Static Upper Extremity Orthoses

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Introduction

Static upper extremity orthoses (braces) are addressed by this guideline, including: shoulder, shoulder-elbow, shoulder-elbow-wrist-hand, elbow, elbow-wrist-hand, elbow-wrist-hand-finger, wrist-hand-finger, wrist-hand, hand-finger, and finger.

Criteria

Prefabricated Static Upper Extremity Orthoses:

A **prefabricated static upper extremity orthosis** is medically necessary in an individual with limited upper extremity joint range of motion or joint stiffness due to **any** of the following:

- Injury or surgery
- Compression of peripheral nerves in the limb
- Arthritis
- Inflammation of the tendons around the joint
- Muscle weakness in the limb
- Contracture of a joint
- Spasticity

Custom-Fabricated Static Upper Extremity Orthoses:

A **custom-fabricated static upper extremity orthosis** is medically necessary in an individual when the basic coverage criteria listed for a prefabricated upper extremity orthosis is met and **all** of the following criteria are met:

- The individual is unable to be fitted with a pre-made brace.
- The condition requiring the brace is anticipated to be permanent or of long-standing duration beyond six months.
- The individual has an upper extremity deformity that necessitates a custom-made brace to fit properly.

Not Covered

- Prophylactic upper extremity static bracing is not medically necessary.

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Replacement Criteria:

Same or Similar Durable Medical Equipment

- Duplication of the same or similar orthoses within the same case is not medically necessary.

A replacement orthosis is medically necessary when **all** of the following apply:

- The individual has been seen recently by their provider and has a documented care plan that includes the use of the brace.
- There is clinical documentation of **any** of the following:
  - The individual is no longer able to wear the brace because of growth or a change in physical condition.
  - The brace has been lost or stolen.
  - The brace is broken, unable to be repaired, and no longer under warranty.

Definitions

- An **orthosis** (brace) is a rigid or semi-rigid device used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. An orthosis can be classified as either prefabricated (off-the-shelf), custom-fitted, or custom-fabricated.
- A **pre-fabricated orthosis** can be used for individuals requiring only minimal self-adjustment. A prefabricated orthosis can also be custom-fitted by a certified orthotist or individual with specialized training. Prefabricated orthoses are available in multiple sizes and can be adjusted to accommodate an individual's functional and anatomical needs.
- A **custom-fabricated orthosis** is made for a specific individual based on clinically-derived castings, tracings, molds, or images of the body part. Custom fabrication may be appropriate when specific fit issues are unable to be addressed by adjusting a prefabricated brace or orthosis (e.g., cutting, bending, adding extra straps). Custom-fabricated additions are appropriate only for custom-fabricated orthoses and should not be billed with prefabricated orthoses.
- A **static joint extension and flexion orthosis** maintains an affected joint in a fixed position near the end range of motion and applies a constant low level of tension on the joint and thus increases the range of motion.
- **Peripheral nerve compression** affecting the upper extremities may present with pain, sensory loss, or weakness involving the shoulder, arm, or hand. Compression commonly affects distal nerve segments, usually related to entrapment, but may also occur proximally at the root level. The following are peripheral nerve impairments affecting the upper extremity, including but not limited to the following:

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- **Carpal Tunnel Syndrome:** The most common upper extremity mononeuropathy. Symptoms usually include painful paresthesias of the first three digits and the radial half of the fourth digit. The symptoms are typically worse at night and characteristically awaken affected individuals from sleep. Conservative treatment of carpal tunnel includes wrist splinting, especially at night or while performing activities that exacerbate symptoms.
- **Posterior interosseous neuropathy**: The posterior interosseous nerve branches off from the radial nerve just proximal to the elbow and innervates the extensor muscles of the forearm. A posterior interosseous neuropathy should be considered in individuals with weakness of the finger extensors that spares the more proximal muscles including brachioradialis and extensor carpi radialis. Conservative treatment may include wrist splinting to maintain function.
- **Ulnar neuropathy at the wrist:** Compression of the ulnar nerve occasionally occurs in the wrist in Guyon's canal. Individuals with ulnar nerve compression at the wrist may present with weakness in the interossei muscles and sensory loss and paresthesias affecting digits four and five. To prevent excessive or prolonged elbow flexion, splints that limit flexion to 45° to 90° may be used at night.
- **Hand osteoarthritis (OA):** Hand OA is one of the most common OA phenotypes and may lead to joint pain, decreased hand strength, and a reduced quality of life. Splints and other assistive devices may be used before or in combination with pharmacologic interventions. Many different splints are available: prefabricated or custom-made; incorporating only the first carpometacarpal (CMC-1) joint or also the wrist or the first metacarpophalangeal (MCP-1) joint; and fabricated of rigid, semi-rigid, or soft material.
- **Elbow Tendinopathy (Lateral Epicondylitis and Medial Epicondylitis):** Elbow Tendinopathy represents a chronic tendinosis involving disorganized tissue and neovessels within the involved tendon. Repetitive athletic or occupational motions, particularly those performed rapidly and forcefully, involving eccentric motion in which a muscle-tendon unit is lengthened while under a load, may increase susceptibility to injury.
- **Contracture/Spasticity management:** Individuals with Cerebral Palsy (CP) may benefit from bracing to enhance musculoskeletal alignment, promote function, and delay or prevent joint contractures. Ankle-foot orthotics are the most frequently used devices, followed by orthotics for the wrist and hand. Orthoses for the knees or hips can also be useful to assist with ambulation or balance. Some braces are intended to be worn with specific activities, such as walking, using a gait trainer, or weight bearing in a stander, while others are intended to be used in sleep to promote joint alignment.

