Orthoses for Scoliosis and Hyperkyphosis Clinical Coverage Criteria

Overview

Spinal orthoses are commonly used in the conservative management of scoliosis and hyperkyphosis in growing children and adolescents to help prevent progression of spinal deformity during periods of skeletal growth. Scoliosis is a three-dimensional spinal deformity that may be idiopathic, neuromuscular, or congenital in origin, while hyperkyphosis refers to excessive thoracic curvature and may result from congenital vertebral abnormalities, Scheuermann's disease, or other conditions. A spinal curve greater than 10 degrees measured by the Cobb method on radiographic imaging is considered scoliosis. Normal thoracic kyphosis typically ranges from 20 to 45 degrees, while curves greater than 45 to 50 degrees are generally considered hyperkyphosis.

Treatment goals for both conditions include slowing or preventing progression of the deformity, maintaining spinal alignment, reducing the likelihood of future surgery, preserving pulmonary function, minimizing pain, and improving posture and quality of life. Orthotic management may involve a thoracic-lumbar-sacral orthosis (TLSO), which is the most commonly prescribed brace type, or a cervical-thoracic-lumbar-sacral orthosis (CTLSO), such as a Milwaukee-type brace, which may be used when greater control of the upper thoracic spine is required. For scoliosis, bracing is generally recommended for skeletally immature patients with moderate curves at risk for progression, while for hyperkyphosis, bracing is primarily used in skeletally immature patients with congenital or Scheuermann-related deformities to reduce worsening of the thoracic curvature during growth. Successful treatment requires active participation by the patient and caregivers, regular clinical and radiographic monitoring, and coordination among the prescribing clinician, orthotist, therapist, and family.

Policy

This Policy applies to the following Fallon Health products:

☒ Fallon Medicare Plus
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
☒ Community Care

Some orthoses for scoliosis require prior authorization.

Fallon Health Clinical Coverage Criteria

Fallon Health Clinical Coverage Criteria for orthoses for scoliosis and kyphosis apply to all plan members.

Orthoses for Scoliosis

A rigid cervical-thoracic-lumbar-sacral (CTLSO) or thoracic-lumbar-sacral orthosis (TLSO) may be considered medically necessary for the treatment of scoliosis in members who meet the following criteria:

1. Diagnosis of:
   a. Infantile idiopathic scoliosis (< 4 years); or
   b. Juvenile idiopathic scoliosis (≥ 4 years < 10 years); or
   c. Adolescent idiopathic scoliosis (≥ 10 years); or
   d. Neuromuscular scoliosis; and
2. Spinal curve Cobb angle is ≥ 25 degrees and < 40, degrees confirmed by radiology; and
3. Member is skeletally immature with remaining growth potential (Risser stage is 0 to 2, corresponding to ≤ 50% ossification of the iliac apophysis), confirmed by radiology; and

4. Use of the orthosis is expected to prevent progression of, or slow progression of, the spinal deformity; and
5. The member and/or caregiver has been educated regarding the purpose, use, and expected duration of orthotic treatment and agrees to participate in the treatment plan.

Orthoses for Hyperkyphosis
A rigid cervical-thoracic-lumbar-sacral orthosis (CTLSO) or thoracic-lumbar-sacral orthosis (TLSO) may be considered medically necessary for the treatment of hyperkyphosis when all of the following criteria are met:
1. Diagnosis of:
   a. Congenital kyphosis; or
   b. Juvenile kyphosis (Scheuermann's Kyphosis); and
2. Thoracic kyphosis is greater than 45 degrees and less than 80 degrees, confirmed by radiographic imaging; and
3. Member is skeletally immature with remaining growth potential; and
4. There is no neurologic deficit secondary to the spinal deformity requiring immediate surgical intervention; and
5. For congenital kyphosis, the deformity is not rapidly increasing in severity and is not predicted to have a high risk of progression requiring immediate surgical management; and
6. Use of the orthosis is expected to prevent progression of, or slow progression of, the spinal deformity; and
7. The member and/or caregiver has been educated regarding the purpose, use, and expected duration of orthotic treatment and agrees to participate in the treatment plan.

