Molina Clinical Policy
Back Braces
Policy No. 067

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DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

Lumbar-sacral orthoses (LSO) and thoracic-lumbar-sacral orthoses (TLSO) are rigid or semi-rigid devices used for the purpose of supporting a weak or deformed body part or restricting motion in a diseased or injured body part. Spinal orthoses are used to immobilize the specified areas of the spine and offer an intimate fit so that they can be typically worn under clothing. Back bracing is also prescribed to treat adolescent idiopathic scoliosis to stop the progression of spinal curvature in a growing child/adolescent or to decrease the amount of curvature of the spine. Spinal orthoses are classified as prefabricated, pre-fitted, or custom-fabricated (Scherl & Hasley 2024; Scherl & Hasley 2025):

- **Prefabricated orthoses** are manufactured without a specific individual in mind. These include off the shelf (OTS) or custom fitted devices that can be modified to fit an individual; an orthosis that is assembled from prefabricated components is also considered prefabricated.
- **Custom-fitted orthoses** are prefabricated and changed to fit a specific individual by bending, molding, or trimming the brace.
- **Custom-fabricated orthoses** are individually constructed for a specific individual; basic materials may include plastic, metal, leather, or cloth in the form of sheets, bars, etc. which are cut, bent, molded, and/or sewed to create the orthosis. Prefabricated parts may also be included.

Prefabricated orthoses are attempted prior to utilizing a custom fitted or custom fabricated orthotic. A custom fitted orthotic may be initially required for unstable spinal fractures that are treated nonoperatively. A custom fabricated (or molded orthotic) is generally required for the treatment of scoliosis and kyphosis. Examples of custom fabricated braces are the Boston and Milwaukee braces (Scherl & Hasley 2024; Scherl & Hasley 2025).

COVERAGE POLICY

Thoracic-lumbar-sacral orthoses, lumbar-sacral orthoses, and lumbar orthoses may be **considered medically necessary** when ALL the following are met:

1. Orthotic or other device is rigid or semi-rigid that supports a weak or deformed body part or can restrict or eliminate motion in a diseased or injured body part
2. Appropriate support and counterforce are demonstrated
3. Orthotic or device is high quality, prefabricated or custom-fabricated, and can endure long-term use
4. Member meets ONE of the following orthotic specific criteria:
    a. **Lumbar Sacral Orthoses (LSO)** may be covered for the treatment of lower back pain when symptoms are emergent

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b. **Supportive Back Braces** may be considered medically necessary when used for ONE of the following indications:
   i. Facilitate healing following injury to the spine or related soft tissues
   ii. Facilitate healing after a surgical procedure on the spine or related soft tissue
   iii. Minimize pain of spinal origin (e.g., joint instability, hypermobility) by restricting mobility of the trunk
   iv. Support weak spinal muscles and/or a deformed spine accompanied by functional disability
c. **Cervical Thoracic Lumbar Sacral Orthoses (CTLSO)** or **Thoracic-Lumbar-Sacral Orthoses (TLSO)** may be considered medically necessary for the treatment of pediatric scoliosis when ALL the following criteria are met:
   i. Idiopathic spinal curve angle greater than 25 degrees
   ii. Member's spinal growth remains immature as evidenced by a Risser grade of 0 – 3, and no more than one (1) year post-menarche in females
   iii. Member has been evaluated for the relative contraindication of thoracic lordosis and deemed appropriate for bracing
d. **Postoperative Back Braces** may be considered medically necessary when:
   i. Bracing is part of the treatment plan and surgical protocol
   ii. Bracing will improve Member's condition
   iii. Brace is applied within six (6) weeks following a surgical procedure of the spine or related soft tissue
e. **Rehabilitation Braces** may be considered medically necessary when the above general criteria 1-3 are met and the brace is applied within six (6) weeks of surgery or injury

