Common ICD-9 Codes
Not a comprehensive or guaranteed list for insurance coverage. Pre-certification will be required.

Covered for a patient who is ambulatory and has knee instability due to a condition specified by any of the following diagnoses:

- **714.0 – 714.4** Rheumatoid arthritis
- **715.16, 715.26, 715.36, 715.96** Osteoarthritis
- **717.0 – 717.5** Meniscal cartilage derangement
- **717.7** Chondromalacia of patella
- **717.81 – 717.9** Knee ligamentous disruption
- **727.65** Rupture of tendon, nontraumatic – quadriceps tendon
- **733.15** Pathologic fracture of femur
- **733.16** Pathologic fracture of tibia or fibula
- **733.93** Stress fracture of tibia or fibula
- **755.64** Congenital deformity of knee
- **821.20 – 821.39** Fracture of femur – lower end
- **822.0, 822.1** Fracture of patella
- **823.00 – 823.42** Fracture of tibia and/or fibula – upper end
- **836.0 – 836.69** Dislocation of knee
- **996.4, 996.66, 996.77, V43.65** Failed total knee arthroplasty
- **340** Multiple sclerosis
- **342.90** Hemiplegia, unspecified
- **343.9** Infantile cerebral palsy, unspecified
- **344.1** Paraplegia of both lower limbs
- **355.0, 355.2** Mononeuritis of lower limb, unspecified

**OA Adjuster for active patients.**
**OA Everyday for non-active patients.**

- **720.0 – 724.9** Ankylosing spondylitis and other inflammatory spondylopathies
- **733.00 – 733.09** Osteoporosis
- **738.5** Other acquired deformity of back or spine
- **741.00 – 741.93** Spina bifida
- **742.51 – 742.9** Diastematomyelia
- **754.2** Lordosis, scoliosis
- **756.10 – 756.19** Congenital anomalies of spine
- **805.00 – 806.9** Fracture of vertebral column with or without spinal cord injury
- **839.00 – 839.59** Other multiple and ill-defined dislocations
- **846.0 – 847.9** Sprains and strains of sacroiliac region
- **952.00 – 953.9** Injury to spinal cord without evidence of spinal bone injury; injury to nerve roots and spinal plexus
- **V54.17** Aftercare for healing traumatic fracture of vertebrae
- **V54.27** Aftercare for healing pathologic fracture of vertebrae
Common ICD-9 Codes
Not a comprehensive or guaranteed list for insurance coverage. Pre-certification will be required.

721.0 – 724.9  Ankylosing spondylitis and other inflammatory spondylopathies
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DonJoy Back with ChairBack
L0637

DonJoy Back
L0627
Common ICD-9 Codes
Not a comprehensive or guaranteed list for insurance coverage. Pre-certification will be required.

726.71  Achilles bursitis or tendonitis
727.06  Tenosynovitis, foot/ankle
719.4   Pain, joint
924.20  Foot contusion
928.20, 928.21  Crushing injury foot, ankle
824.0   Fracture malleolus, medial closed
824.2   Fracture malleolus, lateral closed
824.4   Fracture bimalleolar, closed
824.6   Fracture trimalleolar, closed
825.0   Fracture calcaneus closed
825.25  Fracture metatarsal bone(s) closed
825.21  Fracture talus (astragalus) closed
823.20  Fracture shaft, fibula closed
823.40  Fracture shaft, fibula with tibia closed
823.20  Fracture shaft, tibia closed
823.32  Fracture shaft, fibula with tibia, open
823.30  Fracture shaft, tibia, open
823.35  Fracture metatarsal, open
733.93  Fracture, stress, tibia/fibula
733.94  Fracture, stress, metatarsal
845.01 – 845.10  Ankle sprain, foot sprain
845.09  Achilles tendon sprain
845.03  Sprain distal tibiofibular ligament

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845.01 – 845.10  Ankle sprain, foot sprain
ICD-9 Codes used for Walker Boots
Common ICD-9 Codes
Not a comprehensive or guaranteed list for insurance coverage. Pre-certification will be required.