Replacement of a previously authorized CTLSO or TLSO for scoliosis or hyperkyphosis may be considered medically necessary when all of the following criteria are met:
1. One of the following applies:
   a. The orthosis is lost, irreparably damaged, or has sustained wear that cannot be repaired; or
   b. A significant change in the member's condition (e.g., growth, weight change, progression of deformity, or other physical change) has resulted in poor fit, inadequate function, or inability to achieve treatment goals; or
   c. The orthosis has reached the end of its reasonable useful lifetime and remains medically necessary; and
2. Documentation supports the continued medical necessity of orthotic treatment; and
3. The orthosis continues to be prescribed for management of the same spinal deformity; and
4. The replacement orthosis is of the same type or serves the same therapeutic purpose as the previously prescribed orthosis, unless a change in the member's condition necessitates a different orthotic design; and
5. The member and/or caregiver remains willing and able to participate in the treatment plan.

For skeletally immature members, replacement may be considered medically necessary when growth has resulted in an inadequate fit and the existing orthosis can no longer provide appropriate correction or control of the spinal deformity.

Medicare Variation

Medicare statutes and regulations do not have coverage criteria for orthoses for scoliosis. Medicare does not have an NCD for orthoses for scoliosis. Noridian Healthcare Solutions, LLC, the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) with jurisdiction in the Plan's service area does not have an LCD for orthoses for scoliosis (Medicare Coverage Database search 08/01/2026). When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

MassHealth Variation

MassHealth does not have Guidelines for Medical Necessity Determination orthoses for scoliosis (MassHealth website search 08/01/2026).

In accordance with MassHealth regulations at 130 CMR 442.413: *Medical Necessity*, for items covered by MassHealth, for which there is no MassHealth item-specific medical necessity guideline and for which there is a Medicare Local Coverage Determination (LCD) indicating Medicare coverage of the item under at least some circumstances, the provider must demonstrate medical necessity of the item consistent with the Medicare LCD.

Fallon Health Clinical Coverage Criteria will apply in the absence of an applicable Medicare LCD. If the provider believes that an orthosis described by one of these codes is medically necessary for the member, even though the request does not meet Fallon Health Clinical Coverage Criteria, the provider must submit documentation demonstrating medical necessity in accordance with 130 CMR 450.204: *Medical Necessity*, and 130 CMR 442.413.

Exclusions

- Orthoses for scoliosis and hyperkyphosis are considered not medically necessary when the medical necessity criteria specified in this policy are not met, or the requested use is for indications not supported by the available evidence.

Summary of Evidence

Scoliosis

Scoliosis is a general term comprising a heterogeneous group of conditions consisting in changes in the shape and position of the spine, thorax and trunk. The prevalence of scoliosis in the general population is around 2%–3%, with approximately 20% of cases being secondary to an underlying neuromuscular, congenital, syndromic, or other structural condition. The remaining 80% are cases of idiopathic scoliosis. Idiopathic scoliosis has no identifiable congenital, neuromuscular, or syndromic etiology.

Idiopathic scoliosis may develop at any time during childhood and adolescence. It most commonly appears in periods of growth spurt. The rate of development of spinal curvature changes the most rapidly at the beginning of puberty. Idiopathic scoliosis is further subcategorized based on the age of the disease manifestation: infantile (first 3 years of life), juvenile (4–10 years old), and adolescent (10–18 years old). The latter is the predominant form of scoliosis in the pediatric population.

Adolescent idiopathic scoliosis with a Cobb angle above 10° occurs in the general population in a wide range of prevalence from 0.93 to 12%.

The angle of scoliosis measured on the standing frontal radiograph according to the Cobb method is one of the decisive factors in managing idiopathic scoliosis, and it is directly correlated to all treatment decisions.

- Under 10° of scoliosis, the diagnosis of scoliosis should not be made.
- Over 30° of scoliosis, the risk of progression in adulthood increases, as well as the risk of health problems and reduction of quality of life.
- Over 50°, there is a consensus that it is almost certain that scoliosis is going to progress in adulthood and cause health problems and reduction of quality of life

From these thresholds and taking into account that the recognized measurement error in measuring Cobb angles is 5°, very important decisions are made (Negrini et al., 2018).

