Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

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***Current Policy Effective Date: 5/1/25**
(See policy history boxes for previous effective dates)

Title: Prosthetic Devices

Description/Background

A prosthesis is an artificial substitute used as a replacement, corrective or supportive device to:

- Artificially replace all or part of a missing portion of the body
- Artificially replace all or part of the function of a permanently inoperative, absent or missing portion of the body

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Regulatory Status

N/A

Medical Policy Statement

Prosthetic devices have been **established**. They are considered useful therapeutic devices when prescribed by a qualified professional provider to replace absent or nonfunctioning parts of the human body with an artificial substitute, whether surgically implanted or worn as an anatomic supplement. Specific certificate exclusions may apply.

Inclusionary and Exclusionary Guidelines

Guidelines are generally based on Medicare Part B and Blue Cross/Blue Care Network certificate language. Specific certificate language may vary.

Inclusions:

The prosthetic device must:

- Be prescribed by a qualified healthcare provider
- Meet the Medicare definition of a prosthetic (it is used to replace specific parts of the body or the functions of a permanently inoperative or malfunctioning body part or organ).

Prosthetic appliances include, but are not limited to:

- Internal or surgically implanted permanent prosthesis and external prosthesis to replace all or part of a permanently inoperative or malfunctioning body organ, eg, artificial joints necessary for joint repair or reconstructive surgery
- Breast prostheses (including a surgical brassiere) for postmastectomy individuals.
- Cardiac pacemakers, atomic or electronic
- Intra-ocular lenses as replacement of either surgically removed or congenitally absent crystalline lenses of the eye
- Artificial eyes
- Artificial limbs replacing all or part of absent extremities
- Speech aids
- Urinary collection and retention systems (eg, Foley catheters, tubing and collection bags) in cases of permanent urinary dysfunction (eg, incontinence retention)
- Auditory brain stem implants

Repair or replacement of prosthetic devices may be appropriate when indicated for:

- Repairs and adjustments for preparatory prostheses
- Repairs to make the prosthesis functional
- Repairs or replacement due to a change in the patient's physiological condition
- Irreparable wear or damage
- Maintenance which may be necessitated by the manufacturer's recommendations and must be performed by the prosthetist

Exclusions:

Excluded prosthetic devices include, but are not limited to:

- Hearing aids (refer to the Bone-Anchored Hearing Device policy)
- Garter belts
- Dental appliances
- Experimental or research devices
- Appliances used strictly for cosmetic purposes
- Penile prostheses for psychogenic impotence

Note: There are other indications to replace, repair or adjust a medically appropriate prosthetic device not limited to wear, damage or changes to a medical condition. Please check individual contract/certificate language.

While traveling: Prosthetic devices are covered when the individual is traveling or staying at another location for a specified period of time. Check individual contract/certificate language, and any specific medical policy related to the item. Repair, replacement or adjustment are also covered as defined by the contract/certificate language and the applicable medical policy.

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure.)*

Established codes:

L5000-L9900* V2623-V2629 V2630-V2632

*Note: For MEDICARE, refer to the appropriate Medicare Administrative Contractor (MAC) Article for billing guidance.

Other codes (investigational, not medically necessary, etc.):

N/A

Rationale

It has been documented in the medical literature that the use of prosthetic devices improves the function and quality of life of an individual.

Government Regulations
National:

Medicare Benefit Policy Manual
Chapter 15 – Covered Medical and Other Health Services (Rev. 12532, 03-07-24

§120 Prosthetic Devices (Rev. 1, 10-01-03)
[Note: This is an excerpt, please refer to the entire chapter for further information]

A. General
Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ are covered when furnished on a physician's order. This does not require a determination that there is no possibility that the patient's condition may improve sometime in the future. If the medical record, including the judgment of the attending physician, indicates the condition is of long and indefinite duration, the test of permanence is considered met. (Such a device may also be covered under §60.l as a supply when furnished incident to a physician's service.)

