Orthotic and Prosthetic Appliances and Services: Criteria for Authorization and Reimbursement – Orthotics

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This section contains criteria for the authorization and reimbursement of orthotic appliances and services (*California Code of Regulations*, [CCR], Title 22, Sections 51315 and 51315.1). Additional information is included in the following manual sections in this manual:

Orthotic and Prosthetic Appliances and Services

‹‹*Orthotic and Prosthetic Appliances: Billing Codes – Orthotics*››

Orthotics and Prosthetics: Frequency Limits for Orthotics

Orthotic and Prosthetic Appliances: Billing Examples

Authorization and Restrictions

The criteria for authorization and reimbursement listed in this section refer only to those HCPCS codes that are Medi-Cal benefits. ‹‹Reimbursable orthotic HCPCS codes are listed in the *Orthotic and Prosthetic Appliances: Billing Codes – Orthotics* section of this manual.››

Note: Pursuant to CCR, Title 22, Section 51315.1, the lists of medical conditions that follow specification of orthotic appliances and services are not intended to be exhaustive, and not all of the listed medical conditions will necessarily require the orthotic appliance or service. Documented medical necessity is required to be submitted with the *Treatment Authorization Request* (TAR), specific to the individual recipient and specific to the orthotic appliance or service being requested.

For all HCPCS codes that require a TAR, documentation that the recipient meets the criteria specified for each code must be submitted with the TAR and maintained in the recipient's medical record.

For frequency limits refer to *Orthotics and Prosthetics: Frequency Limits for Orthotics* section of this manual.

Taxable Appliances and Services

Information about taxable orthotic and prosthetic appliances is included in the *Taxable and Non-Taxable Items* section of this manual.

Documentation Requirements

For codes that do not require a TAR, documentation requirements refer to information verifying medical necessity that must be submitted by the prescribing practitioner to the orthotic provider. If audited, the orthotic provider must demonstrate that this documentation was received by the prescribing practitioner.

Shoe Supplies for Diabetics (A5500 thru A5513)

Coverage

Shoe supplies for diabetics, which includes shoes and their fittings, modifications and inserts may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a diagnosis of diabetes mellitus and one or more of the following conditions:

For prefabricated shoes, modifications to prefabricated shoes and inserts:

- Foot ulcers (A5500, A5503 thru A5507, A5512); or,
- Previous amputation of the contralateral foot, or part of either foot, due to microvascular disease secondary to diabetes (A5500, A5503 thru A5507, A5512); or,
- History of foot ulceration of either foot (A5500, A5503 thru A5507, A5512); or,
- Peripheral neuropathy with evidence of callous formation of either foot (A5500, A5503 thru A5507, A5512); or,
- Deformity of either foot, such as rocker bottom foot or Charcot foot (A5500, A5503 thru A5507, A5512); or,
- Compromised vascular disease in either foot (A5500, A5503 thru A5507, A5512); or,
- Positive monofilament examination indicating diabetic neuropathy (A5500, A5503 thru A5507, A5512).

For custom-made shoes, modifications to custom made shoes and inserts:

- One or more of the preceding listed conditions; AND,
- One or more of the following:
  - Neurological manifestations (A5501, A5513); or,
  - Peripheral circulatory disorders (A5501, A5513); or,
  - Other disorders that require treatment or prevention of foot conditions secondary to diabetes (amputations, significant deformities and/or pre-ulcerations) (A5501, A5513).

Authorization and Restrictions

All codes in this section always require authorization (TAR required).

Only orthotists and prosthetists may be authorized and reimbursed for the following appliances as medically necessary:

- HCPCS codes A5500 (prefabricated shoes) and A5512 (prefabricated inserts) may each be authorized and reimbursed for up to four in 12 months. The daily maximum allowable for each code is two, but they do not have to be billed in pairs. The maximum allowable in 12 months may be in any combination of right or left sides.
- HCPCS codes A5501 (custom shoes) and A5513 (custom inserts) may each be authorized and reimbursed for up to two in 12 months. The maximum allowable in 12 months may be in any combination of right or left sides.

Providers will not be authorized and reimbursed for both prefabricated and custom-made shoes or inserts for the same foot in the same 12-month period, unless:

- The claim does not exceed the stated annual frequency limitation for the respective code(s); and,
- The recipient's medical condition has changed to the extent that a custom-made shoe is required for the same side after a prefabricated shoe or insert has been tried.

Diabetic shoe inserts are reimbursable only if a diabetic shoe is billed on the same claim or in the previous 12-month period of time.

Documentation Requirements

‹‹Providers must submit a *Physician Certification of Medical Necessity for Therapeutic Diabetic Shoes and Inserts* form or other document that contains all information requested on the form signed by the physician with the TAR.››

Billing

All codes in this section must be billed with either the modifier LT (left side) or RT (right side).

Documentation of the medical justification for separate reimbursement of a prefabricated or custom-made item for the same foot in the same 12-month interval must be placed in the *Additional Claim Information* field (Box 19) of the claim or on an attachment.

Custom Fabricated Compression Burn Garments (A6501 thru A6513)

Coverage

Custom fabricated compression burn garments may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition such as extensive burns that requires a physician-ordered compression garment to facilitate healing and to prevent excessive scarring (all codes).

Authorization and Restrictions

All codes in this section always require authorization (TAR required).

Billing

HCPCS codes A6504 thru A6508 must be billed with either the modifier LT (left side) or RT (right side).

‹‹Lymphedema Compression Treatment Items (A6521-A6610)

Coverage

Custom fabricated compression garments may be authorized and reimbursed for recipients that meet the established criteria. Non-custom compression garments are not a benefit of the Medi-Cal program.

Criteria

Pneumatic compression devices are covered in the home setting for the treatment of lymphedema if the patient has undergone a four-week trial of conservative therapy and the treating practitioner determines that there has been no significant improvement or if significant symptoms remain after the trial. The trial of conservative therapy must include use of an appropriate compression bandage system or compression garment, exercise, and elevation of the limb. The garment must be custom-fabricated and must provide adequate graduated compression. These could be considered re-usable and not disposable as they would be re-used by the patient.››

Authorization and Restrictions

All codes in this section always require authorization (TAR required).

Providers billing for compression garments must have a written prescription for the specific item(s) from a licensed practitioner. A generic prescription for “compression garment” is not acceptable.

Documented diagnosis of Chronic Lymphedema is necessary.

Frequency limit:

Daytime garments: 1 year, worn daily with regular washing and care.

Nighttime garments: 5 years, worn nightly, with regular washing and care.

Billing

The following HCPCS codes must be billed with the modifier LT (left side) or RT (right side): A6521, A6523, A6525, A6527, A6529, A6553, A6555, A6556, A6557, A6558, A6562, A6563, A6564, A6565, A6573, A6574, A6576, A6577, A6579, A6580, A6610.

‹‹Gradient Compression Stockings and Garments (A6544 thru A6549)››

Coverage

Gradient compression stockings include custom-made stockings and garter belts and may be authorized and reimbursed for recipients that meet the established criteria.

Pre-manufactured and off-the-shelf pantyhose-type, elastic support stockings are not a benefit of the Medi-Cal program.

Providers billing for elastic gradient compression stockings must have a written prescription for the specific item(s) from a licensed practitioner. A generic prescription for “elastic support stockings” is not acceptable.

Criteria

The recipient requires one or both of the following:

- Custom made compression stockings to treat symptomatic venous insufficiency or lymphedema in one or both lower extremities (A6545 and A6549); or,
- A garter belt to hold custom made compression stockings or residual limb shrinker(s) in place (A6544).
- ‹‹A silicone band to hold a custom gradient compression garment in place (A6548).››

Authorization and Restrictions

HCPCS codes A6545 and A6549 always require authorization (TAR required).

Billing

‹‹A6545, A6548 and A6549 must be billed with either the modifier LT (left side) or RT (right side).››

Spinal Orthoses (Cranial [Helmets]) (A8000 thru A8004, S1040)

Coverage

Cranial orthoses (helmets) may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

Recipient requires head protection (A8000 thru A8003).

