MEDICAL POLICY

POLICY TITLE	PROSTHETICS AND ACCESSORIES
POLICY NUMBER	MP-6.018

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I. POLICY

Determinations of medical necessity and appropriateness for Prosthetics will be made following the guidelines set forth in this policy and further described in the Center for Medicare and Medicaid Services (CMS)/Medicare guidelines as documented in the Durable Medical Equipment Regional Carrier Supplier Manual, Region A (also known as DME MAC A Jurisdiction A Supplier Manual). Medicare guidelines for medical necessity prevail unless a specific individual medical policy for the prosthetic exists.

Prosthetics may be considered **medically necessary** and appropriate when:

- They are prescribed by a physician; and
- They are used to replace all or part of an absent internal body organ (including contiguous tissue) OR replace all or part of the function of a permanently inoperative or malfunctioning body part that is lost or impaired as a result of disease, injury or congenital deficit regardless of whether they are surgically implanted or worn outside the body.

The surgical implantation or attachment of covered prosthetics is considered **medically necessary**, regardless of whether the covered prosthetic is functional (i.e., regardless of whether the prosthetic improves or restores a bodily function).

Prosthetics are limited to the most cost-effective medically necessary device required to restore lost body function.

A prosthetic list is attached for use in determining the coverage status of certain prosthetics. The first column lists the generic or brand name of the item and the second column identifies the coverage status of that item. Please refer to the attached list or medical policy if one is referenced.

Fitting, necessary adjustments, repairs, and replacement of prosthetic devices which replace all or part of an absent body organ, permanently inoperative organ, or malfunctioning body part, are eligible services.

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Replacement of medically necessary prosthetic devices or parts will be eligible for coverage if it is determined that the replacement device or part is necessary due to any of the following:

- A change in the physiological condition of the patient;
- An irreparable change in the condition of the device or in a part of the device; or
- The condition of the device, or the part of the device, requires repairs and the cost of the repairs would be more than 60 percent of the cost of a replacement device, or of the part being replaced.

Prosthetic devices dispensed to a patient prior to performance of the procedure that will necessitate the use of the device are **not covered**.

Replacement of lost or stolen devices is **not covered** within the expected useful life of the item.

***NOTE**: Please see summary information on Prosthetics below:*

Item	Coverage Status
Bladder Stimulators (spinal cord electrical stimulators, rectal stimulators or bladder wall stimulators)	Investigational - there is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with this procedure.
Cochlear Implants	MP 1.023 Cochlear Implant
Dentures	Non-covered benefit exclusion
Electrical Continence Aids	MP 1.033 Sacral Nerve Neuromodulation/Stimulation and Pelvic Floor Stimulation Device.
External Breast Prosthesis and Post Mastectomy Bras	Only 1 breast prosthesis per side is considered medically necessary for the useful lifetime of the prosthesis. Two prostheses, 1 per side, are considered medically necessary for those persons who have had bilateral mastectomies. More than 1 external breast prosthesis per side is considered not medically necessary. 2 to 4 post-mastectomy replacement bras medically necessary every 12 months.
Eye Prosthesis	Covered for a patient with absence or shrinkage of an eye due to birth defect, trauma or surgical

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Item	Coverage Status
	removal. Polishing and resurfacing is covered on a twice per year basis
Facial Prosthesis	A facial prosthesis is covered when there is loss or absence of facial tissue due to disease, trauma, surgery, or a congenital defect.
Hearing Prosthetic Devices	MP 1.019 Implantable Bone-Conduction and Bone-Anchored Hearing Prosthetic Devices.
Heel/Sole Lifts	MP 6.028 Foot Orthotics and Other Podiatric Appliances
Hydrophilic Contact Lenses	MP 6.031 Gas Permeable Scleral Contact Lens and Therapeutic Soft Contact Lens
Implants for Cosmetic Purposes	MP 1.004 Cosmetic and Reconstructive Surgery
Mechanical/Hydraulic Incontinence Aids	May be considered medically necessary for use in management of urinary incontinence in patients with permanent anatomic and neurologic dysfunctions of the bladder.
Microprocessor Controlled Knee prosthesis (e.g., Otto Bock C-leg)	MP 6.042 Lower Limb Prostheses
Myoelectric Prosthesis	MP 6.052 Upper Limb Prostheses
MyoPro Orthotic System	Investigational - There is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with this product.
Non-Implantable Pelvic Floor Electrical Stimulator	MP 1.033 Sacral Nerve Neuromodulation/Stimulation and Pelvic Floor Stimulation Devices
Obturator	May be considered medically necessary for the rehabilitation of patients with oral, facial or other anatomical deficiencies by means of prostheses such as an artificial eye, ear, nose, or intra-oral obturator to close a cleft.
Ostomy Care Supplies	Covered for patients with a colostomy or other ostomy.
Penile Prosthetic Implants	MP 2.016 Erectile Dysfunction

