

# Local Coverage Article: Ankle-Foot/Knee-Ankle-Foot Orthoses - Policy Article (A52457)

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## Contractor Information

| Contractor Name                                    | Contract Type | Contract Number | Jurisdiction | State(s)  |
|--|---------------|-----------------|--------------|---|
| <a href="#">CGS Administrators, LLC</a>            | DME MAC       | 17013 -         | DME MAC J-B  | Illinois<br>Indiana<br>Kentucky<br>Michigan<br>Minnesota<br>Ohio<br>Wisconsin<br>Alabama<br>Arkansas<br>Colorado<br>Florida<br>Georgia<br>Louisiana<br>Mississippi<br>North Carolina<br>New Mexico<br>Oklahoma<br>Puerto Rico<br>South Carolina<br>Tennessee<br>Texas<br>Virginia<br>Virgin Islands<br>West Virginia<br>Connecticut<br>District of Columbia<br>Delaware<br>Massachusetts<br>Maryland<br>Maine<br>New Hampshire<br>New Jersey<br>New York - Entire State<br>Pennsylvania<br>Rhode Island<br>Vermont<br>Alaska<br>American Samoa<br>Arizona<br>California - Entire State<br>Guam<br>Hawaii<br>Iowa<br>Idaho<br>Kansas<br>Missouri - Entire State<br>Montana<br>North Dakota<br>Nebraska<br>Nevada<br>Oregon<br>South Dakota |
| <a href="#">CGS Administrators, LLC</a>            | DME MAC       | 18003 -         | DME MAC J-C  |   |
| <a href="#">Noridian Healthcare Solutions, LLC</a> | DME MAC       | 16013 -         | DME MAC J-A  |   |
| <a href="#">Noridian Healthcare Solutions, LLC</a> | DME MAC       | 19003 -         | DME MAC J-D  |   |

## Article Information

### General Information

**Article ID**

A52457

Original ICD-9 Article ID

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Ankle-Foot/Knee-Ankle-Foot Orthoses - Policy Article

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### Article Guidance

**Article Text:****NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES**

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. "reasonable and necessary").

For a beneficiary's equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

Ankle-foot orthoses (AFO) and knee-ankle foot orthoses (KAFO) are covered under the Medicare Braces Benefit (Social Security Act §1861(s)(9)). For coverage under this benefit, the orthosis must be a rigid or semi-rigid device, which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. Items that are not sufficiently rigid to be capable of providing the necessary immobilization or support to the body part for which it is designed do not meet the statutory definition of the Braces Benefit. Items that do not meet the definition of a brace are statutorily noncovered, no benefit.

Both "off-the-shelf" (OTS) and custom-fit items are considered prefabricated braces for Medicare coding purposes. 42 CFR §414.402 establishes that correct coding of AFO and KAFO items is dependent upon whether there is a need for "minimal self-adjustment" during the final fitting at the time of delivery. (See definitions below in Coding Guidelines). If a custom fit code is billed when minimal self-adjustment was provided at final delivery, or if an OTS code is billed when substantial modifications were made at final delivery; the claims will be denied as incorrect coding with a statutory denial.

A static/dynamic Ankle-Foot Orthosis (AFO) (L4396, L4397) and replacement interface (L4392) are denied as noncovered (no Medicare benefit) when they are used solely for the prevention or treatment of a heel pressure ulcer because for these indications they are not used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body (i.e., it does not meet the definition of a brace).

A foot drop splint/recumbent positioning device (L4398) and replacement interface (L4394) are denied as noncovered (no Medicare benefit) when they are used solely for the prevention or treatment of a pressure ulcer because for these indications they are not used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body (i.e., it does not meet the definition of a brace).

Elastic or other fabric support garments (A4467 (BELT, STRAP, SLEEVE, GARMENT, OR COVERING, ANYTYPE)) with or without stays or panels do not meet the statutory definition of a brace because they are not rigid or semi-rigid devices. Code A4467 is denied as noncovered (no Medicare benefit). Refer to the coding guideline below for additional information.

