Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Reason Codes and Statements
January 13, 2025

Reason Code	GENERAL FACE TO FACE EXAM/MEDICAL RECORDS
PMD2A	The documentation does not include a face-to-face examination. Refer to 42 Code of Federal Regulations 410.38, Medicare Program Integrity Manual 5.9.2, Local Coverage Determination 33789 & Local Coverage Article A55426.
PMD2C	The face-to-face examination does not clearly indicate that a major reason for the visit was a mobility evaluation. Refer to 42 Code of Federal Regulations 410.38 (c), Local Coverage Determination 33789 & Local Coverage Article A55426.
PMD2D	The face-to-face examination does not paint a clear picture of the beneficiary's functional abilities and limitations as it does not contain sufficient objective data. Refer to 42 Code of Federal Regulations 410.38 (c), Local Coverage Determination 33789 & Local Coverage Article A55426.
PMD2E	Claim history demonstrates the beneficiary received a similar power mobility device within the past five years. The documentation does not demonstrate a change in medical condition that meets the medical necessity for the requested base. Refer to Medicare Benefit Policy Manual 100-02 Chapter 15, Section 110.2.C & Local Coverage Article A55426.
PMD2F	Claim history demonstrates the beneficiary received same or similar durable medical equipment. The documentation does not indicate the rationale for the power mobility device requested. Refer to Medicare Benefit Policy Manual 100-02 Chapter 15, Section 110.2.C & Local Coverage Article A55426.
PMD2H	The medical documentation demonstrates the beneficiary's primary need for the power mobility device is for use outside of the home. Refer to 42 Code of Federal Regulations 410.38 (a), Medicare Program Integrity Manual 5.9.2 & Local Coverage Determination 33789.
PMD2J	The face-to-face examination contains conflicting information. Refer to Local Coverage Determination 33789.
PMD2K	The face-to-face examination was completed on a limited space template with insufficiently detailed or incomplete narrative to support medical necessity from the physician/practitioner. Refer to 42 Code of Federal Regulations 410.38 (c) & Medicare Program Integrity Manual 3.3.2.1.1.
PMD2S	The face-to-face documentation is illegible.
PMD2V	The face-to-face documentation does not contain the beneficiary's name. Refer to 42 Code of Federal Regulations 410.38 (c), Local Coverage Determination 33789 & Local Coverage Article A55426.

PMD2W	The face-to-face examination does not include the encounter date. Refer to 42 Code of Federal Regulations 410.38 (c), Local Coverage Determination 33789 & Local Coverage Article A55426.
PMD2X	The face-to-face examination is incomplete as it is missing pages. Refer to 42 Code of Federal Regulations 410.38 (c), Local Coverage Determination 33789 & Local Coverage Article A55426.
PMD2Y	The documentation does not demonstrate the beneficiary's power mobility device was lost, stolen or irreparably damaged in a specific incident. Refer to Medicare Benefit Policy Manual 100-02 Chapter 15, Section 110.2.C & Local Coverage Article A55426.
PM2AA	Supplier-produced records, even if signed by the ordering physician/practitioner and attestation letters are deemed not to be part of a medical record for Medicare payment purposes. Refer to Medicare Program Integrity Manual 5.7 & Local Coverage Article A55426.
PM2AB	The addendum to the face-to-face examination was not completed by the treating physician/practitioner. Refer to Medicare Program Integrity Manual 3.3.2.5.
PM2AC	The medical documentation contains conflicting information. Refer to Local Coverage Determination 33789.
PMD2Z	The face-to-face examination (explain identified problem with the face to face)

Reason Code	LCD CRITERIA SPECIFIC
PMD3A	The face-to-face examination does not demonstrate how mobility limitations significantly impair the beneficiary's ability to participate in one or more mobility-related activities of daily living (MRADLs) in the home. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3B	The face-to-face examination does not demonstrate the beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3C	The face-to-face examination does not demonstrate the beneficiary's upper extremity function is insufficient to self-propel an optimally-configured manual wheelchair in the home. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3D	The face-to-face examination does not demonstrate the beneficiary is able to safely transfer to and from the power operated vehicle. Refer to Local Coverage Determination 33789 Policy Article A52498.

PMD3E	The face-to-face examination does not demonstrate the beneficiary is able to operate the tiller steering system of the power operated vehicle. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3F	The face-to-face examination does not demonstrate the beneficiary is able to maintain postural stability and position while operating the power operated vehicle. Refer to Local Coverage Determination 33789.
PMD3G	The face-to-face examination identifies a physical deficit that may prevent the safe use of the power mobility device. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3H	The beneficiary's weight does not meet the weight capacity for the power mobility device requested. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3I	The face-to-face examination does not demonstrate the use of the power mobility device will significantly improve the beneficiary's ability to participate in mobility related activities of daily living (MRADLs). Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3J	The face-to-face examination demonstrates the beneficiary expressed an unwillingness to use the power mobility device in the home. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3K	The face-to-face examination does not demonstrate the beneficiary has the mental capability to safely operate the power mobility device. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3L	The face-to-face examination does not demonstrate a caregiver is unable to adequately propel an optimally configured manual wheelchair. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3M	The face to face examination does not demonstrate the caregiver is available, willing and able to safely operate the power mobility device requested. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3N	The face-to-face examination does not demonstrate the use of a power operated vehicle has been excluded. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3S	The documentation does not demonstrate the beneficiary uses a ventilator which is mounted on the power mobility device. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3T	The documentation does not demonstrate the beneficiary's mobility limitations are due to a neurological condition, myopathy, or congenital skeletal deformity. Refer to Local Coverage Determination 33789 Policy Article A52498.

