Local Coverage Determination (LCD): Ankle-Foot/Knee-Ankle-Foot Orthosis (L33686)

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Contractor Information

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

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
				Utah Washington Wyoming Northern Mariana Islands

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LCD Information

Document Information

LCD ID
L33686

Original ICD-9 LCD ID
L11517
L27229
L11527
L142

LCD Title
Ankle-Foot/Knee-Ankle-Foot Orthosis

Proposed LCD in Comment Period
N/A

Source Proposed LCD
N/A

CMS National Coverage Policy None

Original Effective Date
For services performed on or after 10/01/2015

Revision Effective Date
For services performed on or after 01/01/2017

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
N/A

Notice Period End Date
N/A

Coverage Guidance
Coverage Indications, Limitations, and/or Medical Necessity

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.

The purpose of a Local Coverage Determination (LCD) is to provide information regarding "reasonable and necessary" criteria based on Social Security Act § 1862(a)(1)(A) provisions.

In addition to the "reasonable and necessary" criteria contained in this LCD there are other payment rules, which are discussed in the following documents, that must also be met prior to Medicare reimbursement:

- The LCD-related Standard Documentation Requirements Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- The LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- Refer to the Supplier Manual for additional information on documentation requirements.
- Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

For the items addressed in this LCD, the "reasonable and necessary" criteria, based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

For Ankle-Foot Orthoses (AFO) and Knee-Ankle-Foot Orthoses (KAFO) definitions of off-the-shelf and custom fitted, refer to the CODING GUIDELINES section in the LCD-related Policy Article.

AFOs NOT USED DURING AMBULATION:

An L4396 or L4397 (Static or dynamic positioning ankle-foot orthosis) is covered if either all of criteria 1 - 4 or criterion 5 is met:

1. Plantar flexion contracture of the ankle (see Diagnosis Codes That Support Medical Necessity Group 1 Codes section) with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a nonfixed contracture); and,

2. Reasonable expectation of the ability to correct the contracture; and,

3. Contracture is interfering or expected to interfere significantly with the beneficiary's functional abilities; and,

4. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons.

5. The beneficiary has plantar fasciitis (see Diagnosis Codes That Support Medical Necessity Group 1 Codes section)

If an L4396 or L4397 is used for the treatment of a plantar flexion contracture, the pre-treatment passive range of motion must be measured with a goniometer and documented in the medical record. There must be documentation of an appropriate stretching program carried out by professional staff (in a nursing facility) or caregiver (at home).

An L4396 or L4397 and replacement interface (L4392) will be denied as not reasonable and necessary if the contracture is fixed. Codes L4396, L4397 and L4392 will be denied as not reasonable and necessary for a beneficiary with a foot drop but without an ankle flexion contracture. A component of a static/dynamic AFO that is used to address positioning of the knee or hip will be denied as not reasonable and necessary because the effectiveness of this type of component is not established.

If code L4396 or L4397 is covered, a replacement interface (L4392) is covered as long as the beneficiary continues to meet indications and other coverage rules for the splint. Coverage of a replacement interface is limited to a maximum of one (1) per 6 months. Additional interfaces will be denied as not reasonable and necessary.

Medicare does not reimburse for a foot drop splint/recumbent positioning device (L4398) or replacement interface (L4394). A foot drop splint/recumbent positioning device and replacement interface will be denied as not reasonable and necessary in a beneficiary with foot drop who is nonambulatory because there are other more appropriate treatment modalities.

AFOs AND KAFOs USED DURING AMBULATION:

Ankle-foot orthoses (AFO) described by codes L1900, L1902-L1990, L2106-L2116, L4350, L4360, L4361, L4386, L4387 and L4631 are covered for ambulatory beneficiaries with weakness or deformity of the foot and ankle, who:

1. Require stabilization for medical reasons, and,

2. Have the potential to benefit functionally.

Knee-ankle-foot orthoses (KAFO) described by codes L2000-L2038, L2126-L2136, and L4370 are covered for ambulatory beneficiaries for whom an ankle-foot orthosis is covered and for whom additional knee stability is required.

If the basic coverage criteria for an AFO or KAFO are not met, the orthosis will be denied as not reasonable and necessary.