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Item	Coverage Status
Phrenic Nerve Stimulator	MP 1.034 Implantable Electric Nerve Stimulators (vagus, autonomic nerve and peripheral nerve stimulators)
Testicular Prosthesis	May be considered medically necessary for replacement of congenitally absent testes or testes lost due to disease, injury or surgery.
Tracheal Care Supplies	Covered for patients with a tracheostomy
Urethral Sphincter	May be considered medically necessary for patients with urinary incontinence consequent to permanent and neurological dysfunctions of the bladder
Urinary Collection System	May be considered medically necessary for permanent urinary incontinence, including male external catheters as part of a urinary collection and retention system that replaces the function of the bladder. Intermittent urinary catheters are covered for permanent urinary incontinence, urinary retention, and neurogenic bladders.
Wigs (cranial/scalp prosthesis)	May be considered medically necessary for generalized hair loss present due to one or more of the following conditions: • Chemotherapy for the treatment of cancer • Radiation therapy for the treatment of cancer • Scalp injury • Third degree burn

II. PRODUCT VARIATIONS

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This policy is only applicable to certain programs and products administered by Capital BlueCross please see additional information below, and subject to benefit variations as discussed in Section VI below.

CHIP (aka Capital Cares 4Kids) - When a prosthesis is lost, replacement of the prosthesis with identical components as the original is allowed.

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FEP PPO - For services other than those addressed in specific policies refer to FEP Service Benefit Manual. The FEP Medical Policy manual can be found at: www.fepblue.org.

III. DESCRIPTION/BACKGROUND

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Prosthetics are artificial appliances that are used as a replacement for all or part of a body organ. They are also used to substitute functions of permanently inoperative, absent or malfunctioning body parts.

IV. RATIONALE

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NA

V. DEFINITIONS

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BASIC ACTIVITIES OF DAILY LIVING include and are limited to walking in the home, eating, bathing, dressing, and homemaking.

FUNCTIONAL MOBILITY refers to the ability to move from one place to another to complete an activity or task.

PERMANENTLY INOPERATIVE criteria are met when the medical record, including the judgment of the attending physician, indicates the condition will be of long and indefinite duration.

RECONSTRUCTIVE SURGERY is a procedure performed to improve or correct a functional impairment, restore a bodily function or correct a deformity resulting from birth defect or accidental injury. The fact that a member might suffer psychological consequences from a deformity does not, in the absence of bodily functional impairment, qualify surgery as being reconstructive surgery.

VI. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits and which require preauthorization. There are different benefit plan designs in each product administered by Capital BlueCross. Members and providers should consult the member's health benefit plan for information or contact Capital BlueCross for benefit information.

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VII. DISCLAIMER

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Capital BlueCross's medical policies are developed to assist in administering a member's benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital BlueCross' Provider Services or Member Services. Capital BlueCross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Specific coding does not apply to this policy.

IX. REFERENCES

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1. *Centers for Medicare and Medicaid Services (CMS) Medicare Benefit Policy Manual. Publication 100-02. Chapter 15 Covered Medical and Other Health Services. Effective 7/11/17. [Website]: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf. Accessed December 28, 2020.*
2. *Durable Medical Equipment Regional Carrier (DME MAC JA) Region JA Noridian Healthcare Solutions, Supplier Manual. Last updated 7/24/20. [Website]: https://med.noridianmedicare.com/web/jadme/education/supplier-manual. Accessed December 28, 2020.*
3. *Durable Medical Equipment Regional Carrier (DME MAC JA) Region JA Noridian Healthcare Solutions, LLC Local Coverage Determination (LCD) L33317, External Breast Prosthesis. Last updated 1/01/17. [Website]: https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33317&ContrId=389&ver=29&ContrVer=1&CntrctrSelected=389*1&Cntrctr=389&s=24&DocType=1&bc=AAIAAACAAAAA&. Accessed December 28, 2020.*
4. *Durable Medical Equipment Regional Carrier (DME MAC JA) Region JA Noridian Healthcare Solutions, LLC Local Coverage Determination (LCD) L33737, Eye Prosthesis.*

Last Updated 1/01/17. [Website]: https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33737&ver=12&Date=&DocID=L33737&bc=iAAAABAAAAAA&. Accessed January 8, 2020.