PMD3U	The documentation does not demonstrate the beneficiary is expected to grow in height. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3V	The documentation does not provide sufficient information to demonstrate why the home does not provide adequate access between rooms, maneuvering space and surfaces for the power operated vehicle. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3W	The documentation does not demonstrate the beneficiary requires a drive control interface other than a hand or chin-operated standard proportional joystick and the system is being used on the power mobility device. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3X	The documentation does not demonstrate the beneficiary meets the coverage criteria for a power tilt seating system and the system is being used on the power mobility device. Refer to Local Coverage Determination 33789 and Policy Article A52498
PMD3Z	The documentation in the face-to-face examination (explain identified problem with the documentation related to specific criteria in the LCD). Refer to Local Coverage Determination 33789 and Policy Article A52498.
PM3AA	The documentation does not demonstrate the beneficiary meets the coverage criteria for a power tilt and power recline seating system and the system is being used on the power mobility device. Refer to Local Coverage Determination 33789 and Policy Article A52498.
PM3AB	The documentation does not demonstrate the beneficiary meets the coverage criteria for a power recline seating system and the system is being used on the power mobility device. Refer to Local Coverage Determination 33789 and Policy Article A52498.
PM3AC	The documentation demonstrates the beneficiary meets coverage criteria for a skin protection seat or back cushion which is not appropriate with a Captain's Chair. Refer to Local Coverage Determination 33789 Policy Article A52498.
PM3AD	The documentation demonstrates the beneficiary meets coverage criteria for a positioning seat or back cushion which is not appropriate with a Captain's Chair. Refer to Local Coverage Determination 33789 Policy Article A52498.
PM3AE	The documentation demonstrates the beneficiary does not have special skin protection or positioning needs to support a sling/solid seat/back wheelchair. Refer to Local Coverage Determination 33789 Policy Article A52498.
PM3AF	The documentation does not demonstrate the beneficiary's neurological deficits significantly impact the beneficiary's mobility limitations. Refer to Local Coverage Determination 33789 Policy Article A52498.

PM3AH	The documentation demonstrates the length of need for the power mobility device is less than 3 months and the underlying condition is reversible. Refer to Local Coverage Determination 33789 Policy Article A52498.
PM3AI	The documentation is not considered timely as it is not dated within the preceding 12 months. Refer to Local Coverage Determination 33789 Policy Article A52498.
PM3AJ	The medical record does not contain the beneficiary's weight. Refer to Local Coverage Determination 33789 Policy Article A52498.
PM3AK	Group 2 POVs (K0806, K0807, K0808) have added capabilities that are not needed for use in the home. Therefore, if a Group 2 POV is provided it will be denied as not reasonable and necessary. Refer to Local Coverage Determination L33789.

Reason Code	SUPPORTING MEDICAL DOCUMENTATION
PMD5A	The supporting medical documentation received was illegible.
PMD5D	The supporting medical documentation contains an illegible signature. Refer to Medicare Program Integrity Manual 3.3.2.4.
PMD5Z	The supporting medical documentation (explain identified problem)

Reason Code	ASSISTIVE TECHNOLOGY PROFESSIONAL
PMD6A	The documentation does not demonstrate the supplier's Assistive Technology Professional has a current Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD6B	The documentation does not demonstrate a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certified professional had direct in-person involvement in the selection of the power mobility device. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD6E	The Assistive Technology Professional's Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification has expired. Refer to Local Coverage Determination 33789 Policy Article A52498
PMD6F	The Assistive Technology Professional documentation does not include a date of service. Refer to Local Coverage Determination 33789 Policy Article A52498
PMD6Z	The Assistive Technology Professional documentation (explain identified problem)

