Upper Limb Orthoses

**Medicare**

**ELBOW**
The following braces are covered with a detailed order and medical documentation explaining the patient’s condition requiring specific brace.

L3702-Elbow orthotic, without joints, may include soft interface
L3760-Elbow orthotic, with adjustable position locking joints, prefabricated
L3762-Elbow orthotic, rigid, without joints, may include soft interface

**Wrist/Hand/Finger**
The following braces are covered with a detailed order and medical documentation explaining the patient’s condition requiring specific brace.

L3906-Wrist-hand orthotic, without joints
L3908-Wrist-hand orthotic, wrist extension, control cock-up, non-molded
L3917-Hand orthotic, metacarpal fracture orthotic, pre-fabricated
L3923-Hand finger orthotic, without joints, elastic or not (must be plastic/metal)
L3927-Finger orthotic, without joint/spring, extension/flexion
L3929-Hand finger orthotic, includes nontorsion joints, turnbuckles, springs
L3931-Wrist-Hand-Finger orthotic, includes nontorsion joints, turnbuckles, springs
L3999-Uper limb orthoses, not otherwise specified.

**Medicaid**
Detailed order required prior to dispensing.
CMN must be completed prior to billing.
L3999-Uper limb orthoses, not otherwise specified requires a paper Prior Authorization.

**BCBS/Anthem Missouri Plans**
Detailed order required prior to dispensing.

**UHC**
Prior Authorization for any orthotic over $1,000.
Detailed order required prior to dispensing.

**CoxHealth**
Prior Authorization for all orthotics.
Detailed order required prior to dispensing.
RX

Patient__________________________________________________________

DOB ____/____/____

Phone__________________________________________________________

Physician Name (please print)________________________________________

Phone# ____________________________________________________________

Fax# ______________________________________________________________

Diagnosis

________________________________________________________________________

Specific Brace to be dispensed

________________________________________________________________________

RT________ LT________ Custom________

Quantity________

Special Instructions on use

________________________________________________________________________

Length of Need_______ (99-lifetime)

Physician Signature______________________________________________Date________