

Myoelectric Upper Limb Prosthesis

MEDICAL POLICY NUMBER: 26

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INSTRUCTIONS FOR USE: Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

SCOPE: Providence Health Plan, Providence Health Assurance and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PLAN PRODUCT AND BENEFIT APPLICATION

Commercial

Medicaid/OHP*

Medicare**

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

Myoelectric Upper Limb Prosthesis: Upper Extremity Prosthetics, Orthotics, and Supplies: PHA follows Oregon Health Plan (OHP) per Oregon Administrative Rules (OAR) 410-122-0660 to 0662 and Social Security Act §1833€

**Medicare Members

This Company policy may be applied to Medicare Plan members only when directed by a separate Medicare policy. Note that investigational services are considered “**not medically necessary**” for Medicare members.

COVERAGE CRITERIA

Note: Equipment must be used primarily and customarily to serve a medical purpose. Additional features whose main function is for convenience or improvement of quality of life are not considered medical indications and are therefore not covered.

Upper Limb Myoelectric Prosthetic Device

- I. One myoelectric upper limb prosthetic and/or components per limb per 5 (five) years may be considered **medically necessary** when **all** of the following criteria are met (A.-F.):
 - A. The patient has an amputation or missing limb at the wrist or above (forearm, elbow, etc.); **and**
 - B. Standard body-powered prosthetic devices cannot be used or are insufficient to meet the functional needs of the individual in performing activities of daily living (e.g. self-feeding, bathing, dressing, grooming, work, toileting, hygiene); **and**
 - C. The remaining musculature of the arm(s) contains the minimum microvolt threshold to allow operation of a myoelectric prosthetic device, as demonstrated by functional testing using a physical or computer model prosthesis; **and**
 - D. The patient has demonstrated sufficient neurological and cognitive function to operate the prosthesis effectively; **and**
 - E. The patient is free of comorbidities that could interfere with function of the prosthesis (e.g. neuromuscular disease, etc.); **and**

- F. The patient does not function in an environment that would inhibit function of the prosthesis (i.e. a wet environment or an environment involving electrical discharges that would affect the prosthesis)
- G. Functional evaluation by a qualified professional (e.g., prosthetist) indicates that with training, use of a myoelectric prosthesis is likely to meet the functional needs of the individual (e.g. gripping, releasing, holding, and coordinating movement of the prosthesis) when performing activities of daily living. This evaluation should consider the patient's needs for control, durability (maintenance), function (speed, work capability), and usability.

Note: Medical necessity may be established for **either** upper limb prosthesis with myoelectric components if criterion I. above are met or for a mechanical prosthesis without myoelectric function, but not for both.

- II. Replacement of a **prosthesis** before the 5-year replacement period may be considered **medically necessary** if **both** of the following (A and B) are met:

- A. **One** of the following (1-3) applies:

- 1. There is a significant change in the physical condition of the patient and the current prosthetic no longer meet's the member's medical needs (e.g., pediatric growth, etc.); **or**
- 2. Replacement is needed due to irreparable *damage* (e.g., fire, flood, etc.) or if the existing equipment is lost or stolen; **or**
- 3. The condition of the device, or part of the device, requires repairs and the cost of such repairs would be more than 60% of the cost of a replacement device, or of the part being replaced.

- B. Item is not under manufacturer warranty that would cover the costs of repair or replacement.

Note: Replacement of a medically necessary **part or component** to make the prosthetic functional may be medically necessary before 5-years, and therefore, are not subject to the 5-year limit.

Non-Covered Devices

- III. The following myoelectric upper limb prosthetic devices are considered **not medically necessary** (this is not an all-inclusive list):

- A. Myoelectric upper limb prosthetic components when the above criterion I is not met, including but not limited to replacement of an existing, functioning prostheses (e.g. as an "upgrade" for a prosthesis that still works and fits and meets the member's medical needs).
- B. Upper-limb prosthetic components that use both sensor and myoelectric control.
- C. Gloves for an upper extremity prosthesis.
- D. Partial-hand myoelectric prostheses (L6026) (e.g. i-digit quantum (formerly,

- ProDigits)).
- E. Taska Hand/Taska Hand CX.
 - F. Prosthetic devices or additions/components/attachments that are not required for participation in normal activities of daily living, including those used for convenience, participation in recreational activities and sports, or that otherwise exceed the medical needs (i.e., water-specific/water submersible prosthetics designed to be used for showering, swimming, etc.).
 - G. More than one myoelectric prosthesis per limb per 5 (five) years when the above replacement criterion II are met.
 - H. Repair and/or replacement of a medically necessary prosthetic device when the above criteria are not met.