Reason Code	LCMP/PT/OT
PMD7A	The financial attestation is not signed by the supplier or licensed/certified medical professional (LCMP). Refer to Local Coverage Determination 33789 Policy Article A52498
PMD7B	The documentation does not include a financial attestation stating the licensed/certified medical professional (LCMP) has no financial relationship with the supplier. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD7C	The specialty evaluation completed by the licensed/certified medical professional (LCMP) does not have evidence of concurrence or disagreement by the treating physician/practitioner. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD7D	The licensed/certified medical professional (LCMP) mobility examination does not have evidence of concurrence or disagreement by the treating physician/practitioner. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD7G	The specialty evaluation is illegible.
PMD7I	***The specialty evaluation requires a signature to resolve authenticity concerns related to legitimacy or falsity, signature requirements are not met. Refer to 42 Code of Federal Regulations 410.38 (c) & Medicare Program Integrity Manual 100- 08, Chapter 3, Section 3.3.2.4.***
PMD7J	The financial attestation is not dated. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD7K	The financial attestation statement submitted does not contain the name of the licensed/certified medical professional (LCMP) who completed the specialty evaluation. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD7L	The financial attestation statement submitted does not contain the name of the licensed/certified medical professional (LCMP) who completed the mobility examination. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD7N	The licensed/certified medical professional (LCMP) mobility examination is illegible.
PMD7Q	The licensed/certified medical professional (LCMP) mobility examination was not signed by the LCMP. Refer to Local Coverage Determination 33789; Policy Article A52498 & Program Integrity Manual 3.3.2.4
PMD7R	The specialty evaluation does not contain a date of service. Refer to Local Coverage Determination 33789; Policy Article A52498.

PMD7S	The licensed/certified medical professional (LCMP) mobility examination does not contain a date of service. Refer to Local Coverage Determination 33789; Policy Article A52498.
PMD7T	The specialty evaluation does not include the treating physician/practitioner's signature date. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD7U	The licensed/certified medical professional (LCMP) mobility examination does not include the date of concurrence. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD7X	The specialty evaluation contains conflicting information. Refer to Local Coverage Determination 33789; Policy Article A52498.
PMD7Y	The licensed/certified medical professional (LCMP) mobility examination has been completed on a limited space template with insufficiently detailed or incomplete narrative to support medical necessity from the physician/practitioner. Refer to 42 Code of Federal Regulations 410.38 (c) & Medicare Program Integrity Manual 3.3.2.1.1.
PM7AA	The specialty evaluation does not document the medical necessity for the power mobility device and its special features. Refer to Local Coverage Determination 33789 Policy Article A52498.
PM7AB	The documentation does not include a specialty evaluation completed by the licensed/certified medical professional (LCMP). Refer to Local Coverage Determination 33789 Policy Article A52498.
PM7AC	The documentation does not include a mobility examination completed by the licensed/certified medical professional (LCMP). Refer to Local Coverage Determination 33789 Policy Article A52498.
PM7AD	The licensed/certified medical professional (LCMP) documentation contains conflicting information. Refer to Local Coverage Determination 33789 Policy Article A52498.
PM7AE	The specialty evaluation has been completed on a limited space template with insufficiently detailed or incomplete narrative to support medical necessity from the physician/practitioner. Refer to 42 Code of Federal Regulations 410.38 (c) & Medicare Program Integrity Manual 3.3.2.1.1.
PMD7Z	The licensed/certified medical professional (LCMP) (explain identified problem)

Reason Code	**OTHER**
PMD8A	An affirmative decision was made on a previously submitted Prior Authorization

	request for this beneficiary.
PMD8B	No determination letter was sent to the supplier due to insufficient identification information.
PMD8C	No determination letter was sent to the treating physician/practitioner due to insufficient identification information.
PMD8D	No determination letter was sent to the beneficiary due to insufficient identification information.
PMD8E	The ordering physician is a Podiatrist (DPM) or Chiropractor (DC). Refer to Local Coverage Determination 33789 & Local Coverage Article LA55426.
PMD8Z	The documentation (explain identified problem)

Reason Code	**REJECTION/INVALID PAR**
PMD9M	The documentation demonstrates the power mobility device has been delivered and is therefore not eligible for Prior Authorization.

Reason Code	**GROUP 2 PRESSURE REDUCING SUPPORT SURFACES**
SS001	The medical record does not indicate any pressure ulcers on the trunk or pelvis. Refer to National Coverage Determination 280.1, Local Coverage Determination 33642 and Policy Article 52490.
SS002	The medical record documentation does not indicate the beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis. Refer to National Coverage Determination 280.1, Local Coverage Determination L33642 and Policy Article A52490.
SS003	The medical record does not demonstrate the beneficiary was on a comprehensive ulcer treatment program for at least a month prior to being placed on a group 2 surface. Refer to National Coverage Determination 280.1, Local Coverage Determination L33642 and Policy Article A52490.
SS004	Medical record documentation does not demonstrate the staged ulcer(s) have failed to improve over the past month. Refer to National Coverage Determination 280.1, Local Coverage Determination L33642 and Policy Article A52490.
SS005	The medical record documentation does not demonstrate the beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis. Refer to National

