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Local Coverage Determination (LCD): Ankle-Foot/Knee-Ankle-Foot Orthosis (L142)

Contractor Information

Contractor Name	Contractor Number	Contractor Type
Noridian Administrative Services	19003	DME MAC

LCD Information

Document Information

LCD ID Number
L142

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

Contractor's Determination Number
AFO

AMA CPT/ADA CDT Copyright Statement

Primary Geographic Jurisdiction
Alaska
American Samoa
Arizona
California - Entire State
Guam
Hawaii
Iowa
Idaho
Kansas
Missouri - Entire State
Montana
North Dakota
Nebraska
Nevada
Oregon
South Dakota
Utah
Washington
Wyoming
Northern Mariana Islands

Oversight Region
Region X

DME Region LCD Covers
Jurisdiction D

Original Determination Effective Date
For services performed on or after 10/01/1993

Original Determination Ending Date

Revision Effective Date
For services performed on or after

CMS National Coverage Policy

None

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

For an item to be covered by Medicare, a detailed written order (DWO) 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 the completed DWO, the item will be denied as not reasonable and necessary.

AFOs NOT USED DURING AMBULATION:

An L4396 (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 (ICD-9 diagnosis code 718.47) 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 (ICD-9 diagnosis code 728.71).

If an L4396 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 and replacement interface (L4392) will be denied as not reasonable and necessary if the contracture is fixed. Codes L4396 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 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, L4386 and L4631 are covered for ambulatory beneficiaries with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and 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 **AFO**s 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 (see related Policy Article Coding Guidelines for additional information).

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.

MISCELLANEOUS:

Replacement of a complete orthosis or component of an orthosis due to loss, significant change in the beneficiary's condition, or irreparable accidental damage is covered if the device is still reasonable and necessary. The reason for the replacement must be documented in the supplier's record.

Replacement components (e.g., soft interfaces) that are provided on a routine basis, without regard to whether the original item is worn out, are denied as not reasonable and necessary.

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.

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
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:

A4466	GARMENT, BELT, SLEEVE OR OTHER COVERING, ELASTIC OR SIMILAR STRETCHABLE MATERIAL, ANY TYPE, EACH
A9283	FOOT PRESSURE OFF LOADING/SUPPORTIVE DEVICE, ANY TYPE, EACH
L1900	ANKLE FOOT ORTHOSIS, SPRING WIRE, DORSIFLEXION ASSIST CALF BAND, CUSTOM -FABRICATED
L1902	ANKLE FOOT ORTHOSIS, ANKLE GAUNTLET, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L1904	ANKLE FOOT ORTHOSIS, MOLDED ANKLE GAUNTLET, CUSTOM-FABRICATED
L1906	ANKLE FOOT ORTHOSIS, MULTILIGAMENTUS ANKLE SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L1907	AFO, 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, INCLUDES FITTING AND ADJUSTMENT

L4360	WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L4370	PNEUMATIC FULL LEG SPLINT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L4386	WALKING BOOT, NON-PNEUMATIC, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
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, INCLUDES FITTING AND ADJUSTMENT
L4398	FOOT DROP SPLINT, RECUMBENT POSITIONING DEVICE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
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-9 Codes that Support Medical Necessity
The presence of an ICD-9 code listed in this section is not sufficient by itself to assure coverage. Refer to the section on “Indications and Limitations of Coverage and/or Medical Necessity” for other coverage criteria and payment information.

For HCPCS codes L4392 and L4396:

718.47	CONTRACTURE OF ANKLE AND FOOT JOINT
728.71	PLANTAR FASCIAL FIBROMATOSIS

For HCPCS code L4631:

713.5	ARTHROPATHY ASSOCIATED WITH NEUROLOGICAL DISORDERS

Diagnoses that Support Medical Necessity
For the specific HCPCS codes indicated above, refer to previous section. For all other HCPCS codes, diagnoses are not specified.