Link to [Evidence Summary](#)

POLICY CROSS REFERENCES

None

The full Company portfolio of current Medical Policies is available online and can be [accessed here](#).

POLICY GUIDELINES

BACKGROUND

Myoelectric Prosthesis

Myoelectric prostheses are powered by electric motors with an external power source, utilizing muscle activity from the residual limb for control of joint movement. Surface electrodes placed on the limb stump detect electromyographic signals. A controller then amplifies and processes these signals to drive battery-powered motors that move the hand, wrist and elbow.

LUKE Arm

The LUKE/DEKA prosthetic arm, developed by DEKA Integrations Corp, is a prosthetic arm developed for individuals who have lost all or part of their upper limb. The prosthesis is primarily controlled by a micro-electromechanical system operated through an inertial measurement unit located in a sensor device attached to the top of the shoe. The prosthesis also utilizes signals from myoelectric technology, using EMG electrodes from muscles in the shoulder/upper arm to control movement.¹

Partial-Hand Myoelectric Prostheses (e.g. i-digit quantum (formerly, ProDigits))

Partial-hand myoelectric prostheses are designed to replace the function of digits in individuals missing 1 or more fingers. This type of prosthetic device requires the level of loss or deficiency be distal to the wrist and proximal to the metacarpophalangeal joint.

Taska Hand

The Taska® is a multi-articulating myoelectric hand suitable for all amputees with amputation at the wrist or higher. It is a robust, waterproof (submersible) terminal device for users with an active lifestyle. The encoded laterally compliant fingers and high-speed thumb rotation give the user the precision needed for fine manipulation in everyday tasks. Break-away clutches deliver durability and robustness not found in other hands. The Taska CX is a smaller, faster version of the hand that may be recommended for individuals with smaller hands.

Prosthetic Coverage and Replacement

Myoelectrical hand prostheses generally come with a warranty for parts and labor, however the motor and drive mechanisms typically last 2 to 3 years and may need to be replaced after this period. For pediatric prosthetics, the sockets may need to be replaced every 12 to 18 months due to the growth of the child. However, an entire prosthesis shouldn't generally require replacement before the 5th year.

REGULATORY STATUS

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Approval or clearance by the Food and Drug Administration (FDA) does not in itself establish medical necessity or serve as a basis for coverage. Therefore, this section is provided for informational purposes only.

<i>Prosthetic</i>	<i>Device Name, Product Code</i>	<i>Indication</i>
Myoelectric Upper Limb Prosthetic* <i>*Manufacturers must register prostheses with the FDA, but prostheses do not have to undergo full FDA review</i>	Coapt Complete Control System (K123795) ² , IQZ	To be used exclusively for external prosthetic fittings of the upper limbs.
	DEKA Arm System (DEN120016) ³ , PAE	Indicated for individuals, age 18 years and older, who have partial or full upper limb amputations or congenital defects
Partial-Hand Myoelectric Prosthesis	n/a	No FDA approval documents located.

EVIDENCE REVIEW

A review of the ECRI, Hayes, Cochrane, and PubMed databases was conducted regarding the use of myoelectric upper limb prosthetics. Below is a summary of the available evidence identified through December 2024.

