Priority Health	BILLING POLICY No. 051
PROSTHETICS, ORTHOTICS AND FOOTWEAR	
Date of origin: Nov. 11, 2024	**Review dates: 2/2025, 6/2025, 8/2025, 01/2026, 05/2026**

DEFINITION
This policy identifies the payment and documentation requirements associated with various prosthetic orthotics and footwear.

MEDICAL POLICY
Reference the following Priority Health medical policies for coverage information:

- Prosthetics, External (#91306)
- Orthotics: Shoe Inserts, Orthopedic Shoes (#91420)
- Orthotics/Support Devices (#91339)

POLICY SPECIFIC INFORMATION

Documentation requirements
We align with the Centers for Medicare & Medicaid Services (CMS) standard documentation requirements for supplies and DME. Reference CMS Article A55426 – Standard Documentation Requirements for All Claims Submitted to DME MACs for documentation requirements

Orthopedic footwear / therapeutic shoes
Oxford shoes that are an integral part of a brace are billed using codes L3224 or L3225, one unit of service for each shoe. Oxford shoes that aren't part of a leg brace must be billed with codes L3215 or L3219.

Other shoes that are an integral part of a brace are billed using code L3649 (explanatory notes must be included with all unlisted / not otherwise specified codes). Other shoes that aren't an integral part of a brace must be billed using codes L3216, L3217, L3221, L3222, L3230, L3251, L3252, L3253 or L3649.

Codes for inserts or modifications (A5503, A5504, A5505, A5506, A5507, A5508, A5510, A5512, A5513, A5514) should be used for items related to diabetic shoes (A5500, A5501). They shouldn't be used for items related to footwear coded with codes L3215, L3216, L3217, L3219, L3221, L3222, L3224, L3225, L3230, L3250, L3251, L3252, L3253. Inserts and modifications used with L-coded footwear must be coded using L codes.

Ankle-foot / knee-ankle-foot orthosis
The miscellaneous HCPCS code for billing of AFOs and KAFOs is HCPCS code L2999. Explanatory notes must accompany claim when using L2999 or any miscellaneous HCPCS.

HCPCS codes in Column I and Column II are corresponding HCPCS code sets. These codes represent identical products and shouldn't be reported together.

Column I	Column II
L4360	L4361
L4386	L4387
L4396	L4397

Code L4631 includes all additions; no other codes should be billed with code L4631.

Prefabricated walking boots such as L4360, L4361, L4386 or L4387 describe complete products; add-on codes reported will be unbundled.

Lower limb protheses

Code L5999 must not be used to bill for any features or functions included in the socket or addition codes. Use of L5999 with these items is unbundling.

Code L7520 must not be billed for labor time involved in the replacement of parts that are billed with a specific HCPCS code; labor is included in these codes.

Payments for items listed in Column II are included in the payment for each Column I code. Claims for Column II items billed with the provision of a Column I item will be denied as unbundling.

Column I	Column II
L5781	L7360
L5782	L7364
L5856	L7367
L5857	L7362
L5858	L7366
L5859	L7368
L5973	

Knee orthosis

HCPCS codes located in Column I and Column II within the same row are considered identical products and shouldn't be reported together.

Column I	Column II
L1810	L1812
L1820	L1821
L1832	L1833
L1843	L1851
L1845	L1852
L1847	L1848

The below codes are for components / features that can be physically incorporated in the specified prefabricated base orthosis but are considered to be included in the allowance for the orthosis.

Base code	Addition codes (not separately payable)
L1810	L2390, L2750, L2780, L4002
L1812	L2390, L2750, L2780, L4002
L1820	L2390, L2750, L2780, L2810, L4002
L1821	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
L1833	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
L1848	K0672, L2390, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002

L1850	K0672, L2750, L2780, L2810, L2820, L2830, L4002
L1851	K0672, L2275, L2390, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002
L1852	K0672, L2275, L2390, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002

The below codes are for components / features that can be physically incorporated in the specified custom fabricated base orthosis but are considered to be included in the allowance for the orthosis.

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

Addition codes to knee orthoses are only payable if the base codes for knee orthoses are paid.