The Risser sign constitutes a further parameter for radiographic evaluation and is useful in indicating the patient's growth status, since Risser grading can be done using the same radiographic film as to evaluate the scoliosis. Risser observed that growth of the spine cannot be measured directly on routine radiographs because the spinal growth plates are difficult to visualize. He found that ossification of the iliac crest apophysis occurs at approximately the same time as maturation of the vertebral growth plates. As a result, the degree of iliac apophysis ossification can serve as an indirect indicator of remaining spinal growth and the likelihood of future scoliosis progression. In North America the Risser Grade divides the ossification of the iliac wing into quarters with complete apophysis fusion to the iliac wing occurring at Risser Grade 5.

The grading is as follows

- Grade 0: No ossification of the iliac apophysis (indicates early skeletal growth).
- Grade 1: Ossification begins, covering 0-25% of the iliac crest.
- Grade 2: Ossification progresses to 26-50% of the crest.
- Grade 3: Ossification extends to 51-75% of the crest.
- Grade 4: Ossification completes (76-100%), but the growth plate has not yet fused.
- Grade 5: The iliac apophysis is fully fused with the ilium, indicating the end of skeletal growth

The Risser sign is most commonly used in the management of adolescent idiopathic scoliosis. The risk of scoliosis progression is highest during rapid skeletal growth. A lower Risser Grade (0–2) indicates ongoing growth and a higher likelihood of curve progression, whereas a higher Risser Grade (3-5) signals reduced growth potential and less risk of progression.

Over time, several classification systems have been developed for idiopathic scoliosis. One of the most widely recognized is the James classification, which categorizes scoliosis according to the age at diagnosis. The James classification categorizes idiopathic scoliosis according to age at diagnosis: infantile (0-3 years), juvenile (4-9 years), and adolescent (10 years to skeletal maturity). Earlier diagnosis is associated with a longer period of remaining spinal growth and, therefore, a greater risk for progression of the spinal deformity. This relationship between growth potential and progression risk forms the basis for early orthotic intervention in selected children with infantile and juvenile scoliosis.

This approach remains clinically relevant because the earlier scoliosis is identified during growth, the greater the potential for curve progression before skeletal maturity is reached. Although the term early-onset scoliosis is often used today to encompass both infantile and juvenile scoliosis, Negrini and colleagues favor the James classification because infantile scoliosis follows a distinct natural history and prognosis. Rare exceptions include congenital postural scoliosis identified in newborns, typically associated with syndromic conditions or intrauterine positioning effects, but these cases are uncommon.

Management of idiopathic scoliosis generally depends on severity of the curve progression and the symptomatology. It ranges from conservative treatment with observation, physical therapy and bracing (orthoses) to surgery.

Successful conservative management of scoliosis requires active participation from both the patient and caregivers. Key components include patient and family education, ongoing assessment of treatment adherence, routine monitoring of clinical outcomes, and periodic adjustment of the treatment plan as needed. Optimal results are best achieved through a multidisciplinary team approach that may include a physician, physical therapist, orthotist, and, when appropriate, a psychologist.

For adolescent idiopathic scoliosis, there are well-established brace indications based on:
- Cobb angle
- Skeletal maturity
- Risk of progression

Active observation with serial examination and/or X-rays is indicated for patients with curve magnitude less than 25 degrees without progression, which account for the majority of cases. Operative treatment with spinal fusion is generally reserved for patients with curve magnitude greater than 45–50 degrees.

The Bracing for Adolescent Idiopathic Scoliosis Trial (BrAIST) established the evidence base for current scoliosis bracing recommendations. The multicenter prospective study enrolled patients aged 10 to 15 years with Risser grades 0 to 2 and Cobb angles between 20° and 40°. Participants either underwent randomization to bracing or observation or were allowed to select their preferred treatment while remaining in the study. Treatment consisted of rigid TLSO bracing using Boston-style or Wilmington braces, and adherence was objectively monitored with temperature sensors embedded in the orthoses. The primary endpoint was prevention of curve progression beyond 50° by the time skeletal maturity was reached. Interim analysis demonstrated a significantly higher treatment success rate among patients treated with bracing compared with observation alone (72% versus 48%), leading to early termination of the trial. The BrAIST study is widely regarded as the landmark Level I evidence supporting the effectiveness of bracing for adolescents with moderate idiopathic scoliosis (Weinstein et al., 2013).

