Sentara® Health Plans

Commercial

Orthotics and Braces, DME 251

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Coverage Policy	DME 251
Version	5

Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

Description & Definitions:

Orthotics and braces are use to support joints and/or prevent movement following an injury, or surgery.

Spinal orthoses can protect the spine to prevent further injury or can correct the position of the spine. A spinal orthosis may be prefabricated, custom-fitted (a prefabricated brace modified to fit a person), or custom-fabricated (individually constructed to fit a specific person).

- Custom-fit is a prefabricated orthosis that requires a moderate to maximum adjustment on final delivery.
- A custom-fabricated orthosis is made and fitted to a specific individual.
- "Off-the-shelf" (OTS) is a prefabricated orthosis that requires minimal adjustment on final delivery.

Benik Shorts are custom, compression shorts to provide additional support to back, stomach, hips and thighs for additional support and alignment during exercise.

Suit Therapy is an orthotic, lycra apparel that provides stability for tone, posture and controlled stability.

Criteria:

Orthotic or brace needed, as indicated by **1 or more** of the following:

- **Custom Brace** needed for **1 or more** of the following:
  - Abnormal limb contour interferes with use of prefabricated orthosis
  - Child or person of short stature, when pediatric prefabricated orthosis is not sufficient
  - Contracture or deformity interferes with fitting of prefabricated orthosis
  - Minimal muscle mass limits suspension of prefabricated orthosis.
  - Person of tall stature, when extensions for prefabricated orthosis are not sufficient
  - Tried and failed use of prefabricated orthosis
- **Orthotic or Brace** needed for **1 or more** of the following:
  - Post-surgical
  - prescribed to support, align, prevent or correct a deformity with **ALL** of the following:

        - Evidence of a physical examination within the prior twelve months, for a condition that supports the use of the item prescribed, is documented in the individual's medical record
- **Spinal Orthoses** needed for **1 or more** of the following:
    - An off-the-shelf, unmodified, prefabricated brace when ordered for **1 or more** of the following:
        - To reduce pain by restricting mobility of trunk
        - To facilitate healing following injury to spine or related soft tissues when applied within 6 weeks of injury
        - To facilitate healing following surgical procedure on spine or related soft tissue when applied within 6weeks of surgery
        - To otherwise support weak spinal muscles and/or deformed spine
        - Bracing of children or adolescents with scoliosis
    - A custom fitted brace for **1 or more** of the following
        - Individual has a contraindication to, cannot tolerate or there has been a failure of an unmodified,prefabricated (off-the-shelf) back brace
        - As the initial brace following surgical stabilization of the spine of a traumatic injury
        - As the initial treatment for burst fractures (two or three column injuries) of the thoracic or lumbar spine
    - A custom fabricated brace if the individual cannot tolerate or there has been a failure of a custom fitted backbrace.
    - For Congenital Defects Orthopedic back braces for the treatment of congenital defects of **1 or more** of thefollowing:
        - Adolescent idiopathic scoliosis treatment if utilizing **1 or more** of the following approved bracing systems:
            - Boston scoliosis brace
            - Charleston scoliosis brace
            - Milwaukee scoliosis brace
            - Providence brace
            - Rigo-Cheneau brace
            - Risser jacket
            - Standard thoracolumbosacral orthosis (TLSO)
- Repairs and/or Replacement to medically necessary orthotics and braces for **1 or more** of the following:
    - Repairs due to normal wear and tear to maintain functionality.
    - Replacements due to **1 or more** of the following:
        - Irreparable damage
        - significant change in the individual's condition (i.e. growth in child/adolescent or major weight loss/gain)

Orthotics and Braces is considered not medically necessary for any use other than those indicated in the clinical criteria, to include but not limited to:

