Uniform Medical Plan coverage limits

Updates effective 08/1/2022

The benefit coverage limits listed below apply to these UMP plans:

- Uniform Medical Plan (UMP) Classic (PEBB)
- UMP Select (PEBB)
- UMP Consumer-Directed Health Plan (UMP CDHP) (PEBB)
- UMP Plus–Puget Sound High Value Network (UMP Plus–PSHVN) (PEBB)
- UMP Plus–UW Medicine Accountable Care Network (UMP Plus–UW Medicine ACN) (PEBB)
- UMP Achieve 1 (SEBB)
- UMP Achieve 2 (SEBB)
- UMP High Deductible Plan (SEBB)
- UMP Plus–Puget Sound High Value Network (UMP Plus–PSHVN) (SEBB)
- UMP Plus–UW Medicine Accountable Care Network (UMP Plus–UW Medicine ACN) (SEBB)

Some services listed under these benefits have coverage limits. These limits are either determined by a Health Technology Clinical Committee (HTCC) decision or a Regence BlueShield medical policy. The table below does not include every limit or exclusion under this benefit. For more details, refer to your plan’s Certificate of Coverage.

Uniform Medical Plan Pre-authorization List

The Uniform Medical Plan (UMP) Pre-authorization List includes services and supplies that require pre-authorization or notification for UMP members.
## Durable Medical Equipment

<table>
<thead>
<tr>
<th>These services or supplies have coverage limits</th>
<th>The rules or policies that define the coverage limits</th>
<th>Limit applies to these codes (chosen by your provider to bill for services)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Growth Stimulation</td>
<td>HTCC decision</td>
<td>• 20974, 20975, 20979, E0747, E0748, E0749, E0760</td>
</tr>
<tr>
<td>Continuous Glucose Monitoring</td>
<td>For dates of service prior to January 1, 2022 UMP is subject to HTCC decision</td>
<td>• A9277, A9278, K0554, S1030, S1031</td>
</tr>
<tr>
<td>Implantable Drug Delivery System</td>
<td>HTCC decision</td>
<td>• C1772, C1889, C1891, C2626, E0782, E0783, E0785, E0786, 62350, 62351, 62360, 62361, 62362</td>
</tr>
<tr>
<td>Insulin Infusion Pumps, Automated Insulin Delivery and Artificial Pancreas Device Systems</td>
<td>Regence Medical Policy DME77</td>
<td>• E0784, E0787, S1034</td>
</tr>
<tr>
<td>Microprocessor-Controlled Lower Limb Prosthetics</td>
<td>HTCC decision</td>
<td>• K1014, L5856, L5857, L5858</td>
</tr>
</tbody>
</table>

Use Regence Medical Policy DME81 in addition to the HTCC to review requests regarding "functional level 2" and "experienced user exceptions".

These criteria do not imply or guarantee approval. Please check with your plan to ensure coverage.

Preauthorization requirements are only valid for the month published. They may have changed from previous months and may change in future months.

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August 1, 2022
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Noninvasive Ventilators in the Home Setting</td>
<td>Regence Medical Policy DME87</td>
<td>• E0466</td>
</tr>
<tr>
<td>Power Wheelchairs: Group 3</td>
<td>Regence Medical Policy DME37</td>
<td>• K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864</td>
</tr>
<tr>
<td>Stents, Drug Coated or Drug-Eluting (DES)</td>
<td>HTCC decision</td>
<td>Refer to Cardiac Stenting in the Surgery section.</td>
</tr>
</tbody>
</table>
Power Wheelchairs: Group 3

Effective: October 1, 2021

Next Review: July 2022
Last Review: August 2021

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Power wheelchairs are battery powered mobility devices with integrated or modular seating system, electronic steering and four or more wheel non-highway construction.

MEDICAL POLICY CRITERIA

Note: This policy only addresses the initial provision of Group 3 power wheelchairs (HCPCS codes K0848-K0864). Replacement of a wheelchair or of wheelchair components, as well as wheelchair accessories, are addressed by a separate medical policy, Durable Medical Equipment, Prosthetic and Orthotic Replacements, Duplicates, Repairs, and Upgrades to Existing Equipment (DME75), even if either the initial or the replacement chair is not a Group 3 power wheelchair.