5. *Durable Medical Equipment Regional Carrier (DME MAC JA) Region JA Noridian Healthcare Solutions, LLC Local Coverage Determination (LCD) L33738, Facial Prosthesis. Last updated 1/01/17. [Website]: https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33738&ver=10&CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=Pennsylvania&KeyWord=facial&KeyWordLookUp=Title&KeyWordSearchType=And&FriendlyError=InvalidDocumentType&bc=gAAAACAAAAAA&. Accessed December 28, 2020.*
6. *Lee R, Te AE, Kaplan SA, Sandhu JS. Temporal trends in adoption of and indications for the artificial urinary sphincter. J Urol. 2009 Jun; 181(6):2622-7.*
7. *Livingston PM, White VM, Roberts SB, et al. Women's satisfaction with their breast prosthesis: what determines a quality prosthesis? Eval Rev. 2005 Feb; 29(1):65-83.*

X. POLICY HISTORY

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MP 6.018	**CAC 1/28/03**
	CAC 12/14/04
	CAC 1/31/06
	CAC 1/30/07
	CAC 3/27/07 Milliman Criteria
	CAC 6/26/07
	1-1-08 Changed Definition of Reconstructive Surgery
	CAC 5/27/08
	CAC 7/28/09 Consensus review.
	CAC 7/27/10 Consensus review.
	CAC 7/26/11 Minor Revision. Changed description of prosthetics that may be considered medically appropriate. Changed description of prosthetics coverage limitation to indicate prosthetics are limited to the most cost effective medically necessary device required to restore lost body function – now matches COC. Deleted the definition of medically necessary prosthetics indicating limitation of coverage for prosthetics to those that enable the patient to return to performing basic activities of daily living. Added testicular and eye prosthesis to the list. Policy reviewed and approved by CBC Legal Department.

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	CAC 8/28/12 Minor Revision. Policy title revised to Prosthetics and Accessories. Policy is being revised to add criteria from MP-6.042 Upper and Lower Limb Prosthetics for non-myoelectric prosthetics, accessories/components, definite prosthetics, sockets, and vacuum assisted socket systems (VASS). No change to position statements.
	CAC 7/30/13 Consensus. No change to policy statements. References updated. No coding changes.
	CAC 3/25/14 Consensus. No change to policy statements. References updated.
	CAC 9/30/14 Minor. Extracted information on upper and lower limb prosthetics for nonmyoelectric, non-microprocessor prosthetics, accessories/components, definite prosthetics, sockets, and vacuum assisted socket systems (VASS). This information was placed in a new policy MP 6.057 Upper and Lower Limb Prosthetics (other than Microprocessor and Myoelectric). Coding Reviewed
	CAC 9/29/15 Consensus review. No change to policy statements. References reviewed. Added FEP variation to reference FEP Benefit Manual. LCD numbers changed due to Novitas update to ICD 10. Specific codes do not apply.
	07/15/16 Administrative update. LCD revised to reflect change from NHIC to Noridian LCDs.
	CAC 9/27/16 Consensus. No change to policy statements. References reviewed. Variation reformatted.
	CAC 11/28/17 Consensus review. Policy statements unchanged. References updated. Medicare variations removed, effective 1/01/18, Medicare variations will no longer be listed on Commercial policies.
	5/08/18 Minor Review. Criteria added for prosthetics bras as well as for wigs. Names revised for Upper Limb and Lower Limb Prostheses. References updated.
	1/9/19 Minor Review. Criteria added stating that the MyoPro orthotic is considered investigational.
	01/09/2020 Consensus review. No change to policy statements. References updated.
	12/28/2020 Consensus review. Policy statement unchanged. References updated.

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