AFOs and KAFOs that are custom-fabricated are covered for ambulatory beneficiaries when the basic coverage criteria listed above and one of the following criteria are met:

1. The beneficiary could not be fit with a prefabricated AFO; or,

2. The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months); or,

3. There is a need to control the knee, ankle or foot in more than one plane; or,

4. The beneficiary has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or,

5. The beneficiary has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

If a custom fabricated orthosis is provided but basic coverage criteria above and the additional criteria 1-5 for a custom fabricated orthosis are not met, the custom fabricated orthosis will be denied as not reasonable and necessary.

L coded additions to AFOs and KAFOs (L2180-L2550, L2750-L2768, L2780-L2830) will be denied as not reasonable and necessary if either the base orthosis is not reasonable and necessary or the specific addition is not reasonable and necessary.

Concentric adjustable torsion style mechanisms used to assist knee joint extension are coded as L2999 and are covered for beneficiaries who require knee extension assist in the absence of any co-existing joint contracture.

Concentric adjustable torsion style mechanisms used to assist ankle joint plantarflexion or dorsiflexion are coded as L2999 and are covered for beneficiaries who require ankle plantar or dorsiflexion assist in the absence of any co-existing joint contracture.

Concentric adjustable torsion style mechanisms used for the treatment of contractures, regardless of any co-existing condition(s), are coded as E1810 and/or E1815 and are covered under the Durable Medical Equipment benefit (refer to the CODING GUIDELINES section in the LCD-related Policy Article).

Claims for devices incorporating concentric adjustable torsion style mechanisms used for the treatment of any joint contracture and coded as L2999 will be denied as incorrect coding.

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

Replacement components (e.g., soft interfaces) that are provided on a routine basis, without regard to whether the original item is worn out, are covered under the refill requirements.

GENERAL

A Detailed Written Order (DWO) (if applicable) must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving a completed DWO, the claim shall be denied as not reasonable and necessary.

An item/service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, LCD-related Policy Articles, or DME MAC articles. Claims that do not meet coding guidelines shall be denied as not reasonable and necessary/incorrectly coded.

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. Proof of delivery documentation must be made available to the Medicare contractor upon request. All services that do not have appropriate proof of delivery from the supplier shall be denied as not reasonable and necessary.

Summary of Evidence

N/A

Analysis of Evidence
(Rationale for Determination)

N/A

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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 policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy 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 policy, 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 policy should be assumed to apply equally to all Revenue Codes.

N/A
CPT/HCPCS Codes
Group 1 Paragraph: The appearance of a code in this section does not necessarily indicate coverage.

HCPCS MODIFIERS:

EY - No physician or other licensed health care provider order for this item or service

GA – Waiver of liability statement issued as required by payer policy, individual case

GZ – Item or service expected to be denied as not reasonable and necessary

KX - Requirements specified in the medical policy have been met

LT - Left Side

RT - Right Side

HCPCS CODES:

Group 1 Codes:

A4467	BELT, STRAP, SLEEVE, GARMENT, OR COVERING, ANY TYPE
A9283	FOOT PRESSURE OFF LOADING/SUPPORTIVE DEVICE, ANY TYPE, EACH
A9285	INVERSION/EVERSION CORRECTION DEVICE
L1900	ANKLE FOOT ORTHOSIS, SPRING WIRE, DORSIFLEXION ASSIST CALF BAND, CUSTOM FABRICATED
L1902	ANKLE ORTHOSIS, ANKLE GAUNTLET OR SIMILAR, WITH OR WITHOUT JOINTS, PREFABRICATED, OFF-THE-SHELF
L1904	ANKLE ORTHOSIS, ANKLE GAUNTLET OR SIMILAR, WITH OR WITHOUT JOINTS, CUSTOM FABRICATED
L1906	ANKLE FOOT ORTHOSIS, MULTILIGAMENTOUS ANKLE SUPPORT, PREFABRICATED, OFF-THE-SHELF
L1907	ANKLE ORTHOSIS, SUPRAMALLEOLAR WITH STRAPS, WITH OR WITHOUT INTERFACE/PADS, CUSTOM FABRICATED
L1910	ANKLE FOOT ORTHOSIS, POSTERIOR, SINGLE BAR, CLASP ATTACHMENT TO SHOE COUNTER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L1920	ANKLE FOOT ORTHOSIS, SINGLE UPRIGHT WITH STATIC OR ADJUSTABLE STOP (PHELPS OR PERLSTEIN TYPE), CUSTOM FABRICATED
L1930	ANKLE FOOT ORTHOSIS, PLASTIC OR OTHER MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L1932	AFO, RIGID ANTERIOR TIBIAL SECTION, TOTAL CARBON FIBER OR EQUAL MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L1940	ANKLE FOOT ORTHOSIS, PLASTIC OR OTHER MATERIAL, CUSTOM FABRICATED
L1945	ANKLE FOOT ORTHOSIS, PLASTIC, RIGID ANTERIOR TIBIAL SECTION (FLOOR REACTION), CUSTOM FABRICATED
L1950	ANKLE FOOT ORTHOSIS, SPIRAL, (INSTITUTE OF REHABILITATIVE MEDICINE TYPE), PLASTIC, CUSTOM FABRICATED
L1951	ANKLE FOOT ORTHOSIS, SPIRAL, (INSTITUTE OF REHABILITATIVE MEDICINE TYPE), PLASTIC OR OTHER MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L1960	ANKLE FOOT ORTHOSIS, POSTERIOR SOLID ANKLE, PLASTIC, CUSTOM FABRICATED
L1970	ANKLE FOOT ORTHOSIS, PLASTIC WITH ANKLE JOINT, CUSTOM FABRICATED
L1971	ANKLE FOOT ORTHOSIS, PLASTIC OR OTHER MATERIAL WITH ANKLE JOINT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L1980	ANKLE FOOT ORTHOSIS, SINGLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (SINGLE BAR 'BK' ORTHOSIS), CUSTOM FABRICATED
L1990	ANKLE FOOT ORTHOSIS, DOUBLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (DOUBLE BAR 'BK' ORTHOSIS), CUSTOM FABRICATED
L2000	KNEE ANKLE FOOT ORTHOSIS, SINGLE UPRIGHT, FREE KNEE, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (SINGLE BAR 'AK' ORTHOSIS), CUSTOM FABRICATED
L2005	KNEE ANKLE FOOT ORTHOSIS, ANY MATERIAL, SINGLE OR DOUBLE UPRIGHT, STANCE CONTROL, AUTOMATIC LOCK AND SWING PHASE RELEASE, ANY TYPE ACTIVATION, INCLUDES ANKLE JOINT, ANY TYPE, CUSTOM FABRICATED

L2010 KNEE ANKLE FOOT ORTHOSIS, SINGLE UPRIGHT, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (SINGLE BAR 'AK' ORTHOSIS), WITHOUT KNEE JOINT, CUSTOM FABRICATED

L2020 KNEE ANKLE FOOT ORTHOSIS, DOUBLE UPRIGHT, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (DOUBLE BAR 'AK' ORTHOSIS), CUSTOM FABRICATED

L2030 KNEE ANKLE FOOT ORTHOSIS, DOUBLE UPRIGHT, FREE ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS, (DOUBLE BAR 'AK' ORTHOSIS), WITHOUT KNEE JOINT, CUSTOM FABRICATED

L2034 KNEE ANKLE FOOT ORTHOSIS, FULL PLASTIC, SINGLE UPRIGHT, WITH OR WITHOUT FREE MOTION KNEE, MEDIAL LATERAL ROTATION CONTROL, WITH OR WITHOUT FREE MOTION ANKLE, CUSTOM FABRICATED

L2035 KNEE ANKLE FOOT ORTHOSIS, FULL PLASTIC, STATIC (PEDIATRIC SIZE), WITHOUT FREE MOTION ANKLE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

L2036 KNEE ANKLE FOOT ORTHOSIS, FULL PLASTIC, DOUBLE UPRIGHT, WITH OR WITHOUT FREE MOTION KNEE, WITH OR WITHOUT FREE MOTION ANKLE, CUSTOM FABRICATED