I. Group 3 power wheelchairs (PWC) may be considered medically necessary when both of the following Criteria (A. and B.) are met:
   
   A. All of the following general Criteria (1. – 12.) are met:
      
      1. The patient has had a specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or practitioner who has specific training and experience in rehabilitation wheelchair
evaluations and that documents the medical necessity for the wheelchair and its special features; and

2. The patient has a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:
   a. Prevents the member from accomplishing a MRADL entirely, or
   b. Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform a MRADL, or
   c. Prevents the member from completing MRADLs within a reasonable time frame.

3. Use of a power wheelchair will significantly improve the patient’s ability to participate in MRADLs and the patient will use it in the home. For patients with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver; and

4. The patient does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day. Notes: Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function; and

5. The underlying condition is not reversible and the length of need is more than 3 months; and

6. The patient’s mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker; and

7. The patient is not a candidate for a power operated vehicle; and

8. The patient has the mental (e.g., cognition, judgment) and physical (e.g., vision) capabilities to safely operate the power wheelchair that is provided, in the home setting; or if the patient is unable to safely operate the power wheelchair, the patient has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair that is provided; and

9. The patient’s weight is less than or equal to the weight capacity of the PWC that is provided and greater than or equal to 95% of the weight capacity of the next lower weight class, i.e., a Heavy Duty PWC is covered for a patient weighing 285 – 450 pounds; a Very Heavy Duty PWC is covered for a patient weighing 428 – 600 pounds; an Extra Heavy Duty PWC is covered for a patient weighing 570 pounds or more; and

10. The patient’s home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is provided; and

11. The patient has not expressed an unwillingness to use a power wheelchair in the home; and
12. Any coverage criteria pertaining to the specific wheelchair type (see below) are met.

B. Any of the following Group 3 power wheelchairs (PWC) may be considered **medically necessary** when all of Criteria A. above are met:

1. A Group 3 PWC with no power options (K0848-K0855) when the patient’s mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity.

2. A Group 3 PWC with single power option (K0856-K0860) or multiple power option (K0861-K0864) when **both** of the following (a. and b.) are met:
   a. The patient’s mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity; and
   b. Any one of the following are met:
      i. The patient requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control); or
      ii. The patient uses a ventilator which is mounted on the wheelchair; or
      iii. The patient has a power tilt or a power recline seating system and the system is being used on the wheelchair and one of the following are met:
         a.) The patient is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or
         b.) The patient utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or
         c.) The power seating system is needed to manage increased tone or spasticity.

II. Group 3 power wheelchairs are considered **not medically necessary** when the above criteria are not met, including but not limited to the following:

A. The patient is capable of ambulation within the home but requires a wheelchair for movement outside the home; or

B. The primary benefit of the wheelchair is to allow the patient to perform leisure or recreational activities; or

C. The patient has been approved for a power operated vehicle (POV); or

D. The accessory is used for the convenience of the patient or caregiver and is not necessary for performance of mobility related activities of daily living (MRADLs); or

E. The patient’s functional mobility limitation can be sufficiently resolved with a cane, walker, or manual wheelchair, as described above; or

F. The patient’s home does not provide adequate access, maneuvering space, physical layout (e.g., doorway thresholds), or appropriate surfaces to support the requested device; or
The underlying condition is reversible and the length of need is less than 3 months (e.g., following lower extremity surgery which limits ambulation).

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.

POLICY GUIDELINES

APPROPRIATE POPULATIONS

Group 3 power wheelchairs are reserved for the severely impaired patient afflicted with diseases such as: Amyotrophic Lateral Sclerosis (ALS), spinal cord injuries resulting in quadriplegia, stroke (CVA) with hemiplegia, late stage Parkinson’s, late stage Multiple Sclerosis (MS), cerebral palsy, or Muscular Dystrophy.[1]

A Group 3 power wheelchair would not be appropriate for a beneficiary who has diabetes with peripheral neuropathy. Peripheral neuropathy affects the nerves. It is not a primary neurological condition but rather a symptom of another disease. The Power Mobility Device LCD specifically states that the patient must have a neurological condition; therefore, the beneficiary with peripheral neuropathy does not meet coverage criteria for a group 3 power wheelchair.

