Medical Necessity Guidelines: Upper Limb Prostheses

Effective: November 16, 2022

Prior Authorization Required
If REQUIRED, submit supporting clinical documentation pertinent to service request.

Yes ☒ No ☐

Applies to:
COMMERCIAL Products
☒ Tufts Health Plan Commercial products; Fax: 617.972.9409
• CareLink® – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products
☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304
• The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products
• Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
• Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW
An upper limb prosthesis is a device designed to replace the function of a missing upper limb or body part due to congenital absence or amputation. Upper limb prostheses can be controlled using body-powered system, externally powered system, or a combination of both systems. Prosthetic terminal devices replace lost hand function and include passive, body-powered, and externally powered hooks and hands.

CLINICAL COVERAGE CRITERIA
The Plan may authorize coverage of initial and replacement upper limb prosthesis when the requested prosthesis or component(s) is the most appropriate medically necessary device that adequately meets the functional needs of the member. When possible, The Plan may cover a trial of upper limb prosthesis, with supporting documentation.

Initial Upper Limb Prostheses Authorization
The Plan may authorize the coverage of initial upper limb prosthesis, including body powered prosthesis, when all the following criteria are met:
1. Documentation confirms a comprehensive evaluation has been performed by a board certified [American Board of Certification (ABC) or Board of Certification (BOCP)] prosthetist and prescribed prosthesis/component(s) is based on prosthetist recommendation
2. Functional evaluation indicates requested device does not exceed that which is medically necessary to adequately meet the functional needs of the member
3. Member has sufficient cognitive function, neurological function, cardiovascular reserve and musculoskeletal ability to effectively utilize requested device to complete activities of daily living (ADL’s)
4. Member will reach or maintain a predicted improved functional state, with the use of the prescribed prosthesis within a reasonable and predictable period of time.

Myoelectric Prosthesis
The Plan may authorize coverage of myoelectric upper limb prosthesis when criteria for initial upper limb prosthesis are met AND when all the following additional criteria are met:

1. The member has sufficient neurological, musculoskeletal, myocutaneous, and cognitive function to operate the prosthesis effectively
2. The member has sustained a minimum of a trans metacarpal or above partial limb amputation
3. The member has sufficient microvolt threshold in the residual limb to allow proper function of myoelectric prosthesis
4. A standard body powered prosthetic device cannot be used or is insufficient to meet the functional needs of the member in performing activities of daily living
5. The member functions in an environment that would not inhibit the function of the prosthesis (i.e., a wet environment or situations involving electrical discharges)

**Electric Hand**

The Plan may authorize coverage of electric hand (L6880) or partial hand (L6026) prosthetic component when criteria for initial upper limb prosthesis and myoelectric prosthesis are met and all of the following criteria are met:

1. Documentation by board certified prosthetist that:
   a. Member requires use of device for independence in activities of daily living (ADL’s) including:
      i. Dressing
      ii. Personal hygiene, oral hygiene and grooming
      iii. Toileting
      iv. Feeding; and
   b. Member is willing and able to complete necessary training with Occupational Therapist or Physical Therapist who is trained and who specializes in terminal upper limb myoelectric prosthetic components, including partial hand/electric hand
   c. Documented Occupational or Physical Therapy evaluation supports all of the following:
      i. Member has the potential to function independently with requested terminal device in a reasonable and predictable period of time; and
      ii. ALL functions of the requested device (e.g., wrist rotation, number of articulating digits, thumb opposition, number of grip patterns) do not exceed that which is medically necessary to adequately meet the functional needs to the member; and
      iii. Device will allow member the grip prehension and joint movement required to sustain a minimum level of independent daily living
      iv. Member has sufficient cognitive, musculoskeletal and neurological ability to utilize device to complete ADL’s

**Replacement Prosthesis Authorization all products**

A replacement is the removal and substitution of a component of a prosthesis that has a HCPCS definition.

The Plan may authorize the replacement of upper limb prosthesis or the replacement of any part of such device, if an ordering physician determines that the replacement device, or replacement part of such a device, is necessary when all the following criteria are met:

1. Covered repairs must be performed by a certified prosthetist as described above, or technician working under the supervision of a certified prosthetist.
2. Documentation by Provider that member has demonstrated continuous use of current prosthesis.
3. There is a change in the physiological condition or functional level of the member, which justifies a new prosthesis or replacement part(s)
4. There is an irreparable change in the condition of the device, or in a part of the device
5. The component or prosthesis in need of replacement is not covered under warranty

The Plan may cover the replacement of sockets when there is adequate documentation of functional and/or physiological need, including but not limited to: changes in the residual limb, functional need changes, or irreparable damage or wear/tear due to excessive weight or prosthetic demands of very active amputees.
In addition to the above criteria, the following replacement criteria are applicable to Tufts Health Commercial, Tufts Freedom Plan, Tufts Health Direct, and Tufts Health RITogether products only:

1. The condition of the device, or the part of the device, requires repairs, and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.
2. The component or prosthesis is not in need of replacement as a result of improper use.