ICD-9 Codes that DO NOT Support Medical Necessity
For the specific HCPCS codes indicated above, all ICD-9 codes that are not specified in the preceding section. For all oth HCPCS codes, ICD-9 codes are not specified.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity
For the specific HCPCS codes indicated above, all diagnoses that are not specified in the preceding section. For all other HCPCS codes, diagnoses are not specified.

General Information

Documentation Requirements
Documentations 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.

PRESCRIPTION (ORDER) REQUIREMENTS

GENERAL (PIM 5.2.1)

All items billed to Medicare require a prescription. An order for each new or full replacement item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Items dispensed and/or billed that do not meet these prescription requirements and those below must be submitted with an EY modifier added to each affected HCPCS code.

DISPENSING ORDERS (PIM 5.2.2)

Equipment and supplies may be delivered upon receipt of a dispensing order except for those items that require a written order prior to delivery. A dispensing order may be verbal or written. The supplier must keep a record of the dispensing order on file. It must contain:

- Description of the item
- Beneficiary's name
- Prescribing Physician's name
- Date of the order and the start date, if the start date is different from the date of the order
- Physician signature (if a written order) or supplier signature (if verbal order)

For the “Date of the order” described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The dispensing order must be available upon request.

For items that are provided based on a dispensing order, the supplier must obtain a detailed written order before submitting a claim.

DETAILED WRITTEN ORDERS (PIM 5.2.3)

A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:

- Beneficiary's name
- Physician's name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items)
- Physician signature and signature date

The order must list the unique features of the base code that is billed plus every addition that will be

billed on a separate claim line.

For the “Date of the order” described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

The detailed description in the written order may be either a narrative description or a brand name/model number.

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The DWO must be available upon request.

A prescription is not considered as part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record.

MEDICAL RECORD INFORMATION

GENERAL (PIM 5.7 -5.9)

The **Indications and Limitations of Coverage and/or Medical Necessity** section of this LCD contains numerous reasonable and necessary (R&N) requirements. The **Nonmedical Necessity Coverage and Payment Rules** section of the related Policy Article contains numerous non-reasonable and necessary, benefit category and statutory requirements that must be met in order for payment to be justified. Suppliers are reminded that:

- Supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.

- Templates and forms, including CMS Certificates of Medical Necessity, are subject to corroboration with information in the medical record.

Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs. The medical record is not limited to physician’s office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

The supplier must include on the claim the ICD-9 diagnosis code for the underlying condition for a static or dynamic positioning **AFO** (L4396) or replacement interface material (L4392).

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.

PROOF OF DELIVERY (PIM 4.26, 5.8)

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The signature and date the beneficiary or designee accepted delivery must be legible.

For the purpose of the delivery methods noted below, designee is defined as "Any person who can sign and accept the delivery of DMEPOS on behalf of the beneficiary."

Proof of delivery documentation must be available to the Medicare contractor on request. All services

that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently fail to provide documentation to support their services may be referred to the OIG for imposition of Civil Monetary Penalties or other administrative sanctions.

Suppliers are required to maintain POD documentation in their files. There are three methods of delivery:

1. Delivery directly to the beneficiary or authorized representative
2. Delivery via shipping or delivery service
3. Delivery of items to a nursing facility on behalf of the beneficiary

Method 1—Direct Delivery to the Beneficiary by the Supplier

Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery slip. The POD record must include:

- Beneficiary's name
- Delivery address
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Beneficiary (or designee) signature and date of signature

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

Method 2—Delivery via Shipping or Delivery Service Directly to a Beneficiary

If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD record must include:

- Beneficiary's name
- Delivery address
- Delivery service's package identification number, supplier invoice number or alternative method that links the supplier's delivery documents with the delivery service's records.
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Evidence of delivery

If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim.

Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD record must contain the information specified above.

Method 3—Delivery to Nursing Facility on Behalf of a Beneficiary

When a supplier delivers items directly to a nursing facility, the documentation described for Method 1 (see above) is required.

When a delivery service or mail order is used to deliver the item to a nursing facility, the documentation described for Method 2 (see above) is required.