LIST OF INFORMATION NEEDED FOR REVIEW

REQUIRED DOCUMENTATION:

The information below must be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome.

- Medical records and chart notes pertinent to the PWC request, including history of the present condition(s) and past medical history relevant to mobility needs. Required information includes:
  - Date of face-to-face examination by the treating practitioner, with signed and dated documentation;
  - Elements of the face-to-face should include:
    - Mobility limitation and how it interferes with the performance of ADLs (the physical examination should focus on body systems responsible for ambulatory difficulty or impact on ambulatory ability);
    - Explanation of why a cane, walker, manual wheelchair, or POV (scooter) is unable to meet the mobility needs in the home; and,
    - If the member has the physical and mental abilities to operate a power wheelchair safely in the home.
  - The underlying condition, and whether or not it is reversible.
  - Ambulation-limiting symptoms and the diagnoses responsible for them;
  - Medications or other treatment for these symptoms;
  - Progression of ambulation difficulty over time;
  - Other diagnoses that may relate to ambulatory problems;
  - How far the beneficiary can walk without stopping and the pace of ambulation;

Preauthorization requirements are only valid for the month published. They may have changed from previous months and may change in future months.
What ambulatory assistance (e.g., cane, walker, wheelchair, caregiver) currently used. If the prior mobility device is not a POV, provide details regarding the physical and functional changes that now require the use of a power mobility device;
- Ability to stand up from a seated position without assistance; and,
- Description of the home setting and the ability to perform activities of daily living in the home.
- Length of need

- Physical examination relevant to mobility needs;
  - Weight and height;
  - Cardiopulmonary examination;
  - Musculoskeletal examination (i.e., arm and leg strength and range of motion);
  - Neurological examination (i.e., gait, balance and coordination); and,
  - Clearly distinguish the beneficiary’s abilities and needs within the home from any additional needs for use outside the home.

### CROSS REFERENCES

1. Durable Medical Equipment, Prosthetic and Orthotic Replacements, Duplicates, Repairs, and Upgrades to Existing Equipment, Durable Medical Equipment, Policy No. 75
2. General Medical Necessity Guidance for Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS), Durable Medical Equipment, Policy No. 88

### BACKGROUND

Wheelchairs can be described in HCPCS coding with one code for the wheelchair base and then additional codes for wheelchair options and accessories. The decision for a particular wheelchair base may be influenced by the chair's intended use, the patient's size or level of disability, or based on specific features that will be incorporated into the chair (for example, a heavy-duty base with additional electronics features may be needed to support a power tilt and/or recline option.)

The following is a list of wheelchair bases and their characteristics:

#### POWER WHEELCHAIRS (PWCS)

Power wheelchairs are battery powered mobility devices with integrated or modular seating system, electronic steering and four or more wheel non-highway construction. PWCs are divided into six performance-based groups as listed in Table 1. This policy only addresses Group 3 PWCS:

### Table 1. Power Wheelchairs: Six Performance-based Groups

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Length</td>
<td>40 inches</td>
<td>48 inches</td>
<td>48 inches</td>
<td>48 inches</td>
<td>48 inches</td>
<td>NA</td>
</tr>
<tr>
<td>Width</td>
<td>&lt;24 inches</td>
<td>&lt;34 inches</td>
<td>&lt;34 inches</td>
<td>&lt;34 inches</td>
<td>&lt;34 inches</td>
<td>NA</td>
</tr>
<tr>
<td>Obstacle</td>
<td>20 mm</td>
<td>40 mm</td>
<td>60 mm</td>
<td>75 mm</td>
<td>60 mm</td>
<td>NA</td>
</tr>
<tr>
<td>Height</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimum</td>
<td>3 MPH</td>
<td>3 MPH</td>
<td>4.5 MPH</td>
<td>6 MPH</td>
<td>4 MPH</td>
<td>NA</td>
</tr>
<tr>
<td>Top End</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These criteria do not imply or guarantee approval. Please check with your plan to ensure coverage. Preauthorization requirements are only valid for the month published. They may have changed from previous months and may change in future months.
<table>
<thead>
<tr>
<th>CHAIR/HCPCS</th>
<th>GROUP 1</th>
<th>GROUP 2</th>
<th>GROUP 3</th>
<th>GROUP 4</th>
<th>GROUP 5</th>
<th>GROUP 6</th>
</tr>
</thead>
</table>

