

# Medical Policy



## Hip Orthosis/Legg's Perthes Brace (Orthotic Devices – Lower Limb)

### Description

A hip orthosis (HO) is used to support the hip joint and is normally used to prevent the joint from dislocating or to prevent further injury.

A Legg Perthes brace is used most often in children to keep the femoral head properly positioned in the hip socket.

### Policy

A hip orthosis (HO), Legg Perthes brace or Pavlik harness is **reasonable and necessary** for members with hip disorders.

### Policy Guidelines

Coverage Criteria:

1. Must be ordered by the member's treating practitioner.
2. A HO, Legg Perthes brace, or Pavlik harness will be covered if the member meets one of the following criteria:
  - a. To promote healing and/or proper alignment/positioning following injury, procedure, or surgery of the hip.
  - b. To support lower extremities due to muscle weakness or abnormal muscle tone (e.g., high/low fluctuating tone) of permanent or long-standing duration (six months or longer).
  - c. To support, correct or improve:
    - Biomechanical alignment (e.g., pronation, supination, varus or valgus).
    - Static or dynamic contractures.
    - Congenital or acquired deformities of the lower extremities.
  - d. For members whose medical record shows documentation of a diagnosis listed under covered ICD-10 codes.
3. A custom HO, Legg Perthes brace, or Pavlik Harness will be covered for members meeting criterion #1 and at least one of the following below:

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- a. The member could not be fitted with a prefabricated orthosis, or
- b. The member has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury, or
- c. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

#### Limitations:

1. Evaluation of the member, measurement and/or casting, and fitting of the orthosis are included in the allowance for the orthosis. These services cannot be billed separately.
2. Repair of an orthosis will be covered for restoration to a serviceable condition which is not the result from misuse, non-intentional or intentional.
3. Replacement of an orthosis is covered if any of the criteria are met:
  - a. Documentation of a change in member's condition or size.
  - b. When necessitated by irreparable damage which is not the result of misuse, non-intentional or intentional.
  - c. The cost of repairs to the splint would exceed the purchase price.

#### HCPCS Level II Codes and Description

L1600	Hip orthosis (HO), abduction control of hip joints, flexible, Frejka type with cover, prefabricated, includes fitting and adjustment
L1610	Hip orthosis (HO), abduction control of hip joints, flexible, Frejka cover only, prefabricated, joints, fitting and adjustment
L1620	HO, Abduction control of hip joints, flexible, Pavlik harness, prefabricated, includes fitting and adjustment
L1630	HO, Abduction control of hip joints, semi-flexible (Von Rosen type) custom fabricated
L1640	HO, Abduction control of hip joints, static, pelvic band or spreader bar, thigh cuffs, custom fabricated

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- L1650 HO, Abduction control of hip joints, static, adjustable, (Ifled type), prefabricated, includes fitting and adjustment
- L1652 HO, Bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, includes fitting and adjustment
- L1660 HO, Abduction control of hip joints, static plastic, prefabricated, includes fitting and adjustment
- L1680 HO, Abduction control of hip joints, dynamic, pelvic control, adjustable hip motion control, thigh cuffs (rancho hip action type) custom fabricated
- L1685 HO, Abduction control of hip joint, post-operative hip abduction type, custom fabricated
- L1686 HO, Abduction control of hip joint, post-operative hip abduction type, prefabricated, including fitting and adjustment
- L1690 Combination, bilateral, lumbo-sacral, hip, femur orthosis providing adduction and internal rotation control, prefabricated, including fitting and adjustment
- L1700 Legg Perthes orthosis, (Toronto type), custom fabricated
- L1710 Legg Perthes orthosis, (Newington type), custom fabricated
- L1720 Legg Perthes orthosis, trilateral, (Tachdijan type) custom fabricated
- L1730 Legg Perthes orthosis, Scottish Rite type, custom fabricated
- L1755 Legg Perthes orthosis, (Patten bottom type), custom fabricated

### **ICD-10 Codes That Support Medical Necessity (not all-inclusive)**

- M91.80 Other Juvenile osteochondrosis of hip and pelvis, Unspecified leg
- Q65.00 Congenital dislocation of unspecified hip, unilateral
- Q65.1 Congenital dislocation of hip, bilateral
- Q65.30 Congenital partial dislocation of unspecified hip, unilateral
- Q65.4 Congenital partial dislocation of hip, bilateral
- Q65.01 Congenital dislocation of Right hip
- Q65.02 Congenital dislocation of Left hip
- Q65.31 Congenital partial dislocation of Right hip unilateral
- Q65.32 Congenital partial dislocation of Left hip unilateral
- Q65.82 Coxa vara, congenital
- Q65.89 Other specified congenital deformity of hip
- Q65.9 Congenital deformity of hip, unspecified
  
- S73.6A Dislocation of hip, unspecified, initial encounter
- S73.16A Posterior dislocation of unspecified hip, initial encounter
- S73.26A Obturator dislocation of unspecified hip, initial encounter
- S73.36A Other anterior dislocation of unspecified hip, initial encounter

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#### **Important Note:**

Northwood's Medical Policies are developed to assist Northwood in administering plan benefits and determining whether a particular DMEPOS product or service is reasonable and necessary. Equipment that is used primarily and customarily for a non-medical purpose is not considered durable medical equipment.

Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the member's contract including medical necessity requirements.

The conclusion that a DMEPOS product or service is reasonable and necessary does not constitute coverage. The member's contract defines which DMEPOS product or service is covered, excluded or limited. The policies provide for clearly written, reasonable and current criteria that have been approved by Northwood's Medical Director.

The clinical criteria and medical policies provide guidelines for determining the medical necessity for specific DMEPOS products or services. In all cases, final benefit determinations are based on the applicable contract language. To the extent there are any conflicts between medical policy guidelines and applicable contract language, the contract language prevails. Medical policy is not intended to override the policy that defines the member's benefits, nor is it intended to dictate to providers how to direct care. Northwood Medical policies shall not be interpreted to limit the benefits afforded to Medicare or Medicaid members by law and regulation and Northwood will use the applicable state requirements to determine required quantity limit guidelines.

Northwood's policies do not constitute medical advice. Northwood does not provide or recommend treatment to members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Northwood follows all CMS National Coverage Determinations (NCD) and Local coverage Determinations (LCD), as applicable.

#### **References**

AmeriHealth: Orthotics (Lower Extremity) Policy, <https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf> Accessed and reviewed 12/10/24.

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Aetna: Orthopedic Casts, Braces and Splints

[http://www.aetna.com/cpb/medical/data/1\\_99/0009.html](http://www.aetna.com/cpb/medical/data/1_99/0009.html) Last accessed and reviewed December 10, 2024.

### Change/Authorization History

Revision Number	Date	Description of Change	Prepared/Reviewed by	Approved by	Review Date:	Effective Date:
A	Nov.2006	Initial Release	Rosanne Brugnoni	Ken Fasse	n/a	
01		Annual Review	Susan Glomb	Ken Fasse	Dec.2008	
02	12-22-09	Annual Review/ no changes	Susan Glomb	Ken Fasse	Dec. 2009	
03	12-02-10	Annual Review – No changes	Susan Glomb	Ken Fasse	Dec.2010	
04	07-20-11	Added Important Note to all Medical Policies	Susan Glomb	Dr. B. Almasri		
05	12-05-11	Annual Review. Added Reference to Policy	Susan Glomb	Dr. B. Almasri	Dec. 2011	
06	04-03-12	Added reference to NH Medicaid	Susan Glomb	Dr. B. Almasri		
07	11-29-12	Annual Review – No changes	Susan Glomb	Dr. B. Almasri	Nov 12	
08	12-30-13	Annual Review. No changes	Susan Glomb	Dr. B. Almasri		
09	11-24-14	Annual Review. No changes	Susan Glomb	Dr. B. Almasri		
10	12-15-15	Annual Review. Removed ICD-9 codes and added ICD-10 codes.	Susan Glomb	Dr. B. Almasri		
11	12-19-16	Annual Review. No Changes.	Lisa Wojno	Dr. B. Almasri	December 2016	
12	12-15-17	Annual Review. No Changes.	Lisa Wojno	Dr. Cheryl Lerchin	December 2017	
13	12-6-18	Annual review. Added ICD-10 code Q65.9.	Carol Dimech	Dr. C. Lerchin	December 2018	

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14	12-06-19	Annual Review. No Changes.	Carol Dimech	Dr. C. Lerchin	December 2019	December 2019
15	12-03-20	Annual Review. No Changes.	Carol Dimech	Dr. C. Lerchin	December 3, 2020	December 3, 2020
16	12-10-21	Annual Review. Added NCD, LCD verbiage to "Important Note".	Carol Dimech	Dr. C. Lerchin	December 10, 2021	December 10, 2021
17	12-1-22	Annual Review. No Changes.	Carol Dimech	Dr. C. Lerchin	12-1-22	12-1-22
18	12-18-23	Annual review. Clarification of coverage criteria added. ICD-10 code list not all-inclusive.	Carol Dimech/Susan Glomb	Dr. C. Lerchin	December 18, 2023	December 18, 2023
19	12-10-24	Annual review. No changes.	Carol Dimech/Susan Glomb	Dr. C. Lerchin	12-10-24	12-10-24