Insurance Guideline Summary

Foot/Ankle:

Soft Goods- Ankle lace-up, Velocity, PTTD $83.00

- Patient is ambulatory
- Had an injury, surgery, or chronic instability (will not be covered for osteoarthritis unless you document instability
- Has the potential to benefit functionally

Rigid Goods- Cam Walker$146.00, Pneumatic Walker $272.00

- Patient is ambulatory
- Has weakness and/or instability or fracture
- Has the potential to benefit functionally
- Must not follow a walking cast, but can follow a non-weight bearing cast
- Cannot be used for pain alone

Specialty Rigid Products- meet above requirements along with specialty diagnosis $272.00

Conformer- use with diabetic patients that have a fracture or joint instability
Charcot Conformer- Diabetics with Charcot

Night Splint- Plantar fasciitis only - no other diagnosis or medical condition $155.00

Knee Products:

Soft Goods- Economy hinge 87.00 , Reaction 87.00 , PTO 135, Lateral Stabilizer 135, FreeRunner $135.00

- Patient is ambulatory
- Weakness or deformity of the knee on examination
- Requires stabilization
- Has the potential to benefit functionally

Hinged or rigid- knee immobilizer $82.00, T-scope $624, Recover $624, Roadrunner $624, Shortrunner $624, OA Braces- Freestyle $826 Fusion $858 and ACL braces $858- see Rehab vs Functional- must meet guidelines in red but also fall under one of those categories

- Patient is ambulatory
- Knee instability due to diagnosis below (MUST DOCUMENT INSTABILITY ON EXAM!)
- Knee instability must be documented on exam with objective description of joint laxity
- Recent (within 6 weeks prior to brace being applied) surgical intervention or injury

Approved Diagnosis (must meet above requirements also)

- Rheumatoid Arthritis
- Primary osteoarthritis
- Post-traumatic arthritis
- Patellofemoral disorders
- Chondromalacia patella
- Derangement of Meniscus
- Chronic instability
- Instability due to an injury
- Disruptions of knee ligaments
- Strains of tendons in region on knee
- Failed TKR associated with instability
- Fractures (osteoporosis, stress, pathological & traumatic) Must be provided at the initial encounter- non-covered if at subsequent visit
- Non-union or mal-union
- Osteonecrosis

Rehab vs Functional Braces-

Rehab brace (Knee immobilizer or T-scope) - used as an alternative to knee immobilizer immediately after surgery or an injury to control knee motion and protect the knee during rehab.

Functional knee braces (ACL/OA) are medically necessary if they are needed for activities of daily living, such as standing, walking and climbing stairs and all other requirements are met (instability). They are not medically necessary when used for sports, because participating in sports is considered an elective activity. They are medically necessary with a diagnosis of anterior cruciate ligament insufficiency when a non-operative approach is used.

Cigna: The patient must have documented instability and not be a surgical candidate for a functional knee brace (ACL)

Unloader Brace

An unloader brace is medically necessary with severe symptomatic **osteoarthritis** of the knee that has failed to respond to medical therapy and knee bracing with a neoprene sleeve and they have progressive limitations in activities of daily living. You have to document varus/valgus laxity on exam. CBC use only for medial compartment DJD.

Aetna states that an unloader brace is medically necessary with severe symptomatic osteoarthritis of the knee that has failed to respond to medical therapy and knee bracing with a neoprene sleeve and they have progressive limitations in activities of daily living.