Spinal Orthoses

Lumbar-sacral orthoses (LSO) and thoracic-lumbar-sacral orthoses (TLSO) are eligible for coverage .To qualify, the orthosis must be a rigid or semi-rigid device intended to support a weakened or deformed body part, or to restrict or prevent movement in an injured or diseased area. Devices lacking sufficient rigidity to provide the required support or immobilization do not meet criteria and are not covered.

The reimbursement for an orthosis includes all associated services such as evaluation, measurement and/or casting, and fitting or adjustments. These services are bundled into the overall allowance for the orthosis and are not reimbursed separately.

When supplying orthoses, providers must adhere to the following requirements:

- Furnish the exact product prescribed by the treating practitioner.
- Ensure the medical record supports the necessity for the specific type of orthosis (e.g., prefabricated vs. custom-fabricated).
- Submit claims using only the HCPCS code that accurately represents both the orthosis type and the level of fitting provided.
- Maintain comprehensive documentation within the supplier's records that substantiates the code selected.

For many prefabricated orthoses, corresponding sets of HCPCS codes are available which describe the identical types of items. The corresponding code sets, when available for identical products, are only differentiated by the nature of the final fitting performed at the time of delivery. The corresponding HCPCS code types are:

- HCPCS codes which describe "prefabricated, off-the-shelf." These HCPCS codes must be used when minimal self-adjustment is the extent of the fitting performed at delivery.
- HCPCS codes which describe "prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise." These HCPCS codes must be used when more than minimal self-adjustment is necessary and performed at delivery.

In the following table, the HCPCS codes located in Column I and Column II within the same row are considered a corresponding HCPCS code set. These codes represent identical products which are only differentiated by the nature of the final fitting performed at the time of delivery.

Column I	Column II

L0454	L0455
L0456	L0457
L0466	L0467
L0468	L0469
L0626	L0641
L0627	L0642
L0630	L0643
L0631	L0648
L0633	L0649
L0637	L0650
L0639	L0651

Facial Prosthesis

Facial prosthetics are custom-made, artificial replacements for parts of the face, such as the nose, ears, or eyes, that may be missing due to trauma, surgery, or congenital conditions. These prostheses are designed to restore both the appearance and, in some cases, the function of the missing facial features.

- Supplies such as adhesives, adhesive removers, skin barrier wipes, and tape used in connection with a facial prosthesis are eligible for coverage.

- Facial prostheses provided in an inpatient hospital setting are included in the hospital's bundled payment and should not be billed separately.

- Modifications to a facial prosthesis are eligible for separate reimbursement if performed more than 90 days after the initial delivery and necessitated by a documented change in the member medical condition

- The following services and items are included in the reimbursement allowance for a facial prosthesis and are not separately billable under the prosthetic device benefit:
  - Clinical evaluation of the beneficiary
  - Pre-operative planning and design
  - Materials used in fabrication
  - Labor for creating and fitting the prosthesis
  - Modifications made at delivery or within 90 days post-delivery
  - Repairs due to normal wear and tear within 90 days of delivery
  - Follow-up appointments within 90 days of delivery

- L8048: Use when the prosthesis is:
    - Not described by L8040–L8047, or
    - Contains an attachment component for bone-anchored/internal prostheses (e.g., maxillary obturator). Note: Should not be used for implanted anchoring devices.
- L8049: Labor code for covered modifications or repairs after 90 days post-delivery.
    - Report only lab modification/repair time and associated evaluation.
    - Non-repair evaluations should *not* be billed with L8049

Ocular Prosthesis

- When an ocular component is new and provided as part of orbital, upper facial, or hemi-facial prosthesis, bill V2623 or V2629 separately.
- If the ocular component is reused from the prior prosthesis, do not bill separately
- When an ocular prosthesis is provided as an integral component of a facial prosthesis, it must be billed by the same supplier responsible for the facial prosthesis. Coverage for eye prostheses for members who experience eye absence or shrinkage resulting from congenital conditions, trauma, or surgical removal.
- Polishing and resurfacing procedures (code V2624) are covered twice per calendar year.
- One enlargement (V2625) or reduction (V2626) of the prosthesis is covered without supporting documentation.
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Place of service

Please review specific information regarding DME Place of Service billing requirements in our Durable medical equipment (DME) place of service (POS) billing policy.