L2037 KNEE ANKLE FOOT ORTHOSIS, FULL PLASTIC, SINGLE UPRIGHT, WITH OR WITHOUT FREE MOTION KNEE, WITH OR WITHOUT FREE MOTION ANKLE, CUSTOM FABRICATED

L2038 KNEE ANKLE FOOT ORTHOSIS, FULL PLASTIC, WITH OR WITHOUT FREE MOTION KNEE, MULTI-AXIS ANKLE, CUSTOM FABRICATED

L2106 ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, CUSTOM FABRICATED

L2108 ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, CUSTOM FABRICATED

L2112 ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, SOFT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

L2114 ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, SEMI-RIGID, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

L2116 ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, TIBIAL FRACTURE ORTHOSIS, RIGID, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

L2126 KNEE ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, CUSTOM FABRICATED

L2128 KNEE ANKLE FOOT ORTHOSIS, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, CUSTOM FABRICATED

L2132 KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SOFT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

L2134 KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SEMI-RIGID, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

L2136 KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, RIGID, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

L2180 ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, PLASTIC SHOE INSERT WITH ANKLE JOINTS

L2182 ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, DROP LOCK KNEE JOINT

L2184 ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, LIMITED MOTION KNEE JOINT

L2186 ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, ADJUSTABLE MOTION KNEE JOINT, LERMAN TYPE

L2188 ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, QUADRILATERAL BRIM

L2190 ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, WAIST BELT

L2192 ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, HIP JOINT, PELVIC BAND, THIGH FLANGE, AND PELVIC BELT

L2200 ADDITION TO LOWER EXTREMITY, LIMITED ANKLE MOTION, EACH JOINT

L2210 ADDITION TO LOWER EXTREMITY, DORSIFLEXION ASSIST (PLANTAR FLEXION RESIST), EACH JOINT

L2220 ADDITION TO LOWER EXTREMITY, DORSIFLEXION AND PLANTAR FLEXION ASSIST/RESIST, EACH JOINT

L2230 ADDITION TO LOWER EXTREMITY, SPLIT FLAT CALIPER STIRRUPS AND PLATE ATTACHMENT

L2232 ADDITION TO LOWER EXTREMITY ORTHOSIS, ROCKER BOTTOM FOR TOTAL CONTACT ANKLE FOOT ORTHOSIS, FOR CUSTOM FABRICATED ORTHOSIS ONLY

L2240 ADDITION TO LOWER EXTREMITY, ROUND CALIPER AND PLATE ATTACHMENT

L2250 ADDITION TO LOWER EXTREMITY, FOOT PLATE, MOLDED TO PATIENT MODEL, STIRRUP ATTACHMENT

L2260 ADDITION TO LOWER EXTREMITY, REINFORCED SOLID STIRRUP (SCOTT-CRAIG TYPE)

