Medical Policy

Myoelectric Prosthetic and Orthotic Components for the Upper Limb

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Policy Number: 227
BCBSA Reference Number: 1.04.04

Related Policies

- Functional Neuromuscular Electrical Stimulation, #201
- Microprocessor-Controlled Prostheses for the Lower Limb, #133

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO BlueSM and Medicare PPO BlueSM Members

Prior Authorization Request Form: Myoelectric Prosthetic and Components for the Upper Limb
This form must be completed and faxed to: Medical and Surgical: 1-888-282-0780; Medicare Advantage: 1-800-447-2994.
Click here for Myoelectric Prosthetic and Components for the Upper Limb Prior Authorization Request Form #938

Myoelectric upper limb prosthetic components may be MEDICALLY NECESSARY when all of the following conditions are met:

- The patient has an amputation or missing limb at the wrist or above (eg, forearm, elbow), and
- 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, and
- The remaining musculature of the arm(s) contains the minimum microvolt threshold to allow operation of a myoelectric prosthetic device, and
- The patient has demonstrated sufficient neurological and cognitive function to operate the prosthesis effectively, and
- The patient is free of comorbidities that could interfere with function of the prosthesis (eg, neuromuscular disease), and
- Functional evaluation indicates that with training, use of a myoelectric prosthesis is likely to meet the functional needs of the individual (eg, gripping, releasing, holding, 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, and
• The amputee has been evaluated by an independent qualified professional to determine the most appropriate prosthetic components and control mechanism (e.g., body-powered, myoelectric, or combination of body-powered and myoelectric). The independent qualified professional has verified that the amputee meets all the medical necessity criteria for the device.

Upper-limb prosthetic components with both sensor and myoelectric control are considered INVESTIGATIONAL.

A prosthesis with individually powered digits, including but not limited to a partial hand prosthesis, is considered INVESTIGATIONAL.

Myoelectric controlled upper-limb orthoses are considered INVESTIGATIONAL.

Myoelectric upper limb prosthetic components are NOT MEDICALLY NECESSARY under all other conditions.

Prior Authorization Information

Inpatient
• For services described in this policy, precertification/preauthorization IS REQUIRED for all products if the procedure is performed inpatient.

Outpatient
• For services described in this policy, see below for products where prior authorization might be required if the procedure is performed outpatient.

<table>
<thead>
<tr>
<th>Commercial Managed Care (HMO and POS)</th>
<th>Outpatient</th>
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<tbody>
<tr>
<td>Commercial PPO and Indemnity</td>
<td>Prior authorization is required.*</td>
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<tr>
<td>Medicare HMO BlueSM</td>
<td>Prior authorization is not required.</td>
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<tr>
<td>Medicare PPO BlueSM</td>
<td>Prior authorization is not required.</td>
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</tbody>
</table>

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CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

HCPCS Codes

<table>
<thead>
<tr>
<th>HCPCS codes:</th>
<th>Code Description</th>
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### ICD-10 Procedure Codes

<table>
<thead>
<tr>
<th>Code Description</th>
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<tbody>
<tr>
<td>F0DZ8UZ Prosthesis Device Fitting using Prosthesis</td>
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<tr>
<td>F0DZ8FZ Prosthesis Device Fitting using Assistive, Adaptive, Supportive or Protective Equipment</td>
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The following HCPCS code is considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

### HCPCS Codes

<table>
<thead>
<tr>
<th>Code Description</th>
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<tr>
<td>L6880 Electric hand, switch or myoelectric controlled, independently articulating digits, any grasp pattern or combination of grasp patterns, includes motor(s)</td>
</tr>
<tr>
<td>L8701 Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated</td>
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</tbody>
</table>
Description
Upper-Limb Amputation
The need for a prosthesis can occur for a number of reasons, including trauma, surgery, or congenital anomalies.

Treatment
The primary goals of the upper-limb prostheses are to restore function and natural appearance. Achieving these goals also requires sufficient comfort and ease of use for continued acceptance by the wearer. The difficulty of achieving these diverse goals with an upper-limb prosthesis increases with the level of amputation (digits, hand, wrist, elbow, shoulder), and thus the complexity of joint movement increases. Upper-limb prostheses are classified into 3 categories depending on the means of generating movement at the joints: passive, body-powered, and electrically powered movement. All 3 types of prostheses have been in use for more than 30 years; each possesses unique advantages and disadvantages.

Passive Prostheses
- The passive prostheses rely on manual repositioning, typically using the opposite arm and cannot restore function. This unit is the lightest of the 3 prosthetic types and is thus generally the most comfortable.

Body-Powered Prostheses
- The body-powered prostheses use a body harness and cable system to provide functional manipulation of the elbow and hand. Voluntary movement of the shoulder and/or limb stump extends the cable and transmits the force to the terminal device. Prosthetic hand attachments, which may be claw-like devices that allow good grip strength and visual control of objects or latex-gloved devices that provide a more natural appearance at the expense of control, can be opened and closed by the cable system. Patient complaints with body-powered prostheses include harness discomfort, particularly the wear temperature, wire failure, and the unattractive appearance.

Myoelectric Prostheses
- Myoelectric prostheses use muscle activity from the remaining limb for control of joint movement. Electromyographic signals from the limb stump are detected by surface electrodes, amplified, and then processed by a controller to drive battery-powered motors that move the hand, wrist, or elbow. Although upper-arm movement may be slow and limited to 1 joint at a time, myoelectric control of movement may be considered the most physiologically natural.
- Myoelectric hand attachments are similar in form to those offered with the body-powered prosthesis but are battery-powered. Commercially available examples are listed in the Regulatory Status section.
- A hybrid system, a combination of body-powered and myoelectric components, may be used for high-level amputations (at or above the elbow). Hybrid systems allow for control of 2 joints at once (ie, 1 body-powered, 1 myoelectric) and are generally lighter and less expensive than a prosthesis composed entirely of myoelectric components.