Examples of prosthetic devices include artificial limbs, parenteral and enteral (PEN) nutrition, cardiac pacemakers, prosthetic lenses (see subsection B), breast prostheses (including a surgical brassiere) for postmastectomy patients, maxillofacial devices, and devices which replace all or part of the ear or nose. A urinary collection and retention system with or without a tube is a prosthetic device replacing bladder function in case of permanent urinary incontinence. The foley catheter is also considered a prosthetic device when ordered for a patient with permanent urinary incontinence. However, chucks, diapers, rubber sheets, etc., are supplies that are not covered under this provision. Although hemodialysis equipment is a prosthetic device, payment for the rental or purchase of such equipment in the home is made only for use under the provisions for payment applicable to durable medical equipment.

An exception is that if payment cannot be made on an inpatient's behalf under Part A, hemodialysis equipment, supplies, and services required by such patient could be covered under Part B as a prosthetic device, which replaces the function of a kidney. See the Medicare Benefit Policy Manual, Chapter 11, "End Stage Renal Disease," for payment for hemodialysis equipment used in the home. See the Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services," §10, for additional instructions on hospitalization for renal dialysis.

NOTE: Medicare does not cover a prosthetic device dispensed to a patient prior to the time at which the patient undergoes the procedure that makes necessary the use of the device. For example, the A/B MAC (B) does not make a separate Part B payment for an intraocular lens (IOL) or pacemaker that a physician, during an office visit prior to the actual surgery, dispenses to the patient for his or her use. Dispensing a prosthetic device in this manner raises health and safety issues. Moreover, the need for the device cannot be clearly established until the procedure that makes its use possible is successfully performed. Therefore, dispensing a prosthetic device in this manner is not considered reasonable and necessary for the treatment of the patient's condition.

National Coverage Determination (NCD) for Intraocular Lenses (IOLs) (80.12)
Effective date of this version: 5/19/1997
Benefit Category: Prosthetic Devices

Indications and Limitations of Coverage
Intraocular lens implantation services, as well as the lens itself, may be covered if reasonable and necessary for the individual. Implantation services may include hospital, surgical, and other medical services, including pre-implantation ultrasound (A-scan) eye measurement of one or both eyes.

Local:

Refer to the CGS Administrators, LLC website for the current supplier manual, local coverage determinations and policy articles.

LOCAL COVERAGE DETERMINATIONS AND POLICY ARTICLES

External Breast Prostheses (L33317); Original Effective Date 10/01/2015, Revision Effective Date 01/01/2024.

External Breast Prostheses - Policy Article (A52478); Original Effective Date 10/01/2015, Revision Effective Date 01/01/2020.

Eye Prostheses (L33737); Original Effective Date 10/01/2015, Revision Effective Date 01/01/2020.

Eye Prostheses - Policy Article (A52462); Original Effective Date 10/01/2015, Revision Effective Date 01/01/2020.

Facial Prostheses (L33738); Original Effective Date 10/01/2015, Revision Effective Date 01/01/2020.

Facial Prostheses - Policy Article (A52463); Original Effective Date 10/01/2015, Revision Effective Date 01/01/2020.

Lower Limb Prostheses (L33787); Original Effective Date 10/01/2015, Revision Effective Date 04/01/2024.

Lower Limb Prostheses - Policy Article (A52496); Original Effective Date 10/01/2015, Revision Effective Date 04/01/2024.

CGS Administrators
DME MAC Jurisdiction B Supplier Manual, Updated Spring 2024
Coverage and Medical Policy, Chapter 9
Prosthetic Devices

[Note: This is an excerpt, please refer to the entire chapter for further information]
Prosthetic devices are items which replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ. The test of permanence is considered met if the medical record, including the judgment of the attending physician, indicates that the condition is of long and indefinite duration.

In addition to artificial arms and legs, coverage under this benefit includes, but is not limited to, breast prostheses, eye prostheses, parenteral and enteral nutrition, ostomy supplies, urological supplies in patients with permanent urinary incontinence, and glasses or contact lenses in patients with aphakia or pseudophakia.

Enteral and Parenteral Nutrition therapy is covered under the prosthetic device benefit provision, which requires that the patient must have a permanently inoperative internal body organ or function thereof.

Supplies that are necessary for the effective use of a medically necessary prosthetic device are covered. Equipment, accessories, and supplies (including nutrients) which are used directly with an enteral or parenteral nutrition device to achieve the therapeutic benefit of the prosthesis or to assure the proper functioning of the device are covered.