The recipient has a medical condition in which the head requires cranial molding (S1040) and when the recipient meets both of the following criteria:

- Is 2 years of age or younger; and,
- Has an ICD-10-CM diagnosis code of Q67.2 (dolichocephaly), Q67.3 (plaglocephaly), Q67.4 (other congenital deformities of skull, face and jaw), Q75.001 (craniosynostosis, unspecified type, unilateral), Q75.002 (craniosynostosis, unspecified type, bilateral), Q75.009 (craniosynostosis, unspecified), Q75.01 (sagittal craniosynostosis), Q75.02 (coronal craniosynostosis), Q75.021 (coronal craniosynostosis, unilateral), Q75.022 (coronal craniosynostosis, bilateral), Q75.029 (coronal craniosynostosis, unspecified), Q75.03 (metopic craniosynostosis), Q75.04 (lambdoid craniosynostosis), Q75.041 (lambdoid craniosynostosis, unilateral), Q75.042 (lambdoid craniosynostosis, bilateral), Q75.049 (lambdoid craniosynostosis, unspecified), Q75.05 (multi-suture craniosynostosis), Q75.051 (cloverleaf skull), Q75.052 (pansynostosis), Q75.058 (other multi-suture craniosynostosis), Q75.1 (craniofacial dysostosis), Q75.08 (other single-suture craniosynostosis), Q75.8 (other specified congenital malformations of skull and face bones), Q75.9 (congenital malformation of skull and face bones, unspecified).

Authorization and Restrictions

HCPCS code S1040 always requires authorization (TAR required).

HCPCS code S1040 must be made by a Federal Drug Administration (FDA)-approved laboratory (see following “Documentation Requirements”).

Documentation Requirements

HCPCS code S1040:

- Requires the name and address of the FDA-approved lab that made the appliance. The following are currently approved labs:
  - Becker Orthopedic Appliance Company (Becker Band Cranial Remolding Orthosis)
  - Beverly Hills Prosthetics Orthotics (Cranial Symmetry System)
  - Boston Brace International, Inc. (Static Cranioplasty Orthosis)
  - Center for Orthotic and Prosthetic Care (COPC Band)
  - Children’s Hospital & Medical Center (Clarren Helmet)
  - Children’s Hospital Minneapolis (Cranial Helmet)
  - Children’s Hospital and Regional Medical Center in Seattle, WA (Clarren Helmet)
  - Cranial Solutions (Cranial Solution Orthosis)
  - Cranial Technologies, Inc. (Doc Band)
  - Cranial Technologies, Inc. (Doc Band-Postop)
  - Cranial Technologies, Inc. (Dynamic Orthotic Cranioplasty Band)
  - Danmar Products (Cranial Adjustive Prosthesis)
  - Danmar Products (Danmar Products Michigan Cranial Helmet)
  - Eastern Cranial Affiliates (Static Cranioplasty Orthosis)
  - Fairview Orthopedic Laboratory (Molded Cranial Helmet)
  - Gema, Inc. (Ballert Cranial Molding Helmet)
  - Gillette Children’s Specialty Healthcare (Craniocap)
  - Hanger Orthopedic Group, Inc. (Hanger Cranial Band)

  - Lerman & Son (Lerman & Son Cranial Orthosis Helmet)
  - Mike Milner (Craniocephalic Custom Remolding Orthosis)
  - Northeast Orthotics and Prosthetics, Inc. (Providence Molding Helmet)
  - Orthomerica Products, Inc. (Clarren Helmet [Orthomerica])
  - Orthomerica Products, Inc. (Opi Band)
  - Orthomerica Products, Inc. (Starband Cranial Orthosis)
  - Orthomerica Products, Inc. (Starlight)
  - Orthotic & Prosthetic Lab, Inc. (O&P Cranial Molding Helmet)
  - Orthotic & Prosthetic Lab, Inc. (O&P Bivalve Cranial Molding Helmet)
  - Orthotic Solutions (Cranial Molding Orthosis)
  - Otto Bock Health Care, LP (Cranial Helmet)
  - Precision Prosthetics & Orthotics (Orthosis Helmet Molding)
  - Rehabilitation Institute, Loma Linda University [Loma Linda University Medical Center (LLUMC)]
  - Restorative Health Services, Inc. (Rhs Helmet)
  - Scott E. Allen CP (Plagiocephalic Applied Pressure Orthosis)
- If a cranial molding helmet laboratory that is not listed above is used, a copy of the laboratory's FDA-approved "510k" letter for the helmet must accompany the TAR.

Spinal Orthoses (Cervical and Multiple Post Collars [Collars]) L0113 thru L0200

Coverage

Cervical and multiple post collars may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient requires cervical support and stabilization that can be accomplished with an off-the-shelf appliance, such as in whiplash (L0120 thru L0160).

The recipient has a medical condition that requires a custom fitted or custom molded cervical orthosis to provide rigid or semi-rigid support to the cervical spine to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury, such as in one of the following (L0113, L0170 thru L0200):

- Whiplash or other injury to the neck; or,
- Post-surgical repair of a cervical fracture; or,
- Post-surgical treatment of a ligamentous injury or torticollis; or,
- Treatment of a cervical fracture or a ligamentous injury in lieu of surgery; or
- Any related medical condition that requires maximum support of the cervical spine

Authorization and Restrictions

HCPCS code L0113 always requires authorization (TAR required).

HCPCS code L0120 may be authorized and reimbursed to a pharmacist or pharmacy when the pharmacist/pharmacy is licensed and enrolled in the Medi-Cal program as a provider.

Billing

‹‹Pharmacies billing for code HCPCS L0120 must bill on the *CMS-1500* claim form.››

Spinal Orthoses (Thoracic [Rib Belts]) L0220

Coverage

Thoracic orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition that requires support to the thoracic area to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury, such as for fractured ribs or torn intercostal ligaments.

Note: Use of a rib belt for the control of pain when the pain is greater than what can be controlled with oral pain medication(s) carries the risk of further harm to the recipient, such as constriction of the rib cage to the point of respiratory compromise.

Spinal Orthoses (Thoracic [Anterior-Posterior-Lateral-Rotary Control]) L0450 thru L0457

Coverage

Anterior-posterior-lateral-rotary control orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition such as a slipped or herniated disk; osteoporosis of the thoracic area; a vertebral fracture, with or without surgery; or a related medical condition of the thoracic area and requires one or more of the following to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury:

- Trunk support (all codes); or,
- Reduction of load on the intervertebral discs (all codes); or,
- Reduction of gross trunk motion in the sagittal plane (L0456, L0457).

Spinal Orthoses (Thoracic [Triplanar Control – Modular Segmented Spinal System] [Prefabricated]) L0458 thru L0464

Coverage

Triplanar control – modular segmented spinal system (prefabricated) orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition such as post neck or back surgery, post laminectomy, a vertebral fracture, or a related medical condition of the thoracic area and requires one or both of the following to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury (all codes).

- Reduction of gross trunk motion in three planes (sagittal, coronal and transverse (all codes); or,
- Spinal support and stabilization or immobilization (all codes).

Spinal Orthoses (Thoracic [Triplanar Control – Rigid Frame]) L0470, L0472

Coverage

Triplanar control – rigid frame orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition that requires one or more of the following to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury:

- Reduction of load on the intervertebral discs (L0470); or,
- Reduction of gross trunk motion in three planes (sagittal, coronal and transverse) (both codes); or,
- Hyperextension of the thoracic, lumbar and sacral areas of the back (L0472).

Spinal Orthoses
(Thoracic [Triplanar Control – Rigid Plastic Shell])
L0480 thru L0488

Coverage

Triplanar control – rigid plastic shell orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition that requires reduction of gross trunk motion in three planes (sagittal, coronal and transverse), such as post neck or back surgery (laminectomy or vertebral fracture) when short-term or long-term spinal support and immobilization are required to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury (all codes).