Multiple studies have demonstrated that the effectiveness of scoliosis bracing is closely related to the number of hours the brace is worn each day. Although Allington et al., 1996 did not identify differences in curve progression or surgical rates between full-time and part-time wear schedules with the Wilminton brace, later research established a dose-response relationship between brace wear and treatment success. Findings from the BrAIST trial (Weinstein et al., 2013) showed that patients who wore their braces for an average of at least 12.9 to 17.7 hours daily achieved a 90% treatment success rate, with slightly higher success observed among those wearing the brace 18 or more hours per day. Similarly, Katz and colleagues (2010) reported substantially lower surgical rates among patients who wore their braces for at least 12 hours daily compared with those with lower adherence. Studies have also shown that patients frequently overestimate their brace wear time when self-reporting. As a result, electronic compliance monitors are increasingly recommended to objectively track brace use and provide feedback to patients, families, orthotists, and treating clinicians. Counseling and ongoing monitoring of adherence are considered important strategies for improving treatment effectiveness (Shannon et al., 2021).

For patients with growth remaining and a curve magnitude between 25 and 45 degrees, conservative treatment with a rigid thoracolumbosacral orthosis (TLSO) is indicated until skeletal maturity to limit curve progression. Multiple studies have demonstrated a time-dependent response to success of brace treatment. Rigid TLSOs should be worn for at least 13 hours per day. Rigid TLSOs (e.g., Wilmington, Boston, Rigo-Cheneau) are superior to other brace types, but there is insufficient evidence to recommend a specific type of rigid TLSO. Physiotherapeutic scoliosis-specific exercises should be considered in addition to bracing for patients with moderate curves (Shannon et al., 2021).

Some Types of Braces

- Boston Brace (TLSO): Low-profile, underarm brace for thoracic and lumbar curves, applying corrective pressure to prevent progression. Other models of the Boston brace exist, such as CTLSO.
- Wilmington Brace (TLSO): Fully custom-made, full-contact brace based on a cast of the patient, designed to fit tightly and provide uniform support.
- Milwaukee Brace (CTLSO): Original CTLSO, used for high thoracic curves, includes a neck extension to immobilize the cervical spine.
- Charleston Bending Brace: One of the most commonly prescribed night-time scoliosis braces. The Charleston bending brace applies force on the spine which is only possible while the patient is laying down.

Successful brace treatment requires active involvement of both the patient and caregivers. After the brace is prescribed, standing PA and lateral radiographs are typically obtained within 2 to 6 weeks to confirm appropriate correction and ensure that sagittal alignment has not worsened. Orthotic adjustments are made as needed. Patients are then monitored with periodic clinical evaluations and out-of-brace radiographs, generally every 4 to 6 months during periods of rapid growth and every 6 to 12 months during slower growth. Once skeletal maturity is reached, brace discontinuation is typically gradual, with wear time reduced over approximately six months (Shannon et al., 2021).

Despite appropriate assessment of risk of progression, wear monitoring, and compliance counseling, some patients will not benefit from brace treatment.

There is no role for bracing curves greater than 50 degrees or any curves in skeletally mature patients with idiopathic scoliosis.

Scoliosis has a very high prevalence among patients with neuromuscular disease involving the thoracic spine and truncal muscles. Neuromuscular scoliosis develops in patients with conditions such as cerebral palsy, spinal muscular atrophy, polio, and other lower motor neuron or neurogenic diseases. It is most prevalent in children and adolescents with neuromuscular disorders. The pathogenesis is primarily due to asymmetric muscle forces from abnormal motor control or paralysis, leading to spinal imbalance and progressive curvature. Unlike idiopathic adolescent scoliosis, neuromuscular scoliosis tends to progress even with orthotic compliance. The main indication for spinal orthoses in these patients is to stabilize and delay the progression of the spinal curvature

Scoliosis is the most frequently found spinal deformity in cerebral palsy. It usually starts between the ages of three to ten years and progresses during adolescent growth. If not treated the deformity becomes quite severe by the end of growth causing different problems, not only postural like difficulties seating, but also more structural problems impacting on pulmonary or gastrointestinal function as well as being the source of discomfort and pain due to pelvic-rib impingement with poor sitting tolerance. Motor disability of these children can be assessed by the Gross Motor Function Classification System in five levels, and depending on their motor functional capability, the most severely affected children fall into levels IV and V. Children in groups IV and V present a full spectrum of musculoskeletal deformities, among which, scoliosis is the most frequently found spinal deformity that most often requires surgical treatment. In addition to scoliosis some patients develop a significant kyphosis or hyperlordosis. Spine surgery in these very disabled children is a risky procedure and there has been controversy on the benefits of these operations as well as no clear data showing the impact on the life expectancy from increasing severity of scoliosis (Mineiro and Yazici, 2020).

