CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all health benefit plans administered by CIGNA Companies including plans formerly administered by Great-West Healthcare, which is now a part of CIGNA.

Effective Date 5/15/2010
Next Review Date 5/15/2012
Coverage Policy Number 0362

Subject **Knee Braces**

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Hyperlink to Related Coverage Policies

Lower Limb Orthoses
Stretch Devices for Joint Stiffness and Contractures

INSTRUCTIONS FOR USE

*Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines.*
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Coverage Policy

Coverage for a knee brace/orthotic device is subject to the terms, conditions and limitations of the External Prosthetic Appliances and Devices (EPA) or Durable Medical Equipment (DME) benefit and schedule of copayments. In addition, some benefit plans may specifically exclude or limit coverage for certain braces/orthotic devices. Please refer to the applicable benefit plan document to determine benefit availability and terms, conditions and limitations of coverage. Under many benefit plans, coverage for EPA and DME is limited to the lowest-cost alternative.

In addition, unmodified, prefabricated knee orthoses are generally attempted prior to the use of a custom-fitted orthosis (i.e., prefabricated orthoses that are modified by bending or molding for a specific patient). Custom-fitted orthoses are generally attempted prior to the use of custom-fabricated orthoses (i.e., individually constructed from materials).

If coverage for a knee brace/orthotic device (prefabricated, custom-fitted, or custom-fabricated) is available, the following conditions of coverage apply (Note: The proposed application of the requested knee brace/orthotic device, rather than the name of the brace, needs to be determined in order to apply the coverage criteria).

Fracture knee brace/rehabilitative brace

CIGNA covers a fracture knee brace or a rehabilitative knee brace as medically necessary when applied at the time of initial stabilization (e.g., post-surgery, post-injury, post- fracture).

Patellofemoral knee brace
CIGNA covers a patellofemoral knee brace as medically necessary for the treatment of patellofemoral dislocations or chronic patellar symptomatic subluxation when EITHER of the following criteria has been met:

- following reduction for an acute (initial) patellar dislocation
- failure of a three-month exercise and strengthening rehabilitative program for a diagnosis of recurrent dislocation/subluxation of the patella

Functional knee braces
CIGNA covers a functional knee brace as medically necessary when there is documented knee instability and the individual is not considered a surgical candidate for ligament reconstruction.

Unloading/Offloading knee braces
CIGNA covers an unloading/offloading knee brace as medically necessary for the treatment of moderate to severe osteoarthritis of the knee when ALL of the following criteria are met:

- unicompartmental disease that requires load reduction to an affected compartment
- documented failure of prior medical treatment modalities (e.g., nonsteroidal anti-inflammatory medications, steroid injections, viscoelastic supplementation)
- radiographic documentation of single-compartment osteoarthritis with or without varus/valgus deformity
- persistent knee pain limiting activities of daily living

Noncovered knee braces and associated accessories
CIGNA does not cover ANY of the following knee braces and associated accessories, as they are considered not medically necessary (this list may not be all-inclusive):

- prophylactic knee braces
- functional knee braces utilized solely for participation in sports or to improve athletic performance
- patellofemoral knee braces/sleeves for the treatment of postoperative knee effusion or patellofemoral syndrome without subluxation or dislocation
- functional knee braces after successful reconstructive ligament surgery
- socks and brace sleeves used in conjunction with the orthotic device
- an additional removable or nonremovable interface (HCPCS L2820, L2830, K0672) dispensed with the initial device

Repair/Replacement
CIGNA covers repair and/or replacement of a knee brace/orthotic device under the following circumstances:

- Repair is covered only when anatomical change or reasonable wear and tear renders the item nonfunctional and the repair will make the equipment usable.
- Replacement is covered only when anatomical change or reasonable wear and tear renders the item nonfunctional and nonrepairable.

CIGNA does not cover repair or replacement if the item becomes unusable or nonfunctioning because of member misuse, abuse or neglect.