### Speed-Flat

| Range | 5 miles | 7 miles | 12 miles | 16 miles | 12 miles | NA |

Obstacle height or obstacle climb denotes the vertical height of a solid obstruction that can be climbed.

Minimum top end speed denotes the minimum speed on a flat hard surface that is acceptable for a given category of devices.

Range denotes the minimum distance acceptable for a given category of devices on a single charge of the batteries.

The above six PWC groups are subdivided based on patient weight capacity, seat type, portability and/or power seating system capability.

There are four weight capacity groups. Those listed in Table 2. represent patient weight handling capacity and are not intended to reflect performance.

#### Table 2. Weight Capacity Groups

<table>
<thead>
<tr>
<th>Standard Duty</th>
<th>Heavy Duty</th>
<th>Very Heavy Duty</th>
<th>Extra Heavy Duty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to and including 300 pounds</td>
<td>301-450 pounds</td>
<td>451-600 pounds</td>
<td>601 pounds or more</td>
</tr>
</tbody>
</table>

#### Table 3. Seat Types

<table>
<thead>
<tr>
<th>Sling Seat/Back-Flexible</th>
<th>Solid Seat/ Back-Rigid</th>
<th>Captains Chair</th>
<th>Stadium Style Seat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cloth, vinyl, leather or equal material designed to serve as the support for buttocks or back. They may or may not have thin padding but are not intended to provide cushioning or positioning for the user.</td>
<td>Metal or plastic material usually covered with cloth, vinyl, leather or equal material, with or without some padding material designed to serve as the support for the buttocks or back. They may or may not have thin padding but are not intended to provide cushioning or positioning for the user. PWCs with an automotive-style back and a solid seat pan are considered as a solid seat/back system, not a Captains Chair.</td>
<td>A one or two-piece automotive-style seat with rigid frame, cushioning material in both seat and back sections, covered in cloth, vinyl, leather or equal as upholstery, and designed to serve as a complete seating, support, and cushioning system for the user. It may have armrests that can be fixed, swingaway, or detachable. It may or may not have a headrest, either integrated or separate.</td>
<td>A one or two piece stadium-style seat with rigid frame and cushioning material in both seat and back sections, covered in cloth, vinyl, leather or equal as upholstery, and designed to serve as a complete seating, support, and cushioning system for the user. It may have armrests that can be fixed, swingaway, or detachable. It does not have a headrest. Chairs with stadium style seats are billed using the Captains Chair HCPCS codes.</td>
</tr>
</tbody>
</table>

Portable denotes a PWC that is built of lightweight construction or can be disassembled into lightweight components that allow easy placement into a vehicle for use in a distant location.

Power options that may be added to a PWC to include power tilt, recline, elevating legrests, seat elevators or standing systems. There are three categories of PWCs based on the capability to accept and operate these power options:

- No-power-options PWCs are incapable of accommodating any power options.
Single power option PWCs have the capability to accept and operate only one power accessory at a time on the base.

Multiple power option PWCs have the capability to accept and operate more than one power accessory at a time on the base.

Pediatric PWCs are uniquely sized for use with very small individuals and have the capability for extensive growth through frame adjustments (not just seating) and special features to address developmental issues (e.g., seat to floor placement, standing capability).