5. The nature of the brace meets ONE of the following criteria:
   a. **Prefabricated** (e.g., non-custom, off the shelf)
   b. **Custom Fitted** (prefabricated and then altered for Member): Brace may be considered medically necessary when ONE of the following criteria are met:
      i. A prefabricated brace is contraindicated, Member has a clinically significant intolerance to prefabricated brace, or brace has failed to meet treatment needs
      ii. Brace is the initial one following surgical stabilization of the spine following traumatic injury
   c. **Custom-Fabricated Braces** (individually constructed for Member): Brace may be considered medically necessary when ALL the following criteria are met:
      i. A prefabricated brace is contraindicated, Member has a clinically significant intolerance to prefabricated brace, or brace has failed to meet treatment needs
      ii. A custom-fitted brace is contraindicated, Member has a clinically significant intolerance to brace, or brace has failed to meet treatment needs

Quantity Level Limits for All Back Braces

Replacement for a back brace must meet ONE of the following criteria:

1. Member utilizing a brace for congenital defects or advanced neuromuscular conditions has outgrown the current brace

2. Member's condition has changed, and the current brace cannot be used

3. One brace replacement every five years based on the average lifetime of a back brace

Limitations and Exclusions

1. Spinal orthoses are considered **experimental, investigational, and unproven** due to insufficient evidence in the peer-reviewed medical literature to establish effect on net health outcomes for ALL the following indications:
   a. Management of acute or chronic back pain unaccompanied by functional disability, structural pathology, and/or instability
   b. Treatment of adult kyphosis
   c. Use in sports to improve athletic performance or to prevent injury in an otherwise uninjured body
   d. Duplicate orthoses for convenience or orthotics containing convenience or luxury features

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2. Completely elastic supports (e.g., athletic supporter, joint supports, non-rigid trusses, etc.) and inflatable lumbar supports are NOT considered medically necessary, as they do not last long-term due to the type of materials used to make the supports

3. Upgrades of spinal orthoses are considered a deluxe Durable Medical Equipment (DME) item and NOT medically necessary when the primary purpose is to allow the Member to perform leisure or recreational activities or add a feature which exceeds that which is considered medically necessary to treat the individual's condition (includes comfort, luxury, or convenience features).

DOCUMENTATION REQUIREMENTS: Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

Osteoporosis

Sánchez-Pinto-Pinto et al. (2022) conducted a systematic review of four studies to assess the effectiveness of spinal orthosis on osteoporotic hyperkyphosis in women. Inclusion criteria for the studies were women with osteoporosis, randomized controlled trials (RCTs) only, and spinal orthosis intervention. Quality of life variables were reported measured by limitations of daily living and back pain. Functional variables measured included back extensor strength, abdominal flexor strength, forced expiratory volume in 1 sec, and vital capacity. Osteoporotic-related variables measured included thoracic kyphosis angle, body height, lumbar spine, bone mineral density, and T-scores. Two studies showed improved quality of life, and two studies showed significant improvements in functional variables. Three studies found a significant decrease in thoracic kyphosis angle, two studies obtained a significant increase in body height, and one study observed a significant increase in the lumbar spine bone mineral density. This review is limited by the small number of studies included. The review concluded that women with osteoporosis who use spinal orthosis achieved significant improvements in back pain, back extensor strength, pulmonary function, and quality of life.

Hyperkyphosis in Adolescents

Gheitasi et al. (2022) completed a three arm, blinded RCT with 180 participants, randomized equally into three groups of 60 each: bracing only, bracing plus corrective exercises, and control (no intervention). The intervention lasted for 24 weeks. The brace used was a Milwaukee brace, worn for 22 hours a day, with removal permitted only for exercise sessions and self-care activities. The primary outcome was the thoracic kyphosis angle, measured at baseline and post intervention. Results demonstrated significant differences between the groups. In the bracing plus corrective exercise group, the main thoracic kyphosis angle decreased by 15.5°, while the bracing-only group the mean decrease was 8.8°. The difference between these two groups was statistically significant ($p<0.001$). In contrast, the control group showed an increase of 1.25°, which was statistically significant ($p = 0.0001$). Study limitations included restriction to an adolescent population, limiting generalizability to older adults with age-related hyperkyphosis or osteoporosis. The intervention, while longer than many exercise trials, still does not assess long term adherence or sustainability of improvements beyond 24 weeks. Additionally, kyphosis angles were measured using surface methods rather than radiographic confirmation, which may reduce precision. The authors recommended future research to include longer term follow-up to evaluate durability of improvements, trials across different age groups including older adults, and exploration of psychosocial and functional outcomes. They also suggested investigating optimal brace for schedules to balance effectiveness with comfort and adherence

Scoliosis

The body of literature composed of RCTs, systematic reviews, and observational comparative studies support bracing in skeletally immature patients with adolescent scoliosis. Bracing is noted to reduce the risk of curve progression to ≥ 50° (the usual threshold for surgery) at skeletal maturity. The efficacy of bracing is directly related to the number of hours per day that the brace is worn.