	Coverage Determination 280.1, Local Coverage Determination L33642 and Policy Article A52490.
SS006	The medical record documentation does not demonstrate the beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days. Refer to National Coverage Determination 280.1, Local Coverage Determination L33642 and Policy ArticleA52490.
SS007	The medical record documentation does not demonstrate the beneficiary has been on a group II or III support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days. Refer to National Coverage Determination 280.1, Local Coverage Determination L33642 and Policy Article A52490.
SS008	The medical record document demonstrates that it has been more than 60 days from the date of the mycocutaneous flap or skin graft surgery, and fails to explain the continued medical need for the specialty mattress. Refer to National Coverage Determination 280.1, Local Coverage Determination L33642.
SS009	The order is dated greater than 30 days after the beneficiary was discharged from a hospital or nursing facility. Refer to National Coverage Determination 280.1, Local Coverage Determination L33642 and Policy Article A52490.
SS010	The medical record documentation indicates that all ulcers on the trunk or pelvis are healed. Refer to National Coverage Determination 280.1, Local Coverage Determination L33642 and Policy Article A52490.
SS011	The medical record documentation shows ulcer healing has not continued, and does not demonstrate other aspects of the care plan are being modified to promote healing or the use of the group 2 support surface is reasonable and necessary for wound management. Refer to National Coverage Determination 280.1, Local Coverage Determination L33642 and Policy Article A52490.
SS012	The medical record documentation does not demonstrate the beneficiary has been on a comprehensive ulcer treatment program. Refer to National Coverage Determination 280.1, Local Coverage Determination L33642 and Policy Article A52490.
SS013	The medical record documentation does not demonstrate the beneficiary has been on a comprehensive ulcer treatment program which included use of an appropriate group 1 support surface. Refer to National Coverage Determination 280.1, Local Coverage Determination L33642 and Policy Article A52490.
SS014	The medical record documentation does not demonstrate the beneficiary has been on a comprehensive ulcer treatment program which included use of an appropriate group 1 support surface within the past month. Refer to National Coverage Determination 280.1, Local Coverage Determination L33642 and Policy Article A52490.
SS015	The medical record documentation does not demonstrate the beneficiary has been on a comprehensive ulcer treatment program which included regular assessment by a nurse,

	physician, or other licensed healthcare practitioner within the past month. Refer to National Coverage Determination 280.1, Local Coverage Determination L33642 and Policy Article A52490.
SS016	The medical record documentation does not demonstrate the beneficiary has been on a comprehensive ulcer treatment program which included regular assessment by a nurse, physician, or other licensed healthcare practitioner within the past month. Refer to National Coverage Determination 280.1, Local Coverage Determination L33642 and Policy Article A52490.
SS017	The medical record documentation does not demonstrate the beneficiary has been on a comprehensive ulcer treatment program which included appropriate wound care within the past month. Refer to National Coverage Determination 280.1, Local Coverage Determination L33642 and Policy Article A52490.
SS018	The medical record documentation does not demonstrate the beneficiary has been on a comprehensive ulcer treatment program which included appropriate management of moisture/incontinence within the past month. Refer to National Coverage Determination 280.1, Local Coverage Determination L33642 and Policy Article A52490.
SS019	The medical record documentation does not demonstrate the beneficiary has been on a comprehensive ulcer treatment program which included nutritional assessment and intervention consistent with the overall plan of care within the past month. Refer to National Coverage Determination 280.1, Local Coverage Determination L33642 and Policy Article A52490.

Reason Code	**LOWER LIMB PROSTHETICS (L5856, L5857, L5858, L5973, L5980, L5987)**
LLP01	The medical record documentation does not demonstrate the beneficiary will reach or maintain a defined functional state within a reasonable period of time. Refer to Local Coverage Determination L33787.
LLP02	The medical record documentation does not demonstrate the beneficiary is motivated to ambulate. Refer to Local Coverage Determination L33787.
LLP03	The medical record documentation does not demonstrate the beneficiary's current functional capabilities. Refer to Local Coverage Determination L33787.
LLP04	The medical record documentation does not demonstrate the beneficiary's expected functional potential. Refer to Local Coverage Determination L33787.
LLP05	Coverage criteria for the prosthesis is not met, therefore the related additions will be denied as not reasonable and necessary. Refer to Local Coverage Determination L33787.