Each power wheelchair base code is intended to include all of the following Basic Equipment Package items on initial issue:

- Lap belt or safety belt (E0978)
- Battery charger single mode (E2366)
- Complete set of tires and casters, any type
- Legrests: Fixed, swingaway, or detachable nonelevating leg rests with or without calf pad (E0995)
- Footrests: Fixed, swingaway, or detachable nonelevating foot rests/plates or foot platform without angle adjustment for any PWC or angle adjustable footplates with Group 1 or 2 PWCs (K0037, K0040, K0041, K0042, K0043, K0044, K0045, K0052)
- Fixed, swingaway, or detachable nonadjustable height armrests (E0994, K0015, K0019) with arm pad (K0019)
- Upholstery for seat and back of proper strength and type for patient weight capacity of the power wheelchair (E0981, E0982)
- Weight specific components per patient weight capacity
- Any seat width and depth or back width except for Group 3 or 4 PWCs with a sling/solid seat/back
- Controller and Input Device.

**SUMMARY**

Group 3 power wheelchairs may improve overall health outcomes for some people with mobility limitations. According to the U.S. Centers for Medicare & Medicaid Services, Group 3 power wheelchairs are considered reasonable and medically necessary for specific populations when certain situations exist. Therefore, Group 3 power wheelchairs may be considered medically necessary when policy criteria are met. In all other situations, Group 3 power wheelchair use does not change management and does not improve health outcomes. Therefore, Group 3 power wheelchairs are not medically necessary when policy criteria are not met.

**REFERENCES**


2. U.S. Centers for Medicare & Medicaid Services. Local Coverage Article (LCA): Power Mobility Devices - Policy Article (A52498). Effective Date 01/01/2020. [cited...
NOTE: This policy only addresses Group 3 PWC (HCPCS codes K0848-K0864).

<table>
<thead>
<tr>
<th>Codes</th>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>HCPCS</td>
<td>K0848</td>
<td>Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td></td>
<td>K0849</td>
<td>Power wheelchair, group 3 standard, captains chair, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td></td>
<td>K0850</td>
<td>Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td></td>
<td>K0851</td>
<td>Power wheelchair, group 3 heavy duty, captains chair, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td></td>
<td>K0852</td>
<td>Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds</td>
</tr>
<tr>
<td></td>
<td>K0853</td>
<td>Power wheelchair, group 3 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds</td>
</tr>
<tr>
<td></td>
<td>K0854</td>
<td>Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more</td>
</tr>
<tr>
<td></td>
<td>K0855</td>
<td>Power wheelchair, group 3 extra heavy duty, captains chair, patient weight capacity 601 pounds or more</td>
</tr>
<tr>
<td></td>
<td>K0856</td>
<td>Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td></td>
<td>K0857</td>
<td>Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td></td>
<td>K0858</td>
<td>Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td></td>
<td>K0859</td>
<td>Power wheelchair, group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td></td>
<td>K0860</td>
<td>Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds</td>
</tr>
<tr>
<td></td>
<td>K0861</td>
<td>Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds</td>
</tr>
<tr>
<td></td>
<td>K0862</td>
<td>Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds</td>
</tr>
<tr>
<td></td>
<td>K0863</td>
<td>Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds</td>
</tr>
<tr>
<td></td>
<td>K0864</td>
<td>Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more</td>
</tr>
</tbody>
</table>

Date of Origin: July 2019
**Insulin Infusion Pumps, Automated Insulin Delivery and Artificial Pancreas Device Systems**

**Effective**: July 1, 2022

**Next Review**: October 2022

**Last Review**: June 2022

**IMPORTANT REMINDER**

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

**DESCRIPTION**

An external insulin infusion pump is typically used to deliver insulin into patients with diabetes mellitus. Automated insulin delivery systems (including but not limited to artificial pancreas devices) monitor glucose levels and automatically adjust the delivery of insulin to help achieve tight glucose control.

**MEDICAL POLICY CRITERIA**

**Note**: This policy is does not address stand-alone continuous glucose monitors (CGM) which may be considered medically necessary.

1. An automated insulin delivery system (including artificial pancreas devices) may be considered **medically necessary** for diabetes mellitus when either of the following Criteria are met:
   A. The patient has type 1 diabetes mellitus and all of the following Criteria (1. – 3.) are met:
      1. The device is approved by the Food and Drug Administration (FDA) and the patient meets the FDA approved age requirements for the device (see Policy...
Guidelines); and
2. Glycated hemoglobin level (Hemoglobin A1c or HbA1c) between 5.8% and 10.0%; and
3. Used insulin pump therapy for more than 3 months.