Systematic Reviews

- In 2024, Hayes conducted an evidence review evaluating the safety and efficacy of the LUKE Arm (DEKA Arm; Mobius Bionics) for upper extremity amputation.¹ Searching the literature through September 2021, 2 pretest/posttest studies were identified: a study conducted by the Department of Veterans Affairs to optimize the DEKA arm system and a home study of an advanced upper limb prosthesis. In total, 81 patients were addressed across the two studies. Outcomes of interest to the report included function and performance of activities of daily living, quality of life (QOL), community integration and patient satisfaction with device. Results from the VA's optimization study suggested that scores of dexterity and speed were superior than after 20 to 30 hours of training with the DEKA arm. Nonetheless, patient satisfaction was significantly higher with the DEKA arm compared with their existing prosthesis. At 12-week follow-up, there was little difference in scores on observer-administered measures of dexterity and speed between the DEKA arm and patients' current prostheses. Overall results suggested no significant difference in patients' quality of life or community integration between the DEKA arm and existing prostheses. Hayes ultimately assigned a "D2" rating (insufficient evidence) for the use of the DEKA arm in adults with upper extremity amputation, citing a "very-low-quality body of evidence" in which results did not suggest consistent improvement in patients' function or performance relative to existing prostheses. Other limitations included the studies' small sample sizes and lack of adequate follow-up to compensate for the potential learning curve associated with the new prosthesis.
- In 2015, Carey and colleagues conducted a systematic review evaluating outcomes in patients with either myoelectric (MYO) or body-powered (BP) upper-limb prosthesis.⁴ Investigators systematically searched the literature through July 2013, identified eligible studies, assessed study quality and extracted data. In total, 31 publications were included for review (1 systematic review, 5 clinical trials, 11 cross-sectional studies, 1 qualitative study, 3 case series, 4 case study, and 6 expert opinions), from which 11 empirical evidence statements were developed. Sample sizes ranged from 1 to 1,216 adults, with a median sample size of 12. Outcomes measures included motion analysis, including range of motion; joint angles during ADLs; kinematics and compensatory motion; reaching/pointing velocity and accuracy; and surveys assessing quality of life. Of the 31 publications included for qualitative review, evidence for ranged between "low" (n=18), "moderate" (n=11), and "high" (n=2). The majority of the empirical evidence statements were issued with "low" levels of confidence, and none with "high" confidence.

Overall results were mixed. Body-powered prostheses have been shown to have advantages in durability, training time, frequency of adjustment, maintenance, and feedback. Myoelectric prostheses were shown to improve cosmesis and phantom-limb pain and are more accepted for

light-intensity work. Collectively, studies disagreed as to the relative functional superiority between BP or MYO prostheses. The following evidence statements were drafted:

- Depending on functional needs, control scheme familiarity and user preference, either BP prostheses with conventional hook or MYO are advantages compared with each other or other alternative. (moderate level of confidence)
- Cosmesis is improved with MYO prosthesis over BP prostheses (low level of confidence)
- Prosthetic rehabilitation plan addressing critical factors such as EMG site selection, controls and task training, and comfort by cohesive team will improve function and long-term success of electrically powered prosthesis user. (low level of confidence)
- Roll-on sleeve improves suspension and increases range of motion compared with self-suspending sockets. (insufficient level of confidence)
- Regular MYO prosthetic use supports reduced cortical reorganization and phantom-limb pain intensity (low level of confidence)
- Proportion of rejections are not different between BP or MYO prostheses (insufficient level of confidence)

Limitations included the small sample size and low study quality of the majority of studies included for review (e.g. lack of controlled studies). Investigators concluded that while MYO prostheses can be improved with more advanced control methods, evidence was insufficient to suggest that these methods might apply in larger controlled studies and. significant general advantage. Investigators concluded that evidence is insufficient to determine functional differences between upper-limb prostheses.