Spinal Orthoses (Thoracic [Sagittal-Coronal Control]) L0466 thru L0469, L0490 thru L0492

Coverage

Sagittal or sagittal-coronal control orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition that requires one or more of the following to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury:

- Reduction of load on the intervertebral discs (L0466 thru L0469); or,
- Reduction of gross trunk motion in the sagittal plane (L0466, L0467); or,
- Reduction of gross trunk motion in the sagittal and coronal planes (L0468, L0469, L0490 thru L0492)

Cervical-Thoracic-Lumbar-Sacral Orthoses (Sacroiliac) (L0621 thru L0624)

Coverage

Sacroiliac orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition that requires one or more of the following to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury:

- Support to the pelvic-sacral area of the body (all codes); or,
- Reduction of gross trunk motion of the sacroiliac joint (all codes); or,
- Pendulous abdomen support, such as a recipient with severe ptosis (all codes).

Cervical-Thoracic-Lumbar-Sacral Orthoses (Lumbar) (L0625 thru L0627, L0641, L0642)

Coverage

Lumbar orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition that requires one or more of the following to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury:

- Support to the lumbar area of the body (all codes); or,
- Reduction of load on the intervertebral discs (all codes); or,
- Reduction of gross trunk motion in the sagittal plane (L0626, L0627, L0641, L0642); or,
- Pendulous abdomen support, such as a recipient with severe ptosis (all codes).

Cervical-Thoracic-Lumbar-Sacral Orthoses (Lumbar Sacral) (L0628 thru L0640, L0643 thru L0651)

Coverage

Lumbar-sacral orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition that requires one or more of the following to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury:

- Support to the lumbar-sacral areas of the body (all codes); or,
- Reduction of load on the intervertebral discs (all codes); or,
- Reduction of gross trunk motion in the sagittal plane (all codes); or,
- Reduction of gross trunk motion in the coronal plane, (L0634 thru L0640, L0649 thru L0651); or,
- Flexion of the lumbar spine (L0635, L0636); or,
- Pendulous abdomen support, such as a recipient with severe ptosis (all codes).

Cervical-Thoracic-Lumbar-Sacral Orthoses (Anterior-Posterior-Lateral Control) (L0700, L0710)

Coverage

Anterior-posterior-lateral-control orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition that requires support and maximum external restriction of anterior, posterior and lateral motion to the cervical, thoracic, lumbar and sacral spine to decrease pain, to increase functional capacity, and/or to prevent or ameliorate further injury (both codes).

Halo Procedures (Appliances and Additions) (L0810 thru L0861)

Coverage

Halo procedures include the base appliance and additions, and may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

For the base appliance, the recipient has a medical condition that requires support and maximum external restriction of anterior, posterior and lateral motion to the cervical, thoracic, lumbar and sacral spine to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury (L0810, L0820, L0830).

For requested additions, the recipient has an existing or authorized halo procedure that is compatible with the requested addition(s) and has a medical condition that requires the additional support, control, positioning, protection, or the increased functionality of the halo procedure provided by the requested addition(s) to the base appliance (L0859, L0861).

Authorization and Restrictions

Addition HCPCS codes (L0859, L0861) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes L0859 and L0861 require documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s).

Additions to Spinal Orthoses (L0970 thru L0984)

Coverage

Additions to spinal orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized appliance that is compatible with the requested addition(s) and has a medical condition that requires one or more of the following:

- A corset front addition to provide additional control (L0970, L0972); or
- A corset front addition to provide maximum control (L0974, L0976); or
- An axillary crutch addition to maintain the shoulder in an elevated position (L0978); or
- Peroneal straps to prevent upward shifting of the orthosis (L0980); or
- Supporter grips to hold stockings in place (L0982); or
- A protective body sock worn under the spinal orthosis to prevent skin breakdown (L0984).

Authorization and Restrictions

Addition codes (all codes in this section) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

All codes in this section require documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s).

Billing

HCPCS code L0978 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Scoliosis Procedures (Cervical-Thoracic-Lumbar-Sacral Orthoses) (L1000 thru L1005)

Coverage

Cervical-thoracic-lumbar-sacral orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a diagnosis of scoliosis or other curvature or instability of the spine and the requested appliance is appropriate to the recipient's degree and type of scoliosis or spinal curvature or instability in which all of the following are considered (all codes):

- The degree of spinal curvature or instability; and,
- Any lower extremity length discrepancy; and,
- Goals of treatment.

Authorization and Restrictions

HCPCS code L1001 always requires authorization (TAR required) and is reimbursable only:

- For devices designed for the stabilization of the cervical spine, upper thoracic spine and/or airway; and,
- For children under 1 year of age.

Coverage of L1001 excludes an infant immobilizer used to restrain infants during surgical or radiological procedures (for example, restraint during circumcision).

HCPCS code L1005 is covered only for the treatment of adolescent idiopathic scoliosis or a similar deformity or disease.

Documentation Requirements

There must be documentation of all of the following submitted with the TAR:

- Degree of spinal curvature or instability (all codes); and,
- Description of any lower extremity length discrepancy (all codes); and,
- Description of the goal(s) of treatment, including rotational deformities, flexible versus fixed deformities and active treatment versus stabilization (all codes); and,
- A CCS denial (only for HCPCS code L1001).

Orthotic Devices – Scoliosis Procedures (Additions to Cervical-Thoracic-Lumbar-Sacral Orthoses or Scoliosis Orthoses) (L1010 thru L1120)

Coverage

Additions to cervical-thoracic-lumbar-sacral orthoses or scoliosis orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized appliance that is compatible with the requested addition(s) and has a medical condition that requires one or more of the following:

- A device, padding or pad attachment to assist in the control of the thoracic area (L1010, L1050, L1060, L1080, L1100, L1110); or,
- A kyphosis pad to assist in maintaining alignment in recipients with kyphosis (L1020, L1025); or,
- A lumbar pad to assist in the control of the lumbar area (L1030, L1040); or,
- A device or padding to assist in the alignment of the shoulders and upper spine (L1070); or,
- An attachment(s) to prevent pressure on the anterior chest wall (L1085) or skin irritation (L1120); or,
- A strap or sling to apply/exert a corrective or holding force on the lumbar spine (L1090).

Authorization and Restrictions

Addition codes (all codes in this section) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

All codes in this section require documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s).

Billing

HCPCS codes L1010, L1020, L1025, L1030, L1040, L1050, L1060, L1070, L1080, L1090, L1100, L1110 and L1120 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Scoliosis Procedures (Thoracic-Lumbar-Sacral Orthoses [Low Profile]) (L1200 thru L1290)

Coverage

Thoracic-lumbar-sacral orthoses include the base appliance and additions, and may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

For the base appliance, the recipient has a diagnosis of scoliosis or other curvature or instability of the spine and the requested appliance or addition(s) is appropriate to the recipient's degree and type of scoliosis in which all of the following are considered (all codes):

- The degree of spinal curvature or instability; and,
- Any lower extremity length discrepancy; and,
- Goals of treatment.

For requested additions, the recipient has an existing or authorized appliance that is compatible with the requested addition(s) and has a medical condition that requires one or more of the following:

- An attachment(s) or pad(s) for control of the thoracic area of the spine (L1210, L1220, L1230, L1260); or,
- An attachment(s) to stabilize the lumbar area of the spine (L1240, L1250, L1270, L1290); or,
- An elastic control panel for the ribs (L1280).

Authorization and Restrictions

Addition codes (all codes in this section except L1200) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

Documentation that the recipient meets the criteria specified above must be submitted with the TAR and maintained in the recipient's medical record.

Code L1200 requires documentation of all of the following to be submitted with the TAR:

- Degree of spinal curvature or instability; and,
- Description of any lower extremity length discrepancy; and,
- Description of the goal(s) of treatment, including rotational deformities, flexible versus fixed deformities and active treatment versus stabilization.