B. The patient has gestational diabetes or preconception/pregnancy related suboptimal glycemic control (e.g., erratic blood sugars, ketoacidosis, or symptomatic hypoglycemia).

II. An external insulin infusion pump may be considered medically necessary when either of the following Criteria are met:
A. The patient has diabetes mellitus; or
B. The patient has gestational diabetes or preconception/pregnancy related suboptimal glycemic control (e.g., erratic blood sugars, ketoacidosis, or symptomatic hypoglycemia).

III. A replacement for all or part of the external insulin pump or FDA-approved automated insulin delivery system (including artificial pancreas device systems) may be considered medically necessary when both of the following Criteria (A. and B.) are met:
A. The pump is no longer able to perform its basic function due to one or more of the following:
   1. Device is out of the warranty period; or
   2. Damage or wear; or
   3. The device can no longer meet the patient’s medical needs due to a significant change in the patient’s medical condition (e.g., larger insulin reservoir needed).
B. The current device cannot be repaired or adapted adequately to meet the patient’s medical needs.

IV. The use of an external insulin infusion pump is considered not medically necessary when Criterion II. is not met.

V. A replacement for all or part of the external insulin pump or FDA-approved automated insulin delivery system (including artificial pancreas device systems) that does not meet Criterion III. is considered not medically necessary.

VI. The use of an automated insulin delivery system (including artificial pancreas device systems) is considered investigational when Criterion I. is not met including but not limited to a device that is not approved by the FDA.

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.

POLICY GUIDELINES

FDA-Approved Automated Insulin Delivery Systems (Artificial Pancreas Device Systems)
### Device Age Indication Manufacturer

<table>
<thead>
<tr>
<th>Device</th>
<th>Age Indication</th>
<th>Manufacturer</th>
</tr>
</thead>
<tbody>
<tr>
<td>MiniMed™ 530G System(^{a}) (open-loop, LGS)</td>
<td>≥16 years</td>
<td>Medtronic</td>
</tr>
<tr>
<td>MiniMed™ 630G System with SmartGuard(^{b}) (open-loop, LGS):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- MiniMed™ 630G with Guardian™ Sensor 3</td>
<td>≥14 years</td>
<td>Medtronic</td>
</tr>
<tr>
<td>- MiniMed™ 630G with Enlite™ Sensor</td>
<td>≥16 years</td>
<td>Medtronic</td>
</tr>
<tr>
<td>MiniMed™ 670G System(^{c}) (hybrid closed-loop, LGS or PLGM)</td>
<td>≥7 years</td>
<td>Medtronic</td>
</tr>
<tr>
<td>MiniMed™ 770G System(^{d}) (hybrid closed-loop, LGS or PLGM)</td>
<td>≥2 years(^{e})</td>
<td>Medtronic</td>
</tr>
<tr>
<td>t:sling X2 Insulin Pump with Basal-IQ Technology (LGS)</td>
<td>≥6 years</td>
<td>Tandem</td>
</tr>
<tr>
<td>t:sling X2 Insulin Pump with Control-IQ Technology (HCL)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^{a}\) MiniMed 530G System consists of the following devices that can be used in combination or individually: MiniMed 530G Insulin Pump, Enlite™ Sensor, Enlite™ Serter, the MiniLink Real-Time System, the Bayer Contour NextLink glucose meter, CareLink® Professional Therapy Management Software for Diabetes, and CareLink® Personal Therapy Management Software for Diabetes (at time of approval).

\(^{b}\) MiniMed 630G System with SmartGuard™ consists of the following devices: MiniMed 630G Insulin Pump, Enlite® Sensor, One-Press Serter, Guardian® Link Transmitter System, CareLink® USB, Bayer’s CONTOUR® NEXT LINK 2.4 Wireless Meter, and Bayer’s CONTOUR® NEXT Test Strips (at time of approval).

\(^{c}\) MiniMed 670G System consists of the following devices: MiniMed 670G Pump, the Guardian Link (3) Transmitter, the Guardian Sensor (3), One-Press Serter, and the Contour NEXT Link 2.4 Glucose Meter (at time of approval).

