Medicare Medical Policy

Myoelectric Upper Limb Prosthesis

MEDICARE MEDICAL POLICY NUMBER: 374

Effective Date: 4/1/2026

Last Review Date: 1/2026

Next Annual Review: 1/2027

INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. 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.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

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

PRODUCT AND BENEFIT APPLICATION

☒ Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

NOTE: This policy addresses **myoelectric** upper limb prosthetics only. It does not address **body powered** upper extremity prosthetics, which are considered medically necessary when the device meets the functional needs for an individual to perform normal ADLs. Individuals are generally allowed one prosthetic, per limb, at a time.

Service	Medicare Guidelines
Activity-Specific Upper Limb Myoelectric Prosthetics or Attachments	Activity-specific prostheses (including terminal devices) are considered **not medically necessary**. **NOTE:** Medicare defines prosthetic devices as items which replace all or part of the function of a permanently inoperative or malfunctioning body organ or limb. In order to assess whether or not an item is medically reasonable and necessary, the device must demonstrate it sufficiently meets the functional needs of an individual in performing activities of daily living or ADLs (e.g. self-feeding, bathing, dressing, grooming, work, toileting, hygiene, etc.). Activity-specific prosthetics are designed for a specific function or activity (e.g., a device designed for operating a particular piece of machinery or equipment, or for swimming, weight-lifting, or an attachment designed to enable an individual to participate in a particular sport such as golf). Since these are not used for ADLs, they do not meet Medicare's medically reasonable and necessity coverage requirements. As such, they would be considered an "upgrade" under Medicare as they go beyond what is medically reasonable and necessary.[1]
Replacement or Repairs	Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §120 - Prosthetic Devices, Subsections A and D **NOTE:** I. Replacement of prosthetic limbs, or any part of such devices, are not subject to the standard 5-year reasonable useful lifetime (RUL) restrictions typically seen for Medicare coverage of DME

	and prosthetic devices. Medicare allows one prosthetic at a time, per limb. A same or similar item would be considered a duplicate item. Replacement must still meet standard Medicare medical necessary coverage requirements, detailed below. II. Replacement of medically necessary **non**-functioning myoelectric prosthetics may be **medically necessary** when Medicare's prosthetic replacement requirements in the above manual are met (e.g., irreparable change in condition of device or component, etc.) and the device or required component are not under manufacturer warranty. III. Replacement or upgrades of medically necessary **functioning** myoelectric prosthetics may be **medically necessary** if the device is no longer providing therapeutic benefit due to a change in the physiological condition of the member. IV. Replacement or upgrades of **functioning** myoelectric prosthetics are **not medically necessary** when Medicare's replacement criteria are not met **OR** when the initial device didn't meet coverage criteria. This includes upgrading to newer models when existing devices are still functioning and still providing therapeutic benefit. These replacement or upgrade situations would be considered a "convenience." V. Replacement of an entire prosthetic due to non-functioning component(s) is **not medically necessary** when the component(s) can be repaired or replaced to bring the prosthetic back to good condition, make the prosthetic serviceable for the individual. See *Policy Guidelines* below for more information regarding Medicare and replacement of prosthetics.

Medicare Coverage Criteria: "MA organizations may create publicly accessible internal coverage criteria… when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs." *(§ 422.101(b)(6) – see Policy Guidelines below*)

- **Medicare Coverage Manuals:** While there are no specific CMS coverage criteria specifically for myoelectric upper limb prosthetic components, CMS does address coverage requirements for prosthetics in general.[2] According to the *Social Security Act §1861(s)(9)*, prostheses are covered under the Medicare Artificial Legs, Arms and Eyes benefit.[3] **Broad coverage requirements are provided by Medicare for prosthetics in general.** Specifically, Medicare requires that all durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) be **both** medically reasonable **and** necessary to meet the functional needs of the individual patient.[4] Medicare criteria are considered "not fully established" under CFR § 422.101(6)(i)(A) as additional criteria are needed to interpret or supplement these general coverage provisions in order to determine medical necessity consistently, including determining if there is a "less costly alternative" which can provide the needed and appropriate therapeutic benefit to sufficiently meet the functional medical needs to complete activities of daily living (ADLs).
- **National Coverage Determination (NCD):** Medicare does not have an NCD for myoelectric upper limb prosthetics.
- **Noridian J-D DMEPOS Local Coverage Determination (LCD)/Local Coverage Article (LCA):** As of the most recent policy review, neither DME Medicare Administrative Contractor (MAC) has an LCD or LCA for myoelectric upper limb prosthetics.