Lonstein and Akbarnia described two common scoliosis patterns seen in children with cerebral palsy. Type I consists of single or double major thoracic or lumbar curves associated with a level pelvis and overall spinal balance and is most often observed in ambulatory patients with milder functional impairment. Type II is characterized by a long C-shaped thoracolumbar or lumbar curve accompanied by pelvic obliquity and spinal imbalance and is typically seen in patients with more severe motor involvement. In addition to coronal plane deformities, these patients frequently demonstrate associated sagittal plane abnormalities, including excessive lumbar lordosis and thoracic kyphoscoliosis (Mineiro and Yazici, 2020).

In children with cerebral palsy, nonoperative management may provide temporary benefit, particularly in younger children. However, bracing generally has limited effectiveness in preventing progression of neuromuscular scoliosis. An exception may occur in ambulatory adolescents with spastic diplegia who develop a scoliosis pattern resembling idiopathic scoliosis, where orthotic management may help slow curve progression. For most patients with progressive spinal deformity associated with cerebral palsy, surgical correction remains the only treatment shown to definitively halt progression of the curvature. (Mineiro and Yazici, 2020, Loughenbury and Tsirikos, 2023).

Congenital scoliosis is a spinal deformity resulting from underlying spinal malformation. It accounts for approximately 10% of all scoliosis cases, of which 25% do not progress, 25% progress mildly and 50% need treatment depending on the age, curve characteristics and magnitude and type of anomaly. Although the underlying spinal deformity exists from birth, the curvature may not be clinically apparent on initial physical examination. Congenital spinal deformities can occur as scoliosis, kyphosis, lordosis, or a combination of these conditions. In congenital scoliosis, the curvature is caused by a structural vertebral malformation, such as a hemivertebra or a failure of segmentation. The vertebrae themselves are abnormally formed, making the curve rigid and inflexible. Because the underlying bone anatomy is abnormal, an external brace generally cannot correct or substantially alter the primary congenital deformity. As a result, bracing is usually ineffective for controlling the main congenital curve. To maintain overall balance, the spine often develops a secondary curve above or below the congenital deformity. This is called a compensatory curve. Unlike the primary congenital curve, compensatory curves are frequently responsive to corrective forces. Therefore, while a brace cannot change the malformed vertebrae causing the congenital scoliosis, it may help delay progression of the compensatory curve and potentially postpone surgery in selected cases (Sebaaly et al., 2022).

Hyperkyphosis

Kyphosis, the normal posterior curvature of the thoracic spine, typically measures between 20 and 45 degrees. Hyperkyphosis refers to excessive thoracic curvature, generally defined as a kyphotic angle greater than 45 to 50 degrees. Spinal orthoses may be used in the treatment of selected types of hyperkyphosis when the curve is less than 80 degrees. Surgical intervention is generally considered for more severe deformities, particularly when curves approach or exceed 80 degrees.

Hyperkyphosis may be nonstructural (flexible), such as postural kyphosis, or structural (rigid), resulting from underlying vertebral or soft tissue abnormalities. Common causes of structural hyperkyphosis

include congenital kyphosis, Scheuermann's disease, spondylolisthesis, and osteoporotic vertebral compression fractures.

Congenital hyperkyphosis is a spinal deformity resulting from vertebral malformations present at birth. These deformities may result from failure of vertebral formation, failure of segmentation, or a combination of both. Progression may occur during skeletal growth, particularly in early childhood, and management is based on curve severity, progression risk, and remaining growth potential. Although severe or rapidly progressive deformities frequently require surgical intervention, orthotic treatment may be appropriate for selected patients with less severe deformities and no immediate indication for surgery, with the goal of slowing progression during growth.