LIMITATIONS
The Plan will not cover the following, as they are not considered medically necessary:

- Swim prosthesis
- Shower prosthesis
- Artificial limbs or parts thereof for cosmetic purposes only, including, but not limited to, nonfunctional prostheses, nonfunctional prosthetic covers and non-functional finger prostheses.
- Prostheses with experimental/investigational components (including L6715. Refer to Medical Necessity Guidelines : Noncovered Investigational Services)
- Devices intended for sports, recreation, or work-related purposes
- The Plan will not cover upgrade or enhancement of member’s current prosthesis or prosthetic component(s) when member’s current prosthesis or prosthetic component(s) meets their functional needs and allows the member to perform activities of daily living.
- The Plan will not cover additional or duplicate prosthesis or prosthetic component(s).
- The Plan will not cover repair or replacement of a spare, backup or duplicate prosthesis or prosthetic component(s)
- 3D printed prostheses
- Osseointegrated prostheses
- Myoelectric sensors can be implanted beneath the skin to improve the prosthetic function and control
- Targeted muscle reinnervation

CODES
The following HCPCS code(s) require prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L6000-L6020, L6026, L6050-L6714, L6721-L6810, L6880-L7405, L7499</td>
<td>Upper Limb Prosthetics</td>
</tr>
<tr>
<td>L7510</td>
<td>Repair of prosthetic device, repair or replace minor parts</td>
</tr>
<tr>
<td>L7520</td>
<td>Repair prosthetic device, labor component, per 15 minutes</td>
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</tbody>
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REFERENCES
2. General Laws of Massachusetts - Chapter 176G Health Maintenance Organizations - Section 4S Coverage for prosthetic devices and repairs. Section 4S accessed on March 4, 2022 @ https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176G/Section4S.
hhttps://www.healthquality.va.gov/guidelines/Rehab/ULA/VADoDULACPG_ProviderSummary_Fi
nal_508.pdf.

APPROVAL HISTORY
Subsequent endorsement date(s) and changes made:
- February 28, 2007: Reviewed and renewed without changes
- March 26, 2008: Reviewed and renewed without changes
- October 8, 2008: Special Information box added to MNG format
- March 16, 2009: Additional limitation added regarding cosmetic and nonfunctional prostheses
- March 2010: Reviewed by MSPAC (Medical Specialty Policy Advisory Committee), Medical Policy-
Medical Affairs. No changes
authorization criteria section added
- April 11, 2012: Reviewed by IMPAC. Ability to submit request for a trial prosthesis and a limitation
of experimental/investigational prostheses added
- September 11, 2013: Reviewed by IMPAC, renewed without changes.
Health Plan – Network Health Medicaid Plans.
- December 10, 2014: Reviewed by IMPAC and approved for an effective date of April 1, 2015.
Change to replacement prosthesis criteria; continuous use or useful lifetime restrictions removed.
Documentation by Provider that Member has demonstrated continuous use of current prosthesis
added.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in
"Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- October 14, 2015: Reviewed by IMPAC. Clarification to coding ranges. Addition of L7499 to code
range. Clarification of limitation for finger prostheses.
- December 9, 2015: Reviewed by IMPAC, renewed without changes
- December 14, 2016: Reviewed by IMPAC, renewed without changes
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether,
effective date is August 1, 2017
- November 8, 2017: Reviewed by IMPAC, renewed without changes
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October 2018: Template and disclaimer updated
- March 20, 2019: Reviewed at IMPAC. For effective date July 1, 2019, addition of initial upper limb
criteria to replace criteria for body powered prosthesis. Addition of criteria for electric hand,
coverage applicable to TH Together and TH Unify products only. Clarification of replacement
criteria applicable to Tufts Health Commercial, Tufts Freedom Plan, Tufts Health Direct, and Tufts
Health RITogether products only
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- January 15, 2020: Reviewed at IMPAC. For effective date July 1, 2020, limitations added. Upgrade
or enhancement of member's current prosthesis, an additional or duplicate prosthesis and
repair/replacement of a spare, backup or duplicate prosthesis are not covered
- April 2, 2020: Fax number for Unify updated
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- October 20, 2021: Reviewed by IMPAC, renewed without changes
- February 1, 2022: Template Update
- March 16, 2022: Reviewed by Medical Policy Approval Committee (MPAC) for integration purposes
with Harvard Pilgrim Health Care with an effective date of June 1, 2022, L6026 added.
- November 16, 2022: Reviewed by MPAC, renewed without changes

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION
Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to
provide a better understanding of the basis upon which coverage decisions are made. We make coverage
decisions using these guidelines, along with the Member's benefit document, and in coordination with
the Member’s physician(s) on a case-by-case basis considering the individual Member's health care
needs.
Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.