All codes in this section except L1200 require documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s).

Billing

HCPCS codes L1240, L1250, L1260, L1270, L1280, and L1290 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Scoliosis Procedures (Other Scoliosis Procedures [Body Jackets]) (L1300 thru L1310)

Coverage

Body jackets may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a diagnosis of scoliosis or other curvature or instability of the spine and the requested appliance is appropriate to the recipient's degree and type of scoliosis in which all of the following are considered (both codes):

- The degree of spinal curvature or instability; and,
- Any lower extremity length discrepancy; and,
- Goals of treatment**.**

Documentation Requirements

There must be documentation of all of the following submitted with the TAR:

- Degree of spinal curvature or instability (both codes); and,
- Description of any lower extremity length discrepancy (both codes); and,
- Description of the goal(s) of treatment, including rotational deformities, flexible versus fixed deformities and active treatment versus stabilization (both codes).

Orthotic Devices – Lower Extremity (Hip Orthoses – Flexible [Abduction Control of Hip Joints]) (L1600 thru L1690)

Coverage

Hip orthoses – abduction control of hip joints may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition that requires one or more of the following to decrease pain, to increase functional capacity, and/or to prevent or ameliorate further injury:

- Congenital hip dislocation or hip dysplasia in infants or children when abduction control is required (L1600, L1610, L1620, L1630, L1640, L1650, L1660); or,
- A medical condition that requires abduction and adduction control while allowing for ambulation (L1680); or,
- Post operative control of motion of one hip to prevent dislocation or to facilitate healing of a fracture (for example, total hip replacement) (L1685, L1686); or,
- Rehabilitation of an injured or previously dislocated hip as an alternative to surgery (L1685, L1686); or,
- Post operative control of adduction and rotational guidance of both hips (L1690).

Billing

HCPCS codes L1685 and L1686 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Lower Extremity (Legg Perthes Orthoses) (L1700 thru L1755)

Coverage

Legg Perthes orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a diagnosis of Legg-Calve-Perthes deformity or similar deformity or disease and requires one or more of the following:

- Abduction/adduction control of both hips with limited leg motion (L1700, L1710); or,
- Abduction/adduction control of one hip while allowing ambulation (L1720); or,
- Abduction/adduction control of both hips while allowing free hip and knee motion (L1730); or,
- No weight bearing on one leg while allowing free knee motion (L1755).

Authorization and Restrictions

HCPCS codes L1700, L1710, L1720, L1730 and L1755 may be authorized and reimbursed only for children 20 years of age and younger.

Billing

HCPCS codes L1720 and L1755 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Lower Extremity (Knee Orthoses) (E1810, K0901, K0902, L1810 thru L1860)

Coverage

Knee orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a deformity or injury of, or affecting the knee, such as post surgical repair of ligament tears, post arthroscopy, osteoarthritis or other degenerative joint disease, post polio or rehabilitation of an injured knee and requires one or more of the following to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury:

- Support or protection to the knee (L1810, L1820); or,
- Restriction/control of motion of the knee (L1830, L1834, L1836); or,
- Restriction of motion with adjustable knee joint (E1810, L1831, L1832); or,
- Support and protection of the ligaments of the knee with adjustable knee joint (L1840); or
- Medial-lateral and rotation control of the knee with adjustable knee joint (L1843 thru L1846, K0901, K0902); or,
- Sagittal plane control with inflatable pads and adjustable knee joint (L1847); or,
- Prevention/control of recruvatum (knee hyperextension) (L1850, L1860); or,
- Control of knee flexion in bed (L1850).

Billing

HCPCS codes E1810, K0901, K0902, L1810 thru L1860 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Lower Extremity (Ankle-Foot Orthoses) (L1900 thru L1990)

Coverage

Ankle-foot orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a disease, deformity or injury of, or affecting the lower extremity in which the recipient experiences pain or diminished functional capacity of the lower extremity, and requires one or more of the following:

- Assistance in dorsiflexing of the foot while allowing ankle motion during loading, attached to a shoe (L1900, L1910); or,
- Ankle and foot support (L1904, L1906, L1907); or,
- Maintenance of the foot in a neutral or functional position, attached to a shoe (L1920); or
- Maintenance of the foot in a neutral or functional position (L1930, L1932, L1940); or,
- Maintenance of the foot in a functional position and provision of knee or hip stabilization (L1945); or,
- Control of the foot and ankle (L1950, L1951, L1960); or,
- Control of the foot and ankle with free motion joint(s) at the ankle (L1970, L1971); or,
- Control of the foot and ankle with free motion joint(s) at the ankle, attached to a shoe (L1980, L1990).

Authorization and Restrictions

HCPCS codes L1900, L1910, L1920, L1980 and L1990 are allowable brace device codes that may be affixed as an integral part of a shoe (see criteria under the “Orthopedic Shoes [Orthopedic Footwear]” heading on a following page).

Billing

HCPCS codes L1900 thru L1990 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Lower Extremity (Knee-Ankle-Foot Orthoses or any Combination]) (L2000 thru L2038)

Coverage

Knee-ankle-foot orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a disease, deformity or injury of, or affecting the knee or ankle joint(s) in which the recipient experiences pain or diminished functional capacity of the knee or ankle joint(s), and requires one or more of the following:

- Control of the knee, ankle or foot with free motion joint(s) at the knee and ankle, attached to a shoe (L2000, L2010); or,
- Control of the knee, ankle or foot with a locking knee joint (L2005, L2006); or,
- Control of the knee, ankle or foot with free motion joint(s) at the ankle, attached to a shoe (L2020, L2030); or,
- Control of motion to the knee or ankle with free motion or rigid control at the ankle (L2034, L2036, L2037); or,
- Maintenance of a child's ankle or knee in a fixed position (L2035); or,
- Correction of contractures of the knee or ankle joints while in a recumbent position (L2038).

When used as part of a reciprocating gait orthosis, HCPCS codes L2010, L2020, L2035, L2036 and L2037 must meet the criteria for HCPCS codes L2627 and L2628 specified under the heading "Orthopedic Devices – Lower Extremity (Additions – Pelvic Control)".

Authorization and Restrictions

HCPCS codes L2005 and L2006 always require authorization (TAR required).

HCPCS code L2035 may be authorized and reimbursed only for children 20 years of age and younger.

HCPCS codes L2000, L2010, L2020, and L2030 are allowable brace device codes that may be affixed as an integral part of a shoe (see criteria under the “Orthopedic Shoes [Orthopedic Footwear]” heading on a following page).

Documentation Requirements

When used as part of a reciprocating gait orthosis, codes L2010, L2020 L2035, L2036 and L2037 must meet the documentation requirements for HCPCS codes L2627 and L2628 specified under the heading “Orthopedic Devices – Lower Extremity (Additions – Pelvic Control).”

Billing

HCPCS codes L2000 thru L2038 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Lower Extremity (Hip-Knee-Ankle-Foot Orthoses – Torsion Control) (L20406 thru L2090)

Coverage

Hip-knee-ankle-foot orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a disease, deformity, injury or condition of, or affecting the hip, knee or ankle joint(s) in which the recipient experiences pain or diminished functional capacity of the hip, knee or ankle joint(s), and requires one or both of the following:

- Assistance in control of rotation of both hips (L2040, L2050, L2060);
- Assistance in control of rotation of one hip (L2070, L2080, L2090).

Authorization and Restrictions

HCPCS codes L2050, L2060, L2080, and L2090 are allowable brace device codes that may be affixed as an integral part of a shoe (see criteria under the “Orthopedic Shoes [Orthopedic Footwear] heading on a following page).

Billing

HCPCS codes L2070, L2080 and L2090 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Lower Extremity (Tibial Fracture Cast Orthoses) (L2106 thru L2116)

Coverage

Tibial fracture cast orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a fracture of the tibia or fibula and requires support and stabilization of the fracture site to facilitate healing, decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury (all codes).