Juvenile thoracic kyphosis (Scheuermann’s Kyphosis) is a structural hyperkyphosis that develops during adolescence and is characterized by anterior wedging of three or more consecutive vertebral bodies. The most common form involves the thoracic spine with an apex between T7 and T9, although a less common thoracolumbar pattern may also occur. The severity of Scheuermann's kyphosis is determined by the magnitude of the kyphotic Cobb angle.

Nonoperative treatment is generally recommended for skeletally immature patients with thoracic kyphosis between approximately 50 and 80 degrees and typically consists of physical therapy and spinal orthotic management.

Current evidence supports the use of spinal orthoses in skeletally immature patients because bracing can influence vertebral growth and remodeling during periods of remaining skeletal development. The primary goals of treatment are to reduce thoracic kyphosis, slow or prevent progression of the deformity, improve posture, reduce pain, and potentially avoid the need for surgical intervention. Exercise programs are commonly used in conjunction with orthotic treatment (O’Donnell et al., 2023).

Several orthotic designs are available, including cervical-thoracic-lumbar-sacral orthoses (CTLSOs), such as the Milwaukee brace, and thoracic-lumbar-sacral orthoses (TLSOs), including Boston-style and other three-point corrective braces. Bracing may also improve associated lumbar lordosis. Treatment effectiveness is highly dependent on adherence, with brace wear commonly recommended for at least 16 hours per day until satisfactory correction is achieved. Published studies have demonstrated substantial initial curve correction, improvement in pain, and favorable outcomes when treatment is initiated before skeletal maturity (O’Donnell et al., 2023).

Analysis of Evidence (Rational for Determination)

Spinal orthoses are an established component of conservative management for selected patients with scoliosis and hyperkyphosis who remain skeletally immature and are at risk for progression of spinal deformity. The primary goals of orthotic treatment are to prevent or slow progression of the spinal curvature during growth, improve spinal alignment and posture, reduce the future need for surgical intervention, and minimize associated pain, functional limitations, and cardiopulmonary complications. Treatment decisions are guided by the type of deformity, curve magnitude, remaining growth potential, and risk of progression. For scoliosis, these factors are most commonly assessed using the Cobb angle and indicators of skeletal maturity, such as the Risser sign. Patients with moderate curves and substantial remaining growth are at greatest risk for progression and derive the greatest benefit from orthotic intervention. Conservative treatment is most effective when combined with regular clinical and radiographic monitoring, patient and caregiver education, and a multidisciplinary treatment approach (Negrini et al., 2018; Shannon et al., 2021; Weinstein et al., 2013).

The strongest evidence supporting scoliosis bracing comes from adolescent idiopathic scoliosis. The landmark Bracing in Adolescent Idiopathic Scoliosis Trial (BrAIST) demonstrated that rigid thoracolumbosacral orthoses significantly reduced progression to surgical-range curves when compared with observation alone, establishing orthotic management as the standard of care for skeletally immature patients with moderate idiopathic scoliosis. Treatment effectiveness is highly dependent on adherence, with multiple studies demonstrating a dose-response relationship between brace wear time and successful outcomes. Spinal orthoses may also be used in selected patients with infantile, juvenile, neuromuscular, and congenital scoliosis when the goal is to delay or slow progression of spinal deformity

during growth. Although orthoses are generally less effective in neuromuscular and congenital scoliosis than in idiopathic scoliosis, they may provide important benefits in carefully selected patients by stabilizing the spine, slowing progression, and delaying the need for surgical intervention (Negrini et al., 2018; Shannon et al., 2021; Weinstein et al., 2013; Sebaaly et al., 2022; Mineiro and Yazici, 2020).

