What Providers Need to Know About Early Replacement of Prostheses

This information was developed by the Wisconsin Department of Health Services (DHS) – Office of the Inspector General (OIG) to help educate providers on federal and state program requirements. Featured topics include the rules and regulations that providers must follow, as well as program guidance, best practices, and helpful resources to support program participation efforts.

Overview

According to the Wisconsin Medicaid program, the early replacement of prostheses occurs when an item needs replacing before the end of its established life expectancy due to various reasons, like changes in the condition or functional needs of Medicaid members and irreparable wear or damage to equipment. The OIG created this fact sheet to highlight Wisconsin Medicaid rules and regulations related to the early replacement of prostheses, which requires providers to obtain Prior Authorization (PA) to be reimbursed.

Program Requirements

Under Wis. Admin. Code § DHS 107.24(3)(d), PA is required when Durable Medical Equipment (DME) purchases exceed DHS-established quantity, frequency, or cost limits listed in the Max Fee Schedule* on the ForwardHealth Portal**. This means if one reimbursable prosthesis is purchased in a given time period, the additional purchase of the same prosthesis in the same timeframe is:

- Generally **not** allowed.
- Requires PA to be reimbursed.

*Max Fee Schedule can be found at: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeHome.aspx

**Forward Health Portal can be found at: https://www.forwardhealth.wi.gov/WIPortal/

Learn More

For additional information on PA requirements for prostheses, please refer to DME Max Fees online at:

https://www.forwardhealth.wi.gov/WIPortal/content/provider/maxFee maxFeeDownloadsPdfVersions.htm.spage

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Did you know?

Providers must consider prior dates of related services to determine if the current service is an early replacement and if PA must be sought.

Determining Prior Authorization

The American Medical Association utilizes a unique set of Current Procedural Terminology (CPT) base and replacement claim code pairings for replacement circumstances. This includes base code L-5301 for a previously dispensed below the knee, molded socket and L-5700 for its replacement. To determine if PA is needed for billing the L-5700 replacement socket, providers must:

- Identify Dates of Service (DOS) for dispensing the original (L-5301) or the most recent replacement (L-5700) socket.
- Visit the Max Fee Schedule to find and compare the socket's useful life with the dispensing DOS.
- See the Max Fee Schedule's Purchase/PA Needed column, to verify if PA is required.

In this instance, the Max Fee Schedule states that PA is:

- **Required** for the socket's early replacement.
- **Not required** if the socket reached its useful life.

Billing Tips

In addition to L-5301 and L-5700 as listed above, the Max Fee Schedule offers several other base and replacement code pairings for prostheses, like L-5321 and L-5701. It is important to note that billing both codes at the same time is considered unbundling, which is not allowed under Medicaid rules and regulations. To prevent this and other billing errors, the OIG advises providers to do the following before submitting claims for reimbursement:

- Review all relevant coding guidance.
- Get billing help by calling Provider Services at 800-947-9627.

Contact Us

- For OIG audit assistance, please contact the staff person listed on your audit letter.
- The OIG encourages everyone to report suspected fraud at 877-865-3432 or www.reportfraud.wisconsin.gov.