Repairs, adjustments, and replacement of medically necessary prosthetic devices are covered.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

- Auditory Brain Stem Implant
- Implantable Bone-Conduction and Bone-Anchored Hearing Device
- Cataract Removal Surgery
- Durable Medical Equipment
- Durable Medical Equipment, Prosthetics and Orthotics while Traveling
- Intraocular Lens Implant for Myopia (Nearsightedness)
- Microprocessor-Controlled Prostheses and Orthoses for the Lower Limb

- Myoelectronic Prosthetic Components for the Upper Limb
- Orthotic Devices
- Reconstructive Breast Surgery - Management of Breast Implants

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References

1. Centers for Medicare & Medicaid Services. Medicare Benefit Policy Manual 100-02, Chapter 15 – Covered Medical and Other Health Services, Section 120. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf Accessed 5/28/24.
2. Centers for Medicare and Medicaid. National Coverage Determination (NCD) for Intraocular Lenses (IOLs) (80.12), Publication Number 100-3, Effective date 05/19/1997. https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?ncdid=239&ncdver=1&KeyWord=intraocular&KeyWordLookUp=Title&KeyWordSearchType=Exact&bc=CAAAAAAAAAAA Accessed 5/28/24.
3. CGS Administrators, LLC, JB DME. URL: http://www.cgsmedicare.com/jb/coverage/lcdinfo.html Accessed 5/28/24.
4. CGS Administrators, LLC, Jurisdiction B Supplier Manual, https://www.cgsmedicare.com/jb/pubs/supman/index.html Accessed 5/28/24.
5. CGS Administrators DME MAC Jurisdiction B Supplier Manual, Updated Spring 2024 Supplier Manual Chapter 9 - Coverage and Medical Policy (cgsmedicare.com) Accessed 5/28/24

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 5/28/24, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
6/13/02	6/13/02	6/13/02	Joint policy established
12/8/03	12/8/03	1/16/04	Routine maintenance
4/6/05	4/6/05	4/6/05	Routine maintenance
2/8/06	2/8/06	2/8/06	Routine maintenance
1/01/07	11/1/06	11/19/06	Routine maintenance
9/1/08	7/25/08	09/01/08	Routine maintenance
11/1/09	8/18/09	8/18/09	Routine maintenance
3/1/11	1/4/11	1/4/11	Routine maintenance
3/1/13	10/16/12	10/16/12	Routine maintenance
7/1/14	4/10/14	5/1/14	Routine maintenance Removed D code range from policy; added HCPCS code range V2623-V2629 and V2630-V2632.
1/1/16	10/13/15	11/5/15	Routine maintenance
1/1/17	10/11/16	10/11/16	Routine maintenance Updated Medicare information
11/1/17	8/15/17	8/15/17	Routine maintenance Updated Medicare information
11/1/18	8/21/18	8/21/18	Routine maintenance
11/1/19	8/20/19		Routine maintenance Updated Medicare information
11/1/20	8/18/20		Routine maintenance Updated Medicare information
11/1/21	8/17/21		Routine maintenance Added coverage while traveling
11/1/22	8/16/22		Routine maintenance (ls)
11/1/23	8/15/23		Routine maintenance (jf) Vendor Managed: Northwood Added: Reconstructive Breast Surgery-Management of Breast Implants to related policy section and inclusions. Edited one sentence in the inclusion based on CMS language Medicare

			Benefit Policy Manual Chapter 15 Covered Medical and Other Services dated 3-16-23
11/1/24	8/20/24		Routine maintenance (jf) Vendor Managed: NA -2024 Annual Code Update Add L5615,L5926 L5783, L5841 as payable. Temporary HCPCS codes K1014 and K1022 being deleted.
5/1/25	2/18/25		Added Codes as payable L8720 and L8721 effective 10/1/24 (jf) MPS edited: “The safety and effectiveness of” removed

Next Review Date: 3rd Qtr, 2025

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: PROSTHETIC DEVICES

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered; policy and certificate guidelines apply
BCNA (Medicare Advantage)	See Government Regulations section.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the individual member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.