Regardless the method of delivery, for those beneficiaries that are residents of a nursing facility, information from the nursing facility showing that the item(s) delivered for the beneficiary's use were actually provided to and used by the beneficiary must be available upon request.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

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 “Indications and Limitations of Coverage and or Medical Necessity” section of this policy 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 Indications and Limitations of Coverage and/or Medical Necessity section 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.

REPAIR/REPLACEMENT (BPM Ch 15, §100.2)

A new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs.

The supplier must maintain detailed records describing the need for and nature of all repairs including a detailed explanation of the justification for any component or part replaced as well as the labor time.

A physician's order and/or new Certificate of Medical Necessity (CMN), when required, is needed to reaffirm the medical necessity of the item for replacement of an item.

MISCELLANEOUS

For custom fabricated orthoses, there must be detailed documentation in the treating physician’s records to support the medical necessity of custom fabricated rather than a prefabricated orthosis. This information will be corroborated by the functional evaluation in the orthotist or prosthetist’s records. This information must be available upon request.

A claim for code L2999 must include either a narrative description of the item (for custom fabricated items) or the manufacturer name and model name/number (for pre-fabricated items). For replacement components billed with code L2999, there must also be a HCPCS code or the manufacturer name and model name/number of the base orthosis. 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.

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

Appendices
PIM citations above denote references to CMS Program Integrity Manual, Internet Only Manual 100-8.

Utilization Guidelines
Refer to Indications and Limitations of Coverage and/or Medical Necessity.

Sources of Information and Basis for Decision

Advisory Committee Meeting Notes

Start Date of Comment Period
04/16/1993

End Date of Comment Period
05/31/1993

Start Date of Notice Period
08/01/1993

Revision History Number
AFO0013

Revision History Explanation
Revision Effective Date: 07/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Coverage of concentric adjustable torsion joints (Effective 3/13/2012)
DOCUMENTATION REQUIREMENTS:
Added: Documentation of custom-fabricated items

Revision Effective Date: 01/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Order requirements language to specify a “detailed written order”
Changed: Word “Patient” to “Beneficiary”
DOCUMENTATION REQUIREMENTS:
(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Revised: Prescription requirements
Added: Medical Record Information

11/21/2011 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:
L2005 descriptor was changed in Group 1

Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Statement from policy article regarding routine replacement of components
Deleted: Least costly alternative for custom fabricated orthoses
HCPCS CODES AND MODIFIERS (Effective 1/1/2011):
Added: Code L4631
Revised: GA modifier
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: Code L4631 and ICD-9 code 713.5

Revision Effective Date: 01/01/2010
HCPCS CODES AND MODIFIERS:
Added: A4466
Deleted: L1901
Revised Description: L4396

Revision Effective Date: 12/01/2009
HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers
Deleted: GY modifier
DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of GA and GZ modifiers

Revision Effective Date: 06/01/2009
HCPCS CODES AND MODIFIERS:
Added: KX modifier
Deleted: L2770
DOCUMENTATION:

Added: Instructions for use of KX modifier with both the base and addition code(s)

Revision Effective Date: 04/01/2009
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: L1901 and L2770 from code range of **AFO**-KAFO used with ambulation (Note: Code L2770 invalid for claims with DOS on or after 07/01/2008)
HCPCS CODES AND MODIFIERS:
Revised: Code L4360 descriptor
Deleted: Code L2860

3/1/2008 - In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC Noridian Administrative Services (19003) LCD L142 from DME PSC Electronic Data Systems Corp. (77006) LCD L142.

Revision Effective Date: 01/01/2008
HCPCS CODES AND MODIFIERS:
Added: A9283

Revision Effective Date: 07/01/2007
INDICATIONS AND LIMITATIONS OF COVERAGE:
Removed: References to DMERC.
DOCUMENTATION REQUIREMENTS:
Removed: References to DMERC.

03/01/2006 - In accordance with Section 911 of the Medicare Modernization Act of 2003, this policy was transitioned to DME PSC Electronic Data Systems Corp. (77006) from DMERC CIGNA Government Services (05655).