Modifiers

As indicated in our Prosthetics medical policy, the below modifiers will be required:

HCPCS modifiers

- **Anatomical modifiers** must be used with all footwear HCPCS codes
- AV Modifier: Required when billing codes A4450, A4452, A5120 (adhesive-related items).
- For replacement prostheses:
    - If fabrication begins with a new impression or moulag**e**, use the KM modifie**r**.
    - If fabrication uses a previous master model, use the KN modifie**r**.
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- **KX Modifier** – Modifier should be appended to indicate that policy criteria has been met. Claims reported without KX modifier will deny as non-payable per medical policy. (Commercial, Medicaid products).
- **KX, GA, GY, GZ Modifiers** – Per CMS local coverage determinations, one of these modifiers are required for claim processing. Please review applicable LCD for additional guidelines. (Medicare). See more information about these modifiers in our Provider Manual.
- **CG** - Policy criteria applied

Frequency limits

Usual maximum quantity of supplies:

Code(s)	Limit

A5500	1 Per Year with Modifier LT; 1 Per Year with Modifier RT
A5503, A5504, A5505, A5506	1 Per 6 Months with Modifier LT; 1 Per 6 Months with Modifier RT
A5510, A5512, A5513, A5514	3 Per Year with Modifier LT; 3 Per Year with Modifier RT
L0120, L0130, L0140, L0150, L0170, L0172, L0174, L0180, L0190, L0200	1 Per Year
L0450, L0452, L0454, L0455, L0456, L0457, L0458, L0460, L0462, L0464, L0466, L0467, L0468, L0469, L0470, L0472, L0480, L0482, L0484, L0486, L0488, L0490, L0491, L0492, L0621, L0622, L0623, L0624, L0625, L0626, L0627, L0628, L0629, L0630, L0631, L0632, L0633, L0634, L0635, L0636, L0637, L0638, L0639, L0640, L0641, L0642, L0643, L0648, L0649, L0650, L0651, L0700, L0710	1 Per 1 Year
L0970, L0972, L0974, L0976, L0980	1 Per Year
L1000, L1001, L1005, L1010, L1020, L1030, L1040, L1050, L1060, L1070, L1090, L1200, L1210, L1220, L1230, L1240, L1250, L1260	1 Per Year
L1270	3 Per Year
L1280, L1290	1 Per Year
L1600	1 Per 6 Months
L1610	1 Per Year
L1620, L1630, L1640, L1650	1 Per 6 Months
L1652	1 Per 6 Months with Modifier LT; 1 Per 6 Months with Modifier RT
L1660, L1700, L1710	1 Per 6 Months
L1720	2 Per Year with Modifier LT; 2 Per Year with Modifier RT
L1730, L1755	1 Per 6 Months
L1810, L1812, L1820	1 Per 6 Months with Modifier LT; 1 Per 6 Months with Modifier RT
L1821	1 Per Year
L1830, L1831, L1832, L1833, L1834, L1836, L1840, L1843, L1844, L1845, L1846, L1847, L1848, L1850, L1860, L1900, L1902, L1906, L1907, L1920, L1930, L1932, L1940, L1945, L1950, L1951, L1960, L1970, L1971, L1980, L1990, L2000, L2005, L2010, L2020, L2030, L2034, L2036, L2037, L2038, L2106, L2108, L2112, L2114, L2116, L2136, L2180, L2182, L2184, L2186, L2200, L2210, L2220, L2230, L2265, L2270, L2275	1 Per 6 Months with Modifier LT; 1 Per 6 Months with Modifier RT
L2310	1 Per 6 Months
L2320, L2330, L2335, L2340, L2360, L2390, L2405, L2415, L2425, L2430, L2492, L2550	1 Per 6 Months with Modifier LT; 1 Per 6 Months with Modifier RT
L2760	4 Per 2 Years with Modifier LT; 4 Per 2 Years with Modifier RT
L2780	4 Per 6 Months with Modifier LT; 4 Per 6 Months with Modifier RT
L2785, L2795, L2800, L2810, L2820, L2830	1 Per 6 Months with Modifier LT; 1 Per 6 Months with Modifier RT