Tang et al. (2024) conducted a systematic review evaluating the effectiveness of bracing to achieve curve regression in adolescents with idiopathic scoliosis. Eleven articles were included in the review, all of which were observational

studies. The results revealed moderate evidence to support effective curve regression, particularly in those with a major curve of 25-40 degrees, when braces were worn with strict compliance. Further evidence suggested that an apical ratio closer to 1:1, in-brace correction, and a consistent daily compliance pattern were predictive of curve regression. Seven of the included articles used bracing under the Society of Orthopaedic and Rehabilitation Treatment guidelines and all resulted in curve regression, however, the regression rate was different in each cohort due to variations in brace wear time and brace rigidity. The authors concluded that bracing provides a corrective effect on idiopathic scoliosis curves when there is a high compliance rate and the incorporation of therapeutic exercises.

da Silveira et al. (2022) conducted a prospective randomized study with the aim of showing the benefit of bracing for adolescents with idiopathic scoliosis. The goal of the study was to confirm short- and long-term effects of using a spinal brace, which included utilization of an exercise program for the spine, body balance, and plantar load distribution during gait. The study included 45 adolescents who were undergoing conservative treatment; they were evaluated at two stages of intervention. Significant improvement was found in the main scoliotic curvature, with a 12-degree reduction in Cobb angle pre- and post-short-term immediate use of spinal brace and a 5.3-degree correction after six months of spinal brace use in combination with specific exercises (long term). The authors also found that short- and long-term brace use along with an exercise program increased a patient's anteroposterior and mediolateral balance – a reduction in plantar overload on the heel during gait was also found with an effect size between moderate and high.

McAviney et al. (2020) performed a systematic review to examine the research on the use of spinal orthoses by adults with idiopathic or degenerative scoliosis. Studies were included if they collected data from participants ≥18 years receiving spinal brace/orthosis treatment for primary degenerative or progressive idiopathic scoliosis. Overall, 10 studies with 339 participants were included in the review. Outcomes measured including pain; Cobb angles; and functional improvement measurements of walking distance; progression to surgery; coronal/sagittal balance; magnitude of rib hump, quality of life; and social functioning. Patients reported modest to significant pain reduction after use of a spinal orthosis. Mixed findings were reported in Cobb angle and functional improvements. Evidence shows that orthosis use may have a positive short to medium term influence on pain and function. The authors concluded that additional prospective trials are needed to gain more understanding of the efficacy of bracing in adult scoliosis.

Spinal Fractures
Squires et al. (2023) completed a systematic review and meta-analysis of RCTs evaluating the effectiveness of bracing in patients with vertebral compression fractures. The authors identified and analyzed 3 RCT's with a total of 447 patients, of whom 393 were treated with a brace and 54 were managed without bracing. The primary outcome was pain relief, with secondary outcomes including functional improvement, radiographic measures of kyphotic angle and vertebral height, and quality of life. The pooled analysis demonstrated that bracing was associated with significantly less pain at 3-6 months compared to no brace (standardized mean difference -1.32, 95% CI -1.89 to -0.76, $p < 0.05$, $I^2 = 41\%$), though this benefit diminished by 48 weeks. No significant differences were observed in long term pain, functional outcomes or radiographic parameters. Limitations included heterogeneity in brace type and duration, variability in patient populations, and inconsistently reported brace-wear compliance. The authors concluded that bracing may provide short-term pain relief but does not confer long lasting benefits and recommended future large, high quality randomized trials with standardized braced protocols, longer follow-up, and inclusion of patient reported outcomes.