Billing

HCPCS codes L2106 thru L2116 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Lower Extremity (Femoral Fracture Cast Orthoses) (L2126 thru L2136)

Coverage

Femoral fracture cast orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a fracture of the femur and requires support and stabilization of the fracture site to facilitate healing, decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury (all codes).

Billing

HCPCS codes L2126 thru L2136 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Lower Extremity (Additions to Fracture Orthoses (L2180 thru L2192)

Coverage

Additions to fracture orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized appliance that is compatible with the requested addition(s) and has a medical condition that requires one or more of the following to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury:

- Support for the fracture site with free motion ankle joints and extensions (L2180); or,
- Support for the fracture site with locking knee joints (L2182); or,
- Support for the fracture site with limited motion knee joints (L2184, L2186); or,
- Assistance in controlling rotation of the hip and/or abduction/adduction (L2188, L2192); or,
- Attachment/suspension of fracture orthosis at the waist (L2190).

Authorization and Restrictions

Addition codes (L2180 thru L2192) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes L2180 thru L2192 require documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s).

Billing

HCPCS codes L2180 thru L2192 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Lower Extremity (Additions – Shoe-Ankle-Shin-Knee) (L2200 thru L2397)

Coverage

Additions to shoe-ankle-shin-knee orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized appliance that is compatible with the requested addition(s) and has a medical condition that requires one or more of the following to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury:

- Limited motion of the ankle (L2200); or,
- Assistance with dorsiflexion of the foot (L2210); or,
- Provision of extension and flexion of the foot (L2220); or,
- Interchangeability of shoes (L2230, L2240, L2250); or,
- Creation of a smooth transition through the stance phase of gait and reduction of motion at the ankle foot complex (L2232); or
- Interchangeability of shoes with rigidity (L2260, L2265); or,
- Control of the anatomical position of the ankle (L2270); or,
- Correction of varus/valgus that exceeds that obtained by a standard custom AFO (L2275); or,
- Support to the shin, ankle and/or foot (L2280, L2320, L2330, L2335, L2340, L2350); or,
- Maintenance of separated feet (with adjustable bar) (L2300, L2310); or,
- Rigidity of the sole of the shoe (L2360); or,
- Elimination of weight bearing on the foot (L2370); or,
- Torsion control at the ankle (L2375); or,
- Torsion control at the knee (L2380); or,
- Knee joint(s) to provide greater stability at the knee (L2385, L2387, L2390, L2395); or,
- Provision of suspension and maintenance of proper positioning of the knee (L2387).

Authorization and Restrictions

HCPCS code L2232 always requires authorization (TAR required).

Addition codes (L2200 thru L2397) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

All codes in this section require documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s).

Billing

HCPCS codes L2200, L2210, L2220, L2230, L2232, L2240, L2250, L2260, L2265, L2270, L2275, L2280, L2320, L2330, L2335, L2340, L2350, L2360, L2370, L2375, L2380, L2385, L2387, L2390, L2395, and L2397 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Lower Extremity (Additions to Knee Joints) (L2405 thru L2492)

Coverage

Additions to knee joints may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized appliance that is compatible with the requested addition(s) and has a medical condition that requires a locking device to be added to the knee joint(s) to provide greater stability at the knee (all codes).

Authorization and Restrictions

Addition codes (L2405 thru L2492) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes L2405 thru L2492 require documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s).

Billing

HCPCS codes L2405 thru L2492 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Lower Extremity (Additions – Thigh-Weight Bearing) (L2500 thru L2550)

Coverage

Thigh-weight bearing additions may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized appliance that is compatible with the requested addition(s) and has a medical condition that requires one or more of the following:

- Assistance with weight bearing at the ischium (L2500); or,
- A quadrilateral socket design for weight bearing (L2510, L2520); or,
- A narrow M-L socket design for weight bearing (L2525, L2526); or,
- A thigh lacer to assist with weight bearing (L2530, L2540); or,
- A top to a thigh lacer that is padded for greater support (L2550).

When used as part of a reciprocating gait orthosis, HCPCS codes L2510, L2520 and L2525 must meet the criteria specified for HCPCS codes L2627 and L2628 under the heading "Orthopedic Devices – Lower Extremity (Additions – Pelvic Control)."

Authorization and Restrictions

Addition codes (L2500 thru L2550) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

All codes in this section require documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s).

When used as part of a reciprocating gait orthosis, HCPCS codes L2510, L2520 and L2525 must meet the documentation requirements for HCPCS codes L2627 and L2628 under the heading "Orthopedic Devices – Lower Extremity (Additions – Pelvic Control)."

Billing

HCPCS codes L2500 thru L2550 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Lower Extremity (Additions – Pelvic Control) (L2570 thru L2640)

Coverage

Additions – pelvic control may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized appliance that is compatible with the requested addition(s) and has a medical condition that requires one or more of the following:

- A locking hip joint to increase stability (L2570); or,
- Application of pressure or force to the gluteal area to increase stabilization of the pelvic region and/or encouragement of hip extension (L2580); or,
- A free motion hip joint (L2600, L2620); or,
- A free motion hip joint with a locking mechanism (L2610); or,
- An adjustable flexion free motion hip joint (L2622); or,
- An adjustable extension, flexion and abduction free motion hip joint (L2624); or,
- Reciprocating gait action (L2627, L2628); or,
- Increased control of the hip joint(s) (L2630, L2640).

The following applies to HCPCS codes L2627 and L2628 (reciprocating gait orthoses [RGO]):

- May be authorized only when the recipient is chronologically and developmentally appropriate (beginning around 2 years of age and older) and has both of the following conditions:
  - Thoracic or upper lumbar spine lesions with spasticity; and,
  - Range of motion limitations that nevertheless allow joints to be put in appropriate position for ambulation.

- Contraindications include all of the following:
  - Severe irreducible contractures that prevent establishing normal alignment; and,
  - Severe spasticity or other involuntary muscle activity that prevents free and coordinated mobility; and,
  - Severe obesity (BMI greater than 32); and,
  - Poor upper extremity strength; and,
  - Advanced osteoporosis; and,
  - A fracture(s) or a history of fracture(s); and,
  - History of not following treatment plans (noncompliance); and
  - A pressure sore(s) in area(s) that would be in contact with the orthosis.

Authorization and Restrictions

Addition codes (L2570 thru L2640) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes L2570 thru L2640 require documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s).

The following documentation requirements apply to HCPCS codes L2627 and L2628 (RGO):

- A primary physician must document that the recipient has cardiopulmonary integrity; and,
- An orthopedist or Physical Medicine and Rehabilitation Physician (PMR) must document that no other orthoses would meet the recipient's medical need(s); and,
- A neurologist must document that the spinal cord injury level is above L3; and,
- An independent physical therapist, other than the one in the orthotic/rehab unit, must document that the recipient does not have contractures and/or muscle atrophy that would preclude use of the RGO; and,
- X-rays of the spine must document that there is stability of the spine; and,
- X-rays of the spine, hips and knees must document a lack of advanced osteoporosis and fracture(s); and,

- One of the following ICD-10-CM diagnosis codes must be included on the TAR and claim
  - G82.20 thru G82.22 (paraplegia); or,
  - Q05.6 (thoracic spina bifida without hydrocephalus); or
  - Q05.7 (lumbar spina bifida, without hydrocephalus); or
  - Any related medical condition affecting the spine.
- In addition to the preceding documentation, all of the following documentation is required for recipients 21 years of age and older:
  - Plantigrade feet; and,
  - Knees and hips must not have greater than 10 degrees of contracture; and,
  - The hips must be flexible without rigidity or spasticity; and,
  - Good upper extremity strength; and,
  - Realistic goals and expectations, and has a support system.
- The treating therapist and/or orthotist must submit a report to the primary care physician at six months of use to document the recipient's success or failure with the appliance. This report must be maintained in the therapist/orthotist and primary care physician's medical records for review by the department upon request.