\(^{d}\) MiniMed 770G System consists of the following devices: MiniMed 770G Insulin Pump, the Guardian Link (3) Transmitter, the Guardian Sensor (3), one-press serter, the Accu-Chek Guide Link blood glucose meter, and the Accu-Chek Guide Test Strips. The system requires a prescription.

\(^{e}\) The 770G System may not be safe for use in patients who require less than a total daily insulin dose of 8 units per day because the device requires a minimum of 8 units per day to operate safely.

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### LIST OF INFORMATION NEEDED FOR REVIEW

#### REQUIRED DOCUMENTATION:

The information below **must** be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome.

- **Automated insulin delivery system (artificial pancreas device system)**
  - History and physical
  - Age of patient
  - Name and type of device requested
  - Documented use of insulin pump for more than 3 months
  - When applicable, documentation of gestational diabetes or preconception/pregnancy related suboptimal glycemic control (e.g., erratic blood sugars, ketoacidosis, or symptomatic hypoglycemia)

- **External insulin infusion pumps**
  - Clinical documentation of diabetes mellitus
  - When applicable, documentation of gestational diabetes or preconception/pregnancy related suboptimal glycemic control (e.g., erratic blood sugars, ketoacidosis, or symptomatic hypoglycemia)

- **Replacement and upgrades**
  - History and physical
  - Name and type of device requested
  - Documentation of specifically why pump is no longer able to perform its basic function
Documentation that the current device cannot be repaired or adapted adequately to meet the patient’s needs

CROSS REFERENCES

1. Digital Health Products, Medicine, Policy No. 175
2. Medication Policy Manual, Note: Do a find (Ctrl+F) and enter name in the find bar to locate the appropriate policy.

BACKGROUND

Maintenance of a target blood glucose and target glycated hemoglobin (HgA1c < 7%), a marker which is used as a proxy for average blood glucose, is now considered standard of care for diabetic patients. Also known as tight diabetic control, this strategy is intended to prevent severe hypoglycemic events and lower the risk of cardiovascular disease mortality associated with uncontrolled glycemia.[1] In order to achieve tight glucose control, several devices may be used individually or in combination which includes but is not limited to continuous glucose monitors, insulin pumps, and more recently artificial pancreas device systems. The Food and Drug Administration (FDA) describes the basic design of an artificial pancreas device system (APDS) as a CGM linked to an insulin pump with the capability to automatically stop, reduce, or increase insulin infusion based on specified thresholds of measured interstitial glucose. The APDS components are designed to communicate with each other to automate the process of maintaining blood glucose concentrations at or near a specified range or target and to minimize the incidence and severity of hypoglycemic and hyperglycemic events. An APDS control algorithm is embedded in software in an external processor or controller that receives information from the CGM and performs a series of mathematical calculations. Based on these calculations, the controller sends dosing instructions to the infusion pump.

Different APDS types are currently available for clinical use. Sensor augmented pump therapy (SAPT) with low glucose suspend (LGS) (suspend on low) may reduce the likelihood or severity of a hypoglycemic event by suspending insulin delivery temporarily when the sensor value reaches (reactive) a predetermined lower threshold of measured interstitial glucose. Low glucose suspension (LGS) automatically suspends basal insulin delivery for up to two hours in response to sensor-detected hypoglycemia.

A sensor augmented pump therapy with predictive low glucose management (PLGM) (suspend before low) suspends basal insulin infusion with the prediction of hypoglycemia. Basal insulin infusion is suspended when sensor glucose is at or within 70 mg/dL above the patient-set low limit and is predicted to be 20 mg/dL above this low limit in 30 minutes. In the absence of a patient response, the insulin infusion resumes after a maximum suspend period of two hours. In certain circumstances, auto-resumption parameters may be used.

When a sensor value is above or predicted to remain above the threshold, the infusion pump will not take any action based on CGM readings. Patients using this system still need to monitor their blood glucose concentration, set appropriate basal rates for their insulin pump, and give premeal bolus insulin to control their glucose levels.