Nonrandomized Studies

- In 2019, Ku and colleagues published results of a prospective observational study of 3D-printed myoelectric interface prostheses in patients with upper-am transradial amputation. The primary outcome was change in Orthotics Prosthetics User Survey-Upper Extremity Functional Status (OPUS-UEFS) scores at 3 months follow up. 10 patients were included in the study. At 3 months, the mean OPUS-UEFS score significantly increased from 45.50 to 60.10 ($p= 0.0014$). VAS scores insignificantly decreased at 3 months, implying long term use without discomfort. Limitations of the study include small sample size, short follow up, and lack of randomization or a comparator group. The authors conclude that 3D-printed myoelectric arm prostheses may offer a lower-cost option for patients with amputations, but more research is needed into the longevity of the device.⁵
- In 2018, Salminger and colleagues reported functional outcome scores in below-elbow amputees using four objective measurements related to activities of daily living.⁶ In total, 17 patients who underwent prosthetic fitting after unilateral below-elbow amputation were enrolled. Global upper extremity function was evaluated using the Action Research Arm Test, Southampton Hand Assessment Procedure, the Clothespin-Relocation Test, and the Box and Block Test, which monitor hand and extremity function. Scores for these tests were, respectively: 35.06 ± 4.42 of 57; 65.12 ± 13.95 points, 22.57 ± 7.50 secs; 22.57 ± 7.50 secs; and 20.90 ± 5.74 . No significant correlation was detected between prosthetic wearing time and functional outcome scores. Study limitations include small sample size, lack of long-term follow-up, and the potentially unrepresentative patient cohort (e.g. 1 female, 16 males). Moreover,

high device functionality and consequently high scores in functional evaluation do not predict actual is in daily life.

Partial-Hand Myoelectric Prosthesis (e.g. i-digit quantum (formerly ProDigits))

No evidence was identified addressing the use of partial-hand myoelectric prostheses (e.g. i-digit quantum (formerly ProDigits)).

CLINICAL PRACTICE GUIDELINES

Department of Veteran Affairs and Department of Defense

In 2022, the Department of Veteran Affairs and Department of Defense issued a clinical practice guideline for the management of upper extremity amputation rehabilitation.⁷ The following recommendations were made:

Recommendation 3: There is insufficient evidence to recommend for or against the use of any particular recent treatment advances including hardware, software, surgical, technology, or supplemental surgical interventions, such as:

- Targeted Muscle Reinnervation (TMR)
- Regenerative Peripheral Nerve Interfaces (RPNI)
- Vascularized Composite Allotransplantation (VCA)
- Agonist-Antagonist Myoneural Interface (AMI)
- Implantable Myoelectric Sensor System (IMES)
- Osseointegration (OI)

Recommendation 7: For patients with major unilateral upper limb amputation (i.e., through or proximal to the wrist), we suggest use of a body-powered or externally powered prosthesis to improve independence and reduce disability.

Recommendation 8: There is insufficient evidence to recommend for or against any specific control strategy, socket design, suspension method, or component.⁷

EVIDENCE SUMMARY

Despite the lack of evidence regarding the clinical utility of myoelectric upper limb prostheses, these devices have become a standard of care when the criteria listed above are met. Limited evidence suggests myoelectric devices may improve patients' range of motion and capacity for light work. No published evidence was identified evaluating partial-hand myoelectric prostheses with individually powered digits; therefore partial-hand myoelectric prostheses are considered not medically necessary.

HEALTH EQUITY CONSIDERATIONS

The Centers for Disease Control and Prevention (CDC) defines health equity as the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving health equity requires addressing health disparities and social determinants of health. A health disparity is the occurrence of diseases at greater levels among certain population groups more than among others. Health disparities are linked to social determinants of health which are non-medical factors that influence health outcomes such as the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life. Social determinants of health include unequal access to health care, lack of education, poverty, stigma, and racism.

The U.S. Department of Health and Human Services Office of Minority Health calls out unique areas where health disparities are noted based on race and ethnicity. Providence Health Plan (PHP) regularly reviews these areas of opportunity to see if any changes can be made to our medical or pharmacy policies to support our members obtaining their highest level of health. Upon review, PHP creates a Coverage Recommendation (CORE) form detailing which groups are impacted by the disparity, the research surrounding the disparity, and recommendations from professional organizations. PHP Health Equity COREs are updated regularly and can be found online [here](#).

BILLING GUIDELINES AND CODING

Computerized or microprocessor limbs are based on a patient’s current functional capabilities and their expected functional rehabilitation potential. If more than one prosthetic limb meets a patient’s prosthetic rehabilitation needs, the least costly prosthetic will be approved.

HCPCS code L9900 is never allowed separate reimbursement because it is considered a bundled item or service, even if billed alone.