L2265 ADDITION TO LOWER EXTREMITY, LONG TONGUE STIRRUP

L2270 ADDITION TO LOWER EXTREMITY, VARUS/VALGUS CORRECTION ('T') STRAP, PADDED/LINED OR MALLEOLUS PAD

L2275 ADDITION TO LOWER EXTREMITY, VARUS/VALGUS CORRECTION, PLASTIC MODIFICATION, PADDED/LINED

L2280 ADDITION TO LOWER EXTREMITY, MOLDED INNER BOOT

L2300 ADDITION TO LOWER EXTREMITY, ABDUCTION BAR (BILATERAL HIP INVOLVEMENT), JOINTED, ADJUSTABLE

L2310 ADDITION TO LOWER EXTREMITY, ABDUCTION BAR-STRAIGHT
L2320 ADDITION TO LOWER EXTREMITY, NON-MOLDED LACER, FOR CUSTOM FABRICATED ORTHOSIS ONLY
L2330 ADDITION TO LOWER EXTREMITY, LACER MOLDED TO PATIENT MODEL, FOR CUSTOM FABRICATED ORTHOSIS ONLY
L2335 ADDITION TO LOWER EXTREMITY, ANTERIOR SWING BAND
L2340 ADDITION TO LOWER EXTREMITY, PRE-TIBIAL SHELL, MOLDED TO PATIENT MODEL
L2350 ADDITION TO LOWER EXTREMITY, PROSTHETIC TYPE, (BK) SOCKET, MOLDED TO PATIENT MODEL, (USED FOR 'PTB' 'AFO' ORTHOSES)
L2360 ADDITION TO LOWER EXTREMITY, EXTENDED STEEL SHANK
L2370 ADDITION TO LOWER EXTREMITY, PATTEN BOTTOM
L2375 ADDITION TO LOWER EXTREMITY, TORSION CONTROL, ANKLE JOINT AND HALF SOLID STIRRUP
L2380 ADDITION TO LOWER EXTREMITY, TORSION CONTROL, STRAIGHT KNEE JOINT, EACH JOINT
L2385 ADDITION TO LOWER EXTREMITY, STRAIGHT KNEE JOINT, HEAVY DUTY, EACH JOINT
L2387 ADDITION TO LOWER EXTREMITY, POLYCENTRIC KNEE JOINT, FOR CUSTOM FABRICATED KNEE ANKLE FOOT ORTHOSIS, EACH JOINT
L2390 ADDITION TO LOWER EXTREMITY, OFFSET KNEE JOINT, EACH JOINT
L2395 ADDITION TO LOWER EXTREMITY, OFFSET KNEE JOINT, HEAVY DUTY, EACH JOINT
L2397 ADDITION TO LOWER EXTREMITY ORTHOSIS, SUSPENSION SLEEVE
L2405 ADDITION TO KNEE JOINT, DROP LOCK, EACH
L2415 ADDITION TO KNEE LOCK WITH INTEGRATED RELEASE MECHANISM (BAIL, CABLE, OR EQUAL), ANY MATERIAL, EACH JOINT
L2425 ADDITION TO KNEE JOINT, DISC OR DIAL LOCK FOR ADJUSTABLE KNEE FLEXION, EACH JOINT
L2430 ADDITION TO KNEE JOINT, RATCHET LOCK FOR ACTIVE AND PROGRESSIVE KNEE EXTENSION, EACH JOINT
L2492 ADDITION TO KNEE JOINT, LIFT LOOP FOR DROP LOCK RING
L2500 ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, GLUTEAL/ ISCHIAL WEIGHT BEARING, RING
L2510 ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, QUADRI- LATERAL BRIM, MOLDED TO PATIENT MODEL
L2520 ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, QUADRI- LATERAL BRIM, CUSTOM FITTED
L2525 ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, ISCHIAL CONTAINMENT/NARROW M-L BRIM MOLDED TO PATIENT MODEL
L2526 ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, ISCHIAL CONTAINMENT/NARROW M-L BRIM, CUSTOM FITTED
L2530 ADDITION TO LOWER EXTREMITY, THIGH-WEIGHT BEARING, LACER, NON-MOLDED
L2540 ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, LACER, MOLDED TO PATIENT MODEL
L2550 ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, HIGH ROLL CUFF
L2750 ADDITION TO LOWER EXTREMITY ORTHOSIS, PLATING CHROME OR NICKEL, PER BAR
L2755 ADDITION TO LOWER EXTREMITY ORTHOSIS, HIGH STRENGTH, LIGHTWEIGHT MATERIAL, ALL HYBRID LAMINATION/PREPREG COMPOSITE, PER SEGMENT, FOR CUSTOM FABRICATED ORTHOSIS ONLY
L2760 ADDITION TO LOWER EXTREMITY ORTHOSIS, EXTENSION, PER EXTENSION, PER BAR (FOR LINEAL ADJUSTMENT FOR GROWTH)
L2768 ORTHOTIC SIDE BAR DISCONNECT DEVICE, PER BAR
L2780 ADDITION TO LOWER EXTREMITY ORTHOSIS, NON-CORROSIVE FINISH, PER BAR
L2785 ADDITION TO LOWER EXTREMITY ORTHOSIS, DROP LOCK RETAINER, EACH
L2795 ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, FULL KNEECAP
L2800 ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, KNEE CAP, MEDIAL OR LATERAL PULL, FOR USE WITH CUSTOM FABRICATED ORTHOSIS ONLY
L2810 ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, CONDYLAR PAD
L2820 ADDITION TO LOWER EXTREMITY ORTHOSIS, SOFT INTERFACE FOR MOLDED PLASTIC, BELOW KNEE SECTION
L2830 ADDITION TO LOWER EXTREMITY ORTHOSIS, SOFT INTERFACE FOR MOLDED PLASTIC, ABOVE KNEE SECTION
L2840 ADDITION TO LOWER EXTREMITY ORTHOSIS, TIBIAL LENGTH SOCK, FRACTURE OR EQUAL, EACH
L2850 ADDITION TO LOWER EXTREMITY ORTHOSIS, FEMORAL LENGTH SOCK, FRACTURE OR EQUAL, EACH
L2999 LOWER EXTREMITY ORTHOSES, NOT OTHERWISE SPECIFIED
L4002 REPLACEMENT STRAP, ANY ORTHOSIS, INCLUDES ALL COMPONENTS, ANY LENGTH, ANY TYPE
L4010 REPLACE TRILATERAL SOCKET BRIM
L4020 REPLACE QUADRILATERAL SOCKET BRIM, MOLDED TO PATIENT MODEL
L4030 REPLACE QUADRILATERAL SOCKET BRIM, CUSTOM FITTED
L4040 REPLACE MOLDED THIGH LACER, FOR CUSTOM FABRICATED ORTHOSIS ONLY
L4045 REPLACE NON-MOLDED THIGH LACER, FOR CUSTOM FABRICATED ORTHOSIS ONLY