Commonly prescribed upper extremity orthoses may include:

- **Prefabricated volar wrist braces** (cock up non-molded) are considered medically necessary for the treatment of carpal tunnel syndrome.
- **Splints and Immobilizers**: Certain upper extremity orthopedic problems are routinely treated with splints or splint-like devices:
  - Acromio-clavicular splint
  - Clavicle splint (also called a figure-8 splint)
  - Dynamic upper extremity orthoses (e.g., Dynasplint®)
  - Finger splints
  - Shoulder immobilizer

Evidence Discussion

Literature Review

Upper Extremity Injury, Fracture or Surgery:

- Veltman et al. (2015) conducted a systematic review including eight studies (one randomized trial and seven cohort studies) involving 232 individuals to evaluate non-operative treatment options for posttraumatic elbow stiffness. Static progressive splinting was evaluated in 160 individuals with an average improvement of 36°. Dynamic splinting was evaluated in 72 individuals with an average improvement of 37°. The investigators concluded that both dynamic orthoses and static progressive splinting demonstrated good results for the treatment of elbow stiffness regardless of etiology. The authors recommended to continue non-operative treatment with dynamic or static bracing for 12 months or until lack of progression in range of elbow motion.
- A Cochrane systematic review (Abraham & Handoll, 2008) including 10 trials involving 827 children evaluated removable splintage versus plaster casts for undisplaced compression (buckle) fractures. Compared with traditional casts, the authors noted that a splint was less expensive and less restrictive to wear enabling more children to participate in activities of daily living and other activities. Removable plaster casts did not result in significant differences in outcome but were favored by parents. The authors concluded that minor (buckle) fractures could be treated by a splint that is removable at home.
- Müller et al. (2013) performed a systematic review including 13 studies involving 247 individuals with elbow stiffness of traumatic or postoperative origin and without evidence of ossification to compare the effectiveness of dynamic, static, or static-progressive bracing. The study defined static splints by the use of a constant force, usually worn for long periods of time, potentially up to 12 hours or more daily. Dynamic splints typically use springs or rubber bands with variable force but displacement is constant. Static-progressive splinting (SPS) is an extension of dynamic splinting which uses the same device as dynamic splinting but with constant

tension instead of a dynamic force (e.g., a rubber band). All three types of bracing led to significant improvements in range of motion. The authors concluded that the current evidence strongly supports the use of static-progressive stretching as a first line of treatment in individuals with post-traumatic and postsurgical elbow stiffness.

Upper Extremity Peripheral Nerve Compression and Tendinopathy:

- A 2023 systematic review conducted by Karjalainen et al. reviewed eight trials involving 523 hands and evaluated nocturnal wrist splinting versus no treatment in individuals with carpal tunnel syndrome (CTS). The authors concluded that splinting modestly improved short-term symptoms and hand function (less than three months); however, only low-certainty evidence suggested that the benefits may continue on a long term basis. However, the authors noted that splinting is a relatively inexpensive intervention with no significant long-term harms; thus, small effects could justify its use, specifically when individuals elect to pursue conservative management of CTS.
- A 2023 follow-up study of the INSTinCTS (INjection vs SplinTing in Carpal Tunnel Syndrome) trial reported by Burton et al. compared the effects of corticosteroid injection and night splinting for the initial management of mild-to-moderate CTS. The study evaluated symptoms, resource use, and the need for carpal tunnel surgery over a 24 month period. The authors found that subsequent referral for surgery was more frequent in individuals assigned initially to an injection; however, the generalizability of this finding was limited by the inconsistent use of repeat injections or prolonged splinting as well as the percent of individuals lost to follow-up.
- Hall et al. (2013) reported on a randomized clinical trial including 54 individuals which compared eight weeks of splinting and a structured education program versus no treatment in individuals with CTS. The authors found a statistically significant reduction in pain and an improvement of function in individuals who used a splint. However, the authors noted that future studies are needed to determine the long-term effects of splinting and education for individuals with CTS.
- Shah et al. (2013) conducted a prospective study including 19 individuals to analyze symptom improvement in mild to moderate cubital tunnel syndrome treated with a three month course of rigid night splinting in 45° of elbow flexion and activity modification. Treatment failure was defined as progression to operative management. Outcome measures included: patient-reported splinting compliance, the Quick Disabilities of the Arm, Shoulder, and Hand questionnaire, and the Short Form-12. Follow-up included a standardized physical examination. Twenty one of 24 (88%) extremities were successfully treated without surgery. The investigators observed a high compliance rate with the splinting protocol during the three month treatment period. The Quick Disabilities of the Arm, Shoulder, and Hand score and Short Form-12 physical component summary score improved significantly. Average grip strength increased significantly, and the ulnar nerve provocative testing resolved in 82% of individuals available for follow-up examination. Thus, the investigators concluded that rigid night splinting when combined with activity modification appears

to be a successful, well-tolerated, and durable treatment modality in the management of cubital tunnel syndrome.

- Huisstede et al. (2018) conducted a systematic review including 39 studies to evaluate the effectiveness of conservative and postsurgical interventions for trigger finger, Dupuytren disease, and De Quervain disease. The authors found moderate evidence supporting the effectiveness of a thumb splint when used with corticosteroid injections and post surgery when treating De Quervain tendonitis but not trigger finger. However, the authors noted that more high-quality randomized trials are needed to further evaluate the effectiveness of interventions for trigger finger, Dupuytren disease, and De Quervain disease.

Upper Extremity Arthritis:

- Aebischer et al. (2016) performed a systematic review including 27 studies. The review demonstrated evidence that a multimodal physical or occupational therapy program may be effective in the treatment of an individual with trapeziometacarpal osteoarthritis. The authors recommended a multimodal approach including but not limited to splint application combined with an exercise program and patient education on joint protection. Moreover, the type of splint should be chosen related to the type of activity (e.g., hard work may necessitate a thermoplastic splint). Notably, the authors found evidence that neoprene splints and custom-fabricated thermoplastic splints may equally reduce pain in individuals with trapeziometacarpal arthritis. However, the available evidence did not indicate that the interventions examined significantly improved function or quality of life.
- Ramsey et al. (2014) performed a systematic review including 23 studies to evaluate the effectiveness of wrist splints in individuals with rheumatoid arthritis. The authors reported moderate to strong evidence that wrist splints reduce pain and improve grip strength and dexterity in rheumatoid arthritis; however, there is insufficient evidence on the effects of wrist splints on function.
- A systematic review (Roll & Hardison, 2017) including 59 articles found that in individuals with rheumatoid arthritis, orthoses may improve dexterity in individuals with swan-neck deformity and functional outcomes with mallet finger. However, the authors did not find evidence supporting the effectiveness of orthoses for treatment of the boutonniere deformity.
- Kjeken et al. (2011) reported on a randomized controlled trial including 70 individuals with hand osteoarthritis to evaluate assistive devices and splints as an effective treatment option. Thirty-five participants received provision of information and splints (experimental group) and 35 participants received information only (control group). Outcome measures included activity performance and satisfaction with performance, disease activity, pain, fatigue, and function. The results of the study demonstrated that the use of assistive devices and/or splints resulted in an improvement in activity performance and satisfaction with performance after a three-month follow-up in individuals with hand osteoarthritis.

- Kjeken et al. (2011) conducted a systematic review to evaluate the effects of splinting and exercise programs in hand osteoarthritis. The authors identified two randomized trials which demonstrated that splints significantly reduced hand pain at three month follow-up. In addition, a combination of splints and daily exercises may reduce pain and stiffness and improve function. However, the design of the splint and exercise programs varied across the literature. In conclusion, the authors reported consistent evidence that splints reduce hand pain, but limited evidence for the effects of hand exercises and a combination of hand exercises and splints in hand osteoarthritis.