Revision Effective Date: 01/01/2006
HCPCS CODES AND MODIFIERS:
Added: L2034 and L2387
Deleted: L2039
DOCUMENTATION REQUIREMENTS:
Removed requirement for documentation to be attached to the claim.

Revision Effective Date: 04/01/2005 (July 2010 publication)
HCPCS CODES AND MODIFIERS:
Clerical Error - Added: L1932

Revision Effective Date: 04/01/2005
HCPCS CODES AND MODIFIERS:
Added: L2005, L2232, L4002
Revised: L2035, L2036, L2037, L2038, L2039, L2320, L2330, L2755, L2800, L4040, L4045, L4050, L4055
Deleted: L2435

Revision Effective Date: 07/01/2004
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added coverage of codes L4392 and L4396 for the treatment of plantar fasciitis (ICD-9 diagnosis code 728.71).

Revision Effective Date: 04/01/2004
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added codes L4360 and L4386 to paragraph describing coverage of braces used for edema and pressure ulcers.
HCPCS CODES AND MODIFIERS:
Added: L1907, L1951 and L1971
Revised: L1950, L4350, L4360, L4386
DOCUMENTATION REQUIREMENTS:
Added L4360 and L4386 to list of codes requiring the use of modifier GY when used to treat pressure ulcers.

Revision Effective Date: 07/01/2003
HCPCS CODES AND MODIFIERS:
Corrected HCPCS array to add L4350-L4370 which were inadvertently omitted from 04/01/2003 revision.

Revision Effective Date: 04/01/2003

HCPCS CODES AND MODIFIERS:
Added: L1901, L4386, EY
INDICATIONS ANDLIMITATIONS OF COVERAGE:
Added standard language concerning coverage of items without an order.
Added code L4350, L4360, L4370 and L4386 to range of codes used with ambulatory patients only.
DOCUMENTATION REQUIREMENTS:
Added standard language concerning use of EY modifier for items without an order.
Revised to allow either ICD-9 diagnosis code or narrative description on order for codes L4392 and L4396.

The revision dates listed below are the dates the revisions were published and not necessarily the effective dates for the revisions.

04/01/2002 – Added new HCPCS codes descriptors adding “prefabricated.” Added new descriptor for code L4396. Deleted splint codes now under local carrier jurisdiction-L2102, L2104, L2122, L2124. Added definition of custom-fabricated. Added RT and LT modifiers. Added new GY modifier.

06/01/1999 – Added HCPCS codes. Revised text for entire policy.

07/01/1996 – Corrected description for L1980.

04/01/1996 – Corrected description for L1990.

10/01/1995 – Revised Documentation section, removing Certificate of Medical Necessity requirement.

06/01/1994 – Corrected typo in Coverage and Payment Rules section from 1920 to L1920.

Reason for Change
Coverage Change (actual change in medical parameters)

Related Documents
A19800 - Ankle-Foot/Knee-Ankle-Foot Orthoses - Policy Article - Effective January 2013

LCD Attachments

All Versions

Updated on 05/04/2012 with effective dates 07/01/2012 - N/A
Updated on 02/25/2012 with effective dates 01/01/2012 - 06/30/2012
Updated on 11/21/2011 with effective dates 02/04/2011 - 12/31/2011
Updated on 12/08/2010 with effective dates 02/04/2011 - N/A
Updated on 12/08/2010 with effective dates 02/04/2011 - N/A
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Local Coverage Article for Ankle-Foot/Knee-Ankle-Foot Orthoses - Policy Article - Effective January 2013 (A19800)

Contractor Information

Contractor Name	Contractor Number	Contractor Type
Noridian Administrative Services	19003	DME MAC

Article Information

General Information

Article ID Number
A19800

Article Type
Article

Key Article
Yes

Article Title
Ankle-Foot/Knee-Ankle-Foot Orthoses - Policy Article - Effective January 2013

Primary Geographic Jurisdiction
Alaska
American Samoa
Arizona
California - Entire State
Guam
Hawaii
Iowa
Idaho
Kansas
Missouri - Entire State
Montana
North Dakota
Nebraska
Nevada
Oregon
South Dakota
Utah
Washington
Wyoming
Northern Mariana Islands

DME Region Article Covers
Jurisdiction D

Original Article Effective Date
07/01/2004

Article Revision Effective Date
01/01/2013

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”).