L4050	REPLACE MOLDED CALF LACER, FOR CUSTOM FABRICATED ORTHOSIS ONLY
L4055	REPLACE NON-MOLDED CALF LACER, FOR CUSTOM FABRICATED ORTHOSIS ONLY
L4060	REPLACE HIGH ROLL CUFF
L4070	REPLACE PROXIMAL AND DISTAL UPRIGHT FOR KAFO
L4080	REPLACE METAL BANDS KAFO, PROXIMAL THIGH
L4090	REPLACE METAL BANDS KAFO-AFO, CALF OR DISTAL THIGH
L4100	REPLACE LEATHER CUFF KAFO, PROXIMAL THIGH
L4110	REPLACE LEATHER CUFF KAFO-AFO, CALF OR DISTAL THIGH
L4130	REPLACE PRETIBIAL SHELL
L4205	REPAIR OF ORTHOTIC DEVICE, LABOR COMPONENT, PER 15 MINUTES
L4210	REPAIR OF ORTHOTIC DEVICE, REPAIR OR REPLACE MINOR PARTS
L4350	ANKLE CONTROL ORTHOSIS, STIRRUP STYLE, RIGID, INCLUDES ANY TYPE INTERFACE (E.G., PNEUMATIC, GEL), PREFABRICATED, OFF-THE-SHELF
L4360	WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L4361	WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF
L4370	PNEUMATIC FULL LEG SPLINT, PREFABRICATED, OFF-THE-SHELF
L4386	WALKING BOOT, NON-PNEUMATIC, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L4387	WALKING BOOT, NON-PNEUMATIC, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF
L4392	REPLACEMENT, SOFT INTERFACE MATERIAL, STATIC AFO
L4394	REPLACE SOFT INTERFACE MATERIAL, FOOT DROP SPLINT
L4396	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L4397	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED, OFF-THE-SHELF
L4398	FOOT DROP SPLINT, RECUMBENT POSITIONING DEVICE, PREFABRICATED, OFF-THE-SHELF
L4631	ANKLE FOOT ORTHOSIS, WALKING BOOT TYPE, VARUS/VALGUS CORRECTION, ROCKER BOTTOM, ANTERIOR TIBIAL SHELL, SOFT INTERFACE, CUSTOM ARCH SUPPORT, PLASTIC OR OTHER MATERIAL, INCLUDES STRAPS AND CLOSURES, CUSTOM FABRICATED

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph: The presence of an ICD-10 code listed in this section is not sufficient by itself to assure coverage. Refer to the section on "Coverage Indications, Limitations and/or Medical Necessity" for other coverage criteria and payment information.