Mehta et al. (2022) performed a retrospective review on non-operative management of thoracolumbar spine fractures and the use of thoracolumbar spine orthosis. The benefit of thoracic-lumbar-sacral orthoses (TLSO) bracing is controversial due to reports in the medical literature that prolonged brace use may result in diminished lung capacity, skin breakdown, and paraspinal muscular atrophy – no significant difference was found in pain and functional outcomes between patients treated with or without TLSO. Data from an 18-month period and 42 patients were included and outcomes were documented via a questionnaire. Sixty percent of patients stated that they did not receive satisfactory information about the duration of treatment. 43% stated that brace use that the brace affected activities of daily living, and 73% stopped using the brace before indicated (60% of these patients indicated that they would rather be without the brace, if able).

Kweh et al. (2021) performed a systematic review on the role of spinal orthoses for elderly patients who sustain low energy trauma vertebral fractures. A total of 7 articles were reviewed which included 4 RCTs and 3 prospective cohort studies. Improvement in pain scores and quality of life were reported with bracing. Benefits were found for the use of

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spinal orthoses in patients aged 60 years and older who are neurologically intact with osteoporotic compression vertebral fractures – benefits include biomechanical vertebral stability, reduced kyphotic deformity, enhanced postural stability, greater muscular strength, and superior functional.

Hofler and Jones (2020) performed a systematic review to examine the efficacy of spinal orthoses for osteoporotic vertebral fractures. A total of 16 studies were reviewed including five RCTs, six nonrandomized prospective comparative studies, one retrospective case-control study, and four prospective single-arm studies. Four studies resulted in low-quality evidence that bracing was safe (with or without bedrest). Two studies found low quality evidence that bracing improved pain and disability. Four studies found that using a rigid brace was comparable to use of a soft brace or no brace. Two studies found a benefit of kyphoplasty versus bracing alone. The authors concluded that evidence does not exist to demonstrate that a rigid brace is superior to a soft brace or no brace. Of the RCTs, three overlapped with RCTs reviewed by Kweh et al. (2021), which are discussed above, and two demonstrated that the use of spinal orthoses benefited individuals diagnosed with osteoporotic fractures.

Spinal Fusion

Feng et al. (2024) published an updated meta-analysis evaluating the impact of postoperative bracing following lumbar fusion for degenerative lumbar conditions. This systematic review included five RCTs encompassing a total of 362 patients. The primary outcomes assessed were postoperative pain and functional recovery with secondary measures including fusion rates and complication rates. Across the pooled data the analysis found no statistically significant differences between patients who received postoperative racing and those who did not, in term of pain scores, functional outcomes, or fusion success. The authors noted several limitations, including heterogeneity of brace type, duration of use, and surgical techniques across the included trials, as well as relatively small sample sizes and variable follow up periods. Based on these findings, the study concluded that routine postoperative bracing after lumbar fusion does not provide consistent clinical benefit. The authors recommended that future research focus on larger, high quality randomized trials with standardized brace protocols, longer follow-up, and inclusion of cost effectiveness and patient reported outcomes to better define the role of bracing in postoperative care.

Fujiwara et al. (2019) conducted a randomized study conducted evaluating lumbosacral orthoses (LSO) treatment in patients who underwent posterior lumbar interbody fusion. Seventy-three patients were included in the study with a mean age of 65.6 years. Patients were randomized to three groups: custom-made LSO (C) group, ready-made LSO (R) group, and a no orthosis (N) group. Patients were excluded if they were unable to complete the questionnaire, had a body mass index >30 kg/m2, had a history of lumbar fusion surgery, had malignancy or severe osteoporosis, or had a history of rheumatoid arthritis, inflammatory disease, or chronic kidney disease on hemodialysis. Clinical outcomes assessed include neurologic status using the Japanese Orthopaedic Association (JOA) score, JOA-back pain evaluation questionnaire (JOABPEQ), Roland-Morris Disability Questionnaire and visual analog scale (VAS) for low back pain. Outcomes were assessed preoperatively and at 1 month, 3 months, 6 months, 1 year, and 2 years postoperative. There was no significant difference in JOA scores between groups, but significant improvement in scores were reported in all groups at 1 year postoperative. THE JOABPEQ questionnaire demonstrated significant difference in lumbar function between the N group (45%) and C group (10%) at 1 year postoperative ($p = 0.030$). RDQ scores were significantly improved across all groups at 3 months postoperative. At one-month postoperative VAS scores for low back pain, pain in lower extremities, and numbness in lower extremities showed significant improvements. This study showed that orthosis treatment did not significantly affect clinical outcomes, and the use of LSO can be simplified or omitted in patients after posterior lumbar interbody fusion.