LLP06	Codes L5629, L5638, L5639, L5646, L5647, L5704, L5785, L5962, and L5980 will be denied as not reasonable and necessary when billed with an initial below the knee prosthesis (L5500) or a preparatory below the knee prosthesis (L5510-5530, L5540). Refer to Local Coverage Determination L33787.
LLP07	Codes L5610, L5631, L5640, L5642, L5644, L5648, L5705, L5706, L5964, L5980, and L5710-L5780, L5790-L5795 will be denied as not reasonable and necessary when billed with an initial above the knee prosthesis (L5505) or an above the knee preparatory prosthesis (L5560-5580, L5590-L5600). Refer to Local Coverage Determination L33787.
LLP08	The medical record documentation does not demonstrate the functional classification for the prosthetic foot/feet. Refer to Local Coverage Determination L33787.
LLP09	The medical record documentation does not demonstrate the functional classification for the prosthetic knee(s). Refer to Local Coverage Determination L33787.
LLP10	With the exception of items described by specific HCPCS codes, there should be no separate billing and there is no separate payment for a component or feature of a microprocessor controlled knee, including but not limited to real time gait analysis, continuous gait assessment, or electronically controlled static stance regulator. Refer to the Benefit Policy Manual Pub 100-02 Chapter 15.
LLP11	The medical record documentation does not indicate replacement of a prosthesis or prosthetic component due to 1. A change in the physiological condition of the beneficiary; or 2. Irreparable wear of the device or a part of the device; or 3. The condition of the device, or part of the device, requires repairs and the cost of such repairs would be more than 60% of the cost of a replacement device, or of the part being replaced. Refer to the Social Security Act 1834(h)(1)(G).
LLP12	The physician's order does not indicate replacement of a prosthesis or prosthetic component due to 1. A change in the physiological condition of the beneficiary; or 2. Irreparable wear of the device or a part of the device; or 3. The condition of the device, or part of the device, requires repairs and the cost of such repairs would be more than 60% of the cost of a replacement device, or of the part being replaced. Refer to the Benefit Policy Manual Pub 100-02 Chapter 15.
LLP13	Payment for a prosthesis described by codes L5000-L5020, L5400-L5460, L5987, and L8400 - L8480 is included in the payment to a Skilled Nursing Facility (SNF). Refer to Social Security Act 1861(n) and Local Coverage Article A52496.

Reason Code	**LOWER LIMB PROSTHETICS (FUTURE USE)**

LLP14	The medical record documentation does not demonstrate the beneficiary has a microprocessor (swing and stance phase type (L5856)) controlled (electronic) knee for payment of L5859. Refer to Local Coverage Determination L33787.
LLP15	(Code L5859 when submitted with L5856) The medical record documentation does not demonstrate the beneficiary has a documented comorbidity of the spine and/or sound limb affecting hip extension and/or quadriceps function that impairs K3 level function with the use of a microprocessor-controlled knee alone. Refer to Local Coverage Determination L33787.
LLP16	(Code L5859 when submitted with L5856) The medical record documentation does not demonstrate the beneficiary is able to make use of a product which requires daily charging. Refer to Local Coverage Determination L33787.
LLP17	(Code L5859 when submitted with L5856) The medical record documentation does not demonstrate the beneficiary is able to understand and respond to error alerts and alarms indicating problems with the function of the unit. Refer to Local Coverage Determination L33787.
LLP18	(Code L5859 when submitted with L5856) The medical record documentation does not demonstrate the beneficiary has a K3 functional level only for payment of L5859. Refer to Local Coverage Determination L33787.
LLP19	Codes L5620, L5629, L5645, L5646, L5670, L5676, L5704, and L5962 will be denied as not reasonable and necessary when billed with a below the knee preparatory prefabricated prosthesis (L5535). Refer to Local Coverage Determination L33787.
LLP20	When an initial below knee prosthesis (L5500) or a preparatory below knee prosthesis (L5510-L5530, L5540) is provided, prosthetic substitutions and/or additions of procedures and components are covered in accordance with the functional level assessment except for codes L5629, L5638, L5639, L5646, L5647, L5704, L5785, L5962, and L5980 which will be denied as not reasonable and necessary. Refer to Local Coverage Determination L33787.
LLP21	Codes L5624, L5631, L5648, L5651, L5652, L5705, L5706, L5964, and L5966 will be denied as not reasonable and necessary when billed with an above the knee preparatory prefabricated prosthesis (L5585). Refer to Local Coverage Determination L33787.
LLP22	The microprocessor foot or ankle system addition with power assist which includes any type motor (L5969) is not covered because there is insufficient information to demonstrate that the item meets the Medicare standard to be considered reasonable and necessary as per PIM Chapter 13. Claims for L5969 will be denied as not reasonable and necessary. Refer to Local Coverage Determination L33787.
LLP23	A user-adjustable heel height feature (L5990) will be denied as not reasonable and necessary. Refer to Local Coverage Determination L33787.