For HCPCS codes L4392, L4396 and L4397:

Group 1 Codes:

ICD-10 Codes	Description
M24.571	Contracture, right ankle
M24.572	Contracture, left ankle
M24.573	Contracture, unspecified ankle
M24.574	Contracture, right foot
M24.575	Contracture, left foot
M24.576	Contracture, unspecified foot
M72.2	Plantar fascial fibromatosis

Group 2 Paragraph: For HCPCS code L4631:

Group 2 Codes:

ICD-10 Codes	Description
A52.16	Charcot's arthropathy (tabetic)
M14.671	Charcot's joint, right ankle and foot

ICD-10 Codes	Description
M14.672	Charcot's joint, left ankle and foot
M14.679	Charcot's joint, unspecified ankle and foot

ICD-10 Codes that DO NOT Support Medical Necessity
Group 1 Paragraph: For the specific HCPCS code indicated above, all ICD-10 codes that are not specified in the preceding section. For all other HCPCS codes, diagnoses are not specified.

Group 1 Codes: N/A

ICD-10 Additional Information Back to Top

General Information

Associated Information
DOCUMENTATION REQUIREMENTS
Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

GENERAL DOCUMENTATION REQUIREMENTS

In order to justify payment for DMEPOS items, suppliers must meet the following requirements:

- Prescription (orders)
- Medical Record Information (including continued need/use if applicable)
- Correct Coding
- Proof of Delivery

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information regarding these requirements.

Refer to the Supplier Manual for additional information on documentation requirements.

Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

Items covered in this LCD have additional policy-specific requirements that must be met prior to Medicare reimbursement.

Refer to the LCD-related Policy article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information.

Miscellaneous

Appendices

Utilization Guidelines

Refer to Coverage Indications, Limitations and/or Medical Necessity

Sources of Information

N/A

Bibliography

N/A

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Revision History Information

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
		No changes have been made to this LCD	
01/01/2017	R5	*03/29/2018: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.*	• Other
01/01/2017	R4	Revision Effective Date: 01/01/2017: COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Removed: Standard Documentation Language Added: New reference language and Directions to Standard Documentation Requirements Added: General Requirements HCPCS CODES: Added: HCPCS Code A4467 & A9285 Deleted: HCPCS Code A4466 Revised: HCPCS Code L1906 ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY: Deleted: ICD-10 Diagnoses (M14.661, M14.662, M14.669) for L4631; diagnoses not pertinent to this orthosis DOCUMENTATION REQUIREMENTS: Removed: Standard Documentation Language Added: General Documentation Requirements Added: New reference language and Directions to Standard Documentation Requirements POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Removed: Standard Documentation Language Added: Directions to Standard Documentation Requirements Removed: Information under Miscellaneous and Appendices RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements article	• Provider Education/Guidance • Revisions Due To ICD-10-CM Code Changes • Revisions Due To CPT/HCPCS Code Changes
07/01/2016	R3	Effective July 1, 2016 oversight for DME MAC LCDs 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 LCDs.	• Change in Assigned States or Affiliated Contract Numbers
01/01/2016	R2	**Revision Effective Date: 01/01/2016:** COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Added: L4361 "clerical correction" HCPCS CODES: Revised: L1902 and L1904 long narrative description DOCUMENTATION REQUIREMENTS: Revised: Standard Documentation Language to remove start date verbiage from Prescription Requirements (Effective 11/5/2015) Moved: Repair/Replacement verbiage to correct location Updated: Miscellaneous section when billing L2999	• Provider Education/Guidance • Revisions Due To CPT/HCPCS Code Changes
10/01/2015	R1	Revision Effective Date: 05/01/2015 COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:	• Provider Education/Guidance

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
		Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility DOCUMENTATION REQUIREMENTS: Added: Continued Need & Continue Use Revised: Standard Documentation Language to add who can enter date of delivery date on the POD Added: Instructions for Equipment Retained from a Prior Payer POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Updated: Documentation responsibilities for prefabricated vs. custom fabricated devices to reflect revision of April 2015 bulletin article Revised: Repair to beneficiary-owned DMEPOS Revised: Instructions for HCPCS L2999	

