Back to Search Results

Local Coverage Determination (LCD): KNEE ORTHOSES (L27058)

Contractor Information

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

LCD Information

Document Information

LCD ID Number
L27058

LCD Title
KNEE ORTHOSES

Contractor's Determination Number
KNEE

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 07/01/2008

Original Determination Ending Date

Revision Effective Date
For services performed on or after

07/01/2012

Revision Ending Date

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.

PREFABRICATED KNEE ORTHOSES (L1810, L1820, L1830 - L1832, L1836, L1843, L1845, L1847, L1850):

A **KNEE** flexion contracture is a condition in which there is shortening of the muscles and/or tendons with the resulting inability to bring the **KNEE** to 0 degrees extension or greater (i.e., hyperextension) by passive range of motion. (0 degrees **KNEE** extension is when the femur and tibia are in alignment in a horizontal plane). A **KNEE** extension contracture is a condition in which there is shortening of the muscles and/or tendons with the resulting inability to bring the **KNEE** to 80 degrees flexion or greater by passive range of motion. A contracture is distinguished from the temporary loss of range of motion of a joint following injury, surgery, casting, or other immobilization.

A **KNEE** orthosis with joints (L1810) or **KNEE** orthosis with condylar pads and joints with or without patellar control (L1820) are covered for ambulatory beneficiaries who have weakness or deformity of the **KNEE** and require stabilization.

If an L1810 or L1820 is provided but the criteria above are not met, the orthosis will be denied as not reasonable and necessary.

A **KNEE** orthosis with a locking **KNEE** joint (L1831) or a rigid **KNEE** orthosis (L1836) is covered for beneficiaries with flexion or extension contractures of the **KNEE** (ICD-9 diagnosis code 718.46) with movement on passive range of motion testing of at least 10 degrees (i.e., a nonfixed contracture).

If an L1831 or L1836 orthosis is provided but the criterion above is not met, the orthosis will be denied as not reasonable and necessary.

There is no proven clinical benefit to the inflatable air bladder incorporated into the design of code L1847; therefore, claims for code L1847 will be denied as not reasonable and necessary.

A **KNEE** immobilizer without joints (L1830), or a **KNEE** orthosis with adjustable **KNEE** joints (L1832), or a **KNEE** orthosis, with an adjustable flexion and extension joint that provides both medial-lateral and rotation control (L1843, L1845), are covered if the beneficiary has had recent injury to or a surgical procedure on the **KNEE**(s) and has one of the following diagnoses:

Diagnosis	ICD-9
Rheumatoid arthritis	714.0 – 714.4
Osteoarthritis	715.16, 715.26, 715.36, 715.96
Meniscal cartilage derangement	717.0 – 717.5

Chondromalacia of patella	717.7
KNEE ligamentous disruption	717.81 – 717.9
Rupture of tendon, nontraumatic - quadriceps tendon	727.65
Pathologic fracture of femur	733.15
Pathologic fracture of tibia or fibula	733.16
Aseptic necrosis of tibia or fibula	733.49
Malunion of fracture – nonunion of fracture	733.81-733.82
Stress fracture of tibia or fibula	733.93
Congenital deformity of **KNEE**	755.64
Fracture of femur - lower end	821.20 – 821.39
Fracture of patella	822.0, 822.1
Fracture of tibia and/or fibula - upper end	823.00 – 823.42
Dislocation of **KNEE**	836.0 – 836.69
Sprains and strains of **KNEE**	844.0 – 844.2, 844.8
Late effect of fracture of lower extremities	905.4
Failed total **KNEE** arthroplasty	996.40 – 996.49, 996.66, 996.77, V43.65

KNEE ORTHOSES L1832, L1843 and L1845 are also covered for a beneficiary who is ambulatory and has **KNEE** instability due to a condition specified in any diagnosis listed above; or one of the following diagnoses:

Diagnosis	ICD-9
Multiple sclerosis	340
Hemiplegia, unspecified; dominant side; nondominant side	342.90, 342.91, 342.92
Infantile cerebral palsy, unspecified	343.9
Paraplegia of both lower limbs	344.1
Mononeuritis of lower limb, unspecified	355.0, 355.2

A **KNEE** orthosis, Swedish type, prefabricated (L1850) is covered for a patient who is ambulatory and

has **KNEE** instability due to genu recurvatum - hyperextended **KNEE** (736.5).

For codes L1832, L1843, L1845 and L1850, **KNEE** instability must be documented by examination of the beneficiary and objective description of joint laxity (e.g., varus/valgus instability, anterior/posterior Drawer test).

Claims for L1832, L1843, L1845 or L1850 will be denied as not reasonable and necessary when the beneficiary does not meet the above criteria for coverage. For example, they will be denied if only pain or a subjective description of joint instability is documented.

“Addition” codes are grouped into four (4) categories in relation to **KNEE** orthosis base codes.