General Background

A brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part. It must be a rigid or semi-rigid device, used for the purpose of supporting a weak or deformed body member, or of restricting or eliminating motion in a diseased or injured part of the body. It must provide support and counterforce on the limb on which it is being used. Knee braces can be constructed from a variety of materials, such as foam, metal, plastic, elastic material or straps, and includes three basic components: a superstructure (i.e., rigid shell), a hinge, and a strap system.

The major functions of knee brace designs are to resist abnormal joint motions, to augment the inherent mechanical stability of a normal knee, and to assist in restoration of normal mechanical stability in an injured or rehabilitating knee (France and Paulos, 1994). Tibiofemoral knee braces are recommended for treatment of knee instability due to injury (e.g., fracture) or surgery, for treatment of painful osteoarthritis of the knee, or when required to perform activities of daily living. Knee braces may also be indicated for prevention of further injury due to previous knee instability; however, knee braces are not considered medically necessary when used for participation in sports or recreational activities or in the absence of disease. Participation in sports and recreational activities are considered elective activities.

Knee braces may be either custom fabricated or prefabricated (i.e., “off the shelf"). Custom-fabricated braces (HCPCS codes L1834, L1840, L1844, L1846, and L1855-L1880) are those that require precise measurements or molds/casting (i.e., custom-molded) of the patient’s knee and may only be used by the individual patient. Prefabricated braces (HCPCS codes L1810 - L1832, L1836, L1843, L1845, L1847, and L1850) may be purchased off the shelf in stores. Patients may be fitted for prefabricated (custom-fitted) braces, and require adjustments by an orthotist; however, selection is restricted by the limited availability of popular sizes (e.g., small, medium, large). Evidence in the published scientific literature does not indicate that custom-fabricated knee braces are more effective than prefabricated or custom-fitted braces. Custom-fabricated knee braces are only medically necessary when a prefabricated brace cannot be used as a result of abnormal limb structure or knee deformity, or for an extreme deviation from average sizes.

Descriptive terminology and codes for lower limb orthotic devices fall under the guidelines of the Health Care Procedure Coding System (HCPCS). Knee braces are often described according to their intended use (e.g., immobilizer, derotational, varus-valgus adjustment); however, some braces are described based on the composition of the brace (e.g., elastic type material, molded plastic). Consequently, the use and interpretation of the device based on HCPCS coding may vary. Therefore, the proposed application of the requested knee brace/orthotic device, rather than the name of the brace or assigned HCPCS code, needs to be determined in order to establish medical necessity.

Certain additional features/attachments to a knee brace may be considered medically necessary if they are required to provide additional functional improvement to the individual. However, some additions are considered an integral component of the brace and as such are generally not separately reported. Removable and nonremovable interfaces (surface of the device in contact with the individual’s skin) are typically included with the initial device; however removable interfaces may need replacement with continued use. Braces requiring high-strength, lightweight material (HCPCS code L2755) may be recommended for patients who meet the requirements for a knee brace and who either work in an environment requiring a brace designed for high-impact/high-stress activities, or for patients who weigh more than 250 lbs. In some cases a brace may be considered an integral part of the treatment plan for fractures or surgery.

U.S Food and Drug Administration (FDA): According to the FDA, a limb orthosis (brace) is a device intended for medical purposes that is worn on the upper or lower extremities to support, to correct, or to prevent deformities, or to align body structures for functional improvement. Limb orthoses are regulated by the FDA as Class I devices and are exempt from premarket notification procedures.

Types of Knee Braces
There are four basic kinds of knee braces referenced in the published literature:

- prophylactic braces, which are designed to prevent or reduce the severity of knee injury
- functional braces, which are designed to (a) provide stability for the anterior-cruciate ligament (ACL) or other ligament deficiency of the knee and (b) provide protection for the ACL or other ligaments after repairs or reconstructions
- rehabilitative braces, which are designed to allow protected motion of injured knees or knees that have been treated operatively
- unloader/offloader braces, which are designed to provide pain relief in arthritic knees