Dailey et al. (2014) reported on a trial of preoperative bracing prior to lumbar infusion to determine the efficacy of braces; the authors also analyzed the use following lumbar surgery to promote a successful arthrodesis. Lumbar orthoses do not eliminate motion in the lumbar spine hence their efficacy have been questioned. Low back pain may be minimized with the use of lumbar bracing however evidence is low; prophylactic use of braces does not reduce the incidence of low-back pain or decrease the amount of lost productivity in the general working population. While lumbar bracing is effective in select populations, it is not effective for patients with chronic low-back pain. Rigid braces were found to be more effective over soft braces. Data does not exist that demonstrates a benefit of preoperative external bracing following lumbar spinal fusion for low back pain. In addition, bracing does not improve fusion rates or clinical outcomes after instrumented lumbar fusion for degenerative disease.

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Idiopathic Back Pain

Annaswamy et al. (2021) conducted a prospective, unblinded, RCT of 61 adults with uncomplicated chronic low back pain (CLBP). CLBP was defined as pain present for > 12 weeks. Data was collected at baseline, 6 weeks, 12 weeks, and 6 months post-intervention. The data collected was Numerical Rating Scale to measure pain intensity, Pain Disability Questionnaire (PDQ), Patient-Reported Outcome Measurement Information System (PROMIS), and EuroQol 5-Dimension (EQ-5D) to measure patient-reported function and quality of life. All participants attended educational sessions on the anatomy and physiology of back pain, exercise instruction, and how to maintain a home exercise program. Additionally, all participants recorded an exercise diary with self-reported pain scores. The interventional group (n = 25) received a LSO to wear for up to 4 hours a day. The control group (n = 34) simply maintained the diary. The trial was stopped halfway through the recruitment process, as the intended goal was 120 participants, as the interim analysis showed worsening PDQ, PROMIS, and ED-5D scores in the interventional group at the 6 month period versus a steady improvement in the control group. Despite worsening scores in the interventional group, there were no serious adverse events reported. These results revealed that the addition of an LSO did not improve patient outcomes compared to education and exercise instruction alone.

Morrisette et al. (2014) conducted a prospective, single blinded, RCT to evaluate two types of LSO versus standard care in the treatment of CLBP. A total of 98 participants were randomized with data collected at baseline and 2 weeks post treatment which consisted of Oswestry Disability Index (ODI) scores, Patient Specific Activity Scores, pain ratings, and Fear and Avoidance Belief Questionnaire. The standard care group (n = 29) received medication and physical therapy. The inextensible LSO group (n=37) received standard care plus the stiff orthosis. The extensible LSO group (n = 32) received standard care plus the flexible orthosis. The only statistically significant difference found was an improvement in ODI scores between the inextensible LSO group versus the control group and extensible LSO group. Individuals wearing the inextensible LSO had 4.7 times higher odds of achieving 50% or greater improvement in the ODI scores compared to those assigned to standard care group (95% CI 1.2, 18.5, p=0.03). All other measures did not reveal any statistically significant differences in improvement of pain scores, Patient Specific Activity Scores, and Fear and Avoidance Belief Questionnaire scores among the groups.

National and Specialty Organizations

The **North American Spine Society (NASS)** (2020) published the guideline *Diagnosis and Treatment of Low Back Pain*. Based on several randomized control trials, the NASS outlines evidence on the efficacy of lumbosacral and sacroiliac braces to improve pain and function in patients with subacute low back pain.

The **NASS** (2011) also published the guideline *Diagnosis and Treatment of Degenerative Lumbar Spinal Stenosis*. The use of a lumbosacral corset is recommended to increase walking distance and decrease pain in patients with lumbar spinal stenosis as evidence does not show that results are maintained once the brace is removed.

The **American College of Physicians (ACP)** published the guideline *Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain*. The clinical recommendations include the use of lumbar supports / braces as a noninvasive, nonpharmacologic therapy option (Qaseem et al. 2017).