- Eligible for separate payment
- Not reasonable and necessary
- Not separately payable
- Incompatible

The following table lists addition codes which describe components or features that can be and frequently are physically incorporated in the specified prefabricated base orthosis. Addition codes may be separately payable if:

- They are provided with the related base code orthosis; and
- The base orthosis is reasonable and necessary; and
- The addition is reasonable and necessary.

Addition codes will be denied as not reasonable and necessary if the base orthosis is not reasonable and necessary or the addition is not reasonable and necessary.

Base Code	Addition Codes - Eligible for Separate Payment
L1810	None
L1820	None
L1830	None
L1831	None
L1832	L2397, L2795, L2810
L1836	None
L1843	L2385, L2395, L2397
L1845	L2385, L2395, L2397, L2795
L1847	None
L1850	L2397

The following table lists addition codes which describe components or features that can be physically incorporated in the specified prefabricated base orthosis but are considered not reasonable and necessary. These addition codes, if they are billed with the related base code, will be denied as not reasonable and necessary.

Base Code	Addition Codes - Not Reasonable and Necessary
L1810	L2397
L1820	L2397

L1830	L2397
L1831	L2397, L2795
L1832	L2405, L2415, L2492, L2785
L1836	L2397
L1843	L2405, L2492, L2785
L1845	L2405, L2415, L2492, L2785
L1847	L2397, L2795
L1850	L2275

Refer to the related Policy Article for information on addition codes that are considered not separately payable or incompatible with prefabricated **KNEE** orthosis base codes.

CUSTOM FABRICATED KNEE ORTHOSES (L1834, L1840, L1844, L1846, L1860):

A custom fabricated orthosis is covered when there is a documented physical characteristic which requires the use of a custom fabricated orthosis instead of a prefabricated orthosis. Examples of situations which meet the criterion for a custom fabricated orthosis include, but are not limited to:

1. Deformity of the leg or **KNEE**;
2. Size of thigh and calf;
3. Minimal muscle mass upon which to suspend an orthosis.

Although these are examples of potential situations where a custom fabricated orthosis may be appropriate, suppliers must consider prefabricated alternatives such as pediatric **KNEE ORTHOSES** in patients with small limbs, straps with additional length for large limbs, etc.

If a custom fabricated orthosis is provided but the medical record does not document why that item is medically necessary instead of a prefabricated orthosis, the custom fabricated orthosis will be denied as not reasonable and necessary.

Custom fabricated **ORTHOSES** (L1834, L1840, L1844, L1846, L1860) are not reasonable and necessary in the treatment of **KNEE** contractures in cases where the patient is nonambulatory.

A custom fabricated **KNEE** immobilizer without joints (L1834) is covered if criteria 1 and 2 are met:

1. The coverage criteria for the prefabricated orthosis code L1830 are met; and
2. The general criterion for a custom fabricated orthosis is met.

If an L1834 orthosis is provided and both criteria 1 and 2 are not met, the orthosis will be denied as not reasonable and necessary.

A custom fabricated derotation **KNEE** orthosis (L1840) is covered for instability due to internal ligamentous disruption of the **KNEE** (717.81–717.9).

A custom fabricated **KNEE** orthosis with an adjustable flexion and extension joint (L1844, L1846) is covered if criteria 1 and 2 are met:

1. The coverage criteria for the prefabricated orthosis codes L1843 and L1845 are met; and
2. The general criterion for a custom fabricated orthosis is met.

If an L1844 or L1846 orthosis is provided and both criteria 1 & 2 are not met, the orthosis will be denied as not reasonable and necessary.

A custom fabricated **KNEE** orthosis with a modified supracondylar prosthetic socket (L1860) is covered for a patient who is ambulatory and has **KNEE** instability due to genu recurvatum - hyperextended **KNEE**

(736.5).

The following table lists addition codes which describe components or features that can be and frequently are physically incorporated in the specified custom fabricated base orthosis. Addition codes may be separately payable if:

- They are provided with the related base code orthosis; and
- The base orthosis is reasonable and necessary; and
- The addition is reasonable and necessary.

Addition codes will be denied as not reasonable and necessary if the base orthosis is not reasonable and necessary or the addition is not reasonable and necessary.

Base Code	Addition Codes - Eligible for Separate Payment
L1834	L2795
L1840	L2385, L2390, L2395, L2397, L2405, L2415, L2425, L2430, L2492, L2755, L2785, L2795
L1844	L2385, L2390, L2395, L2397, L2405, L2492, L2755, L2785
L1846	L2385, L2390, L2395, L2397, L2405, L2415, L2492, L2755, L2785, L2795, L2800
L1860	None

The following table lists addition codes which describe components or features that can be physically incorporated in the specified custom fabricated base orthosis but are considered not reasonable and necessary. These addition codes, if they are billed with the related base code, will be denied as not reasonable and necessary.