Prophylactic Knee Braces: The objective of using a prophylactic knee brace is to prevent or reduce the severity of injury to a healthy knee. The prophylactic knee brace is generally indicated for protection of the

medial-collateral ligament (MCL) against valgus knee stresses and ACL protection from rotational stress in similar situations. They are often used by patients who are at high risk for MCL injury (e.g., football players) and typically include neoprene sleeves or wraps. This type of brace may consist of unilateral or bilateral bars, hinges, and adhesive straps. Data are inconsistent and evidence in the published medical literature indicates that the effectiveness of prophylactic knee braces is questionable (Pietrosimone, et al., 2009; Rishiraj, et al., 2009). Some authors report reduction of frequency and severity of MCL injury, while others report increase in injuries due to excessive preloading. is insufficient evidence to provide strong conclusions that use of prophylactic knee braces significantly reduces knee injuries (AAOS, 2003; AAP, 2001). Models of prophylactic knee devices include, but are not limited to the following:

- DonJoy Protective Knee Guard (dj Orthopedics, Inc., Vista, CA)
- McDavid Protective Knee Guard (McDavid Sports Medical Products, Woodridge, IL).

Functional Knee Braces: Functional knee braces, also referred to as derotational braces (e.g., HCPCS code L1840), provide stability to an unstable knee when rotational and anterior-posterior forces are applied to the ligaments. Their main function is to reduce risk of injuries without significantly impairing function (AAP, 2003) and can either be purchased off the shelf or custom fabricated. The brace is designed to be worn during activities and to allow protected motion, as well as to prevent excessive loading.

The published, peer-reviewed scientific literature reveals few clinical studies to support improvement in subjective responses with use of the functional brace, such as increased stability, decreased pain, improved performance or increased patient confidence. In addition, authors report that lower extremity muscle strengthening, flexibility, and improvement and refinement of athletic techniques are more important than functional bracing when treating ligamentous knee injuries (Paluska and McKeag, 2000; Risberg, et al., 1999). Functional knee braces are typically used by athletes with ACL injuries although functional braces used for participation in sports are not considered medically necessary. In some cases they may be used as a supplement to reconstructive surgery or as part of a rehabilitation program to prevent strain to ACL grafts. The effectiveness of and the need for bracing post-ACL reconstruction is debated however. The literature does not support prophylactic functional knee brace use to prevent reinjury after graft maturation following a successful ACL reconstruction (DeLee, 2003). In a prospective, randomized multicenter clinical trial conducted by McDevitt and associates (2004), the authors acknowledged that postoperative functional bracing did not change the clinical outcome after ACL reconstruction. Risberg et al. (1999) conducted a prospective, randomized clinical trial evaluating the effects of bracing after ACL reconstruction and reported similar findings; this group of authors found no statistically significant differences regarding knee joint laxity, range of motion, muscle strength, functional knee test or pain in the subjects who wore braces compared to subjects who did not. Due to the inconsistent findings reported in the literature, further studies are needed to demonstrate that the use of functional knee braces for this purpose results in improved patient outcomes. Nonetheless, there is some evidence in the published scientific literature to indicate that functional braces are beneficial when the patient has demonstrated knee instability and is not a candidate for ACL reconstruction. Swirtun et al. (2005) evaluated the effect of functional knee bracing on non-operated acute ACL-deficient patients and reported improved stability in subjects who used the brace compared to those who did not.

Models of functional knee braces include, but are not limited to the following:

- DonJoy Defiance CI (dj Orthopedics, Inc., Vista, CA)
- DonJoy Legend Ligament Knee Brace (dj Orthopedics, Inc., Vista, CA)
- Townsend Rebel (Townsend Design, Bakersfield, CA)
- Ultimate Dynamic (Bledsoe Brace Systems, Grande Prairie, TX).