LLP24	The medical record documentation does not demonstrate the beneficiary has a K4 functional level for the high activity knee control frame (L5930). Refer to Local Coverage Determination L33787.
LLP25	The medical record documentation does not demonstrate a functional level of two or above for payment of an axial rotation unit (L5982-L5986). Refer to Local Coverage Determination L33787.
LLP26	The medical record documentation does not demonstrate a functional level of three or above for payment of a pneumatic or hydraulic polycentric hip joint (L5961). Refer to Local Coverage Determination L33787.
LLP27	The medical record documentation does not justify the need for more than two test (diagnostic) sockets (L5618-L5628). Refer to Local Coverage Determination L33787.
LLP28	A test socket is not reasonable and necessary for an immediate prosthesis (L5400 – L5460). Refer to Local Coverage Determination L33787.
LLP29	No more than two of the same socket inserts (L5654 – L5665, L5673, L5679, L5681, L5683) are allowed per individual prosthesis at the same time. Refer to Local Coverage Determination L33787.
LLP30	A prosthetic donning sleeve (L7600) will be denied as non-covered. Refer to Local Coverage Article A52496.
LLP31	Code L7520 must not be billed for labor time involved in the replacement of parts that are billed with a specific HCPCS code. Refer to Local Coverage Article A52496.
LLP32	Foot covers are included in the codes for a prosthetic foot component and are not separately payable. Refer to Local Coverage Article A52496.
LLP33	The beneficiary's potential functional level is zero (0), therefore the prosthesis will be denied as not reasonable and necessary. Refer to Local Coverage Determination L33787.
LLP34	A pneumatic or hydraulic polycentric hip joint (L5961) is covered for beneficiaries whose functional level is 3 or above. Refer to Local Coverage Determination L33787.
LLP35	Codes L5681 and L5683 are for use only with the initial issue of a custom fabricated socket insert. Additional inserts (either custom fabricated or prefabricated) provided at the time of initial issue or replacement socket inserts are coded L5673 and L5679. Refer to Local Coverage Article A52496.
LLP36	Codes L5647 and L5652 describe a modification to a prosthetic socket that incorporates a suction valve in the design. The items described by these codes are not components of a suspension locking mechanism (L5671). Refer to Local Coverage Article A52496.
LLP37	Code L7700 is not to be used to bill for gaskets, seals, or other sealing materials that are included as part of an insert. L7700-(GASKET OR SEAL, FOR USE WITH

	PROSTHETIC SOCKET INSERT, ANY TYPE, EACH) describes a stand-alone (i.e., not integrated into or a part of a prosthetic socket insert) sealing ring that is added to a socket insert to assist in providing or maintaining negative pressure for socket suspension. Unit of service (UOS) is 1 (one) item. Refer to Local Coverage Article A52496.
LLP38	Codes L5940-L5960 for ultra-light materials may only be used when materials such as carbon fiber, fiberglass, Kevlar®, or other advanced composite lamination materials are used in the fabrication of a socket for an endoskeletal prosthesis. For codes L5940-L5960, the unit of service is per limb. Refer to Local Coverage Article A52496.
LLP39	Codes L5962, L5964, and L5966 are specialized covers intended to be worn over an existing prosthesis, for protection against unusually harsh environmental situations. Protective outer surface coverings are different from the covering that is already reimbursed as part of L5704 – L5707. Refer to Local Coverage Article A52496.
LLP40	There is no separate payment for batteries (L7360, L7364, and L7367) and/or battery chargers (L7362, L7366, and L7368) billed concurrently with a powered base item (L5781, L5782, L5856, L5857, L5858, L5859, L5973). Refer to Local Coverage Article A52496.
LLP41	The medical record does not contain any identifying information to determine the Certified Prosthetist/Orthotist (CPO) who performed the evaluation.
LLP42	Documentation was not submitted from the prosthetist to support functional level.

Reason Code	**KNEE ORTHOSES**
OR000	The medical record documentation does not demonstrate the beneficiary is ambulatory for a knee orthosis that is necessary due to knee instability. Refer to Local Coverage Determination L33318 and Policy Article A52465.
OR001	The medical record documentation does not demonstrate the beneficiary has weakness or deformity of the knee. Refer to Local Coverage Determination L33318 and Policy Article A52465.
OR002	The medical record documentation does not demonstrate the beneficiary requires stabilization. Refer to Local Coverage Determination L33318 and Policy Article A52465.
OR003	The medical record documentation does not demonstrate the beneficiary has flexion or extension contractures of the knee with movement on passive range of motion testing of at least 10 degrees. Refer to Local Coverage Determination L33318 and Policy Article A52465.

OR004	The medical record documentation does not support the beneficiary has had a recent injury or a surgical procedure on the knee(s). Refer to Local Coverage Determination L33318 and Policy Article A52465.
OR005	The medical record documentation does not demonstrate knee instability due to an applicable group 4 diagnosis code. Refer to Local Coverage Determination L33318 and Policy Article A52465.
OR006	The medical record documentation does not demonstrate knee injury or surgery due to an applicable group 2 or group 4 diagnosis code. Refer to Local Coverage Determination L33318 and Policy Article A52465.
OR007	The medical record documentation does not demonstrate the beneficiary has knee instability due to genu recurvatum – hyperextended knee. Refer to Local Coverage Determination L33318 and Policy Article A52465.
OR008	The medical record documentation does not demonstrate knee instability by examination of the beneficiary. Refer to Local Coverage Determination L33318 and Policy Article A52465.
OR009	The medical record documentation does not demonstrate an objective description of joint laxity. Refer to Local Coverage Determination L33318 and Policy Article A52465.
OR010	The medical record documentation does not demonstrate a physical characteristic which requires the use of a custom fabricated orthosis instead of a prefabricated orthosis. Refer to Local Coverage Determination L33318 and Policy Article A52465.
OR011	The medical record documentation does not demonstrate instability due to internal ligamentous disruption of the knee. Refer to Local Coverage Determination L33318 and Policy Article A52465.
OR012	The medical record documentation does not demonstrate the beneficiary weighs more than 300 pounds. Refer to Local Coverage Determination L33318 and Policy Article A52465.
OR013	The medical record documentation does not demonstrate the beneficiary requires knee extension assist in the absence of any co-existing joint contracture. Refer to Local Coverage Determination L33318 and Policy Article A52465.
OR014	Claims history indicates same or similar durable medical equipment within the last two years. Refer to Local Coverage Determination L33318 and Policy Article A52465.
OR015	Claims history indicates same or similar durable medical equipment within the last three years. Refer to Local Coverage Determination L33318 and Policy Article A52465.
OR016	Claims history indicates same or similar durable medical equipment within the last one year. Refer to Local Coverage Determination L33318 and Policy Article A52465.