In order 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 and knee-ankle foot orthoses are covered under the Braces benefit category (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. It must provide support and counterforce (i.e., a force in a defined direction of a magnitude at least as great as a rigid or semi-rigid support) on the limb or body part that it is being used to brace. Items that do not meet the definition of a brace are noncovered.

A static/dynamic Ankle-Foot Orthosis (**AFO**) (L4396) and replacement interface (L4392) are denied as noncovered (no benefit category) 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). For reasonable and necessary determinations for the use of L4396 and L4392 refer to the Medical Necessity Coverage and Payment Rules under “**AFO**s Not Used During Ambulation” in the **AFO**/KAFO Local Coverage Determination.

A foot drop splint/recumbent positioning device (L4398) and replacement interface (L4394) are denied as noncovered (no benefit category) 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). For reasonable and necessary determinations for the use of L4398 and L4394 refer to the Medical Necessity Coverage and Payment Rules under “**AFO**s Not Used During Ambulation” in the **AFO**/KAFO Local Coverage Determination.

A foot pressure off-loading/supportive device (A9283) is denied as noncovered (no benefit category), 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.

Elastic support garments do not meet the statutory definition of a brace because they are not rigid or semi-rigid devices. Devices that are not rigid or semi-rigid must be coded A4466. Code A4466 is denied as noncovered (no benefit category).

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

Replacement components (e.g., soft interfaces) that are provided on a routine basis, without regard to whether the original item is worn out, are not covered.

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

CODING GUIDELINES

Ankle flexion contracture is a condition in which there is shortening of the muscles and/or tendons that plantarflex the ankle with the resulting inability to bring the ankle to 0 degrees by passive range of motion. (0 degrees ankle position is when the foot is perpendicular to the lower leg.)

Foot drop is a condition in which there is weakness and/or lack of use of the muscles that dorsiflex the ankle but there is the ability to bring the ankle to 0 degrees by passive range of motion.

Plantar fasciitis is an inflammation of the heel of the foot typically resulting from trauma to the deep tissue of the foot (i.e., plantar fascia).

A prefabricated orthosis is one which is manufactured in quantity without a specific beneficiary in mind. A prefabricated orthosis may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific beneficiary (i.e., custom fitted). An orthosis that is assembled from prefabricated components is considered prefabricated. Any orthosis that does not meet the definition of a custom-fabricated orthosis is considered prefabricated.

A custom-fabricated orthosis is one which is individually made for a specific beneficiary starting with basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item.

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) 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-L2030, L2034, L2036-L2108, L2126-L2128 and L4631 describe custom-fabricated orthoses. These codes must not be used for prefabricated (i.e., non-custom-fabricated) orthoses.

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

Codes L1900, L1902-L1990, L2106-L2116, L4350, L4360, L4386 and L4631 are used for an ankle-foot orthosis which is worn when a beneficiary is ambulatory. Code L4396 is 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. For example, replacement soft interfaces used with ankle contracture orthoses or foot drop splints are billed with codes L4392 and L4394, respectively. Replacement components that do not have a unique HCPCS code must be billed with a "not otherwise specified" code - L2999. HCPCS codes L4050-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 **AFO**/KAFO Local Coverage Determination Indications and Limitations of Coverage and/or Medical Necessity).

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 **AFO**/KAFO Local Coverage Determination Indications and Limitations of Coverage and/or Medical Necessity).

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 **AFO**/KAFO Local Coverage Determination Indications and Limitations of Coverage and/or

Medical Necessity).

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 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).

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 Pricing, Data Analysis, and Coding (PDAC) contractor for guidance on the correct coding of these items.

Coding Information

No Coding Information has been entered in this section of the article.