A foot pressure off-loading/supportive device (A9283) is denied as noncovered (no Medicare benefit), because it does not support a weak or deformed body member or restrict or eliminate motion in a diseased or injured part of the body.

An inversion/eversion correction device (A9285) is denied as noncovered (no Medicare benefit), because it does not act as a brace; that is, it does not support a weak or deformed body member or restrict or eliminate motion in a diseased or injured part of the body.

Socks (L2840, L2850) used in conjunction with orthoses are denied as noncovered (no Medicare benefit).

Refer to the Orthopedic Footwear policy for information on coverage of shoes and related items which are an integral part of a brace.

There is no separate payment if CAD-CAM technology is used to fabricate an orthosis. Reimbursement is included in the allowance of the codes for custom fabricated orthoses.

Evaluation of the beneficiary, measurement and/or casting, and fitting/adjustments of the orthosis are included in the allowance for the orthosis. There is no separate payment for these services.

Payment for ankle-foot orthoses or knee-ankle foot orthoses are included in the payment to a hospital or skilled nursing facility (SNF) if:

1. The orthosis is provided to a beneficiary prior to an inpatient hospital admission or Part A covered SNF stay; and,

2. The medical necessity for the orthosis begins during the hospital or SNF stay (e.g., after ankle, foot, or knee surgery).

A claim should not be submitted to the DME MAC in this situation.

Payment for ankle-foot orthoses or knee-ankle foot orthoses are also included in the payment to a hospital or a Part A covered SNF stay if:

1. The orthosis is provided to a beneficiary during an inpatient hospital or Part A covered SNF stay prior to the day of discharge; and,
2. The beneficiary uses the item for medically necessary inpatient treatment or rehabilitation.

A claim must not be submitted to the DME MAC in this situation.

Payment for ankle-foot orthoses or knee-ankle foot orthoses delivered to a beneficiary in a hospital or a Part A covered SNF stay is eligible for coverage by the DME MAC if:

1. The orthosis is medically necessary for a beneficiary after discharge from a hospital or Part A covered SNF stay; and,
2. The orthosis is provided to the beneficiary within two days prior to discharge to home; and,
3. The orthosis is not needed for inpatient treatment or rehabilitation, but is left in the room for the beneficiary to take home.

## **POLICY SPECIFIC DOCUMENTATION REQUIREMENTS**

In addition to policy specific documentation requirements, there are general documentation requirements that are applicable to all DMEPOS policies. These general requirements are located in the DOCUMENTATION REQUIREMENTS section of the LCD.

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this Policy Article under the Related Local Coverage Documents section for additional information regarding GENERAL DOCUMENTATION REQUIREMENTS and the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS discussed below.

### **General Requirements**

The supplier must include on the claim line the diagnosis code(s) for HCPCS codes L4396, L4397, L4392 and L4631.

For a custom-fabricated orthosis, there must be documentation in the supplier's records to support the medical necessity of that type device rather than a prefabricated orthosis. This information must be available upon request.

When providing these items suppliers must:

- Provide the product that is specified by the ordering physician
- Be sure that the ordering physician's medical record justifies the need for the type of product (i.e., Prefabricated versus Custom Fabricated)
- Only bill for the HCPCS code that accurately reflects both the type of orthosis and the appropriate level of fitting
- Have detailed documentation in the supplier's record that justifies the code selected

For prefabricated orthoses (L1902, L1906, L1910, L1930, L1932, L1951, L1971, L2035, L2112-L2116, L2132-L2136, L4350, L4360, L4361, L4370, L4386, L4387 and L4396-L4398), there is no physical difference between orthoses coded as custom fitted versus those coded as off-the-shelf. The differentiating factor for proper coding (see definitions in Coding Guidelines below) is the need for "minimal self-adjustment" at the time of fitting by the beneficiary, caretaker for the beneficiary, or supplier. This minimal self-adjustment does not require the services of a certified orthotist or an individual who has specialized training. Items requiring minimal self-adjustment are coded as off-the-shelf orthoses. For example, adjustment of straps and closures, bending or trimming for final fit or comfort (not all-inclusive) fall into this category.