Reason Code	SPINAL ORTHOSES
OR100	The medical record documentation does not demonstrate the spinal orthosis is indicated to reduce pain by restricting mobility of the trunk; or to facilitate healing following an injury to the spine or related soft tissues; or to facilitate healing following a surgical procedure on the spine or related soft tissue; or to otherwise support weak spinal muscles and/or a deformed spine. Refer to Local Coverage Determination L33790 and Policy Article A52500.
OR101	The medical record documentation does not demonstrate a physical characteristic which requires the use of a custom fabricated orthosis instead of a prefabricated orthosis. Refer to Local Coverage Determination L33790 and Policy Article A52500.
OR102	The supplier's record does not contain detailed documentation to support the medical necessity of a custom fabricated orthoses rather than a prefabricated orthosis. Refer to Local Coverage Determination L33790 and Policy Article A52500.
OR103	Claims history indicates same or similar durable medical equipment within the last five years. Refer to Medicare Benefit Policy Manual Chapter 15, Section 110.2 (C).
OR104	Documentation does not include a detailed description of the modifications necessary for the item requiring more than minimal self-adjustment by a qualified practitioner at the time of fitting the orthosis orthoses. Refer to applicable Local Coverage Determination/Policy Article.
OR105	The medical record documentation demonstrates the beneficiary is in a wheelchair. Spinal Orthoses are not specifically designed for beneficiaries in wheelchairs. Refer to Local Coverage Determination L33790 and Policy Article A52500.

Reason Code	PMD ACCESSORIES
AC000	The documentation does not support the medical necessity for the following item(s). Refer to Local Coverage Determinations policies L33789, L33792, L33312 and Local Coverage Articles A52498, A52504, A52505.
AC001	This HCPCS code is included in the allowance for another submitted item. Refer to Local Coverage Determinations policies L33789, L33792, L33312 and Local Coverage Articles A52498, A52504, A52505.
AC002	This item is non-affirmed as the item is presumptively not medical in nature. Refer to Local Coverage Determinations policies L33789, L33792, L33312 and Local Coverage Articles A52498, A52504, A52505.

AC003	Each power operated vehicle (POV) is to include all items on initial issue (i.e., no separate billing/payment at the time of initial issue). Refer to Local Coverage Determinations policies L33789, L33792, L33312 and Local Coverage Articles A52498, A52504, A52505.
AC004	The requested HCPCS code is not included on the Voluntary Prior Authorization Accessory list.
AC005	Accessories are only prior authorized in conjunction with a required base device; which was previously submitted for review. As a result, the accessories are not separately eligible for prior authorization. Refer to the Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items Operational Guide.

Reason Code	NON-SPINAL ELECTRICAL OSTEOGENESIS STIMULATOR (E0747)
OS000	The medical record documentation does not support the beneficiary has nonunion of a long bone fracture defined as radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the osteogenesis stimulator. Refer to National Coverage Determination 150.2, Local Coverage Determination L33796, and Policy Article A52513.
OS001	The medical record documentation does not include a minimum of two sets of radiographs prior to starting treatment of a nonunion long bone fracture, separated by a minimum of 90 days. Each set must include multiple views of the fracture site and a written interpretation by a practitioner stating there has been no clinically significant evidence of fracture healing between the two sets of radiographs. Refer to National Coverage Determination 150.2, Local Coverage Determination L33796, and Policy Article A52513.
OS002	The medical record documentation does not support the beneficiary has a long bone fracture. A long bone is limited to a clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal, or metatarsal. Refer to National Coverage Determination 150.2, Local Coverage Determination L33796, and Policy Article A52513.
OS003	The medical record documentation does not support failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the last surgery. Refer to National Coverage Determination 150.2, Local Coverage Determination L33796, and Policy Article A52513.
OS004	The medical record documentation does not support congenital pseudarthrosis. Refer to National Coverage Determination 150.2, Local Coverage Determination L33796, and Policy Article A52513.