Rehabilitative Knee Braces: Rehabilitative knee braces (e.g., HCPCS codes L1832, L1844) are intended to control the knee flexion-extension angle during the initial healing period after cruciate ligament or meniscal fracture management or reconstructive surgery. Rehabilitative braces are typically used short term for the early postoperative period to protect the fracture site or surgical repair while range-of-motion, weight-bearing and muscle activity are initiated. This type of brace generally consists of foam liners, rigid bars with hinges, and nonelastic straps that hold the brace in place, and they are frequently purchased off the shelf. They are designed to allow controlled joint motion and are commonly used for 6–12 weeks post-acute injury or surgery. They allow adjustment for swelling and are easy to remove for examinations and, therefore, may be preferred

over splinting or casting postoperatively. They are preferred over full knee immobilization because they allow motion and loading and have been shown to decrease muscle atrophy, maintain cartilage health, and decrease the chance of knee stiffness (France and Paulos, 1994). There is little published evidence and data supporting the use of rehabilitative braces, although they appear to be well accepted clinically and avoid the risks to the knee associated with cast immobilization. Rehabilitative knee braces include, but are not limited to the following:

- DonJoy IROM (dj Orthopedics, Inc., Vista, CA)
- Bledsoe Post Operative Knee Brace (Bledsoe Brace Systems, Grande Prairie, TX)
- ROM (Townsend Design, Bakersfield, CA)

Unloading/ Offloading Knee Braces: Unloading braces are recommended for the treatment of pain and disability that may result from moderate to severe osteoarthritis of the knee. Grading of osteoarthritis is often determined by the Kellgren-Lawrence scale which describes the severity of articular cartilage changes associated with osteoarthritis. The scale emphasizes patellofemoral joint space narrowing and the presence of osteophytes as determined by radiographs. Grade 3 or 4 on the grading scale is considered moderate to severe osteoarthritis:

Grade 0 No osteophytes
Grade 1 Doubtful osteophytes
Grade 2 Minimal osteophytes, possible narrowing, cysts and sclerosis
Grade 3 Moderate or definite osteophytes with moderate joint space narrowing
Grade 4 Severe with large osteophytes and definite joint space narrowing

Osteoarthritis of the knee is associated with an overload of a focal area of cartilage. This focal overload leads to failure of the load-bearing capacity of the affected cartilage and subchondral bone. Unloading /offloading knee braces externally apply a three-point bending force, with one force applied at the center of the knee and two opposing forces proximal and distal to the knee joint, to reduce joint reactive forces in the involved compartment (Cole and Harner, 1999).

Unicompartmental osteoarthritis of the knee is defined as a condition characterized by degenerative articular cartilage in the medial or lateral aspect of the tibiofemoral joint, which may be associated with meniscal disruption, ligamentous instability and malalignment (Iorio and Healy, 2003). Nonoperative treatment for unicompartmental degenerative arthritis of the knee generally involves the reduction of pain through modalities such as oral and injectable medications, weight loss, exercise, physical therapy, canes, crutches, braces, and orthoses. Forces applied through bracing can shift pressure from the degenerative compartment to the less worn compartment. Bracing may also improve proprioception in unstable knees. In most cases, unicompartmental osteoarthritis and varus and valgus deformities can be treated by unloading braces, although joint disease that is present in both medial and lateral compartments and patellofemoral joint disease has not been successfully treated with braces (Pruitt, 2005).

Angular deformities of the joint can also lead to focal overload and predisposition to osteoarthritis. Varus deformities cause overload to the medial compartment, while valgus deformities cause overload to the lateral compartment. Knee braces with varus or valgus adjustments (e.g., HCPCS code L1843, L1844, L1845) may be medically necessary for patients who are ambulatory and require bracing to alleviate pressure on the medial or lateral compartment of the knee.

Evidence in the published, peer-reviewed scientific literature evaluating the use of knee bracing for osteoarthritis consists of case series, few randomized controlled trials (RCT), comparative trials and systematic reviews (Matsuno, et al., 1997; Kirkley, et al., 1999; Richards, et al., 2005; Brouwer, et al., 2007; Richmond, et al., 2009; Rannou, et al., 2010). In general, the reported outcomes support some effectiveness and demonstrate reduction in pain, improved functionality, and reduced loading to the damaged compartment. Richmond et al. (2009) published a clinical practice guideline for nonarthroplasty treatment of OA of the knee, approved by the AAOS, and reported that the authors were unable to make a recommendation for or against the use of a brace with varus-directing force for patients with medical unicompartmental OA of the knee. The evidence reviewed by the authors consisted of one systematic review and two RCTs, one of which did not have sufficient data for analysis. The systematic review, which included a review of the other RCT, concluded there was limited evidence supporting effectiveness of the device.