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Associated Documents

Attachments N/A

Related Local Coverage Documents Article(s) A52457 - Ankle-Foot/Knee-Ankle-Foot Orthoses - Policy Article
A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs

Related National Coverage Documents N/A

Public Version(s) Updated on 03/28/2018 with effective dates 01/01/2017 - N/A Updated on 03/09/2017 with effective dates 01/01/2017 - N/A Some older versions have been archived. Please visit the MCD Archive Site to retrieve them. Back to Top

Keywords

N/A Read the **LCD Disclaimer** Back to Top

END OF LOCAL COVERAGE DETERMINATION

Per the Code of Federal Regulations, 42 C.F.R § 426. 325, only those portions of the currently effective Local Coverage Determination (LCD) that are based on section 1862(a)(1)(A) of the Social Security Act, may be challenged through an acceptable complaint as described in 42 C.F.R § 426.400. Also, per 42 C.F.R § 426.325 items that are not reviewable, and therefore cannot be challenged, include the Policy Article. Please note the distinction of the documents when reviewing the materials.

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

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Contractor Information

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

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
				Utah Washington Wyoming Northern Mariana Islands

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Article Information

General Information

Article ID
A52457

Original ICD-9 Article ID
A19885
A47227
A19806
A19800

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

Original Article Effective Date
10/01/2015

Revision Effective Date
01/01/2017

Revision Ending Date
N/A

Retirement Date
N/A

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 codes appropriately describe the items and 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, L4386, L4387, L4396 and L4397) 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, ANY TYPE).
- 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, ANY TYPE).
- 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, ANY TYPE).
- 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 List.

L1960 describes an Ankle Foot Orthosis (AFO) which 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, that 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
7. Totally encapsulated.

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, A5513, and K0903 (code K0903 effective for DOS on or after 04/01/2018) (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, INCLUDES SOFT INTERFACE MATERIAL). 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, INCLUDES SOFT INTERFACE MATERIAL). 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, ANY TYPE, EACH) 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).

Prefabricated walking boots are coded using codes L4360, L4361, L4386 or L4387. These codes describe complete products. Claims for add-on codes used with walking boots coded L4360, L4361, L4386 or L4387 will be denied as unbundling.
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, L4386, L4387 and L4631. 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 RTLT 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.

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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
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Revision History Information

Revision History Date	Revision History Number	Revision History Explanation
01/01/2017	R5	Revision Effective Date: 01/01/2017 CODING GUIDELINES: Revised: Code pairs to accurately reflect parallel codes Updated: HCPCS code narratives to align with HCPCS code table Added: Walking boot add-on bundling information *04/05/2018: At this time 21st Century Cures Act applies to new and revised LCDs that restrict coverage, which require comment and notice. This revision is to an article that is not a local coverage determination.*
01/01/2017	R4	Revision Effective Date: 01/01/2017 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Revised: Brace Benefit explanation to remove reference to "counterforce" that is no longer applicable Revised: Prefabricated and off-the-shelf (OTS) "minimal self-adjustment" regulatory definition discussion to improve consistency with regulatory definition of minimal self-adjustment Deleted: A4466 Added: A4467 Added: Instructions for A9285 Added: Policy specific documentation requirements from LCD

Revision History Date	Revision History Number	Revision History Explanation
		CODING GUIDELINES: Removed: Reference to classification algorithm summary Revised: OTS and custom-fit definitions to improve consistency with regulatory definition of "minimal self-adjustment" Added: Section on coding of elastic and similar materials Deleted: A4466 Added: A4467 Added A9285 RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements Language Article
07/01/2016	R3	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.
01/01/2016	R2	**Revision Effective Date: 01/01/2016** CODING GUIDELINES: Added: L4361 "clerical correction"
10/01/2015	R1	Revision Effective Date: 01/01/2015 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Information for hospital and SNF reimbursement CODING GUIDELINES: 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

Public Version(s) Updated on 03/28/2018 with effective dates 01/01/2017 - N/A Updated on 03/10/2017 with effective dates 01/01/2017 - N/A Some older versions have been archived. Please visit MCD Archive Site to retrieve them. Back to Top

Keywords

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