Fabrication of an orthosis using CAD/CAM or similar technology without the creation of a positive model with minimal self-adjustment at delivery is considered as OTS.

Items requiring substantial modification by a qualified practitioner (as defined in the Coding Guidelines below) are coded as custom fitted (L1910, L1930, L1932, L1951, L1971, L2035, L2112-L2116, L2132-L2136, L4360, L4386, L4396). Documentation must be sufficiently detailed to include, but is not limited to, a detailed description of the modifications necessary at the time of fitting the orthosis to the beneficiary. This information must be available upon request.

For custom fabricated orthoses (L1904, L1907, L1920, L1940-L1950, L1960, L1970, L1980-L2034, L2036-L2038, L2106-L2108, L2126-L2128, L4631), there must be detailed documentation in the treating physician's records to support the medical necessity of custom fabricated rather than a prefabricated orthosis as described in the Coverage Indications, Limitations and/or Medical Necessity section of the related LCD. This information will be corroborated by the functional evaluation in the orthotist or prosthetist's records. This information must be available upon request.

## MODIFIERS

KX, GA, and GZ MODIFIERS:

Suppliers must add a KX modifier to the AFO/KAFO base and addition codes only if all of the coverage criteria in the "Coverage Indications, Limitations and or Medical Necessity" section in the related LCD have been met and evidence of such is retained in the supplier's files and available to the DME MAC upon request.

If all of the criteria in the Coverage Indications, Limitations and/or Medical Necessity section of the related LCD have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.

Claims lines billed with codes without a KX, GA or GZ modifier will be rejected as missing information.

## MISCELLANEOUS

In addition, if the item is custom fabricated, a complete and clear description of the item, including what makes this item unique, and a breakdown of charges (material and labor used in fabrication). This information should be entered in the narrative field of an electronic claim.

A claim for code L4205 must include an explanation of what is being repaired. A claim for code L4210 must include a description of each item that is billed. This information should be entered in the narrative field of an electronic claim.

All codes for orthoses or repairs of orthoses billed with the same date of service must be submitted on the same claim.

Refer to the Orthopedic Footwear policy for information on documentation requirements for shoes and related items which are an integral part of a brace.

## **CODING GUIDELINES**

Off-the-shelf (OTS) orthotics are:

- Items that are prefabricated.
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom fitted.
- OTS items require minimal self-adjustment for fitting at the time of delivery for appropriate use and do not require expertise in trimming, bending, and molding, assembling, or customizing to fit an individual.
- This fitting does not require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthoses to fit the item to the individual beneficiary.

The term "minimal self-adjustment" is defined at 42 CFR §414.402 as an adjustment the beneficiary, caregiver for the beneficiary, or supplier of the device can perform and that does not require the services of a certified orthotist (that is, an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification) or an individual who has specialized training. For example, adjustment of straps and closures, bending or trimming for final fit or comfort (not all-inclusive) fall into this category. See "substantial modification" definition below for additional information.

Use of CAD/CAM or similar technology to create an orthosis without the production of a positive model of the patient may be considered as OTS if the final fitting at the time of delivery to the patient requires minimal self-adjustment not requiring expertise as described in this section.

Custom fitted orthotics are:

- Devices that are prefabricated.
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom fitted.
- Classification as custom fitted requires substantial modification for fitting at the time of delivery in order to provide an individualized fit, i.e., the item must be trimmed, bent, molded (with or without heat), or otherwise modified resulting in alterations beyond minimal self-adjustment.
- This fitting at delivery does require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthosis to fit the item to the individual beneficiary.

In contrast to "minimal self-adjustment"; "substantial modification" is defined as changes made to achieve an individualized fit during the final fitting at the time of delivery of the item that requires the expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthotics such as a physician, treating practitioner, an occupational therapist, or physical therapist in compliance with all applicable Federal and State licensure and regulatory requirements. A certified orthotist is defined as an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification.