Base Code	Addition Codes - Not Reasonable and Necessary
L1834	L2397, L2800
L1840	L2275, L2800
L1844	None
L1846	None
L1860	L2397

Refer to the related Policy Article for information on addition codes that are considered not separately payable or incompatible with custom fabricated **KNEE** orthosis base codes.

MISCELLANEOUS:

Heavy duty **KNEE** joint codes (L2385, L2395) are covered only for patients who weigh more than 300 pounds.

Coverage of a removable soft interface (K0672) is limited to a maximum of two (2) per year beginning one (1) year after the date of service for initial issuance of the orthosis. Additional replacement interfaces will be denied as not reasonable and necessary. Refer to the Coding Guidelines section of the related Policy Article for information on denial of removable soft interfaces that are billed separately at the time of initial issue of the orthosis.

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 for the treatment of contractures are coded as E1810 and 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.

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
A9270	NON-COVERED ITEM OR SERVICE
K0672	ADDITION TO LOWER EXTREMITY ORTHOSIS, REMOVABLE SOFT INTERFACE, ALL COMPONENTS, REPLACEMENT ONLY, EACH
L1810	KNEE ORTHOSIS, ELASTIC WITH JOINTS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L1820	KNEE ORTHOSIS, ELASTIC WITH CONDYLAR PADS AND JOINTS, WITH OR WITHOUT PATELLAR CONTROL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L1830	KNEE ORTHOSIS, IMMOBILIZER, CANVAS LONGITUDINAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

L1831	KNEE ORTHOSIS, LOCKING KNEE JOINT(S), POSITIONAL ORTHOSIS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L1832	KNEE ORTHOSIS, ADJUSTABLE KNEE JOINTS (UNICENTRIC OR POLYCENTRIC), POSITIONAL ORTHOSIS, RIGID SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L1834	KNEE ORTHOSIS, WITHOUT KNEE JOINT, RIGID, CUSTOM-FABRICATED
L1836	KNEE ORTHOSIS, RIGID, WITHOUT JOINT(S), INCLUDES SOFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L1840	KNEE ORTHOSIS, DEROTATION, MEDIAL-LATERAL, ANTERIOR CRUCIATE LIGAMENT, CUSTOM FABRICATED
L1843	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L1844	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED
L1845	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L1846	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED
L1847	KNEE ORTHOSIS, DOUBLE UPRIGHT WITH ADJUSTABLE JOINT, WITH INFLATABLE AIR SUPPORT CHAMBER(S), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L1850	KNEE ORTHOSIS, SWEDISH TYPE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
L1860	KNEE ORTHOSIS, MODIFICATION OF SUPRACONDYLAR PROSTHETIC SOCKET, CUSTOM-FABRICATED (SK)
L2275	ADDITION TO LOWER EXTREMITY, VARUS/VALGUS CORRECTION, PLASTIC MODIFICATION, PADDED/LINED
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
L2385	ADDITION TO LOWER EXTREMITY, STRAIGHT KNEE JOINT, HEAVY DUTY, 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
L2750	ADDITION TO LOWER EXTREMITY ORTHOSIS, PLATING CHROME OR NICKEL, 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
L2999	LOWER EXTREMITY ORTHOSES, NOT OTHERWISE SPECIFIED
L4002	REPLACEMENT STRAP, ANY ORTHOSIS, INCLUDES ALL COMPONENTS, ANY LENGTH, ANY TYPE
L4205	REPAIR OF ORTHOTIC DEVICE, LABOR COMPONENT, PER 15 MINUTES
L4210	REPAIR OF ORTHOTIC DEVICE, REPAIR OR REPLACE MINOR PARTS
L9900	ORTHOTIC AND PROSTHETIC SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS "L" CODE

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 L1831 and L1836:

718.46	CONTRACTURE OF LOWER LEG JOINT

For HCPCS codes L1830, L1834:

714.0 - 714.4	RHEUMATOID ARTHRITIS - CHRONIC POSTRHEUMATIC ARTHROPATHY
715.16	OSTEOARTHROSIS LOCALIZED PRIMARY INVOLVING LOWER LEG
715.26	OSTEOARTHROSIS LOCALIZED SECONDARY INVOLVING LOWER LEG
715.36	OSTEOARTHROSIS LOCALIZED NOT SPECIFIED WHETHER PRIMARY OR SECONDARY INVOLVING LOWER LEG
715.96	OSTEOARTHROSIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED INVOLVING LOWER LEG
717.0 - 717.5	OLD BUCKET HANDLE TEAR OF MEDIAL MENISCUS - DERANGEMENT OF MENISCUS NOT ELSEWHERE CLASSIFIED
717.7	CHONDROMALACIA OF PATELLA
717.81 - 717.9	OLD DISRUPTION OF LATERAL COLLATERAL LIGAMENT - UNSPECIFIED INTERNAL DERANGEMENT OF KNEE
727.65	NONTRAUMATIC RUPTURE OF QUADRICEPS TENDON
733.15	PATHOLOGICAL FRACTURE OF OTHER SPECIFIED PART OF FEMUR
733.16	PATHOLOGICAL FRACTURE OF TIBIA OR FIBULA
733.49	ASEPTIC NECROSIS OF OTHER BONE SITES
733.93	STRESS FRACTURE OF TIBIA OR FIBULA
755.64	CONGENITAL DEFORMITY OF KNEE (JOINT)
821.20 - 821.39	FRACTURE OF LOWER END OF FEMUR UNSPECIFIED PART CLOSED - OTHER FRACTURE OF LOWER END OF FEMUR OPEN
822.0 - 822.1	CLOSED FRACTURE OF PATELLA - OPEN FRACTURE OF PATELLA
823.00 - 823.42	CLOSED FRACTURE OF UPPER END OF TIBIA - TORUS FRACTURE OF FIBULA WITH TIBIA
836.0 - 836.69	TEAR OF MEDIAL CARTILAGE OR MENISCUS OF KNEE CURRENT - OTHER DISLOCATION OF KNEE OPEN
844.0 - 844.2	SPRAIN OF LATERAL COLLATERAL LIGAMENT OF KNEE - SPRAIN OF CRUCIATE LIGAMENT OF KNEE
844.8	SPRAIN OF OTHER SPECIFIED SITES OF KNEE AND LEG
996.40 - 996.49	UNSPECIFIED MECHANICAL COMPLICATION OF INTERNAL ORTHOPEDIC DEVICE, IMPLANT, AND GRAFT - OTHER MECHANICAL COMPLICATION OF OTHER INTERNAL ORTHOPEDIC DEVICE, IMPLANT, AND GRAFT
996.66	INFECTION AND INFLAMMATORY REACTION DUE TO INTERNAL JOINT PROSTHESIS
996.77	OTHER COMPLICATIONS DUE TO INTERNAL JOINT PROSTHESIS

V43.65	KNEE JOINT REPLACEMENT

For HCPCS Code L1840:

717.81 - 717.9	OLD DISRUPTION OF LATERAL COLLATERAL LIGAMENT - UNSPECIFIED INTERNAL DERANGEMENT OF KNEE

For HCPCS codes L1832, L1843, L1844, L1845, and L1846

340	MULTIPLE SCLEROSIS
342.90	UNSPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING UNSPECIFIED SIDE
342.91	UNSPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING DOMINANT SIDE
342.92	UNSPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
343.9	INFANTILE CEREBRAL PALSY UNSPECIFIED
344.1	PARAPLEGIA
355.0	LESION OF SCIATIC NERVE
355.2	OTHER LESION OF FEMORAL NERVE
714.0 - 714.4	RHEUMATOID ARTHRITIS - CHRONIC POSTRHEUMATIC ARTHROPATHY
715.16	OSTEOARTHROSIS LOCALIZED PRIMARY INVOLVING LOWER LEG
715.26	OSTEOARTHROSIS LOCALIZED SECONDARY INVOLVING LOWER LEG
715.36	OSTEOARTHROSIS LOCALIZED NOT SPECIFIED WHETHER PRIMARY OR SECONDARY INVOLVING LOWER LEG
715.96	OSTEOARTHROSIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED INVOLVING LOWER LEG
717.0 - 717.5	OLD BUCKET HANDLE TEAR OF MEDIAL MENISCUS - DERANGEMENT OF MENISCUS NOT ELSEWHERE CLASSIFIED
717.7	CHONDROMALACIA OF PATELLA
717.81 - 717.9	OLD DISRUPTION OF LATERAL COLLATERAL LIGAMENT - UNSPECIFIED INTERNAL DERANGEMENT OF KNEE
727.65	NONTRAUMATIC RUPTURE OF QUADRICEPS TENDON
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836.0 - 836.69	TEAR OF MEDIAL CARTILAGE OR MENISCUS OF KNEE CURRENT - OTHER DISLOCATION OF KNEE OPEN
844.0 - 844.2	SPRAIN OF LATERAL COLLATERAL LIGAMENT OF KNEE - SPRAIN OF CRUCIATE LIGAMENT OF KNEE
844.8	SPRAIN OF OTHER SPECIFIED SITES OF KNEE AND LEG
996.40 - 996.49	UNSPECIFIED MECHANICAL COMPLICATION OF INTERNAL ORTHOPEDIC DEVICE, IMPLANT, AND GRAFT - OTHER MECHANICAL COMPLICATION OF OTHER INTERNAL ORTHOPEDIC DEVICE, IMPLANT, AND GRAFT
996.66	INFECTION AND INFLAMMATORY REACTION DUE TO INTERNAL JOINT PROSTHESIS
996.77	OTHER COMPLICATIONS DUE TO INTERNAL JOINT PROSTHESIS
V43.65	KNEE JOINT REPLACEMENT

For HCPCS Codes L1850, L1860:

736.5	GENU RECURVATUM (ACQUIRED)

Diagnoses that Support Medical Necessity
For the specific HCPCS codes indicated above, refer to the 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 previous section.