• Therefore, in the absence of **fully established** Medicare coverage criteria in a manual, NCD, LCD, or other regulatory guidance for the service area in which the testing is being performed, Company criteria below are applied for medical necessity decision-making. Medicare statutes and regulation provide general coverage criteria for diagnostic testing, but additional criteria to interpret or supplement the Medicare criteria are being used in order to determine medical necessity consistently. These additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services These additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms (e.g., infection, soft tissue scarring, ulcerations), including from delayed or decreased access to items or services, **because the use of this additional criteria based on peer-reviewed evidence evaluates how a myoelectric prosthetic may improve patient function or performance relative to existing prostheses**. When the internal coverage criteria below are not met, these items are considered not medically necessary, as they are not expected to provide a clinical benefit, potentially hindering pursuit of other treatments with demonstrated efficacy, including the use of a standard body powered prosthetics. • ***NOTE:*** *The summary of evidence, as well as the list of citations/references used in the development of the Company's internal coverage criteria, are publicly available and can be found using the Company medical policy link below [CFR § 422.101(6)(ii)(A) and (B)].*	
Myoelectric Upper Limb Prosthetics – Initial Provision	Company medical policy for Myoelectric Upper Limb Prosthesis I. These services may be considered **medically necessary** for Medicare when the Company medical policy criteria are met. II. These services are considered **not medically necessary** for Medicare Plan members either when the Company medical policy criteria are **not** met ***or*** when a service is deemed "not medically necessary" by the Company policy. See *Policy Guidelines below.* **NOTE:** See the "Billing Guidelines and Coding" section below for important notes regarding correct coding for HCPCS codes L6026, L6715, L6880, or L7007-L7009 when provided for the initial issue of a prosthetic.

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A).* If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. *(Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021)*

POLICY CROSS REFERENCES

None

The full Company portfolio of Medicare Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

DEFINITIONS

Activities of Daily Living (ADL). Activities performed during a normal day such as getting in and out of bed, dressing, bathing, eating, and using the bathroom.[5]

Instrumental activities of daily living (IADLs). These activities include tasks such as, but not limited to, shopping, food preparation, using the telephone, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances.[5]

Repair. The replacement of parts or components that make up the base item is considered to be a repair.[6]

Replacement. The furnishing of new separately payable accessories that were not part of the initial base item but are part of the repair are considered to be replacements.[6]

BACKGROUND

Upper extremity (limb) prosthetics are generally categorized and described by the level of amputation and the type of power source utilized to operate the limb. Types of upper extremity prostheses include the following:[7]

- Body powered - This type relies on a system of mechanisms such as cable(s)/linkage(s)/anchor point(s) and upon the coordination of contracting muscles create motion of the prosthetic limb's joints via the control mechanism.
- External (i.e., myoelectric) power – This type is controlled by the use of electric signals from the body's muscles which are translated and amplified via battery power to eventual control of the prosthetic components.
- Passive/restorative – This type does not have active motion within the prosthesis. Passive prostheses may allow motion of the next proximal joint; without controlling a motion within the prosthesis. Motion of the passive prosthesis is not described as external or body power.

A hybrid- type prosthesis combines body power and external power components into one prosthetic limb.[7]

Upper-extremity amputations are defined by the level at which they occur. Examples of upper limb amputation levels include the following:

- Transphalangeal amputation: resection of the thumb or fingers at distal interphalangeal (DIP), proximal interphalangeal (PIP), or metacarpophalangeal (MCP) levels or at any level in between.
- Transmetacarpal amputation: resection through the metacarpals.
- Transcarpal amputation: resection through the carpal bones.
- Transmetacarpal and transcarpal amputations are less advised because, except for select circumstances, they provide for decreased functional outcomes.
- Wrist disarticulation: transection between the carpals and radius/ulna.
- Transradial amputation: below-elbow amputation (may be classified as long, medium, or short).
- Elbow disarticulation: transection through the elbow joint.