Types of unloading braces include, but are not limited to the following:

- GII Unloader® (Ossur North America, Aliso Viejo, CA)
- Townsend Premier Reliever (Townsend Design, Bakersfield, CA)
- DonJoy OAAdjuster (dj Orthopedics, Inc., Vista, CA)

Fracture brace: Another less commonly utilized knee brace is a fracture brace (e.g., HCPCS code L1832). This type of brace has been employed for the treatment of tibial-femoral fractures and may be custom-made or prefabricated. It is a functional brace that is applied after initial stabilization. It allows protected weightbearing and motion of the joints above and below the fracture. Published literature indicates this brace promotes early joint movement, prevention of contractures, and early weightbearing, which results in earlier healing. The DonJoy IROM Knee Brace (dj Orthopedics, Inc., Vista, CA) is a type of fracture knee brace that may be used for tibial plateau fractures or patella fractures.

Patellofemoral knee brace: Knee sleeves, also known as patellofemoral knee braces (e.g., HCPCS code L1810), are elastic sleeves used to provide a feeling of support to the knee. These devices are intended to resist lateral displacement of the patella and thereby decrease knee pain. Plain knee sleeves may be used to treat postoperative knee effusions and patellofemoral pain syndrome, although clinical efficacy is not well established. The sleeve may be modified to include an opening for the patella, movable straps or a buttress (e.g., felt, inflatable air pocket) and to function as a counterforce brace for the treatment of joint disorders, such as dislocation, patellar subluxation, or patellar hypermobility.

The clinical effectiveness of knee bracing is considered controversial for the treatment of patellofemoral pain syndrome (France and Paulos, 1994; Paluska and McKeag, 2000; LaBella, 2004; Lun, te al., 2005; Chew, et al., 2007). Dixit et al. (2007) reported knee braces were unlikely to produce better outcomes compared to physical therapy. France and Paulos (1994) considered the device ineffective for the treatment of patellofemoral pain. In some studies decreased pain and improved function has been reported with use of these braces however, rehabilitative treatments have been provided at the same time. In addition, most reported patient outcomes are subjective reports of pain relief.

Types of patellofemoral knee braces include, but are not limited to, the following devices:

- Bledsoe Sport Max (Bledsoe Brace Systems, Grande Prairie, TX)
- DonJoy On-Track (dj Orthopedics, Inc., Vista, CA)
- Lateral knee stabilizer with “J” shaped buttress (FLA Orthopedics®, Inc., Miramar, FL)
- Omni Scientific Sport sleeve (Omni Scientific Inc., Martinez CA)

Other Orthoses and Accessories
Orthoses and accessories that are used for participation in sports, to improve athletic performance, that are used to prevent injury in an otherwise uninjured body part, and that are used in conjunction with the device (e.g., socks, brace sleeves) are considered not medically necessary.

Heavy duty knee joints may be medically necessary for patients who weigh more than 300 pounds.

Professional Societies/Organizations
The American Academy of Orthopaedic Surgeons (AAOS) published the following position statements regarding the use of knee braces in 2003:

- The AAOS believes that prophylactic knee braces may provide limited protection against injuries to the medial collateral ligament in football players. Scientific studies have not consistently demonstrated similar protection by prophylactic braces to other knee ligaments, menisci, or articular cartilage.
- The AAOS believes that there is insufficient scientific evidence to recommend the use of prophylactic knee braces in all football players.
- The AAOS believes that after ACL reconstruction, there may be a role for rehabilitation braces used in the early post-surgical phase, but functional braces used later during recovery appear to provide no added protection to the knee following a well-performed reconstruction.