Orthotic treatment also has an important role in selected patients with structural hyperkyphosis, particularly congenital kyphosis and Scheuermann's disease. Current evidence supports the use of spinal orthoses in skeletally immature patients with moderate thoracic hyperkyphosis because bracing may influence vertebral growth and remodeling during periods of remaining skeletal development. The goals of treatment include reducing thoracic kyphosis, slowing or preventing progression of the deformity, improving posture and spinal balance, reducing pain, and potentially avoiding surgical intervention. Both cervical-thoracic-lumbar-sacral orthoses (CTLSOs), such as the Milwaukee brace, and thoracic-lumbar-sacral orthoses (TLSOs) have been used successfully in the management of Scheuermann's kyphosis. While the evidence base for congenital kyphosis is more limited, orthotic treatment may be appropriate in selected patients with less severe deformities and no immediate indication for surgery, particularly when the objective is to slow progression during growth. Successful treatment depends on patient adherence, appropriate brace selection and fitting, and ongoing monitoring throughout skeletal maturation (O'Donnell et al., 2023; Negrini et al., 2018; de Mauroy et al., 2010).

Coding

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage or reimbursement.

There are 7 base Healthcare Common Procedure Codes (HCPCS) available to fully describe scoliosis braces: L1000, L1005, L1006, L1007, L1200, L1300, L1310.

Five codes - L1005, L1006, L1007, L1300, and L1310- are all inclusive and are not billed with addition codes.

Two codes - L1000 and L1200 - have specific addition codes which can be used to describe components utilized to support or resist the progression of the user's specific spinal curve pattern (see section on addition codes below).

The addition codes billable with L1000 are L1010, L1020, L1025, L1030, L1040, L1050, L1060, L1070, L1080, L1085, L1090, L1100, L1110, L1120. These addition codes will be denied if billed without the related base code, L1000.

The addition codes billable with L1200 are L1210, L1220, L1230, L1240, L1250, L1260, L1270, L1280, L1290. These addition codes will be denied if billed without the related base code, L1200.

Unlisted codes are not addressed in this policy. Refer to Fallon Health’s Unlisted Codes policy for use of unlisted codes.

The following codes are nonpayable by MassHealth: L1006, L1007. Claims will deny vendor liable.

Code	Description	Prior Authorization (PA) Required
L1000	Cervical-thoracic-lumbar-sacral orthosis (CTLSO) (Milwaukee), inclusive of furnishing initial orthosis, including model	PA Required eff 12/1/2026
L1001	Cervical-thoracic-lumbar-sacral orthosis (CTLSO), immobilizer, infant size, prefabricated, includes fitting and adjustment	No
L1005	Tension based scoliosis orthosis and accessory pads, includes fitting and adjustment	PA Required eff 12/1/2026
L1006	Scoliosis orthosis, sagittal-coronal control provided by a rigid lateral frame, extends from axilla to trochanter, includes all accessory pads, straps and interface, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise	PA Required eff 12/1/2026

L1007	Scoliosis orthosis, sagittal-coronal control provided by a rigid lateral frame, extends from axilla, to trochanter, includes all accessory pads, straps, and interface, custom fabricated	Yes
L1010	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, axilla sling	No
L1020	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, kyphosis pad	No
L1025	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, kyphosis pad, floating	No
L1030	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, lumbar bolster pad	No
L1040	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, lumbar or lumbar rib pad	No
L1050	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, sternal pad	No
L1060	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, thoracic pad	No
L1070	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, trapezius sling	No
L1080	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, outrigger	No
L1085	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, outrigger, bilateral with vertical extensions	No
L1090	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, lumbar sling	No
L1100	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, ring flange, plastic or leather	No
L1110	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, ring flange, plastic or leather, molded to patient model	No
L1120	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, cover for upright, each	No
L1200	Thoracic-lumbar-sacral orthosis (TLSO), inclusive of furnishing initial orthosis only	PA Required eff 12/1/2026
L1210	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), lateral thoracic extension	No
L1220	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), anterior thoracic extension	No
L1230	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), Milwaukee type superstructure	No
L1240	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), lumbar derotation pad	No
L1250	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), anterior ASIS pad	No
L1260	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), anterior thoracic derotation pad	No
L1270	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), abdominal pad	No
L1280	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), rib gusset (elastic), each	No
L1290	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), lateral trochanteric pad	No

L1300	Other scoliosis procedure, body jacket molded to patient model	PA Required eff 12/1/2026
L1310	Other scoliosis procedure, postoperative body jacket	PA Required eff 12/1/2026

References

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Policy history

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Instructions for Use

Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

Fallon Health generally follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in accordance with the definition of Medical Necessity in 130 CMR 450.204.

For plan members enrolled in NaviCare, Fallon Health first follows CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.