For prefabricated orthoses (L1902, L1906, L1910, L1930, L1932, L1951, L1971, L2035, L2112- L2116, L2132- L2136, L4350, and L4398), there is no HCPCS coding distinction between orthoses that are custom-fit versus those provided as off-the-shelf (OTS). Regardless of the type of fitting provided at the time of delivery, these prefabricated HCPCS code appropriately describes the item must be used for Medicare billing.

There are products that may be either fit by the beneficiary or require custom fitting at the time of final delivery. There are parallel sets of HCPCS codes (L4360, L4361, L4370, L4386, L4387 and L4396) that describe identical types of items. The codes are only differentiated based upon the nature of the final fitting performed at the time of delivery. The alternative HCPCS code types are:

- HCPCS codes which describe "PREFABRICATED, OFF-THE-SHELF" must be used when minimal self-adjustment is the extent of the fitting performed at delivery.
- HCPCS codes which describe "PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE" must be used when substantial modification is necessary at delivery

Use of CAD/CAM or similar technology to create an orthosis without a positive model of the patient may be considered as custom fitted if the final fitting at the time of delivery to the patient requires substantial modification requiring expertise as described in this section.

Kits are:

- A collection of components, materials, and parts that require further assembly before delivery of the final product.
- The elements of a kit may be packaged and complete from a single source or may be an assemblage of separate components from multiple sources by the supplier.

#### Elastic and Similar Stretchable Materials

For items where the HCPCS code specifies "elastic" or other similar terminology for stretchable material, use the code that is most applicable to the item. A NOC (Not Otherwise Classified) or miscellaneous HCPCS code must not be used instead of the specific code. Refer to the long code narrative and any relevant coding guideline for the criteria applicable for each HCPCS code.

For items where the HCPCS code does not specify elastic or other similar terminology for stretchable material, the following guidelines apply:

- Items that are primarily constructed of elastic or other stretchable materials (e.g. support items made of material such as neoprene or spandex (elastane, Lycra®) (not all-inclusive)) must be coded as A4467 (BELT, STRAP, SLEEVE, GARMENT, OR COVERING, ANYTYPE).
- Items that are primarily constructed of elastic or other stretchable materials (e.g. support items made of material such as neoprene or spandex (elastane, Lycra®)] (not all-inclusive)) that contain stays and/or panels must be coded as A4467 (BELT, STRAP, SLEEVE, GARMENT, OR COVERING, ANYTYPE).
- Items that are primarily constructed of inelastic material (e.g., canvas, cotton or nylon (not all-inclusive)) that are incapable of providing the necessary immobilization or support to the body part for which it is designed must be coded using A4467 (BELT, STRAP, SLEEVE, GARMENT, OR COVERING, ANYTYPE).
- Items that are primarily of constructed inelastic material (e.g., canvas, cotton or nylon (not all-inclusive)) that are incapable of providing the necessary immobilization or support to the body part for which it is designed and that have stays and/or panels capable of providing the required immobilization or support to the body part for which it is designed, must be coded using A4467 (BELT, STRAP, SLEEVE, GARMENT, OR COVERING, ANY TYPE).
- Items that are primarily constructed of inelastic material (e.g., canvas, cotton or nylon (not all-inclusive)) capable of providing the necessary immobilization or support to the body part for which it is designed must be coded using the applicable specific HCPCS code for the type of product. A NOC (Not Otherwise Classified) or miscellaneous HCPCS code must not be used instead of the specific code. Refer to the long code narrative and any relevant coding guideline for the criteria applicable for each HCPCS code.
- Items that are primarily of constructed inelastic material (e.g., canvas, cotton or nylon (not all-inclusive)) capable of providing the necessary immobilization or support to the body part for which it is designed and that have stays and/or panels capable of providing the required immobilization or support to the body part for which it is designed, must be coded using the applicable specific HCPCS code for the type of product. A NOC (Not Otherwise Classified) or miscellaneous HCPCS code must not be used instead of the specific code. Refer to the long code narrative and relevant coding guideline for the criteria applicable for each HCPCS code.
- Items that are not capable of providing the necessary immobilization or support to the body part for which it is designed (regardless of materials) must be coded using A9270 (NONCOVERED ITEM OR SERVICE).