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### Common ICD-9 Codes

Not a comprehensive or guaranteed list for insurance coverage. Pre-certification will be required.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>718.12</td>
<td>Loose body upper arm</td>
</tr>
<tr>
<td>718.32</td>
<td>Recurrent dislocation of joint/upper arm, elbow joint</td>
</tr>
<tr>
<td>718.4</td>
<td>Joint contracture – upper arm</td>
</tr>
<tr>
<td>719.02</td>
<td>Joint effusion upper arm</td>
</tr>
<tr>
<td>719.43</td>
<td>Joint pain – forearm</td>
</tr>
<tr>
<td>726.31</td>
<td>Medial epicondylitis</td>
</tr>
<tr>
<td>762.32</td>
<td>Lateral epicondylitis</td>
</tr>
<tr>
<td>832.01</td>
<td>Dislocation of elbow; open/closed</td>
</tr>
<tr>
<td>841.1</td>
<td>Ulnar collateral ligament sprain</td>
</tr>
<tr>
<td>841.2</td>
<td>Sprain radiohumeral ligament</td>
</tr>
<tr>
<td>841.9</td>
<td>Sprain elbow/forearm</td>
</tr>
</tbody>
</table>
SOFT GOODS BILLING SIMPLIFIED
More Information available at www.dmeinfo.com

Resources and Helpful Links
For Billing DME Claims to Medicare

(Disclaimer: This document is meant to be a reference only and is not intended to be a comprehensive guide to billing DMEPOS claims to Medicare. The DME Supplier is fully responsible for properly completing and submitting DME claims to Medicare and proper coding of products.)

Form CMS 855s Enrollment Form for Medicare Supplier Number (DMEPOS)

DMEPOS Fee Schedule
http://www.cms.hhs.gov/DMEPOSFeeSched/LSDMEPOSFEE/list.asp#TopOfPage

DME MAC Information
- **Jurisdiction A**: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont
  - 866-419-9458
  - http://www.medicarenhic.com
- **Jurisdiction B**: Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin
  - 866-590-6727
- **Jurisdiction C**: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia and West Virginia
  - 866-270-4909
- **Jurisdiction D**: Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Washington and Wyoming
  - 866-243-7272
  - http://www.noridianmedicare.com

PDAC (Pricing, Data Analysis and Coding)
- Information on HCPCS codes, Modifiers, Fee Schedules
  - https://www.dme pdac.com/

To Purchase a HCPCS Level II Coding Book
http://www.shopingenix.com/Category/100040/100089/

Medicare Claims Processing Manual Chapter 20 – DMEPOS
Tips for Billing Orthotics to Medicare

√ Bill DME claims electronically to Medicare using form CMS HCFA-1500 form.

√ Select the most appropriate HCPCS code for the product.¹

√ Medicare no longer provides reimbursement for most add-on codes applied to the base HCPCS code of orthotics.

√ Bill “12” for place of service
  o Indicates "Patient’s Home"

√ Bill the appropriate modifier ²²:
  o “NU” (New Equipment) → crutches, canes, walkers, pulley systems, arch supports, hip abduction pillows, arm elevator pillows
  o “GY” → non-covered items
  o “RRKH” → for E0218 products
  o Back braces, cervical collars and rib belts do NOT have a modifier
  o “RT/LT” (Right or Left) → for all other products, including non-covered items
  o “KX” → Required for knee and ankle-foot orthoses to affirm that medical necessity coverage criteria has been met and supporting documentation is on file

√ Include the Date of Injury (DOI)
  o For ICD-9 codes of 800.00 or higher

√ Bill DME claim using the appropriate ICD9 code for the injury or condition
  o *Note: Only the prescriber can determine the appropriate ICD9³

√ Maintain all supporting documentation to demonstrate medical necessity for the product
  o May include: chart notes, surgery notes, LMN/CMN, product description

√ Bill DME claims to the appropriate DME MAC for the patient
  o This address and carrier is different from the address to which you submit your medical claims.