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 previous section.

For all other HCPCS codes, diagnoses are not specified.

General Information

Documentation Requirements
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.

PRESCRIPTION (ORDER) REQUIREMENTS

GENERAL (PIM 5.2.1)

All items billed to Medicare require a prescription. An order for each 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

For items provided on a periodic basis, including drugs, the written order must include:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed

- Number of refills

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).

Frequency of use information on orders must contain detailed instructions for use and specific amounts to be dispensed. Reimbursement shall be based on the specific utilization amount only. Orders that only state "PRN" or "as needed" utilization estimates for replacement frequency, use, or consumption are not acceptable. (PIM 5.9)

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.

CONTINUED USE

Continued use describes the ongoing utilization of supplies or a rental item by a beneficiary.

Suppliers are responsible for monitoring utilization of DMEPOS rental items and supplies. No monitoring of purchased items or capped rental items that have converted to a purchase is required. Suppliers must discontinue billing Medicare when rental items or ongoing supply items are no longer being used by the beneficiary.

Beneficiary medical records or supplier records may be used to confirm that a DMEPOS item continues to be used by the beneficiary. Any of the following may serve as documentation that an item submitted for reimbursement continues to be used by the beneficiary:

1. Timely documentation in the beneficiary's medical record showing usage of the item, related option/accessories and supplies.

2. Supplier records documenting the request for refill/replacement of supplies in compliance with the Refill Documentation Requirements This is deemed to be sufficient to document continued use for the base item, as well.

3. Supplier records documenting beneficiary confirmation of continued use of a rental item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in this policy.

CONTINUED MEDICAL NEED

For all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time period. Entries in the beneficiary's medical record must have been created prior to, or at the time of, the initial DOS to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

For ongoing supplies and rental DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review. Any of the following may serve as documentation justifying continued medical need:

1. A recent order by the treating physician for refills
2. A recent change in prescription
3. A properly completed CMN or DIF with an appropriate length of need specified
4. Timely documentation in the beneficiary's medical record showing usage of the item.

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy.

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

<u>Method 1—Direct Delivery to the Beneficiary by the Supplier</u>

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

REPAIR/REPLACEMENT (BPM Ch 15, §100.2)

Documentation Section

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

An order is not necessary for the repair of an orthosis; however, claims for code L4210 must be accompanied by a description of the part that is being repaired or replaced. This information should be entered into the narrative field on an electronic claim.

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.

KX, GA, and GZ MODIFIERS

Suppliers must add a KX modifier to **KNEE ORTHOSES** 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.

MISCELLANEOUS

For custom fabricated **ORTHOSES** (L1834, L1840, L1844, L1846, L1855-L1880), 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.

When billing L2999, the following information should accompany the claim: manufacturer's name; product name; justification of patient's medical necessity for the item. 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) must be included with the claim.

The beneficiary's condition (ICD-9 diagnosis code) that necessitates the need for the **KNEE** orthosis must be included on the claim.

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
09/10/2004

End Date of Comment Period
10/25/2004

Start Date of Notice Period
03/20/2008

Revision History Number
1

Revision History Explanation
Revision Effective Date: 07/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Order requirements language to specify a “detailed written order”
Added: Coverage for concentric adjustable torsion joints (Effective 3/13/2012)
Added: Code L2755 to Addition Codes – Eligible for Separate Payment table
Added: ICD-9 codes 733.81-733.82 and 905.4 for L1830, L1832, L1843, L1845 to coverage table per request for reconsideration.
Changed: Word “Patient” to “Beneficiary”
HCPCS CODES AND MODIFIERS
Added: Code L2755
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-9 codes 733.81-733.82 and 905.4 for L1830, L1832, L1834, L1843, L1844, L1845, L1846 per request for reconsideration.
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)
Added: Refill requirements, general medical record information requirements, continued use and continued need requirements, and proof of delivery requirements

08/05/2011 - The Jurisdiction C contractor adopted a new business name. This LCD revision only includes the change from CIGNA Government Services to CGS Administrators, LLC. No coverage information was included in this revision and no provider action is needed regarding this revision.