Billing

HCPCS codes L2570, L2600, L2610, L2620, L2622, L2624 and L2630 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Lower Extremity (Additions – Thoracic Control) (L2650 thru L2680)

Coverage

Additions – thoracic control may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized appliance that is compatible with the requested addition(s) and has a medical condition that requires one or both of the following:

- Gluteal pressure for support and balance (L2650); or,
- Greater torso control (L2660, L2670 and L2680).

Authorization and Restrictions

Addition codes (L2650 thru L2680) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes L2650 thru L2680 require documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s).

Orthotic Devices – Lower Extremity (Additions – General) (K0672, L2750 thru L2861)

Coverage

Additions – general may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized appliance that is compatible with the requested addition(s) and has a medical condition that requires one or more of the following:

- Protective finish for metal surfaces of the orthosis (for conditions in which excess wetness may erode or oxidize the surface [recipient incontinence]) (L2750, L2755, L2780); or
- Provision of length adjustment to the orthosis (L2760); or,
- Addition of a disconnect device (L2768); or
- Control of the locking mechanism (L2785); or,
- A free motion knee joint (L2795); or,
- Control of flexion and varus/valgus position of the knee (L2800, L2810); or,
- A soft interface material or a sock to decrease skin irritation from the orthosis (K0672, L2820, L2830, L2840, L2850); or,
- Torsion control of any joint to improve the range of motion and control of that joint (L2861).

Authorization and Restrictions

HCPCS code K0672 always requires authorization (TAR required) and is not separately reimbursable with knee orthoses for the same date of service.

Addition codes (K0672, L2750 thru L2861) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes K0672, L2750 thru L2861 require documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s).

Billing

HCPCS codes K0672, L2750 thru L2861 must be billed with either the modifier LT (left side) or RT (right side).

Orthopedic Shoes (Foot – Insert, Removable, Molded to Patient) (L3000)

Coverage

HCPCS code L3000 (foot insert, removable, molded to patient model, Berkeley shell, each), may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition of the foot (feet) that requires a custom fitted insert to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury.

Documentation Requirements

One of the following ICD-10-CM diagnosis codes must be included on the TAR and the claim:

ICD-10-CM Diagnosis Codes

E10.40	G12.23 thru G12.25	G71.12
E10.41	G12.8	‹‹G71.20››
E10.51 thru E10.610	G12.9	‹‹G71.21››
E11.40	G12.20 thru G12.22	‹‹G71.29››
E11.42	G12.29	‹‹G71.220››
E11.51	G14	G71.228
E11.52	G24.1	G72.9
E13.51	G24.2	G80.0 thru G80.2
E13.52	G60.0	G80.4 thru G80.9
G11.9	G60.1	G82.22
‹‹G11.10››	G61.0	G82.52
‹‹G11.11››	G70.00	G82.54
‹‹G11.19››	G70.01	G83.10 thru G83.14
G12.0	G71.0	G83.9
G12.1	G71.11	

ICD-10-CM Diagnosis Codes (Continued)

M05.071 thru M05.079	M06.871 thru M06.879	M33.90
M05.171 thru M05.179	M08.071 thru M08.079	M72.2
M05.271 thru M05.279	M08.271 thru M08.279	Q05.2
M05.371 thru M05.379	M08.471 thru M08.479	Q05.7
M05.471 thru M05.479	M08.871 thru M08.879	Q07.9
M05.571 thru M05.579	M08.971 thru M08.979	Q66.6
M05.671 thru M05.679	M12.071 thru M12.079	Q66.70 thru Q66.72
M05.771 thru M05.779	M14.671 thru M14.679	Q72.70
M05.871 thru M05.879	M20.10 thru M20.12	Q74.3
M06.071 thru M06.079	M20.60 thru M20.62	Q78.0
M06.271 thru M06.279	M21.531 thru M21.549	Q79.9
M06.371 thru M06.379	M21.611 thru M21.629	R27.0

Billing

Billing codes are in the *Orthotic and Prosthetic Appliances: Billing Codes – Orthotics* section of this manual.

HCPCS code L3000 must be billed with either the modifier LT (left side) or RT (right side).

Orthopedic Shoes (Hallux-Valgus Splints) (L3100)

Coverage

HCPCS code L3100 (hallux-valgus night dynamic splint prefabricated, off-the-shelf) may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition of the foot that requires that the big toe be held in the proper anatomical position (dynamically adducted).

Billing

HCPCS code L3100 must be billed with either the modifier LT (left side) or RT (right side).

Orthopedic Shoes (Foot – Abduction and Rotation Bars) (L3140 thru L3160)

Coverage

Foot – abduction and rotation bars may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition of the foot (feet) that requires one or more of the following to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury:

- Increased internal or external rotation of the foot (feet) (attached to shoes, shoes included) (L3140); or,
- Increased internal or external rotation of the foot (feet) (attached to shoes, shoes not included) (L3150); or,
- Independent positioning of hind foot and forefoot for adduction or abduction (L3160).

Authorization and Restrictions

HCPCS code L3160 always requires authorization (TAR required).

Billing

HCPCS code L3160 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Shoes (Orthopedic Footwear) (L3201 thru L3222 and L3230 thru L3265)

Coverage

Orthopedic footwear may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

Stock orthopedic and stock conventional shoes (L3201 thru L3222 and L3260) including in-depth shoes may be authorized and reimbursed only when at least one of the shoes is attached to a prosthesis or brace:

- A “brace” means an orthosis involving the foot that extends above the ankle and is made of metal or other durable rigid material that immobilizes, restricts movement in a given direction, controls mobility, assists with movement, reduces weight-bearing forces or holds body parts in the correct position.
- “Attached to a prosthesis or brace” means the prosthesis or brace is permanently affixed to the shoe as an integral part of the shoe. The allowable brace device codes that may be affixed as an integral part of the shoe are limited to the following HCPCS codes: L1900, L1910, L1920, L1980, L1990, L2000, L2010, L2020, L2030, L2050, L2060, L2080 and L2090.

For stock orthopedic and stock conventional shoes, the recipient has a medical condition of the foot (feet) that requires one or more of the following:

- Increased pronation or supination of the foot (feet) (L3201 thru L3204, L3206, L3207); or,
- Post surgical footwear to allow for changes in volume of the foot (feet) (L3208, L3209, L3211); or,
- A shoe that holds the heel firmly in place (L3212 thru L3214); or,
- A firm heel counter and a strong shank (L3215, L3219); or,
- Accommodation of a deformed foot (feet) or a foot orthosis(es) (L3216, L3217, L3221, L3222); or,
- Footwear to allow for changes in volume, fractures, amputation or ulcers of the foot (feet) (L3260).

Custom-made orthopedic shoes (L3230 thru L3252 and L3265) include both the base shoe(s) and any required addition(s) to the base shoe(s), and may be authorized and reimbursed only when the recipient does not require a shoe(s) provided under the diabetic shoe program but whose medical need(s) cannot be met by modification(s) to stock orthopedic or stock conventional shoes, such as one of the following:

- Charcot or rheumatoid foot deformities; or,
- Partial foot amputations; or,
- Post muscle flap surgery when a recipient 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.
- A related medical condition that requires a custom-made orthopedic shoe(s).

For custom-made shoes, the recipient's documented medical condition of the foot (feet) requires one or more of the following accommodations:

- A severely deformed foot (feet), custom fabricated (L3230); or,
- A toe or distal partial foot amputation, custom fabricated (L3250); or,
- A sensitive foot (feet) or pressure sore(s) or area(s), custom fabricated (L3251, L3252).

Addition codes to custom-made shoes may be authorized when the recipient has an existing or authorized shoe that is compatible with the requested addition, and has a medical condition of the foot that requires one or more of the following:

- Accommodation of sensitive foot (feet) and pressure areas, custom fitted, temporary use (L3253, L3265); or,
- An addition to a shoe(s) to accommodate abnormal size or width (L3254); or,
- An addition to a shoe(s) to accommodate abnormal size or length (L3255); or,
- An addition to a shoe(s) to accommodate different size feet (L3257).