Ankle-foot orthoses described by codes L1900, L1910 - L1990, extend well above the ankle (usually to near the top of the calf) and are fastened around the lower leg above the ankle. These features distinguish them from foot orthotics which are shoe inserts that do not extend above the ankle and ankle gauntlets described by codes L1902 – L1907.

Code L1906 describes a multiligamentous ankle support that provides control of the ankle joint between the medial and lateral malleoli while allowing for dorsiflexion and plantar flexion by way of a hinge or joint mechanism. This off-the-shelf ankle support includes a rigid stirrup and foot plate which provides functional tracking of the ankle with hind-foot and mid-foot stability during ambulation. This, in conjunction with wrap-around straps and the inherent gauntlet design, offers areas of multiligamentous support as described by the code. There are no additional HCPCS codes for this type of prefabricated ankle orthosis. Effective for claims with dates of service on or after April 1, 2012, the only products which may be billed to Medicare using code L1906 are those for which a written coding verification has been made by the Pricing, Data Analysis, and Coding (PDAC) contractor and that are listed in the Product Classification Matrix.

L1960 describes an Ankle Foot Orthosis (AFO) provides ankle control for beneficiaries with musculoskeletal or neuromuscular dysfunction. The AFO is designed to provide rigid immobilization of the ankle-foot complex in the sagittal, coronal, and transverse planes. The custom fabricated solid ankle AFO can be constructed from thermosetting materials, thermoplastics, or composite type materials.

L2340 is a pre-tibial shell, custom fabricated, provides a rigid overlapping interlocking anterior tibial control between the tibial tuberosity to a point no greater than 3 inches proximal to the medial malleolus. The pre-tibial shell can be constructed from thermosetting materials, thermoplastics, or composite type materials.

Code L2755 describes an addition to a lower extremity orthosis composed of high strength and/or lightweight material such as kevlar, carbon fiber or other laminated or impregnated composite material.

A nonambulatory ankle-foot orthosis may be either an ankle contracture splint, night splint or a foot drop splint.

A static or dynamic positioning ankle-foot orthosis (L4396, L4397) is a prefabricated ankle-foot orthosis which has all of the following characteristics:

1. Designed to accommodate either plantar fasciitis or an ankle with a plantar flexion contracture up to 45°; and,

2. Applies a dorsiflexion force to the ankle; and,
3. Used by a beneficiary who is minimally ambulatory, or nonambulatory; and,
4. Has a soft interface.

A foot drop splint/recumbent positioning device (L4398) is a prefabricated ankle-foot orthosis which has all of the following characteristics:

1. Designed to maintain the foot at a fixed position of 0° (i.e., perpendicular to the lower leg); and,
2. Not designed to accommodate an ankle with a plantar flexion contracture; and,
3. Used by a beneficiary who is nonambulatory; and,
4. Has a soft interface.

Code L4631 describes a Charcot's restraint orthotic walker (CROW) orthosis. Code L4631 is a custom fabricated ankle-foot orthosis which has all of the following characteristics:

1. Designed to maintain the foot at a fixed position of 0° (i.e., perpendicular to the lower leg); and,
2. Allows for varus or valgus deformity correction; and,
3. Contains a rocker bottom sole with a custom arch support; and,
4. Incorporates a rigid anterior tibial shell; and,
5. Used by a beneficiary who is ambulatory; and,
6. Has a soft interface.

Code L4631 includes all additions including straps and closures. No additional codes may be billed with code L4631.

Codes L1900, L1904, L1907, L1920, L1940-L1950, L1960-L1970, L1980-L2034, L2036-L2108, L2126-L2128 and L4631 describe custom-fabricated orthoses. These codes must not be used for prefabricated orthoses.

Codes L1902, L1906, L1910, L1930-L1932, L1951, L1971, L2035, L2112-L2116, L2132-L2136, and L4350-L4398 describe prefabricated orthoses. These codes must not be used for custom-fabricated orthoses.