Revision Effective Date: 7/01/2011
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-9 codes 342.91 and 342.92 for L1832, L1843 – L1846 (typographical correction to ICD-9 codes)

Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least costly alternative for multiple HCPCS codes
HCPCS CODES AND MODIFIERS:
Added: Code L4002
Revised: GA modifier
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-9 code 844.8 for codes L1830, L1832, L1834 and L1843-L1846

Revision Effective Date: 01/01/2010
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Coverage criteria for L1810, L1820
Added: Definition for **KNEE** instability
Revised: Coverage criteria for L1832
HCPCS CODES AND MODIFIERS:
Deleted: L1800, L1815, L1825
Added: A4466
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Revised: Covered diagnoses for L1832

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

08/08/2009 - This policy was updated by the ICD-9 2009-2010 Annual Update.

Effective Date: 04/01/09
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: ICD-9 diagnosis codes 844.0 – 844.2 and 996.40 – 996.49 to range of codes for L1830, L1832, L1834, L1843, L1844, L1845 and L1846 in response to request for reconsideration.
Deleted: Codes L1800, L1815, L1825 from prefabricated **KNEE ORTHOSES**
Deleted: Codes L1800, L1815, L1825 from Base code & Addition Codes - Eligible for Separate Payment
Deleted: Codes L1800, L1815, L1825 from Base code & Addition Codes - Not Medically Necessary
HCPCS CODES AND MODIFIERS:
Revised: KX modifier

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-9 diagnosis codes 844.0 – 844.2 and 996.40 – 996.49 to range of codes for L1830, L1832, L1834, L1843, L1844, L1845 and L1846
DOCUMENTATION:
Added: Clarified that use of KX modifier is applicable to both the base and addition codes.
Revised: Changed DMERC to DME MAC

Revision Effective Date: 07/01/08
HCPCS CODES:
Added: K0672

Reason for Change
Coverage Change (actual change in medical parameters)
HCPCS Addition/Deletion
Maintenance (annual review with now changes, formatting, etc)
Narrative Change

Related Documents
A47178 - Knee Orthosis - Policy Article - Effective July 2012

LCD Attachments

All Versions

Updated on 05/05/2012 with effective dates 07/01/2012 - N/A
Updated on 03/08/2012 with effective dates 07/01/2011 - 06/30/2012
Updated on 05/31/2011 with effective dates 07/01/2011 - N/A
Updated on 05/20/2011 with effective dates 07/01/2011 - N/A
Updated on 12/10/2010 with effective dates 02/04/2011 - 06/30/2011
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Local Coverage Article for KNEE Orthosis - Policy Article - Effective July 2012 (A47178)

Contractor Information

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

Article Information

General Information

Article ID Number
A47178

Article Type
Article

Key Article
Yes

Article Title
KNEE Orthosis - Policy Article - Effective July 2012

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
07/01/2008

Article Revision Effective Date
07/01/2012

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.

KNEE ORTHOSES are covered under the 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. 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.

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 will be denied as non-covered (no benefit category).

The following chart reflects the reasonable useful lifetime of prefabricated **KNEE ORTHOSES**:

L1810	1 year
L1820	1 year
L1830	1 year
L1831	2 years
L1832	2 years
L1836	3 years
L1843	3 years
L1845	3 years
L1850	2 years

The reasonable useful lifetime of custom fabricated **ORTHOSES** is 3 years.

Replacement during the "reasonable useful lifetime" is covered if the item is lost or irreparably damaged. Replacement for other reasons, including but not limited to irreparable wear, during the period of reasonable useful lifetime is denied as noncovered. L-coded additions to **KNEE ORTHOSES** (L2275 -

L2830, K0672) will be denied as noncovered when the base orthosis is noncovered.

Brace sleeves (A9270) used in conjunction with **ORTHOSES** are noncovered because 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).

Repairs to a covered orthosis 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.

CODING GUIDELINES:

An orthosis (brace) is 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. An orthosis can be either prefabricated or custom-fabricated.

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 (no other beneficiary would be able to use this orthosis) 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 vacuum forming, 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.

A molded-to-beneficiary-model orthosis is a particular type of custom fabricated orthosis in which either:

a. An impression of the specific body part is made (usually by means of a plaster or fiberglass cast) and this impression is then used to make a positive model (usually of plaster) of the body part; or
b. Detailed measurements are taken of the beneficiary 's extremity and are used to modify a positive model (which has been selected from a large library of models) to make it conform to the beneficiary's body shape and dimensions; or
c. A digital image of the beneficiary's extremity is made using computer (CAD-CAM) software which then directs the carving of a positive model.

The orthosis is then individually fabricated and molded over the positive model of the beneficiary.

Code L1810 describes a prefabricated **KNEE** orthosis constructed of latex, neoprene, spandex or other elastic material. There are no condylar pads. There are hinges or joints.

Code L1820 describes a prefabricated **KNEE** orthosis with hinges or joints, constructed of latex, neoprene, spandex or other elastic material. There are medial and lateral condylar pads.