- The AAOS believes that, whereas functional knee braces offer limited control of functional instability symptoms in patients with anterior cruciate ligament deficient knees, they have not been shown to prevent the development of meniscal tears and articular cartilage wear.
- The AAOS believes that some unloader braces may provide significant reduction in pain when properly fitted in selected patients with osteoarthritis of the knee.

The American Academy of Pediatrics (AAP) (2001) published a technical report on the use of knee braces in young athletes and concluded, "There is insufficient evidence to recommend the use of prophylactic knee braces for the pediatric athlete, and available studies do not support the prescribing of most knee braces. However, the use of knee sleeves, functional braces, and postoperative braces have been accepted clinically on the basis of subjective performance. If used, knee braces should complement, rather than replace, rehabilitative therapy and required surgery."

Summary
Knee braces are considered useful in the treatment of knee injuries and disease. On the basis of current clinical knowledge, the use of rehabilitative knee braces and unloading braces has been well accepted. Prophylactic knee braces are most often recommended for participation in sports or recreational activities and are not considered medically necessary. Fracture braces are recommended in some cases and are likely to encourage osteogenesis. Functional knee braces have not been shown to improve long-term patient outcomes and are not considered medically necessary. Patellofemoral braces have been recommended for a select group of patients. Typically, prefabricated orthoses are used in treating conditions prior to the use of a custom-fitted orthosis, and custom-fitted orthoses are generally attempted prior to the use of custom-fabricated orthoses when clinically appropriate.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary:

HCPCS Codes	Description
L1810	KO, elastic with joints, prefabricated, includes fitting and adjustment
L1820	KO, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment
L1830	KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment
L1831	Knee orthosis, locking knee joint(s), positional orthosis, prefabricated, includes fitting and adjustment
L1832	KO, adjustable knee joints, positional orthosis, rigid support, prefabricated, includes fitting and adjustment
L1834	KO, without knee joint, rigid, custom fabricated
L1836	Knee orthosis, rigid, without joint(s), includes soft interface material, prefabricated, includes fitting and adjustment
L1840	KO, derotation, medial-lateral, anterior cruciate ligament, custom fabricated
L1843	Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint, 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, medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated
L1845	KO, double upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, prefabricated, includes fitting and adjustment
L1846	KO, double upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, custom fabricated
L1847	KO, double upright with adjustable joint, with inflatable air support chamber(s),

	prefabricated, includes fitting and adjustment
L1850	KO, Swedish type, prefabricated, includes fitting and adjustment
L1860	KO, modification of supracondylar prosthetic socket, custom fabricated (SK)

ICD-9-CM Diagnosis Codes	**Description**
715.16	Primary localized osteoarthrosis, lower leg
715.26	Secondary localized osteoarthrosis, lower leg
715.36	Localized osteoarthrosis not specified whether primary or secondary, lower leg
717.0 - 717.9	Internal derangement of knee
718.86	Other joint derangement, not elsewhere classified, lower leg
727.66	Nontraumatic rupture of patellar tendon
736.5	Genu recurvatum (acquired)
822.0	Closed fracture of patella
822.1	Open fracture of patella
836.0 - 836.69	Dislocation of knee
844.0 – 844.9	Sprains and strains of knee and leg
V58.78	Aftercare following surgery of the musculoskeletal system, NEC
	Multiple / varied

Not covered/Not medically necessary:

HCPCS Codes	**Description**
K0672†	Addition to lower extremity orthosis, removable soft interface, all components, replacement only, each
L2820†	Soft interface for molded plastic, below knee section
L2830†	Soft interface for molded plastic, above knee section
L2840	Addition to lower extremity orthosis, tibial length sock, fracture or equal, each
L2850	Addition to lower extremity orthosis, femoral length sock, fracture or equal, each
L2397	Addition to lower extremity orthosis, suspension sleeve

†**Note: Not covered/not medically necessary when billed in addition to the initial dispensing of the device.**

***Current Procedural Terminology (CPT®) ©2010 American Medical Association: Chicago, IL.**

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Policy History

Pre-Merger Organizations	Last Review Date	Policy Number	Title
CIGNA HealthCare	5/15/2008	0362	Knee Braces

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