Codes L1900, L1902-L1990, L2106-L2116, L4350, L4360, L4361, L4386, L4387 and L4631 are used for an ankle-foot orthosis which is worn when a beneficiary is ambulatory.

Codes L4396 and L4397 are used for an ankle-foot orthosis which is worn when a beneficiary is nonambulatory, or minimally ambulatory.

Code L4398 is used for an ankle-foot orthosis which is worn when a beneficiary is nonambulatory.

Some replacement items have unique Healthcare Common Procedure Coding System (HCPCS) codes. Replacement components that do not have a unique HCPCS code must be billed with a "not otherwise specified" code - L2999. Items that have unique codes must not be billed using a NOC code.

HCPCS codes L4050 and L4055 do not describe replacement soft interfaces used with contracture orthoses.

Foot orthotics are shoe inserts that do not extend above the ankle. The correct codes for foot orthotics provided for beneficiaries without diabetes are L3000-L3090 (Refer to the Orthopedic Footwear policy for more information). Multiple density foot orthotics used in the management of diabetic foot problems are coded A5512 and A5513 (Refer to the Therapeutic Shoes for Persons with Diabetes policy for more information).

All claims for devices that contain a concentric adjustable torsion style mechanism in the knee joint for any condition other than an assistive function to joint extension motion must be coded as Durable Medical Equipment



using code E1810 (dynamic adjustable knee extension/flexion device). If a concentric adjustable torsion style mechanism in the knee joint is used solely to provide an assistive function for joint extension, it must be coded as L2999 (See Coverage Indications, Limitations and/or Medical Necessity section of the related LCD).

All claims for devices that contain a concentric adjustable torsion style mechanism in the ankle joint for any condition other than an assistive function to joint plantar- or dorsiflexion motion must be coded as Durable Medical Equipment using code E1815 (dynamic adjustable ankle extension/flexion device). If a concentric adjustable torsion style mechanism in the ankle joint is used solely to provide an assistive function for joint plantar or dorsiflexion, it must be coded as L2999 (See Coverage Indications, Limitations and/or Medical Necessity section of the related LCD).

Claims for devices that contain a concentric adjustable torsion style mechanism in the knee or ankle joint and that are being used to treat any condition other than an assistive function to joint extension motion are not covered under the Braces benefit and will be denied as incorrect coding when billed using code L2999 (See Coverage Indications, Limitations and/or Medical Necessity section of the related LCD).

Code A9283 (foot pressure off-loading/supportive device) is used for an item that is designed primarily to reduce pressure on the sole or heel of the foot. It may be a shoe-like item, an item that is used inside a shoe and may or may not extend outside the shoe, or an item that is attached to a shoe. It may be prefabricated or custom fabricated. Code A9283 does not include items that meet the definition of a therapeutic shoe for diabetes (A5500, A5501).

Certain products may have both covered and non-covered uses, as defined by the Braces benefit category, and must be coded based on the beneficiary's condition. For example, when used as a brace for the treatment of an orthopedic condition, walking boots are coded L4360, L4361 and L4386. However, walking boots must be coded A9283 when used solely for the prevention or treatment of a lower extremity ulcer or pressure reduction.

When using code A9283, there is no separate billing using addition codes. Replacement liners for devices billed with A9283 must be billed with code A9270 (noncovered item or service).

Code A9285 (INVERSION/EVERSION CORRECTION DEVICE) is designed to provide off-loading pressure to the knee for the treatment of knee osteoarthritis. The device is applied at the foot and extends across the ankle to apply pressure to the side of the leg below the knee. It does not provide any support at the ankle.

The right (RT) and left (LT) modifiers must be used with orthosis base codes, additions, and replacement parts. When the same code for bilateral items (left and right) is billed on the same date of service, bill both items on the same claim line using the RTL modifiers and 2 units of service. Claims billed without modifiers RT and/or LT will be rejected as incorrect coding.