CODING & BILLING INFORMATION

HCPCS (Healthcare Common Procedure Coding System)

Code	Description
L0450	Thoracic-lumbar-sacral orthosis (TLSO), flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, off-the-shelf
L0452	Thoracic-lumbar-sacral orthosis (TLSO), flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, custom fabricated
L0454	Thoracic-lumbar-sacral orthosis (TLSO), flexible, provides trunk support, extends from sacrococcygeal junction to above T-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise

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	customized to fit a specific patient by an individual with expertise
L0455	Thoracic-lumbar-sacral orthosis (TLSO), flexible, provides trunk support, extends from sacrococcygeal junction to above T-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, off-the-shelf
L0456	Thoracic-lumbar-sacral orthosis (TLSO), flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L0457	Thoracic-lumbar-sacral orthosis (TLSO), flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated, off-the-shelf
L0458	Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment
L0460	Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L0462	Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment
L0464	Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, modular segmented spinal system, four rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment
L0466	Thoracic-lumbar-sacral orthosis (TLSO), sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L0467	Thoracic-lumbar-sacral orthosis (TLSO), sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated, off-the-shelf
L0468	Thoracic-lumbar-sacral orthosis (TLSO), sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal, and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L0469	Thoracic-lumbar-sacral orthosis (TLSO), sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated, off-the-shelf

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L0470	Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding extends from sacrococcygeal junction to scapula, lateral strength provided by pelvic, thoracic, and lateral frame pieces, rotational strength provided by subclavicular extensions, restricts gross trunk motion in sagittal, coronal, and transverse planes, provides intracavitary pressure to reduce load on the intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment
L0472	Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, hyperextension, rigid anterior and lateral frame extends from symphysis pubis to sternal notch with two anterior components (one pubic and one sternal), posterior and lateral pads with straps and closures, limits spinal flexion, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment
L0480	Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, one-piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated
L0482	Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, one-piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated
L0484	Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, two-piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated
L0486	Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, two-piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated
L0488	Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, one-piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, prefabricated, includes fitting and adjustment
L0490	Thoracic-lumbar-sacral orthosis (TLSO), sagittal-coronal control, one-piece rigid plastic shell, with overlapping reinforced anterior, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates at or before the T-9 vertebra, anterior extends from symphysis pubis to xiphoid, anterior opening, restricts gross trunk motion in sagittal and coronal planes, prefabricated, includes fitting and adjustment
L0491	Thoracic-lumbar-sacral orthosis (TLSO), sagittal-coronal control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment
L0492	Thoracic-lumbar-sacral orthosis (TLSO), sagittal-coronal control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment
L0621	Sacroiliac orthosis (SO), flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, off-the-shelf
L0622	Sacroiliac orthosis (SO), flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated

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L0623	Sacroiliac orthosis (SO), provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, off-the-shelf
L0624	Sacroiliac orthosis (SO), provides pelvic-sacral support, with rigid or semi-rigid panels placed over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated
L0625	Lumbar orthosis (LO), flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, off-the-shelf
L0626	Lumbar orthosis (LO), sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L0627	Lumbar orthosis (LO), sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L0628	Lumbar-sacral orthosis (LSO), flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf
L0629	Lumbar-sacral orthosis (LSO), flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated
L0630	Lumbar-sacral orthosis (LSO), sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L0631	Lumbar-sacral orthosis (LSO), sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L0632	Lumbar-sacral orthosis (LSO), sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated
L0633	Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L0634	Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated
L0635	Lumbar-sacral orthosis (LSO), sagittal-coronal control, lumbar flexion, rigid posterior frame/panel(s), lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel,

	pendulous abdomen design, prefabricated, includes fitting and adjustment
L0636	Lumbar-sacral orthosis (LSO), sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, custom fabricated
L0637	Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L0638	Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated
L0639	Lumbar-sacral orthosis (LSO), sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L0640	Lumbar-sacral orthosis (LSO), sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated
L0641	Lumbar orthosis (LO), sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf
L0642	Lumbar orthosis (LO), sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf
L0643	Lumbar-sacral orthosis (LSO), sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf
L0648	Lumbar-sacral orthosis (LSO), sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf
L0649	Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf
L0650	Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid anterior and posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf
L0651	Lumbar-sacral orthosis (LSO), sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by