Authorization and Restrictions

HCPCS codes L3201, L3204, L3208 and L3212 may be authorized and reimbursed only for children 2 years of age and younger.

HCPCS codes L3202, L3203, L3206, L3207, L3209, L3211, L3213 and L3214 may be authorized and reimbursed only for children 20 years of age and younger.

A custom-made shoe (L3230 thru L3252 and L3265) may be authorized and reimbursed only when it has all of the following characteristics:

- Made and molded to the recipient model for a specific recipient; and,
- Constructed over a positive model of the recipient's foot; and,
- Made from leather or other suitable material of equal or better quality; and,
- Has removable inserts as an integral part of the shoe that can be altered or replaced as the recipient's condition warrants; and,
- Has some form of shoe closure.

For custom-made orthopedic shoes (L3230 thru L3252): the prescribing practitioner 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.

Billing

HCPCS codes L3201 thru L3211, L3215 thru 3222 and L3230 thru L3255, and L3260 thru L3265 must be billed with either the modifier LT (left side) or RT (right side).

When billing for a stock orthopedic or stock conventional shoes (including in-depth shoes) (L3201 thru L3222 and L3260), the provider must state in the *Additional Claim Information* field (Box 19) of the claim form which shoe(s) is (are) attached to which device, and if that device is new or existing. For example, "Left shoe attached to a new L1990," or "Left and right shoes attached to existing bilateral L2000s."

Orthopedic Shoes (Shoe Modifications [Lifts, Wedges, Heels]) (L3300 thru L3485)

Coverage

Shoe modifications of stock orthopedic shoes and stock conventional shoes include additions, modifications and service, and may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

Modification(s) of stock conventional or stock orthopedic shoes may be authorized and reimbursed when a recipient's medical need(s) can be met by such modification(s) (all codes).

The recipient has an existing or authorized shoe(s) that is compatible with the requested modification(s) and has a medical condition that requires one or more of the following:

- Elevation of a part or the whole of the foot to account for differing limb lengths (L3300 thru L3334); or,
- A wedge placed in one or more parts of the shoe to provide righting of the foot and a more normal gait due to ankle or foot problems (L3340 thru L3370, L3400 thru L3430); or,
- A severe wedge to control clubfoot (L3380); or,
- A wedge to control or prevent medial or lateral motion of the ankle (L3390); or,
- A heel addition that allows a more normal gait due to ankle or foot problems (L3440 thru L3470); or,
- A heel pad with a cutout or depression to relieve pressure on a specific spot, such as for a foot spur (L3480, L3485).

Authorization and Restrictions

HCPCS codes L3300 thru L3485 will be authorized and reimbursed only when the base shoe(s) has been provided or when the shoe modification is being replaced or repaired.

Documentation Requirements

HCPCS codes L3300 thru L3485 require documentation that the recipient has an existing or authorized shoe(s) that is compatible with the requested modification(s).

Billing

HCPCS codes L3300 thru L3485 must be billed with either the modifier LT (left side) or RT (right side).

Claims for shoe modification lift/build-up codes L3300 thru L3334 require the following documentation in the *Additional Claim Information* field (Box 19) or on an attachment:

- Exact description of the modification made to the shoe; and,
- Name of provider or outside vendor performing the shoe modification; and,
- If modification is performed by an outside vendor: name, date and invoice number used to bill the provider for shoe modification services.

Orthopedic Shoes (Miscellaneous Shoe Additions) (L3500 thru L3595)

Coverage

Miscellaneous shoe additions may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized shoe(s) that is compatible with the requested addition(s) and has a medical condition that requires one or more of the following:

- A full or half sole added for stabilization of the foot and increased comfort in walking (L3500 thru L3540); or,
- An addition to reduce wear of the shoe (L3550, L3560); or,
- An extension to the lace area to accommodate high insteps or deformities (L3570); or,
- Relief of pressure in one or more parts of the shoe (L3580, L3590, L3595).

Authorization and Restrictions

Addition codes (L3500 thru L3595) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes L3500 thru L3595 require documentation that the recipient has an existing or authorized shoe(s) that is compatible with the requested addition(s).

Billing

HCPCS codes L3500 thru L3595 must be billed with either the modifier LT (left side) or RT (right side).

Orthopedic Shoes (Transfer or Replacement) (L3600 thru L3640)

Coverage

Shoe orthosis transfers and replacements may be authorized and reimbursed for recipients that meet the established criteria.

“Transfer” means a standard laboratory procedure for general shoe work for the purpose of transfer and fixation of an orthosis from one shoe to another.

Criteria

The recipient has an existing or authorized shoe(s) and an existing or authorized orthosis(es) that are compatible with the requested transfer or replacement and has a medical condition that requires the orthosis(es).

Authorization and Restrictions

Transfer and replacement codes (L3600 thru L3640) will be authorized and reimbursed separately only when the base appliance has been provided.

Documentation Requirements

HCPCS codes L3600 thru L3640 require documentation that the recipient has an existing or authorized shoe(s) and orthosis(es) that are compatible with the requested transfer and replacement.

Billing

HCPCS codes L3600 thru L3640 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Upper Limb (Shoulder Orthoses) (L3650 thru L3678)

Coverage

Shoulder orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition of, or affecting the shoulder joint that requires that the shoulder be held in place to prevent or limit motion in order to protect the shoulder joint from injury or provide support and stabilization during functional activities (all codes).

Authorization and Restrictions

HCPCS code L3677 always requires authorization (TAR required).

HCPCS codes L3650 thru L3678 include fitting and adjustment; no separate reimbursement will be made.

Billing

HCPCS codes L3670, L3671, L3674, L3675, L3677 and L3678 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Upper Limb (Elbow, Elbow-Wrist-Hand and Elbow-Wrist-Hand-Finger Orthoses) (L3702 thru L3766)

Coverage

Elbow, elbow-wrist-hand and elbow-wrist-hand-finger orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition of, or affecting the elbow, wrist, hand or finger joint(s) that requires one or more of the following to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury:

- Elbow support (L3702, L3710, L3762); or,
- Control of movement of the elbow (L3720, L3730, L3740, L3760); or,
- Support to the elbow, wrist and hand (L3763, L3764); or,
- Support to the elbow, wrist, hand and finger (L3765, L3766).

Authorization and Restrictions

HCPCS codes L3702 thru L3766 include fitting and adjustment; no separate reimbursement will be made.

Documentation Requirements

Requested orthotics for the treatment of contractures must include documentation of why an off-the-shelf orthotic will not meet the recipient's medical need(s).

Billing

HCPCS codes L3702 thru L3766 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Upper Limb (Wrist-Hand-Finger Orthoses) (L3806 thru L3809)

Coverage

Wrist-hand-finger orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition of, or affecting the wrist, hand or finger(s) that requires one or more of the following to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury:

- Control of movement of the wrist; with joint (L3806); or,
- Support to the wrist, hand and finger, holding the finger(s) and/or wrist in a functional position; without joint(s) (L3807 thru L3809).

Authorization and Restrictions

HCPCS code L3807 always requires authorization (TAR required).

All codes in this section include fitting and adjustment; no separate reimbursement will be made.

Billing

HCPCS codes L3806 thru L3809 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Upper Limb (Additions) (L3891 thru L3901)

Coverage

Additions to upper limb orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized orthosis that is compatible with the requested addition(s) and has a medical condition that requires an addition to a wrist or elbow joint to enhance and control movement of the wrist, finger or elbow joint(s).

Authorization and Restrictions

Addition codes (L3891 thru L3901) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

Documentation Requirements

HCPCS codes L3891 thru L3901 require documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s).

Billing

HCPCS codes L3891 thru L3901 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Upper Limb (External Power) (L3904)

Coverage

Externally powered upper limb orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition of, or affecting the wrist, hand or finger(s) that requires an externally powered wrist-hand-finger orthosis to allow effective movement of the wrist, hand and fingers.