L2850	1 Per Year with Modifier LT; 1 Per Year with Modifier RT
L3000, L3001, L3002, L3003, L3010, L3020, L3030	2 Per Year with Modifier RT; 2 Per Year with Modifier LT
L3170, L3201, L3202, L3203, L3204, L3206, L3207, L3208, L3209, L3211, L3212, L3213, L3214	1 Per 6 Months with Modifier LT; 1 Per 6 Months with Modifier RT
L3215, L3216, L3217, L3219, L3221, L3222, L3224, L3225, L3230, L3250, L3251, L3252, L3253	2 Per 6 Months with Modifier LT; 2 Per 6 Months with Modifier RT
L3254, L3255, L3257, L3260, L3265	1 Per 6 Months with Modifier LT; 1 Per 6 Months with Modifier RT
L3300, L3310, L3320, L3332, L3334	2 Per Year with Modifier RT; 2 Per Year with Modifier LT
L3340	4 Per Year with Modifier LT; 4 Per Year with Modifier RT
L3350, L3360	2 Per Year
L3370, L3380, L3390	4 Per Year with Modifier LT; 4 Per Year with Modifier RT
L3400, L3410, L3420, L3430, L3440, L3450, L3455, L3460, L3465, L3470, L3500, L3510, L3520, L3530, L3540, L3550, L3560, L3570, L3580, L3590, L3595, L3600, L3610, L3620, L3630	2 Per Year with Modifier LT; 2 Per Year with Modifier RT
L3640	1 Per Year
L3650, L3660, L3670, L3674	1 Per Year with Modifier LT; 1 Per Year with Modifier RT
L3677, L3678	1 Per Year
L3702	1 Per Year with Modifier LT; 1 Per Year with Modifier RT
L3710	2 Per Year with Modifier LT; 2 Per Year with Modifier RT
L3720, L3730, L3740, L3760, L3761, L3762, L3807, L3809, L3908, L3912, L3913, L3915, L3916, L3917, L3918, L3919, L3923, L3924	1 Per Year with Modifier LT; 1 Per Year with Modifier RT
L3925, L3927, L3929, L3930, L3931, L3960	1 Per 2 Years
L3962, L3980, L3982, L3984	1 Per Year with Modifier LT; 1 Per Year with Modifier RT
L4002	2 Per Year
L4055, L4060, L4070, L4080, L4100, L4110	1 Per Year with Modifier LT; 1 Per Year with Modifier RT
L4130	2 Per Year
L4205	4 units twice per year
L4210	2 Per Year with Modifier LT; 2 Per Year with Modifier RT
L4350	1 Per Year with Modifier LT; 1 Per Year with Modifier RT
L4360	2 Per Year
L4361	2 Per Year
L4370	2 Per Year
L4386, L4387, L4392, L4394	1 Per Year with Modifier LT; 1 Per Year with Modifier RT
L5000, L5010, L5020, L5050, L5060, L5100, L5105, L5150, L5160, L5200, L5210, L5220,	1 Per 5 Years with Modifier LT; 1 Per 5 Years with Modifier RT

