (limit 6)	Preauthorize	X8904	Fork strap	Preauthorize
	Miscellaneous Supports		X8906	Back check	Preauthorize
X9036	Sacroiliac support elastic	Preauthorize	X8908	Knee joints, upper, each	Preauthorize
X9038	Rib belt with shoulder straps	Preauthorize	X8910	Knee joints, lower, each	Preauthorize
X9040	Elastic anklette	Preauthorize	X8912	Knee joints, complete, each	Preauthorize
	(5) REPAIRS FOR PROSTHESIS, LABOR AND MATERIAL		X8914	Knee joint bearing or ring, each	Preauthorize
L7500	Repair of prosthetic device, hourly rate (excludes V5335 repair of oral or laryngeal prosthesis or artificial larynx)	Preauthorize	X8916	Two way ankle joint	Preauthorize
L7510	Repair of prosthetic device, repair or replace minor parts (excludes V5335 repair of oral or laryngeal prosthesis or artificial larynx)	Preauthorize	X8918	PTB type plastic socket and shin	Preauthorize
	Repairs - Symes or Below Knee		X8920	Wood socket, knee bearing	Preauthorize
X8876	SACH foot, standard, B.K.	Preauthorize	X8922	Plastic socket, supra condylar	Preauthorize
X8878	Single axis or hydra-cadence foot	Preauthorize	X8924	Air cushion socket	Preauthorize
X8880	Greissinger foot	Preauthorize	X8926	Air cushion supra condylar socket	Preauthorize
X8882	Insert for socket (soft)	Preauthorize	X8928	SACH heel, cushion	Preauthorize
X8884	Insert for socket, supra condylar (soft)	Preauthorize	X8930	Replace endoskeletal cover	Preauthorize
X8886	Gel insert (silicone)	Preauthorize		Repairs - Knee Bearing or Above Knee	
X8888	Gel insert, supra condylar (silicone)	Preauthorize	X8932	Open end, above knee or knee bearing	Preauthorize
X8890	PTB cuff suspension	Preauthorize	X8934	Suction, wood or plastic, above knee	Preauthorize
X8892	Distal molded end pad (silastic)	Preauthorize	X8936	Plastic total contact suction socket, above knee	Preauthorize
X8894	Injection molded silicone distal pad	Preauthorize	X8938	Wood or molded leather socket, above knee, or knee bearing	Preauthorize
X8896	Thigh lacer, molded	Preauthorize	X8940	Air cushion socket, above knee	Preauthorize
X8898	Thigh lacer, fashion	Preauthorize	X8942	Insert for socket (soft), above knee or knee bearing	Preauthorize
X8900	Waist belt, unilateral, standard	Preauthorize	X8944	Gel insert (silicone), above knee or knee bearing	Preauthorize
X8902	Waist belt, bilateral	Preauthorize	X8946	Pelvic band, metal	Preauthorize
			X8948	Hip joint, upper	Preauthorize
			X8950	Hip joint, lower	Preauthorize

Prosthetics Maximum Reimbursement Rates

Code	Descriptor	Amount
X8952	Leather pelvic belt, padded and lined	Preauthorize
X8954	Socket, quadrilateral, adjustable	Preauthorize
X8956	Silesian bandage belt	Preauthorize
X8958	SACH foot	Preauthorize
X8960	Single axis foot	Preauthorize
X8962	Greissinger foot	Preauthorize
X8964	Two way ankle joint	Preauthorize
X8966	Hydra-cadence leg cover only	Preauthorize
X8968	Hydra-cadence foot	Preauthorize
X8970	Distal end pad (silicone)	Preauthorize
X8972	Injected molded silicone distal pad	Preauthorize
X8974	Knee bolt	Preauthorize
X8976	Knee friction tighteners	Preauthorize
X8978	Valve replacement	Preauthorize
X8980	Repair for hydra-pneumatic knee units	Preauthorize
X8982	Replace above knee endoskeletal cover	Preauthorize
	Repairs - Hip Disarticulation or Hemipelvectomy	
X8984	Socket, plastic, with hip joint	Preauthorize
X8986	Single axis foot	Preauthorize
X8988	SACH foot	Preauthorize
X8990	Greissinger foot	Preauthorize
X8992	Two way ankle joint	Preauthorize
X8994	Hydra-cadence leg cover only	Preauthorize
X8996	Hydra-cadence foot	Preauthorize
X8998	Knee bolt	Preauthorize
X9000	Knee friction tighteners	Preauthorize

Code	Descriptor	Amount
X9002	Repair for hydra-pneumatic knee units	Preauthorize
X9004	Replace D endoskeletal cover	Preauthorize
	Lower Extremity Repairs, General	
X9010	Bumper, rubber or spring	Preauthorize
X9012	Bushing, foot joints, replace	Preauthorize
X9014	Knee-shin assembly, standard, wood	Preauthorize
X9016	Liner, to inside of socket	Preauthorize
X9018	Laminate shin section	Preauthorize
X9020	Laminate thigh section	Preauthorize
X9022	Refinishing foot, including reupholstering	Preauthorize
	Upper Extremity Repairs, General	
X9024	Positive internal locking elbow, with forearm list assist	Preauthorize
X9026	Outside locking hinges, standard	Preauthorize
X9028	Figure-8, harness, unilateral	Preauthorize
X9006	Prosthetics - upper extremity repairs, Full cuff	Preauthorize
X9008	Polycentric or S/A hinge (upper section), pair	Preauthorize
	(6) MISCELLANEOUS	
L8499	Unlisted procedure for miscellaneous prosthetic services	Preauthorize
L8500	Artificial larynx, any type	\$ 550.00
L8501	Tracheostomy speaking valve	\$ 101.00
X9030	Consultation one hour	Preauthorize
X9032	Mileage, per mile	Preauthorize