Code L4205 (Repair of orthotic device, labor component, per 15 minutes) may only be billed for time involved with the actual repair of an orthosis or for medically necessary adjustments made more than 90 days after delivery. Code L4205 must not be used to bill for time involved with other professional services including, but not limited to:

- Evaluating the beneficiary
- Taking measurements, making a cast, making a model, use of CAD/CAM
- Making modifications to a prefabricated item to fit it to the individual beneficiary
- Follow-up visits
- Making adjustments at the time of or within 90 days after delivery

Suppliers must distinguish between repair and replacement of an orthosis. When an orthotic is replaced, there is no separate billing for the above services because reimbursement for these services is included in the allowance for the replacement item.

Repairs to a covered orthosis due to wear or to accidental damage are covered when they are necessary to make the orthosis functional. The reason for the repair must be documented in the supplier's record. If the expense for repairs exceeds the estimated expense of providing another entire orthosis, no payment will be made for the amount in excess.

The allowance for the labor involved in replacing an orthotic component that is coded with a specific L code is included in the allowance for that component. The allowance for the labor involved in replacing an orthotic component that is coded with the miscellaneous code L4210 is separately payable in addition to the allowance for that component.

Addition codes L4002 – L4130, and L4392 are for billing of replacement components and are not payable at initial issue of a base orthosis. When claims for code(s) L4002 – L4130, and L4392 are billed at the time of initial issue

of a base orthosis, the addition code(s) will be rejected as incorrect coding.

Suppliers should contact the PDAC contractor for guidance on the correct coding of these items. [Back to Top](#)

## Coding Information

### **Bill Type Codes:**

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

N/A

### **Revenue Codes:**

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

**CPT/HCPCS Codes** N/A

**ICD-10 Codes that are Covered** N/A

**ICD-10 Codes that are Not Covered** N/A

[Back to Top](#)

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## Revision History Information

| <b>Revision History Date</b> | <b>Revision History Number</b> | <b>Revision History Explanation</b>  |
|------------------------------|--------------------------------|--|
| 01/01/2017                   | R4                             | Revision Effective Date: 01/01/2017<br>NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:<br>Revised: Brace Benefit explanation to remove reference to "counterforce" that is no longer applicable<br>Revised: Prefabricated and off-the-shelf (OTS) "minimal self-adjustment" regulatory definition discussion to improve consistency with regulatory definition of minimal self-adjustment<br>Deleted: A4466<br>Added: A4467<br>Added: Instructions for A9285<br>Added: Policy specific documentation requirements from LCD<br>CODING GUIDELINES:<br>Removed: Reference to classification algorithm summary<br>Revised: OTS and custom-fit definitions to improve consistency with regulatory definition of "minimal self-adjustment"<br>Added: Section on coding of elastic and similar materials<br>Deleted: A4466<br>Added: A4467<br>Added A9285<br>RELATED LOCAL COVERAGE DOCUMENTS:<br>Added: LCD-related Standard Documentation Requirements Language Article |
| 07/01/2016                   | R3                             |  |

| Revision History Date | Revision History Number | Revision History Explanation   |
|-----------------------|-------------------------|--|
| 01/01/2016            | R2                      | Effective July 1, 2016 oversight for DME MAC Articles is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the Articles.<br><b>Revision Effective Date: 01/01/2016</b><br>CODING GUIDELINES:<br>Added: L4361 "clerical correction"<br>Revision Effective Date: 01/01/2015 |
| 10/01/2015            | R1                      | NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:<br>Added: Information for hospital and SNF reimbursement<br>CODING GUIDELINES:<br>Added: Reference to classification algorithm summary   |

[Back to Top](#) **Related Local Coverage Document(s)** Article(s) [A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs](#) LCD(s) [L33686 - Ankle-Foot/Knee-Ankle-Foot Orthosis](#)

**Related National Coverage Document(s)** N/A

**Statutory Requirements URL(s)** N/A

**Rules and Regulations URL(s)** N/A

**CMS Manual Explanations URL(s)** N/A

**Other URL(s)** N/A

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