L5230, L5250, L5270, L5280, L5301, L5312, L5321, L5331, L5341	
L5500, L5505, L5510, L5520, L5530, L5540, L5560, L5570, L5580, L5590, L5595	1 Per 2 Years with Modifier LT; 1 Per 2 Years with Modifier RT
L5618, L5620, L5622, L5624, L5626, L5628	3 Per 2 Years with Modifier LT; 3 Per 2 Years with Modifier RT
L5629, L5630, L5631, L5632, L5634, L5636, L5637, L5638	1 Per 2 Years with Modifier LT; 1 Per 2 Years with Modifier RT
L5643, L5645	1 Per 5 Years with Modifier LT; 1 Per 5 Years with Modifier RT
L5650	1 Per 2 Years with Modifier LT; 1 Per 2 Years with Modifier RT
L5651	1 Per 5 Years with Modifier LT; 1 Per 5 Years with Modifier RT
L5652, L5654, L5655, L5656, L5658, L5666, L5668, L5670, L5671, L5672, L5676, L5678, L5680, L5681, L5683, L5684	1 Per 2 Years with Modifier LT; 1 Per 2 Years with Modifier RT
L5685	4 Per Year with Modifier LT; 4 Per Year with Modifier RT
L5686, L5688, L5690, L5692, L5694, L5695, L5696, L5697, L5698, L5699, L5703	1 Per 2 Years with Modifier LT; 1 Per 2 Years with Modifier RT
L5704	2 Per 2 Years
L5705	2 Per 2 Years
L5710, L5712, L5714, L5810, L5812, L5850, L5910, L5920, L5940, L5950, L5960	1 Per 2 Years with Modifier LT; 1 Per 2 Years with Modifier RT
L5962	1 Per Year with Modifier LT; 1 Per Year with Modifier RT
L5970, L5971, L5972, L5974, L5976, L5978	1 Per 2 Years with Modifier LT; 1 Per 2 Years with Modifier RT
L5982, L5985	1 Per 5 Years with Modifier LT; 1 Per 5 Years with Modifier RT
L5986, L5988	1 Per 2 Years with Modifier LT; 1 Per 2 Years with Modifier RT
L6100, L6110, L6120, L6130, L6200, L6250, L6300, L6600, L6605	1 Per 5 Years with Modifier LT; 1 Per 5 Years with Modifier RT
L6610, L6615, L6616, L6620, L6635, L6645, L6650, L6655, L6660, L6665, L6670, L6672, L6675, L6676, L6677	1 Per 2 Years with Modifier LT; 1 Per 2 Years with Modifier RT
L6680, L6682, L6684	2 Per 5 Years with Modifier LT; 2 Per 5 Years with Modifier RT
L6691, L6692	1 Per 2 Years with Modifier LT; 1 Per 2 Years with Modifier RT
L6711, L6712, L6713, L6714, L6721, L6722	1 Per Year
L6805, L6810	1 Per 5 Years with Modifier LT; 1 Per 5 Years with Modifier RT
L6883, L6884, L6885	2 Per 2 Years with Modifier LT; 2 Per 2 Years with Modifier RT
L6890	2 Per Year with Modifier LT; 2 Per Year with Modifier RT
L6895	2 Per 2 Years with Modifier LT; 2 Per 2 Years with Modifier RT
L7510	2 Per Year
L7520	4 twice per year
L7600, L8000	2 Per 6 Months

L8010, L8015	2 Per 6 Months with Modifier LT; 2 Per 6 Months with Modifier RT
L8020, L8030	2 Per 2 Years with Modifier LT; 2 Per 2 Years with Modifier RT
L8032	4 Per Year with Modifier LT; 4 Per Year with Modifier RT
L8400, L8410	6 Per 6 Months with Modifier LT; 6 Per 6 Months with Modifier RT
L8415	3 Per 6 Months with Modifier LT; 3 Per 6 Months with Modifier RT
L8417, L8420, L8430	6 Per 6 Months with Modifier LT; 6 Per 6 Months with Modifier RT
L8435	3 Per 6 Months with Modifier LT; 3 Per 6 Months with Modifier RT
L8440, L8460	1 Per 6 Months with Modifier LT; 1 Per 6 Months with Modifier RT
L8465	1 Per Year with Modifier LT; 1 Per Year with Modifier RT
L8470, L8480	6 Per 6 Months with Modifier LT; 6 Per 6 Months with Modifier RT
L8485	3 Per 6 Months with Modifier LT; 3 Per 6 Months with Modifier RT
L8499	1 Per Day
S1040	1 Per 2 Years
S5199	100 Per Month
V2623	1 Per 5 Years with Modifier LT; 1 Per 5 Years with Modifier RT
V2624	1 Per 6 Months with Modifier LT; 1 Per 6 Months with Modifier RT
V2627	1 Per 5 Years with Modifier LT; 1 Per 5 Years with Modifier RT
V2628	2 Per Day

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added "Disclaimer" section
June 19, 2025	Added "Frequency limits" section, in alignment with MDHHS guidelines. Limits will be effective Aug. 25, 2025
Aug. 14, 2025	Added "Spinal Orthoses" section
Sept 15,2025	Added "Facial prosthesis" and "Ocular prosthesis" sections. Changes effective 11/17/2025
Jan 2026	No revisions
May 2026	Added modifier CG to the modifiers section