Reason Code	SPINAL ELECTRICAL OSTEOGENESIS STIMULATOR (E0748)
OS100	The medical record documentation does not support a failed spinal fusion where a minimum of nine months has elapsed since the last surgery. Refer to National Coverage Determination 150.2, Local Coverage Determination L33796, and Policy Article A52513.
OS101	The medical record documentation does not support a multilevel spinal fusion surgery which involves 3 or more vertebrae. Refer to National Coverage Determination 150.2, Local Coverage Determination L33796, and Policy Article A52513.
OS102	The medical record documentation does not support a history of a previously failed spinal fusion at the same spinal fusion site. Refer to National Coverage Determination 150.2, Local Coverage Determination L33796, and Policy Article A52513.

Reason Code	ULTRASONIC ELECTRICAL OSTEOGENESIS STIMULATOR (E0760)
OS200	The medical record documentation does not include a minimum of two sets of radiographs prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days. Each set must include multiple views of the fracture site and a written interpretation by a practitioner stating there has been no clinically significant evidence of fracture healing between the two sets of radiographs. Refer to National Coverage Determination 150.2, Local Coverage Determination L33796, and Policy Article A52513.
OS201	The medical record documentation supports the fracture is of the skull or vertebrae. Refer to National Coverage Determination 150.2, Local Coverage Determination L33796, and Policy Article A52513.
OS202	The medical record documentation supports the fracture is tumor related. Refer to National Coverage Determination 150.2, Local Coverage Determination L33796, and Policy Article A52513.
OS203	The medical record documentation indicates a fresh fracture or delayed union; therefore, the use of an ultrasonic electrical osteogenesis stimulator is not medically necessary. Refer to National Coverage Determination 150.2, Local Coverage Determination L33796, and Policy Article A52513.
OS204	The ultrasonic osteogenesis stimulator is non-covered; therefore, the ultrasound conductive coupling gel is non-covered. Refer to Local Coverage Determination L33796 and Policy Article A52513.
OS205	The ultrasonic osteogenesis stimulator is not medically necessary as it is being used with other noninvasive osteogenesis stimulators. Refer to National Coverage

	Determination 150.2, Local Coverage Determination L33796, and Policy Article A52513.

Reason Code	ANKLE FOOT ORTHOSES (L1951)
AFO00	The medical record documentation does not support the beneficiary is ambulatory. Refer to Local Coverage Determination L33686 and Policy Article A52457.
AFO01	The medical record documentation does not support the beneficiary has weakness or deformity of the foot and ankle. Refer to Local Coverage Determination L33686 and Policy Article A52457.
AFO02	The medical record documentation does not support the beneficiary requires stabilization for medical reasons. Refer to Local Coverage Determination L33686 and Policy Article A52457.
AFO03	The medical record documentation does not support the beneficiary has the potential to benefit functionally. Refer to Local Coverage Determination L33686 and Policy Articles A52457.
AFO04	The medical record documentation does not demonstrate one of the following criteria: The beneficiary could not be fit with a prefabricated AFO; or, The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months); or, There is a need to control the knee, ankle or foot in more than one plane; or, The beneficiary has a documented neurological, circulatory, or orthopedic status that requires custom fabricating to prevent tissue injury; or, The beneficiary has a healing fracture which lacks normal anatomical integrity or anthropometric proportions. Refer to Local Coverage Determination L33686 and Policy Article A52457.
AFO05	The orthotist's functional evaluation does not corroborate the medical records submitted by the treating practitioner. Refer to Local Coverage Determination L33686 and Policy Article A52457.
AFO06	Documentation does not include a detailed description of the modifications necessary for the item requiring more than minimal self-adjustment by a qualified practitioner at the time of fitting the ankle foot orthosis. Refer to Local Coverage Determination L33686 and Policy Article A52457.

Reason Code	ADMINISTRATIVE/OTHER *(For Transmission via esMD)*
PMDXD	Other
PMDXE	The system used to retrieve the Subscriber/Insured details using the given MBI is temporarily unavailable.
PMDXF	***The documentation is incomplete***
PMDXG	This submission is an unsolicited response
PMDXH	***The documentation cannot be matched to a case/claim***
PMDXI	***This is a duplicate of a previous transaction***
PMDXJ	The date(s) of service on the cover sheet received is missing or invalid.
PMDXK	The NPI on the cover sheet received is missing or invalid.
PMDXL	The state where services were provided is missing or invalid on the cover sheet received.
PMDXM	The Medicare ID on the cover sheet received is missing or invalid.
PMDXN	The billed amount on the cover sheet received is missing or invalid.
PMDXO	The contact phone number on the cover sheet received is missing or invalid.
PMDXP	The Beneficiary name on the cover sheet received is missing or invalid
PMDXQ	The Claim number on the cover sheet received is missing or invalid
PMDXR	The ACN on the coversheet received is missing or invalid
GEX19 (Effective 10/01/2021)	Provider is exempted from submitting this PA request