√ Medicare’s “reasonable useful lifetime” for most products is typically 1-3 years. If the same HCPCS is billed before this period of time passed, coverage will likely be denied
  o *Note: See “Medicare Knee Orthoses Requirements” below for “reasonable useful lifetime” requirements for knee braces*

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¹ DJO provides possible coding suggestions based on publicly available information as a convenience to our customers. We do not make claims, promises or guarantees as to the availability of reimbursement for any DJO product. It is within the sole discretion of the customer to determine the appropriate billing code for a product, as well as, whether the use of a product complies with medical necessity and other documentation requirements of the payor. DJO accepts no responsibility whatsoever in this regard.

² Refer to Medicare Claims Processing Manual for full description of modifiers and their use.

³ The physician is fully responsible for proper determination of appropriate ICD-9 codes. For more information refer to your Medicare Claims Processing Manual
Tips for Billing Knee and Ankle-Foot Orthoses to Medicare

**Medicare Knee Orthoses Requirements**

- Medicare will **NOT** provide reimbursement for **MOST** add-on codes applied to the base HCPCS code for knee products.
- Application of and billing knee products to Medicare must follow strict coverage criteria specifying the medical necessity for the product.
- Claims for knee braces must include the “KX” modifier only if all supporting documentation is on file to demonstrate medical necessity for the product, followed by the “RT” or “LT” modifier.
- Supporting documentation may include chart notes, a Letter of Medical Necessity (LMN) or any other patient record that will demonstrate medical necessity for the product prescribed.
- Medicare has established a “reasonable useful lifetime” for knee braces. If the same HCPCS code is billed before this period of time has passed, coverage will likely be denied:
  - L1810, L1820, L1830 → 1 year
  - L1831, L1832, L1847, L1850 → 2 years
  - L1836, L1843, L1845, L1846 → 3 years

**Medicare Noncoverage of Elastic Garments**

- The Medicare determination of noncoverage for elastic garments can be found here: [https://www.noridianmedicare.com/cgi-bin/coranto/viewnews.cgi?%3fid=EkFkyuVEuAemyxFTMD&tmpl=dme_viewnews&style=part_ab_viewnews](https://www.noridianmedicare.com/cgi-bin/coranto/viewnews.cgi?%3fid=EkFkyuVEuAemyxFTMD&tmpl=dme_viewnews&style=part_ab_viewnews)
- CMS has determined that elastic garments do not meet the statutory definition of a brace because they are not rigid or semi-rigid devices.
- Effective for claims with dates of service on or after April 1, 2009, these items will be denied as noncovered, no benefit category.
- The following HCPCS codes are affected:

**Medicare Ankle-Foot Orthoses Requirements**

- The Medicare Ankle-Foot Orthoses Local Coverage Determination (LCD) and Article can be found here: [http://www.medicarenhic.com/dme/medical_review/mr_lcds/mr_lcd_current/L11527_2009-06-01_PA_2009-06.pdf](http://www.medicarenhic.com/dme/medical_review/mr_lcds/mr_lcd_current/L11527_2009-06-01_PA_2009-06.pdf)
- Claims for Ankle-Foot Orthoses must include the “KX” modifier only if all supporting documentation is on file to demonstrate medical necessity for the product, followed by the “RT” or “LT” modifier.
- The following HCPCS codes are affected:

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4 Refer to the Medicare Knee Orthoses LCD for a complete list of non-covered and covered add-on codes.
5 Refer to the Medicare Knee Orthoses LCD for a complete list of required ICD-9 diagnosis codes for each product.
6 Refer to the Medicare LCD for a complete list of affected HCPCS Codes.