Upper Extremity Contractures/Spasticity:

- Tyson & Kent (2011) conducted a systematic review including four randomized trials with 126 participants to establish whether upper limb orthotics for individuals with stroke or other non-progressive brain lesions improve function and/or other impairments. The authors concluded that the use of upper limb orthoses in individuals with non-progressive brain lesions and spasticity did not improve function of the upper limb, wrist, or fingers when used without botulinum toxin.
- Harvey et al. (2017) performed a Cochrane systematic review including 18 studies involving 549 participants to examine the effectiveness of stretch in individuals with neurological and non-neurological conditions, such as burns, arthritis, spinal cord injury, stroke and frailty. The types of interventions included stretch administered through positioning programs, splints, serial casting, or as part of manual therapy. Joint mobility data was evaluated to determine the short-term effects of the intervention defined as effects present up to one week after the final stretch intervention. The authors reported high-quality evidence that stretch does not have clinically worthwhile short-term effects on joint mobility. However, the authors identified limitations to the study, noting that the effectiveness of stretch administered for many months or years is unknown, as most studies included applied stretch for between four and twelve weeks.
- Saal et al. (2017) performed a systematic review to determine the effects of interventions to prevent and treat disabilities in older individuals with contractures. Splints were examined in four studies, which revealed inconclusive results regarding joint mobility or spasticity. One of the four studies reported significant improvement in the passive range of motion in wrist extension after radial fracture; however, the authors noted that it remains unclear whether wearing splints over different lengths of time affects spasticity after a stroke. Thus, the investigators reported inconclusive results regarding the use of splinting on joint mobility or spasticity due to joint contractures.
- Jackman et al. (2014) performed a systematic review including six studies to determine the effectiveness of hand splinting for improving hand function in children with cerebral palsy (CP). The study identified 'Non-functional hand splints' as devices designed for the primary purpose of improving outcomes in the body function and structure; for example, a resting hand splint used to prevent or correct muscle

contracture or a supination cast used to lengthen muscles or inhibit muscle tone. Of note, 'non-functional hand splints' may interfere with voluntary hand function and are therefore worn either at night or for short periods of time. The second type of hand splint identified in the study, 'functional hand splints,' are designed to improve outcomes in activity and participation, such as with activities of daily living (e.g., utensil holding while eating) or handwriting). An example of a 'functional hand splint' includes a wrist cock-up splint designed to stabilize and position the wrist during activities. Five studies investigated 'non-functional hand splints' and one study investigated a 'functional hand splint'. The authors found moderate-quality evidence that the use of a non-functional hand splint in addition to physical therapy was more effective that therapy alone in children with spasticity caused by a neurological condition. However, the authors noted that the benefits of non-functional splints were diminished two to three months after splint wearing stopped. In addition, although the evidence supports a small, immediate benefit of functional hand splints; the authors noted that further research of higher methodological quality is needed.

Professional Societies/Organizations:

- The American College of Occupational and Environmental Medicine (ACOEM) (Hegmann et al., 2013) recommended elbow slings for nondisplaced and occult radial head fractures, dislocations, and severe elbow sprains. Casts are recommended for minimally displaced fractures and other elbow fractures. In addition, the consensus panel recommended elbow straps or braces for individuals with medial or lateral epicondylitis; cock-up wrist braces may be appropriate in severe cases or when elbow straps and braces are ineffective. The authors also recommended slings and splints for triceps or biceps tendinosis. Notably, the consensus panel recommended nocturnal elbow splinting for the prevention of flexion for individuals with ulnar neuropathy at the elbow. The treatment of individuals with pronator or radial tunnel syndrome was advised to be similar to treatment of ulnar neuropathy at the elbow.
- A College of Occupational Therapists Clinical Practice guideline (Ashford et al., 2015) recommended orthotic support in individuals with chronic arthritis or osteoarthritis, including individuals with the swan-neck deformity. In addition, the authors noted that for the upper limb, splints should not be used routinely to correct or prevent contractures but may be beneficial for reducing pain and preventing contractures in individuals with certain neurological conditions, such as stroke.
- The American Heart Association/American Stroke Association Guidelines for Adult Stroke Rehabilitation and Recovery, Weinstein et al, 2016 reported reported that serial casting or static adjustable splints may be considered to improve elbow or wrist contracture in individuals with stroke. Moreover, the guidelines recommended that application of resting hand splints in combination with early botulinum toxin injection to wrist and finger flexors may also be effective for the prevention of contractures in individuals with stroke.