Other Information

Revision History Explanation
Revision Effective Date: 01/01/2013 (February Publication)
CODING GUIDELINES
Deleted: Height definition for AFO codes L1900, L1910-L1990

Revision Effective Date: 01/01/2013
CODING GUIDELINES:
Revised: Height definition for AFO codes L1900, L1910-L1990

Revision Effective Date: 07/01/2012 (July Publication)
Deleted: Coding verification for codes L1930, L1932, L1940, L1960, L1970 and L1971

Revision Effective Date: 07/01/2012 (May Publication)
CODING GUIDELINES:
Added: Coding guidelines for L1906
Revised: Coding guidelines for concentric adjustable torsion joints (Effective 3/13/2012)
Added: Coding verification for codes L1906, L1930, L1932, L1940, L1960, L1970 and L1971
Added: Repair and replacement guidelines

Revision Effective Date: 02/04/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language
Revised: Clarified noncoverage statements for L4392, L4394, L4396 and L4398
CODING GUIDELINES:
Added: Definition of L4631
Revised: Clarified proper coding instructions based on brace use

Revision Effective Date: 01/01/2010
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Information on code A4466
CODING GUIDELINES
Deleted: Reference to invalid code L2770

Revision Effective Date: 12/01/2009
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Information on code A9283
CODING GUIDELINES:
Revised: Instructions for coding A9283
Revised: Instructions for code L2770
Revised: Instructions for coding concentric adjustable torsion joints
Revised: Instructions for RT/LT modifiers

Revision Effective Date: 06/01/2009
CODING GUIDELINES:
Deleted: Code L2035 from the custom-fabricated orthoses list
Deleted: Codes K0628 and K0629 from the list used in diabetic foot problems management
Added: Codes A5512 and A5513 to the list used in diabetic foot problems management
Added: Code L4392 to list of codes rejected as incorrect coding when billed with initial issue of a base orthosis.

Revision Effective Date: 04/01/2009
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Noncoverage language for elastic support garments
CODING GUIDELINES:
Deleted: Code L1901 from the prefabricated orthoses list and from the ankle-foot orthosis worn by ambulatory patients.
Added: Code L2770 is invalid for dates of service (DOS) on or after 07/01/2008.
Revised: Removed Column I/Column II table in lieu of statement about billing replacement codes at time of initial issue.
Revised: SADMERC to PDAC

3/1/2008 - In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC Noridian Administrative Services (19003) Article A19800 from DME PSC Electronic Data Systems Corp. (77006) Article A19800.

Revision Effective Date: 01/01/2008
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Noncoverage statement regarding A9283.
CODING GUIDELINES:
Added: Definition of A9283

Revision Effective Date: 07/01/2007
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Changed title of previous Therapeutic Shoes for Diabetics LMRP, to the new LCD title – Therapeutic Shoes for Persons with Diabetes.
CODING GUIDELINES:
Changed title of previous Therapeutic Shoes for Diabetics LMRP, to the new LCD title – Therapeutic Shoes for Persons with Diabetes.
Removed: Reference to DMERC.

03/01/2006 - In accordance with Section 911 of the Medicare Modernization Act of 2003, this article was transitioned to DME PSC Electronic Data Systems Corp. (77006) from DMERC CIGNA Government Services (05655).

Revision Effective Date: 01/01/2006
CODING GUIDELINES:
Added: L2034
Deleted: L2039

Revision Effective Date: 04/01/2005
HCPCS CODES AND MODIFIERS:
Added: L2005, L2232, L4002
Revised: L2035, L2036, L2037, L2038, L2039, L2320, L2330, L2755, L2800, L4040, L4045, L4050, L4055
Deleted: L2435

Revision Effective Date: 07/01/2004
LMRP Converted to LCD and Policy Article.
CODING GUIDELINES:
Revised definition of L4396 to include use in the treatment of plantar fasciitis.

Related Document(s)
LCD(s)
L142 - Ankle-Foot/Knee-Ankle-Foot Orthosis

All Versions

Updated on 02/04/2013 with effective dates 01/01/2013 - N/A
Updated on 12/02/2012 with effective dates 01/01/2013 - N/A
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