Medical Necessity Guidelines: Upper Limb Prostheses
Effective: November 8, 2017

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

<table>
<thead>
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<th>Applies to:</th>
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<tr>
<td>COMMERCIAL Products</td>
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<tr>
<td>☑Tufts Health Plan Commercial products; Fax: 617.972.9409</td>
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<tr>
<td>☑Tufts Health Freedom Plan products; Fax: 617.972.9409</td>
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<tr>
<td>• CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization</td>
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<tr>
<td>TUFTS HEALTH PUBLIC PLANS Products</td>
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<tr>
<td>☑Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055</td>
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<tr>
<td>☑Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055</td>
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<tr>
<td>☑Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404</td>
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<tr>
<td>☑Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 781.393.2607</td>
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<td>*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.</td>
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<td>SENIOR Products</td>
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<td>• Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List</td>
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<tr>
<td>• Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List</td>
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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
A prosthesis is a device or an artificial substitute designed to replace, as much as possible, the function or appearance of a missing limb or body part (Bodeau and Mipro, 2002).

CLINICAL COVERAGE CRITERIA
Tufts Health Plan may authorize coverage of initial (new) and replacement upper limb prosthesis when the requested prosthesis or component(s) is the most appropriate medically necessary model that adequately meets the medical needs of the member (MGL 176G § 4S). When possible, Tufts Health Plan may cover a trial of upper limb prosthesis, with supporting documentation.

Initial Prosthesis Authorization:
- **Body Powered Prosthesis**
  Tufts Health Plan may authorize the coverage of body-powered upper extremity prosthesis when this type of device appropriately meets the Member’s functional needs.

- **Myoelectric Prosthesis**
  Tufts Health Plan may authorize coverage of myoelectric upper limb prosthesis when all of the following criteria are met.
  - The Member has sufficient neurological, myocutaneous, and cognitive function to operate the prosthesis effectively
  - The Member has sustained a minimum of a wrist or above partial limb amputation
  - The Member has sufficient microvolt threshold in the residual limb to allow proper function of the prosthesis
  - 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
  - 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)
Replacement Prosthesis Authorization
A replacement is the removal and substitution of a component of a prosthesis that has a HCPCS definition.

- Tufts Health Plan may authorize the replacement of upper limb prosthesis or the replacement of any part of such devices, 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:
  - Documentation by Provider that Member has demonstrated continuous use of current prosthesis.
  - There is a change in the physiological condition or functional level of the Member, which justifies a new prosthesis or replacement parts.
  - There is an irreparable change in the condition of the device, or in a part of the device.
  - 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.
  - The component or prosthesis in need of replacement is not covered under warranty and is not in need of replacement as a result of improper use.

- Tufts Health 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.

LIMITATIONS
Tufts Health 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.
- Bilateral myoelectric prostheses
- Prostheses with experimental/investigational components (including L6026, L6715, L6880, refer to Noncovered Investigational Services List)

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>L6000-L6020, L6050-L6714, L6721-L6810, L6881-L7405, L7499</td>
<td>Upper limb prosthetics</td>
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<tr>
<td>L7510</td>
<td>Repair of prosthetic device, repair or replace minor parts</td>
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<tr>
<td>L7520</td>
<td>Repair prosthetic device, labor component, per 15 minutes</td>
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REFERENCES

APPROVAL HISTORY

Subsequent endorsement date(s) and changes made:
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.