- An international, multidisciplinary group guideline (Morris et al., 2011) from a consensus conference on the management of cerebral palsy noted that although there is limited evidence, splinting is commonly used for management of flexion spasticity at the elbow and wrist in adults with cerebral palsy. The authors noted that static wrist-hand orthoses do not appear to improve immediate function relative to dynamic bracing and unbraced conditions. Moreover, the authors questioned the ability of orthoses to prevent or delay wrist and hand contractures due a paucity of available evidence.
- A specialty practice guideline from the American Academy of Orthopaedic Surgeons (Graham et al., 2016) reported strong evidence that the use of immobilization (brace/splint/orthosis) should improve patient-reported outcomes in the treatment of CTS. However, the authors recommended against postoperative immobilization in individuals after carpal tunnel release, noting that post-operative splinting may be beneficial for some individuals.

Codes included

The inclusion of any code in this table does not imply that the code is under management or requires prior authorization. Refer to the applicable health plan for management details. Prior authorization of a code listed in this table is not a guarantee of payment. The Certificate of Coverage or Evidence of Coverage policy outlines the terms and conditions of the member's health insurance policy.

HCPCS	Description
L3671	Shoulder orthosis, shoulder joint design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3674	Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, with or without non-torsion joint/ turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3677	Shoulder orthosis (SO), shoulder joint design, without joints, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L3678	Shoulder orthosis, shoulder joint design, without joints, may include soft interface, straps, prefabricated, off-the-shelf
L3702	Elbow orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment

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HCPCS	Description
L3720	Elbow orthosis, double upright with forearm/arm cuffs, free motion, custom fabricated
L3730	Elbow orthosis, double upright with forearm/arm cuffs, extension/ flexion assist, custom fabricated
L3740	Elbow orthosis, double upright with forearm/arm cuffs, adjustable position lock with active control, custom fabricated
L3760	Elbow orthosis, with adjustable position locking joint(s), prefabricated, item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L3761	Elbow orthosis, with adjustable position locking joint(s), prefabricated, off-the-shelf
L3763	Elbow wrist hand orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3764	Elbow wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3765	Elbow wrist hand finger orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3766	Elbow wrist hand finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3806	Wrist hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, custom fabricated, includes fitting and adjustment
L3808	Wrist hand finger orthosis, rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment
L3807	Shoulder orthosis (SO), shoulder joint design, without joints, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L3809	Wrist hand finger orthosis, without joint(s), prefabricated, off-the-shelf, any type

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HCPCS	Description
L3891	Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism for custom fabricated orthotics only, each
L3900	Wrist hand finger orthosis, dynamic flexor hinge, reciprocal wrist extension/ flexion, finger flexion/extension, wrist or finger driven, custom fabricated
L3901	Wrist hand finger orthosis, dynamic flexor hinge, reciprocal wrist extension/ flexion, finger flexion/extension, cable driven, custom fabricated
L3904	Wrist hand finger orthosis, external powered, electric, custom fabricated
L3905	Wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3912	Hand finger orthosis (hfo), flexion glove with elastic finger control, prefabricated, off-the-shelf
L3915	Wrist hand orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L3916	Wrist hand orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, off-the-shelf
L3917	Hand orthosis, metacarpal fracture orthosis, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L3918	Hand orthosis, metacarpal fracture orthosis, prefabricated, off-the-shelf
L3921	Hand finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3923	Hand finger orthosis, without joints, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

HCPCS	Description
L3924	Hand finger orthosis, without joints, may include soft interface, straps, prefabricated, off-the-shelf
L3929	Hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L3930	Hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, off-the-shelf
L3960	Shoulder elbow wrist hand orthosis, abduction positioning, airplane design, prefabricated, includes fitting and adjustment
L3961	Shoulder elbow wrist hand orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3962	Shoulder elbow wrist hand orthosis, abduction positioning, erb's palsey design, prefabricated, includes fitting and adjustment
L3967	Shoulder elbow wrist hand orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3971	Shoulder elbow wrist hand orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3973	Shoulder elbow wrist hand orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3975	Shoulder elbow wrist hand finger orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment

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HCPCS	Description
L3976	Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3977	Shoulder elbow wrist hand finger orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3978	Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3980	Upper extremity fracture orthosis, humeral, prefabricated, includes fitting and adjustment
L3981	Upper extremity fracture orthosis, humeral, prefabricated, includes shoulder cap design, with or without joints, forearm section, may include soft interface, straps, includes fitting and adjustments

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