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	overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated, off-the-shelf
L0700	Cervical-thoracic-lumbar-sacral orthosis (CTLSO), anterior-posterior-lateral control, molded to patient model, (Minerva type)
L0710	Cervical-thoracic-lumbar-sacral orthosis (CTLSO), anterior-posterior-lateral control, molded to patient model, with interface material, (Minerva type)
L0720	Cervical-thoracic-lumbar-sacral-orthoses (CTLSO), anterior-posterior-lateral control, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L4000	Replace girdle for spinal orthosis (cervical-thoracic-lumbar-sacral orthosis (CTLSO) or spinal orthosis SO)
L1000	Cervical-thoracic-lumbar-sacral orthosis (CTLSO) (Milwaukee), inclusive of furnishing initial orthotic, including model
L1001	Cervical-thoracic-lumbar-sacral orthosis (CTLSO), immobilizer, infant size, prefabricated, includes fitting and adjustment
L1005	Tension based scoliosis orthosis and accessory pads, includes fitting and adjustment
L1006	Scoliosis orthosis (SO), 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
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
L1010	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, axilla sling
L1020	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, kyphosis pad
L1025	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, kyphosis pad, floating
L1030	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, lumbar bolster pad
L1040	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, lumbar or lumbar rib pad
L1050	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, sternal pad
L1060	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, thoracic pad
L1070	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, trapezius sling
L1080	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, outrigger
L1085	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, outrigger, bilateral with vertical extensions
L1090	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, lumbar sling
L1100	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, ring flange, plastic or leather
L1110	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, ring flange, plastic or leather, molded to patient model
L1120	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO), scoliosis orthosis, cover for upright, each
L1200	Thoracic-lumbar-sacral orthosis (TLSO), inclusive of furnishing initial orthosis only
L1210	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), lateral thoracic extension
L1220	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), anterior thoracic extension
L1230	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), Milwaukee type superstructure
L1240	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), lumbar derotation pad
L1250	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), anterior ASIS pad
L1260	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), anterior thoracic derotation pad
L1270	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), abdominal pad
L1280	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), rib gusset (elastic), each
L1290	Addition to thoracic-lumbar-sacral orthosis (TLSO), (low profile), lateral trochanteric pad
L1499	Spinal orthosis not otherwise specified

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APPROVAL HISTORY

02/11/2026	Policy revised. Clarified specific pain indications for bracing in indications and limitations. Updated Riser grade to 0 -3 for scoliosis bracing. Removed duplicate criteria. Annual Review will remain December 2026. IRO Peer Reviewed on January 23, 2026, by a practicing physician board certified in Orthopedic Surgery.
12/10/2025	Policy reviewed. No changes to coverage criteria. Updated Summary of Medical Evidence and References.
12/11/2024	Policy revised. Coverage criteria updated with removal of referral information in LSO criteria; under CTLSO/TLSO criteria clarified for scoliosis on curve angle to greater than 25 degrees, Risser grade and menarche timing. Under CTLSO/TLSO duplicate spinal curve criteria and worsening spinal curve documentation criteria removed. Custom brace and brace replacement criteria clarified. IRO Peer Reviewed on November 11, 2024, by a practicing physician board certified in Orthopedic Surgery.
04/10/2024	Policy reviewed. No changes to criteria. Updated Summary of Medical Evidence and References.
04/13/2023	Revision to coverage limitations and exclusions to remove “Management of preoperative or postoperative spinal fusion surgery” and “Treatment of spinal burst fractures with or without neurological deficits.”
02/08/2023	Policy revised. Updated criteria in Coverage Policy section to include TLSO, CTLSO, and LSO as well as other types of back braces, updated Overview, Summary of Medical Evidence and Reference sections. Reviewed by a practicing physician board certified in orthopedic surgery.
04/13/2022	Policy reviewed; no changes to criteria; updated Summary of Medical Evidence and Reference sections.
04/05/2021	Policy reviewed, no changes to criteria; added descriptions for each HCPCS code on 6/15/2021.
04/23/2020	Policy reviewed; no changes to criteria; updated Summary of Medical Evidence and Reference sections.
06/19/2019	Policy reviewed; no changes to criteria; updated Summary of Medical Evidence and Reference sections.
03/08/2018	Policy reviewed, no changes to criteria.

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