PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="4">7Guideline/Procedure Number: MCUG3032 (previously UG100332)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Guideline/Procedure Title: Orthotic and Prosthetic Appliances Guidelines</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 02/21/1995</td><td colspan="4">Next Review Date: 11/12/2026
Last Review Date: 11/12/2025</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 11/12/2025</td></tr>
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I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3013 – Durable Medical Equipment (DME) Authorization

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the criteria for approval of orthotic and prosthetic appliances.

VI. GUIDELINE / PROCEDURE:

A. Partnership HealthPlan of California (Partnership) covers orthotic and prosthetic appliances when such appliances are necessary for the restoration of function or replacement of body parts, as prescribed in writing by a physician, a podiatrist or a non-physician medical practitioner functioning within the scope of their license. Partnership utilizes Medi-Cal and InterQual® criteria to determine medical necessity for authorizations of orthotic and prosthetic devices. External independent consultants may be utilized on a case-by-case basis. Exceptions to these guidelines may be made based on the individual needs of the Member or the unique characteristics of the delivery system.
B. The definition of medical necessity is health care services that are necessary to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, prescribed appliances will be covered only as medically necessary to restore bodily functions essential to activities of daily living, to prevent significant disability or serious deterioration of health, or to alleviate severe pain. The prescribing physician or podiatrist must supply the vendor with information required to document the medical necessity for the item.
C. A Treatment Authorization Request (TAR) is required when the cost for repair/maintenance, purchase or rental exceeds $250 for orthotics or $500 for prosthetics.

D. TAR requests for orthotic or prosthetic appliances must include the diagnosis related to the functional disability, a copy of prescribing physician prescription, a statement concerning the Member's functional disability that would benefit from the appliance, and a statement explaining the reason more cost effective options would not meet the Member's needs.

E. A repair of an appliance will not be authorized when the repair cost is equal to or exceeds the purchase cost of a new appliance.

F. For appliance claims submitted by report, the vendor must list the item description, manufacturer name, model number, catalog page, suggested retail price, cost of part(s) used, cost of labor per hour and total cost/hours, description of and medical justification for any special features (custom modification or special accessories) and medical condition necessitating the appliance.

G. Orthopedic Shoes
   1. Stock orthopedic and stock conventional shoes are a covered benefit when a. or b. is met below:
      a. At least one of the shoes is an integral part of a leg brace and is medically necessary for the proper functioning of the brace or
      b. The recipient has a diagnosis of Diabetes Mellitus and one or more of the following conditions:
         1) Current foot ulcers or a history of foot ulceration
         2) Previous foot amputation
         3) Peripheral neuropathy with evidence of callous formation of either foot
         4) Peripheral vascular disease
         5) Positive monofilament examination indicating diabetic neuropathy
         6) Deformity of either foot, such as rocker bottom foot or Charcot foot
   2. Modification of stock conventional shoes or stock orthopedic shoes is covered when the patient's medical need can be satisfied with such modification.
   3. Custom-made orthopedic shoes are reimbursable if the recipient's medical need cannot be met by modifications to stock orthopedic or stock conventional shoes. Clinical conditions that might require custom-made shoes include but are not limited to Charcot or rheumatoid foot deformities, some partial foot amputations, or when a patient requires a muscle flap to cover a large or unusual soft tissue foot defect that then is too bulky to be accommodated by an in-depth shoe.
   4. The prescribing physician must document the nature, cause and severity of the foot problem leading to the conclusion that a custom-made orthopedic shoe is the only alternative (CCR, Title 22, Section 51315). A custom-made shoe has the following characteristics:
      a. Made and molded to patient model for a specific patient
      b. Constructed over a positive model of the patient's foot
      c. Made from leather or other suitable material of equal quality
      d. Has removable inserts as an integral part of the shoe that can be altered or replaced as the patient's condition warrants
      e. Has some form of shoe closure

H. Custom Foot Orthotics
   1. Orthotics are covered when medically necessary for the following acute or chronic foot conditions:
      a. Rehabilitative foot orthotics following foot surgery or trauma
      b. Plantar fasciitis
      c. Inflammatory conditions such as bursitis of the foot, tenosynovitis, plantar fascial fibromatosis
      d. Neurologically impaired feet
      e. Vascular conditions of the foot including poor circulation or peripheral vascular disease
      f. Musculoskeletal deformities such as bunions, hallux valgus, talipes deformities, toe deformities
   2. Foot orthotics are not medically necessary and are not covered for the following conditions:
      a. Back pain
      b. Knee pain
      c. Pes planus (flat feet)

d. Pronation
e. Corns or calluses
f. Hip osteoarthritis
g. Lower leg injuries

I. Dynamic Splinting
1. Partnership reviews authorization requests for dynamic splints for the knee (E1810) on a case by case basis as described in MCUP3013 Durable Medical Equipment (DME) Authorization.

VII. REFERENCES:
A. Medi-Cal Provider Manual/ Guidelines: Orthotic and Prosthetic Appliances and Services *(ortho)*
B. InterQual® Durable Medical Equipment Criteria
C. Title 22 California Code of Regulations (CCR) 51315 and 51315.1

VIII. DISTRIBUTION:
A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 06/1/00; 09/20/00; 12/19/01; 11/20/02; 09/15/04; 10/19/05; 08/20/08; 11/18/09; 05/18/11; 02/20/13; 01/20/16; 09/21/16; 09/20/17; *10/10/18; 11/13/19; 10/14/20; 10/13/21; 10/12/22; 11/08/23; 11/13/24; 11/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.