Additional coding for extra components for use with prostheses is not allowed with HCPCS code L6880 because this code is considered “all-inclusive.”

The following codes may be used, depending on what prosthesis was ordered. There may also be supplies/components that could be used in conjunction with of these devices.

CODES*		
CPT	None	
HCPCS	L6029	Upper extremity addition, test socket/interface, partial hand including fingers
	L6030	Upper extremity addition, external frame, partial hand including fingers
	L6031	Replacement socket/interface, partial hand including fingers, molded to patient model, for use with or without external power
	L6032	Addition to upper extremity prosthesis, partial hand including fingers, ultralight material (titanium, carbon fiber or equal)
	L6033	Addition to upper extremity prosthesis, partial hand including fingers, acrylic material
	L6628	Upper extremity addition, quick disconnect hook adapter, otto bock or equal

	L6629	Upper extremity addition, quick disconnect lamination collar with coupling piece, otto bock or equal
	L6632	Upper extremity addition, latex suspension sleeve, each
	L6680	Upper extremity addition, test socket, wrist disarticulation or below elbow
	L6687	Upper extremity addition, frame type socket, below elbow or wrist disarticulation
	L6715	Terminal device, multiple articulating digit, includes motor(s), initial issue or replacement
	L6700	Upper extremity addition, external powered feature, myoelectronic control module, additional emg inputs, pattern-recognition decoding intent movement
	L7406	Addition to upper extremity, user adjustable, mechanical, residual limb volume management system
	L6810	Addition to terminal device, precision pinch device
	L6880	Electric hand, switch or myoelectric controlled, independently articulating digits, any grasp pattern or combination of grasp patterns, includes motor(s)
	L6881	Automatic grasp feature, addition to upper limb electric prosthetic terminal device
	L6882	Microprocessor control feature, addition to upper limb prosthetic terminal device
	L6890	Addition to upper extremity prosthesis, glove for terminal device, any material, prefabricated, includes fitting and adjustment
	L6925	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
	L6935	Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
	L6945	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
	L6955	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
	L6965	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
	L6975	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
	L7400	Addition to upper extremity prosthesis, below elbow/wrist disarticulation, ultralight material (titanium, carbon fiber or equal)
	L7403	Addition to upper extremity prosthesis, below elbow/wrist disarticulation, acrylic material

	L7007	Electric hand, switch or myoelectric controlled, adult
	L7008	Electric hand, switch or myoelectric, controlled, pediatric
	L7009	Electric hook, switch or myoelectric controlled, adult
	L7045	Electric hook, switch or myoelectric controlled, pediatric
	L7180	Electronic elbow, microprocessor sequential control of elbow and terminal device
	L7181	Electronic elbow, microprocessor simultaneous control of elbow and terminal device
	L7190	Electronic elbow, adolescent, variety village or equal, myoelectronically controlled
	L7191	Electronic elbow, child, variety village or equal, myoelectronically controlled
	L8465	Prosthetic shrinker, upper limb, each
	L7368	Lithium ion battery charger, replacement only
	L6026	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device, excludes terminal device(s)
	L9900	Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS "L"; code

***Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company [Medical Policy](#), [Reimbursement Policy](#), [Pharmacy Policy](#) and [Provider Information website](#) for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

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6. Salminger S, Vujaklija I, Sturma A, et al. Functional Outcome Scores With Standard Myoelectric Prostheses in Below-Elbow Amputees. *American journal of physical medicine & rehabilitation*. 2019;98(2):125-129.
7. Department of Veteran Affairs/Department of Defense. VA/DoD Clinical Practice Guideline For The Management of Upper Extreity Amputation Rehabilitation. https://www.healthquality.va.gov/guidelines/Rehab/ULA/VADoDULACPG_Final_508.pdf. Published 2022. Accessed 12/22/2024.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Converted to new policy template.
3/2024	Change in denial type from “investigational” to “not medically necessary.”
4/2025	Annual review. Reformatting of criterion. Additional criterion on replacement prosthetic/components, frequency, and non-covered devices. Updated Billing Guideline. Q2 2025 code set update. New codes.