Priority Health	BILLING POLICY No. 051

PROSTHETIC ORTHOTICS AND FOOTWEAR

Effective date: Jan. 20, 2025 **Date of origin: Nov. 11, 2024**	**Review dates: 2/2025**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

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.

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
- **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.

DISCLAIMER

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