Documentation Requirements

HCPCS code L3904 requires documentation that the recipient requires a powered appliance to effectively perform activities of daily living or instrumental activities of daily living, and cannot effectively use a manually operated appliance.

Billing

HCPCS code L3904 must be billed with either the modifier LT (left side) or RT (right side).

Orthotic Devices – Upper Limb (Other Wrist-Hand-Finger) (L3905 thru L3956)

Coverage

Other wrist-hand-finger orthoses includes custom fitted wrist-hand-finger orthoses and joint additions to an upper extremity orthosis, and may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition of, or affecting the wrist, hand or finger(s) that requires one or more of the following:

- A wrist-hand orthosis to hold the hand or wrist in a prescribed position and to enhance and control movement of the hand or wrist; with joint(s) (L3905, L3915, L3916, L3931); or,
- Support to the wrist and hand; no joints (L3906, L3908); or,
- Support to the hand and fingers, holding the finger(s) and/or hand in a functional position (L3912, L3913, L3921, L3923, L3924, L3929, L3930); or,
- A hand orthosis to hold the metacarpals in proper alignment for healing of a fracture(s) or other injury (L3917, L3918); or,
- Support to the hand; no joint (L3919); or,
- Support to the finger(s), holding the finger(s) in a prescribed position; with or without joint(s) (L3925, L3927, L3933, L3935); or,
- The incorporation of a joint into an upper extremity orthosis where the base code does not include an articulation (L3956).

Authorization and Restrictions

HCPCS code L3956 always requires authorization (TAR required).

Addition code (L3956) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

HCPCS codes L3905 thru L3956 include fitting and adjustment; no separate reimbursement will be made.

HCPCS code L3908 may be authorized and reimbursed to a pharmacist or pharmacy when the pharmacist/pharmacy is licensed and enrolled in the Medi-Cal program as a provider.

Documentation Requirements

HCPCS code L3956 requires documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s).

Billing

HCPCS codes L3905 thru L3956 must be billed with either the modifier LT (left side) or RT (right side).

‹‹Pharmacies billing for HCPCS code L3908 must bill on the *CMS-1500* claim form.››

Shoulder-Elbow-Wrist-Hand Orthoses (Abduction Positioning) (L3960 thru L3967)

Coverage

Abduction positioning orthoses include abduction positioning, custom fitted orthoses and mobile arm supports, and may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition of, or affecting the shoulder, elbow, wrist or hand, such as post surgery of the shoulder, elbow or wrist joint(s), or treatment of Erb's Palsy or related medical condition that requires one or more of the following to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury:

- Maintenance of the shoulder in an abducted position (L3960, L3961); or,
- Specially designed for the treatment of Erb's Palsy (L3962).

Mobile arm supports may be authorized when one of the criteria above is met and the recipient requires such support attached to a wheelchair, chair or table.

Authorization and Restrictions

HCPCS codes L3960 thru L3967 include fitting and adjustment; no separate reimbursement will be made.

Billing

HCPCS codes L3960 thru L3967 must be billed with either the modifier LT (left side) or RT (right side).

Shoulder-Elbow-Wrist-Hand Orthoses (Additions to Mobile Arm Supports) (L3971 thru L3978)

Coverage

Additions to mobile arm supports include both additions and adaptations to the mobile arm support or the addition(s) to the mobile arm support, and may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized mobile arm support that is compatible with the requested addition(s) and has a medical condition that requires one or more addition(s) or adaptation(s) to enhance the functionality of the mobile arm support without which the recipient's medical or functional need(s) would not be met (all codes).

Authorization and Restrictions

Addition codes (L3971 thru L3978) will be authorized reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

HCPCS codes L3971 thru L3978 include fitting and adjustment; no separate reimbursement will be made.

Documentation Requirements

HCPCS codes L3971 thru L3978 require documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s).

Billing

HCPCS codes L3971 thru L3978 must be billed with either the modifier LT (left side) or RT (right side).

Shoulder-Elbow-Wrist-Hand Orthoses (Fracture Orthoses) (L3980 thru L3995)

Coverage

Fracture orthoses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a fracture of the upper extremity and requires support and stabilization of the fracture site to facilitate healing, to decrease pain, to increase functional capacity and/or to prevent or ameliorate further injury:

- Fracture of the humerus (L3980, L3981); or,
- Fracture of the radius or ulnar (L3982); or,
- Fracture of the wrist (L3984); or,
- Decrease in skin irritation from the orthosis (L3995).

Authorization and Restrictions

Addition code (L3995) will be authorized and reimbursed separately only when the base appliance has been provided or when the addition is being replaced or repaired.

HCPCS codes L3980 thru L3982, and L3984 include fitting and adjustment; no separate reimbursement will be made.

Documentation Requirements

HCPCS code L3995 requires documentation that the recipient has an existing or authorized appliance that is compatible with the requested addition(s).

Billing

HCPCS codes L3980 thru L3995 must be billed with either the modifier LT (left side) or RT (right side).

Repairs of Orthotic Appliances) (L4000 thru L4210)

Coverage

Repairs of orthotic appliances may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has an existing or authorized orthosis that requires repair, maintenance or replacement AND the repair cost is less than the cost of purchasing a new orthosis (all codes).

Authorization and Restrictions

Labor (L4205) may be reimbursed for up to a maximum of three hours (12 units). Additional labor time requires authorization (TAR required).

Documentation Requirements

For repair, maintenance and replacement, documentation must include clinical information with reference to age of the appliance, physical condition of the appliance and the anticipated functional level of the recipient.

Billing

HCPCS codes L4020 thru L4130 and L4010 must be billed with either the modifier LT (left side) or RT (right side). HCPCS codes L4002, L4205, and L4210 may be billed with modifier's LT (left side) or RT (right side) but these modifiers are not required for this code.

Claims for labor (L4205) are reimbursed in 15-minute units on a per unit basis. However labor may be rounded up to the nearest half-hour for the total repair job (for example, 1 hour and 20 minutes = 6 units of labor).

Claims for labor (L4205) must be accompanied by all of the following information:

- Description of the service provided; and,
- Reason/justification for the repair; and,
- Labor time to accomplish the work; and,
- Labor rate or hourly charge.

Claims for parts (L4210) must be accompanied by all of the following information:

- Description of the service provided; and,
- Reason/justification for repair; and,
- Invoice for parts/material in excess of $2.

Ancillary Orthotic Services (L4350 thru L4631)

Coverage

Ancillary orthotic services may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition that requires minimal support and positioning of the lower extremity:

- Support to the ankle (L4350); or,
- Support to the foot and ankle (walking boot) (L4360, L4361, L4386, L4387, L4631); or,
- Support to the lower leg (L4370); or,
- Positioning and pressure reduction to the foot and ankle with minimal ambulation (L4396, L4397); or,
- Positioning of the ankle to reduce or prevent foot drop (L4398).

Authorization and Restrictions

HCPCS codes L4350 thru L4631 include fitting and adjustment; no separate reimbursement will be made.

Billing

HCPCS codes L4350 thru L4631 must be billed with either the modifier LT (left side) or RT (right side).

TRUSS
(L8300 thru L8330)

Coverage

Trusses may be authorized and reimbursed for recipients that meet the established criteria.

Criteria

The recipient has a medical condition resulting in an abdominal hernia or a similar deformity or disease and requires a truss to reduce the hernia (all codes).

Authorization and Restrictions

HCPCS codes L8300 thru L8330 may be authorized and reimbursed to a pharmacist or pharmacy when the pharmacist/pharmacy is licensed and enrolled in the Medi-Cal program as a provider.

Billing

HCPCS codes L8300 and L8330 must be billed with either the modifier LT (left side) or RT (right side).

‹‹Pharmacies billing for any code in this section must bill on the *CMS-1500* claim form.››

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.