Code L1830 describes a prefabricated **KNEE** orthosis immobilizer, with rigid metal or plastic stays placed laterally and posteriorly. The interface material is constructed of canvas, closed cell foam or equal. The thigh and calf cuffs are one-piece construction held in place by velcro straps or equal. The orthosis immobilizes the **KNEE** joint and prevents flexion or extension. There are no hinges or joints.

Codes L1831 and L1847 describe prefabricated **KNEE ORTHOSES** with joint(s) which lock the **KNEE** into a particular position. Code L1847 is distinguished from L1831 by the addition of an air bladder in the space behind the **KNEE**. These **ORTHOSES** are designed for beneficiaries who are nonambulatory. They are typically used to treat flexion/extension contractures of the **KNEE**.

An adjustable flexion and extension joint is one which enables the practitioner to set limits on flexion and extension but allows the beneficiary free motion of the **KNEE** within those limits. The increments of adjustability must be, at a minimum, 15 degrees. The joint may be either unicentric or polycentric.

Code L1832 describes a prefabricated **KNEE** orthosis that has double uprights and adjustable flexion and extension joints. Medial-lateral control of the **KNEE** is accomplished by the solid metal (or similar

material) structure of the double uprights. It may have condylar pads. This orthosis is designed for a beneficiary who can bear weight on the **KNEE** and is capable of ambulation. It is typically used for early rehabilitation following **KNEE** surgery.

Codes L1834 and L1836 describe rigid **KNEE** orthosis without a **KNEE** joint. Both are designed to prevent **KNEE** motion. These **ORTHOSES** are designed for beneficiaries who can bear weight on the **KNEE**, are capable of ambulating, and need additional support provided through immobilization of the **KNEE** joint. Code L1834 refers to a custom fabricated **KNEE** orthotic while L1836 refers to one that is pre-fabricated.

Code L1840 describes a custom fabricated **KNEE** orthosis with **KNEE** joints designed to protect the ligaments of the **KNEE** through medial-lateral torsion, providing stability and preventing rotation.

Codes L1843 and L1844 describe prefabricated and custom fabricated (respectively) **KNEE ORTHOSES** which are constructed of rigid thigh and calf cuffs and a single upright with an adjustable flexion and extension **KNEE** joint. It must have condylar pads. Through a series of straps/supports that cross over and around the **KNEE** joint, rotational control and varus or valgus force is exerted on the **KNEE** joint. These **ORTHOSES** are designed to open the medial or lateral compartment of the **KNEE** to provide pain relief due to osteoarthritis. These **ORTHOSES** are designed for beneficiaries who are fully ambulatory.

Codes L1845 and L1846 describe prefabricated and custom fabricated (respectively) **KNEE ORTHOSES** that have double uprights, condylar pads, and an adjustable flexion and extension joint and provide both medial-lateral and rotation control. Medial-lateral control of the **KNEE** is accomplished by the solid metal (or similar material) structure of the double uprights. Rotation control is accomplished by the combination of (1) solid metal (or similar material) in the anterior portion of the thigh and calf cuffs and (2) the condylar pads. These **ORTHOSES** are designed for beneficiaries who are fully ambulatory.

The only products which may be billed using code L1845 are those for which a written coding verification has been made by the Pricing, Data Analysis, and Coding (PDAC) contractor. Information concerning the documentation that must be submitted to the PDAC for a Coding Verification Request can be found on the PDAC web site or by contacting the PDAC. A Product Classification List with products which have received a coding verification can be found on the PDAC web site. Products which have not received coding verification review from the PDAC must be billed using code A9270.

L1850 describes a prefabricated orthosis with double uprights and thigh and calf pads. It may or may not have joints. These **ORTHOSES** are used to prevent hyperextension of the **KNEE** joint in ambulatory beneficiaries.

L1860 describes a custom fabricated orthosis without joints, constructed of plastic or other similar material. These **ORTHOSES** are used to prevent hyperextension of the **KNEE** joint in ambulatory beneficiaries.

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.

“Addition” codes are grouped into four (4) categories in relation to **KNEE** orthosis base codes.

- Eligible for separate payment
- Not medically necessary
- Not separately payable
- Incompatible

Addition codes in the first two categories are addressed in the related LCD. Addition codes that are not separately payable are addressed in the tables below.

The following table lists addition codes which describe components or features that can be physically incorporated in the **specified prefabricated bases orthosis** but are considered to be included in the allowance for the orthosis. The addition codes will be denied as not separately payable if they are billed with the related base code.