- any orthosis used on uninjured body parts or to prevent injury
- Benik shorts
- Comfort, non-therapeutic braces
- Copes scoliosis brace
- Post Partum Recovery Garment
- Pregnacy Belt
- Repair or replacement when an orthosis becomes unusable or non-functioning because of misuse, abuse or neglect
- Rosenberger brace
- Robotic lower body exoskeleton suits (e.g., the ReWalk Personal Exoskeleton, K1007)

- Full body robotic exoskeleton also know as a Powered exoskeleton suits to exceptions using the combination of upper and lower components (K1007 and L8701/L8702)
- ScoliBrace
- ScoliSmart activity suit
- Spinal orthosis for as a preoperative diagnostic tool prior to lumbar fusion surgery
- Spine and Scapula Stabilizing brace (the S3 brace)
- SpineCor Dynamic Corrective Brace
- Suit therapy
- UNYQ customized brace

Document History:

Revised Dates:

- 2026: June – Implementation date of October 1, 2026. Criteria updated.
- 2026: May – Annual review. Remove codes that do not require authorization. Add Robotic lower body exoskeleton suits and Full body robotic exoskeleton to exceptions with related codes
- 2025: June – Implementation date of September 1, 2025. Criteria updated references updated.
- 2025: May 06 – Updated criteria to include spinal braces and non-custom orthotics, including coding.
- 2024: June

Reviewed Dates:

- 2025: October – Implementation date of February 1, 2026. No changes.
- 2025: May 06 – Updated criteria to include spinal braces and non-custom orthotics, including coding.

Origination Date: June 2024

Coding:

Medically necessary with criteria:

Coding	Description
L1610	Hip orthosis (HO), abduction control of hip joints, flexible, (Frejka cover only), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
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
L2492	Addition to knee joint, lift loop for drop lock ring
L3891	Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism for custom fabricated orthotics only, each
L3900	Wrist-hand-finger orthosis (WHFO), dynamic flexor hinge, reciprocal wrist extension/ flexion, finger flexion/extension, wrist or finger driven, custom fabricated
L3901	Wrist-hand-finger orthosis (WHFO), dynamic flexor hinge, reciprocal wrist extension/ flexion, finger flexion/extension, cable driven, custom fabricated

L3904	Wrist-hand-finger orthosis (WHFO), external powered, electric, custom fabricated
L8300	Truss, single with standard pad
L8310	Truss, double with standard pads
L8320	Truss, addition to standard pad, water pad
L8330	Truss, addition to standard pad, scrotal pad

Considered Not Medically Necessary:

Coding	Description
K1007	Bilateral hip, knee, ankle, foot (HKAFO) device, powered, includes pelvic component, single or double upright(s), knee joints any type, with or without ankle joints any type, includes all components and accessories, motors, microprocessors, sensors
L8701	Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated
L8702	Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated
L8720	External lower extremity sensory prosthesis, cutaneous stimulation of mechanoreceptors proximal to the ankle, per leg
L8721	Receptor sole for use with L8720, replacement, each

U.S. Food and Drug Administration (FDA) - approved only products only.

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Special Notes: *

- Coverage:
  - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to Products:
  - Policy is applicable to Sentara Health Plan Commercial products.
- Authorization Requirements:
  - Pre-certification by the Plan is required.
  - Refer to MCG for:
    - Ankle-Foot and Knee-Ankle-Foot Orthotics (A-0894)
    - Knee Braces, Custom (A-0879)
    - Knee Braces (A-0332)
- Special Notes:

- Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving, and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
- Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.
- MUST SEE MEMBER BENEFIT FOR DETERMINATION. We only cover DME that is Medically Necessary and prescribed by an appropriate Provider. We also cover colostomy, ileostomy, and tracheostomy supplies, and suction and urinary catheters. We do not cover DME used primarily for the comfort and wellbeing of a Member. We will not cover DME if We deem it useful, but not absolutely necessary for Your care. We will not cover DME if there are similar items available at a lower cost that will provide essentially the same results as the more expensive items.

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Keywords:

Orthotics, Braces, Joints, Support Joints, Pregnancy Belt, Belly Band, custom-fabricated