- Transhumeral amputation: above-elbow (standard length is 50 percent to 90 percent of humeral length).
- Shoulder disarticulation: transection through the shoulder joint.
- Interscapulothoracic disarticulation (forequarter): amputation removing the entire shoulder girdle (scapula and all or part of the clavicle) (some surgeons choose to leave part of the medial clavicle).

The remaining part of the limb is referred to as the "stump" or "residual limb."

Description

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.

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 recommended for individuals with smaller hands.

MEDICARE AND MEDICAL NECESSITY

Only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. MA organizations (MAOs) make medical necessity determinations based on coverage and benefit criteria, current standards of care, the member's unique personal medical history (e.g., diagnoses, conditions, functional

status, co-morbidities, etc.), physician recommendations, and clinical notes, as well as involvement of a plan medical director, where appropriate. *(§ 422.101(c)(1))*

In addition:

> "MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs. Current, widely-used treatment guidelines are those developed by organizations representing clinical medical specialties, and refers to guidelines for the treatment of specific diseases or conditions. Acceptable clinical literature includes large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question, or large systematic reviews or meta-analyses summarizing the literature of the specific clinical question." *(§ 422.101(b)(6) and Medicare Managed Care Manual, Ch. 4, §90.5)*

The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development.

While prosthetics are eligible for coverage, Medicare requires that all durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) be **both** medically *reasonable* **and** *necessary* to meet the functional needs of the individual patient.[4] This includes determining if there is a "less costly alternative" which can provide the needed and appropriate therapeutic benefit for the individual.[8] For myoelectric prosthetic coverage, documentation must include, but is not limited to, rationale for why a body powered device is not sufficient to meet the functional medical needs of the member to complete their activities of daily living (ADLs). Items which provide features beyond what is medically reasonable and necessary to support the body member would fall under the category of an "upgrade." Upgraded items include "excess components" to a prosthetic device (e.g., a feature, an accessory, or a service) that are in addition to, or more extensive than, the item that is reasonable and necessary under Medicare's coverage requirements.[1]

Since there are not fully established coverage criteria for myoelectric upper limb prosthetics available in applicable Medicare statutes, regulations, NCDs or LCDs, then Company medical policy criteria will be applied. See the Medicare Coverage Criteria table above for more information regarding the use of internal coverage criteria when Medicare coverage criteria are not fully established.

Replacement of Prostheses

Replacement of medically necessary prosthetics are subject to Medicare rules for prosthetic device replacement. Specifically, documentation must demonstrate the following:

1. There is no warranty provision provided by the manufacturer to either replace or repair the current device[9]; **and**
2. The initial provision of the device met coverage criteria; **and**
3. Either a or b below:

a. A change in physiological condition of the member and their current device does not adequately provide the necessary therapeutic benefit; **or**
b. There is an irreparable change in the condition of the device or part of the device.

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

BILLING GUIDELINES AND CODING

GENERAL

While not directly related to medical necessity, CMS provides billing and coding guidance for the reporting of powered L-coded items. Specifically, Medicare doesn't allow additional coding for extra components for use with prostheses reported with HCPCS code L6880 because this code is considered "all-inclusive."[10-12]

In addition, effective January 1, 2022, only products which have received code verification review by the PDAC Contractor are eligible to be reported or billed using HCPCS codes L6715 or L6880.[13] The PDAC Product Classification List (PCL) search tool can be used to determine which products have received this review.

Correct Coding and Unbundling[12]

HCPCS code L6026 describes a base code for a transcarpal/metacarpal or a partial hand disarticulation, myoelectric-controlled prosthesis which includes all necessary components ***besides*** the terminal device. These are five external powered terminal devices which are available to be used with L6026. These are:

1. HCPCS code L6715: HCPCS L6715 describes one complete multiple articulating digit (finger or thumb) and the necessary motors. Since this code is reported "per digit," then if more than one digit is billed, the appropriate Units of Service (UOS) for code L6715 should reflect this.
    - On initial issue, L6715 is only to be paired with L6026
    - However, L6715 can also be used as a "replacement digit(s)" as part of a prosthetic repair.