Aetna & CBC OA Braces are covered for Medial compartment only (not lateral)

Post-operative Hip Braces: $1013.00

Hip braces are only covered for the following hip related diagnosis. They are not covered for spine surgeries

- Partial hip hemiarthroplasty
- Total hip arthroplasty
- Conversion of previous hip surgery to total hip arthroplasty
- Osteotomy and transfer of greater trochanter of femur
- Arthroscopy with removal of loose body or foreign body; debridement with synovectomy
- Arthroscopy with femoroplasty
- Arthroscopy with acetabuloplasty
- Arthroscopy with labral repair

Spine:

Lumbar & Thoracic- Horizon 627 $379, Horizon 631 $945, Horizon 637 $989, Horizon 456 $916, Vista TLSO $1369

Documentation must state:

- To reduce pain by restricting mobility of the trunk, regardless of the cause
- To facilitate healing of a fracture

Cervical- Miami J $243, Aspen CTO $456 & Soft cervical collar $40(may or may not be covered depending on insurance)

- Medically necessary with injury or cervical disease, including Stenosis, degenerative disc disease, herniated disc, spondyloysis, etc.

Upper Extremity:

Shoulder Immobilizer $89, Clavicle $59, Humeral Cuff $277, T-scope elbow $419, Carpal tunnel $59, thumb spica $100

- Considered medically necessary for fractures, sprains, strains, weakness, instability, or diagnosis commonly treated with splints or splint-like devices

Canes $40, Crutches $52 and Walkers $114:

- Diagnosis and documentation must indicate that ambulation is impared.

- The patient has a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living **in the home**; **and**
- The patient is able to safely use the mobility device; **and**
- The functional mobility deficit can be sufficiently resolved with the use of the mobility device

Mobility Related Activities of Daily living are:

Toileting, feeding, dressing, grooming, and bathing performed in customary locations in the home

Products for post-operative use:

For HIGHMARK, MEDICARE INPATIENT, AND AETNA SPINE are considered part of the surgical procedure and are non-billable to the insurance . All products must meet the medical necessity at the time they are be provided and the patients need to be instructed to use the product at that time.

FOR ALL OTHER INSURERS AND FOR MEDICARE OUTPATIENT PROCEDURES, the braces are billable for post surgery use if you document the date that the brace will be used.

Products provided for fracture care

Must be provided at the initial visit and not at a follow-up visit when routine healing is present. For example if you see Sally Jones on Monday and diagnosis her with a lateral malleolus fracture but you send her for an MRI on Tuesday to confirm the diagnosis. The DME must be provided on Monday because when she returns it would be considered a subsequent encounter and the products are not covered as the diagnosis was already established.

Documentation Requirements for TENS units and for E-Stim Units

TENS:

- Indications: Chronic intractable pain (not LBP, adhesive capsulitis, neuropathic pain or hip fracture pain)
    - Lasting 3 months or longer
    - Did not respond to NSAIDs, ice, rest, and/or PT
- Must have a TENS Trial (Prescription "TENS trial, use daily, disp 30 supply")
    - At least one month, less than 2 months
    - Must have a follow up visit after one month
        - At that visit, must document:
            - How often used (usually daily)
            - How long used (at least an hour)
            - The results of treatment (if positive, will approve)
- (Of note, for those who can remember**, Medicare and Aetna will pay for acute post op pain in the first 30 days).**

Electrical/Muscle Stim Units

- Indications: Disuse atrophy (Note must include description of muscle atrophy and the diagnosis must include it also) after:
    - Immobilization of a limb
    - Major knee surgery not responding to PT
- Prescription:
    - "E-Stim use daily, dispense 30 days supply"

IF YOU SEE A PATIENT BACK IN FOLLOWUP FOR ANY REASON, PLEASE DOCUMENT HOW OFTEN THEY ARE USING THE DEVICE AND THE RESULTS. IT MAKES IT EASIER TO RENEW THE SUPPLY RE-ORDER.

BONE STIM

- Appendicular Skeleton:
    - Must be at least 3 months from fracture or surgery
    - Serial radiographs must confirm no progression of healing for those 3 months
- Spine
    - Patient must be at high risk for failed fusion: Multi-level fusion, Grade III or more spondy, current smoker, diabetes, alcoholic, steroid use or renal disease
    - Failed spinal fusion at least 6 months post op with no evidence of progression of the fusion radiographically over 3 months