Technology in this area is rapidly changing, driven by advances in biomedical engineering and by the U.S. Department of Defense Advanced Research Projects Agency, which is funding a public and private collaborative effort on prosthetic research and development. Areas of development include the use of skin-like silicone elastomer gloves, "artificial muscles," and sensory feedback. Smaller motors,
microcontrollers, implantable myoelectric sensors, and reinnervation of remaining muscle fibers are being developed to allow fine movement control. Lighter batteries and newer materials are being incorporated into myoelectric prostheses to improve comfort.

The LUKE Arm (previously known as the DEKA Arm System) was developed in a joint effort between DEKA Research & Development and the U.S. Department of Defense Advanced Research Projects Agency program. It is the first commercially available myoelectric upper-limb that can perform complex tasks with multiple simultaneous powered movements (eg, movement of the elbow, wrist, and hand at the same time). In addition to the electromyographic electrodes, the LUKE Arm contains a combination of mechanisms, including switches, movement sensors, and force sensors. The primary control resides with inertial measurement sensors on top of the feet. The prosthesis includes vibration pressure and grip sensors.

**Myoelectric Orthoses**

The MyoPro (Myomo) is a myoelectric powered upper-extremity orthotic. This orthotic device weighs about 1.8 kilograms (4 pounds), has manual wrist articulation, and myoelectric initiated bi-directional elbow movement. The MyoPro detects weak muscle activity from the affected muscle groups. A therapist or prosthesis/orthotist can adjust the gain (amount of assistance), signal boost, thresholds, and range of motion. Potential users include patients with traumatic brain injury, spinal cord injury, brachial plexus injury, amyotrophic lateral sclerosis, and multiple sclerosis. Use of robotic devices for therapy has been reported. The MyoPro is the first myoelectric orthotic available for home use.

**Summary**

Myoelectric prostheses are powered by electric motors with an external power source. The joint movement of an upper-limb prosthesis or orthosis (eg, hand, wrist, and/or elbow) is driven by microchip-processed electrical activity in the muscles of the remaining limb or limb stump.

For individuals who have a missing limb at the wrist or higher who receive myoelectric upper-limb prosthesis components at or proximal to the wrist, the evidence includes a systematic review and comparative studies. Relevant outcomes are functional outcomes and quality of life. The goals of upper-limb prostheses relate to restoration of both appearance and function while maintaining sufficient comfort for continued use. The identified literature focuses primarily on patient acceptance and rejection; data are limited or lacking in the areas of function and functional status. The limited evidence suggests that, when compared with body-powered prostheses, myoelectric components possess the similar capability to perform light work; however, myoelectric components could also suffer a reduction in performance when operating under heavy working conditions. The literature has also indicated that the percentage of amputees who accept the use of a myoelectric prosthesis is approximately the same as those who prefer to use a body-powered prosthesis, and that self-selected use depends partly on the individual’s activities of daily living. Appearance is most frequently cited as an advantage of myoelectric prostheses, and for patients who desire a restorative appearance, the myoelectric prosthesis can provide greater function than a passive prosthesis with equivalent function to a body-powered prosthesis for light work. Because of the different advantages and disadvantages of currently available prostheses, myoelectric components for persons with an amputation at the wrist or above may be considered when passive, or body-powered prostheses cannot be used or are insufficient to meet the functional needs of the patient in activities of daily living. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have a missing limb at the wrist or higher who receive sensor and myoelectric controlled upper-limb prosthetic components, the evidence includes a series of publications from a 12-week home study. Relevant outcomes are functional outcomes and quality of life. The prototypes for the advanced prosthesis were evaluated by the U.S. military and Veterans Administration. Demonstration of improvement in function has been mixed. After several months of home use, activity speed was shown to be similar to the conventional prosthesis, and there were improvements in the performance of some activities, but not all. There were no differences between the prototype and the participants’ prostheses for outcomes of dexterity, prosthetic skill, spontaneity, pain, community integration, or quality of life. Study
of the current generation of the sensor and myoelectric controlled prosthesis is needed to determine whether newer models of this advanced prosthesis lead to consistent improvements in function and quality of life. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have a missing limb distal to the wrist who receive a myoelectric prosthesis with individually powered digits, no peer-reviewed publications evaluating functional outcomes in amputees were identified. Relevant outcomes are functional outcomes and quality of life. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals with upper-extremity weakness or paresis who receive a myoelectric powered upper-limb orthosis, the evidence includes a small within-subject study. Relevant outcomes are functional outcomes and quality of life. The largest study (N=18) identified tested participants with and without the orthosis but did not provide any training with the device. Performance on the tests was inconsistent. Studies are needed that show consistent improvements in relevant outcome measures. Results should also be replicated in a larger number of patients. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Policy History**

<table>
<thead>
<tr>
<th>Date</th>
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<tr>
<td>1/2019</td>
<td>Clarified coding information.</td>
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<tr>
<td>1/2015</td>
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<tr>
<td>6/2014</td>
<td>Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.</td>
</tr>
<tr>
<td>4/2014</td>
<td>Clarified coding information.</td>
</tr>
<tr>
<td>12/2013</td>
<td>BCBSA National medical policy review. Title changed.</td>
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**Information Pertaining to All Blue Cross Blue Shield Medical Policies**

Click on any of the following terms to access the relevant information:

- [Medical Policy Terms of Use](#)
- [Managed Care Guidelines](#)
- [Indemnity/PPO Guidelines](#)
- [Clinical Exception Process](#)
- [Medical Technology Assessment Guidelines](#)
References