2. HCPCS code L6880: HCPCS L6880 describes **a complete terminal device** that can only be used with HCPCS code L6026 when a partial hand residual limb contains no digits. HCPCS code L6880 includes the following:
    - All necessary components, and this L code describes a product that is all-inclusive. Billing of any additional features or functions used to describe a manufacturer's terminal device is considered unbundling.
    - Five (5) articulating digits and the necessary motors.

- All grasp patterns are included in the L6880 HCPCS code language. The use of HCPCS code L6881 in addition to L6880 would be considered unbundling.
- All switch/myoelectric controls are included in L6880 HCPCS code language. The use of code L6882 would also be considered unbundling.
- Use of HCPCS code L6880 is only appropriate with externally powered custom fabricated sockets such as HCPCS codes L6026, L6920, L6925, L6930, L6935, L6940, L6945, L6950, L6955, L6960, L6965, L6970, and L6975.

The use of HCPCS code L6715 with L6880 **on initial issue *will be denied as unbundling***. However, if provided as a "replacement digit(s)" as part of a prosthetic repair, then HCPCS L6715 may be reported for a previously supplied L6880. *(Exception: If L6880 is under the manufacturer's warranty, HCPCS code L6715 as a replacement should **not** be billed to the plan.)*

3. HCPCS code L7007
4. HCPCS code L7008
5. HCPCS code L7009

Billing of more than one terminal device with HCPCS code L6026 is considered incorrect coding.

IMPORTANT NOTE: HCPCS code L7499 must **not** be used for the billing of any additional features or components, programming, adjustment, etc. with HCPCS codes L6026, L6715, L6880, or L7007-L7009 as these codes are considered all-inclusive. The use of HCPCS code L7499 on initial issue, with the any of the above HCPCS codes, is considered unbundling.

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

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.

HCPCS Code L9900

HCPCS code L9900 is never allowed separate reimbursement because Medicare considers this code to be a bundled item or service, no matter what it is used to represent, and even if billed alone. While several LCAs and LCDs specifically call out this code as non-covered when used for specific types of devices, not all possible scenarios where this code may be used are addressed in LCDs or LCAs; however, the Noridian webpage for *Two New Codes Established for Miscellaneous Supplies* provides general noncoverage information, for any use not found in an LCD or LCA.[14]

CODES*		
CPT	None	
HCPCS	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)
	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
	L6611	Addition to upper extremity prosthesis, external powered, additional switch, any type
	L6621	Upper extremity prosthesis addition, flexion/extension wrist with or without friction, for use with external powered terminal device
	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
	L6646	Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable abduction friction control, for use with body powered or external powered system
	L6680	Upper extremity addition, test socket, wrist disarticulation or below elbow
	L6687	Upper extremity addition, frame type socket, below elbow or wrist disarticulation
	L6700	Upper extremity addition, external powered feature, myoelectronic control module, additional EMG inputs, pattern-recognition decoding intent movement
	L6715	Terminal device, multiple articulating digit, includes motor(s), initial issue or replacement
	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
	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
	L7259	Electronic wrist rotator, any type
	L7368	Lithium ion battery charger, replacement only
	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
	L7406	Addition to upper extremity, user adjustable, mechanical, residual limb volume management system (with or without lamination kit)
	L7499	Upper extremity prosthesis, not otherwise specified
	L8465	Prosthetic shrinker, upper limb, each
	L9900	Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS "L" code

***Coding Notes:**

- The code list above 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. According to Medicare, "presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare." The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. *(Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician's Fee Schedule, A. Physician's Services)*
- 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

1. Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), §120 - DME MACs - Billing Procedures Related To Advanced Beneficiary Notice (ABN) Upgrades.

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POLICY REVISION HISTORY

DATE	REVISION SUMMARY
3/2023	New Medicare Advantage medical policy
3/2024	Annual review; Add replacement and repair criteria; Language revision due to Company policy change from “investigational” to “not medically necessary”, added code
4/2025	Annual review & Q2 2025 Code Updates; Clarify intent is to limit to one prosthetic, per limb, at a time
10/2025	Q4 2025 code updates
4/2026	Annual review; add codes