Base Code	Addition Codes - Not Separately Payable
L1810	L2390, L2750, L2780, L4002

L1820	L2390, L2750, L2780, L2810, L4002
L1830	K0672, L4002
L1831	K0672, L2390, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002
L1832	K0672, L2390, L2425, L2430, L2750, L2780, L2820, L2830, L4002
L1836	K0672, L2750, L2780, L2810, L2820, L2830, L4002
L1843	K0672, L2275, L2390, L2425,L2430, L2750, L2780, L2810, L2820, L2830, L4002
L1845	K0672, L2275, L2390, L2425,L2430, L2750, L2780, L2810, L2820, L2830, L4002
L1847	K0672, L2390, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002
L1850	K0672, L2750, L2780, L2810, L2820, L2830, L4002

The following table lists addition codes which describe components or features that can be physically incorporated in the **specified custom fabricated bases orthosis** but that are considered to be included in the allowance for the orthosis. The addition codes will be denied as not separately payable if they are billed with the related base code.

Base Code	Addition Codes - Not Separately Payable
L1834	K0672, L2820, L2830, L4002
L1840	K0672, L2320, L2330, L2750, L2780, L2810, L2820, L2830, L4002
L1844	K0672, L2275, L2320, L2330, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002
L1846	K0672, L2275, L2320, L2330, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002
L1860	K0672, L2820, L2830, L4002

All addition codes that are not listed as either separately payable or not reasonable and necessary in the tables in the LCD or as not separately payable in the tables above describe components or features that either cannot be physically incorporated in the specified base orthosis or whose narrative description is incompatible with base orthosis code (e.g., billing a prefabricated base code with an addition code which specifies that is it only used with custom fabricated **ORTHOSES**). These incompatible addition codes will be rejected as incorrect coding.

A replacement removable soft interface for a **KNEE** orthosis is billed with code K0672 (lower extremity orthosis, not otherwise specified). One unit of service includes all the components that are used at the same time on a single orthosis.

Either a nonremovable soft interface (L2820, L2830) or two (2) removable soft interfaces (K0672) are included in the allowance for a **KNEE** orthosis. Soft interfaces billed separately at the time of initial issue will be denied as not separately payable.

Codes L2320 and L2330 (non-molded and molded lacers, respectively) may only be billed as

replacement items.

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 codes 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 KO 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** 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 KO Local Coverage Determination Indications and Limitations of Coverage and/or Medical Necessity).

The allowance for the labor involved in replacing/repairing an orthotic component that is coded with a specific L code is included in the allowance for that component. The allowance for the labor (L4205) involved in replacing/repairing an orthotic component that is coded with the miscellaneous code L4210 is separately payable in addition to the allowance for that component.

Code L4002 is for billing of replacement component(s) and is not payable at initial issue of a base orthosis. When code L4002 is billed at the time of initial issue of a base orthosis, it will be denied as not separately payable.

The right (RT) and/or left (LT) modifiers must be used when billing for 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 for 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 L2999 (lower extremity orthosis, not otherwise specified) should be used only when billing for item (s) that do not meet the definition of an existing code(s).

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.

Similarly, code L4210 (Repair of orthotic device, repair or replace minor parts) must not be used for casting supplies or other materials used in the fitting or fabrication of an orthosis.

Should a supplier wish to submit a claim for services/items that are included in the allowance for the orthosis, code L9900 (Orthotic and prosthetic supply, accessory and/or service component of another HCPCS L code) must be used. Code L9900 is denied as not separately payable.

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: 07/01/2012
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Reference to LCD for R & N requirements
Changed: Patient to Beneficiary
CODING GUIDELINES:
Added: Definition of code L2755
Added: Coding guidelines for concentric adjustable torsion joints (Effective 3/13/2012)

08/05/2011 - The Jurisdiction C contractor adopted a new business name. This LCD revision only includes the change from CIGNA Government Services to CGS Administrators, LLC. No coverage information was included in this revision and no provider action is needed regarding this revision.

Revision Effective Date: 02/04/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language
CODING GUIDELINES:
Added: Code L4002 to correct coding tables
Added: Instructions for L4002

Revision Effective Date: 01/01/2010
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Reference to code A4466
CODING GUIDELINES:
Deleted: Definitions for L1800, L1815, and L1825
Deleted: Reference to code L2770

Revision Effective Date: 12/01/2009
CODING GUIDELINES:
Revised: Instructions for L2770
Revised: Instructions for coding concentric adjustable torsion joints
Revised: Instructions for RT/LT modifiers

Revision Effective Date: 04/01/2009
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Deleted: Codes L1800, L1815, L1825 from the reasonable useful lifetime chart
Added: Noncoverage language for elastic support garments
CODING GUIDELINES:
Deleted: Codes L1800, L1815, L1825 from Base code & Addition Codes - Not Separately Payable
Deleted: Code L2860
Revised: SADMERC to PDAC

Related Document(s)
LCD(s)
L27058 - Knee Orthoses

All Versions

Updated on 05/05/2012 with effective dates 07/01/2012 - N/A
Updated on 12/10/2010 with effective dates 02/04/2011 - N/A
Some older versions have been archived. Please visit MCD Archive Site to retrieve them.