A control-to-range system reduces the likelihood or severity of a hypoglycemic or hyperglycemic event by adjusting insulin dosing only if a person's glucose levels reach or
approach predetermined higher and lower thresholds. When a patient's glucose concentration is within the specified range, the infusion pump will not take any action based upon CGM readings. Patients using this system still need to monitor their blood glucose concentration, set appropriate basal rates for their insulin pump, and give premeal bolus insulin to control their glucose levels.

A control-to-target system sets target glucose levels and always tries to maintain these levels. This system is fully automated and requires no interaction from the user (except for calibration of the CGM). There are two subtypes of control-to-target systems: insulin-only and bihormonal (e.g., glucagon). There are no systems administering glucagon marketed in the United States.

An APDS may also be referred to as a “closed-loop” system. A closed-loop system has automated insulin delivery and continuous glucose sensing and insulin delivery without patient intervention. The systems utilize a control algorithm that autonomously and continually increases and decreases the subcutaneous insulin delivery based on real-time sensor glucose levels. There are no completely closed-loop insulin delivery systems marketed in the United States.

A hybrid closed-loop system also uses automated insulin delivery with continuous basal insulin delivery adjustments. However, at mealtime, the patient enters the number of carbohydrates they are eating for the insulin pump to determine the bolus meal dose of insulin. A hybrid system option with the patient administration of a premeal or partial premeal insulin bolus can be used in either control-to-range or control-to-target systems.

REGULATORY STATUS

There are several APDS devices approved by the Food and Drug Administration (FDA). These systems are regulated by the FDA as class III device systems.

The MiniMed® 530G System includes a threshold suspend or LGS feature.[2] The threshold suspend tool temporarily suspends insulin delivery when the sensor glucose level is at or below a preset threshold within the 60- to 90-mg/dL range. When the glucose value reaches this threshold, an alarm sounds. If patients respond to the alarm, they can choose to continue or cancel the insulin suspend feature. If patients fail to respond, the pump automatically suspends action for two hours, and then insulin therapy resumes.

The MiniMed® 630G System with SmartGuard™, which is similar to the 530G, includes updates to the system components including waterproofing.[3] The threshold suspend feature can be programmed to temporarily suspend delivery of insulin for up to two hours when the sensor glucose value falls below a predefined threshold value. The MiniMed 630G System with SmartGuard™ is not intended to be used directly for making therapy adjustments, but rather to provide an indication of when a finger stick may be required. All therapy adjustments should be based on measurements obtained using a home glucose monitor and not on the values provided by the MiniMed 630G system. The device is not intended to be used directly for preventing or treating hypoglycemia but to suspend insulin delivery when the user is unable to respond to the SmartGuard™ Suspend on Low alarm to take measures to prevent or treat hypoglycemia themselves.

The MiniMed® 670G System is a hybrid closed-loop insulin delivery system consisting of an insulin pump, a glucose meter, and a transmitter, linked by a proprietary algorithm and the SmartGuard Hybrid Closed Loop.[4] The system includes an LGS feature that suspends insulin delivery when the sensor glucose value falls below the predefined threshold value. The criteria do not imply or guarantee approval. Please check with your plan to ensure coverage. Preauthorization requirements are only valid for the month published. They may have changed from previous months and may change in future months.

August 1, 2022
delivery; this feature either suspends delivery on low-glucose levels or suspends delivery before low-glucose levels, and has an optional alarm (manual mode). Additionally, the system allows semiautomatic basal insulin-level adjustment (decrease or increase) to preset targets (automatic mode). As a hybrid system; basal insulin levels are automatically adjusted, but the patient needs to administer premeal insulin boluses. The CGM component of the MiniMed 670G System is not intended to be used directly for making manual insulin therapy adjustments; rather it is to provide an indication of when a glucose measurement should be taken. The MiniMed 670G System was originally approved for marketing in the United States on September 28, 2016 (P160017) and received approval for marketing with a pediatric indication (ages 7-13 years) on June 21, 2018 (P160017/S031).

On August 31, 2020, the MiniMed® 770G System received Premarket Approval from the FDA. The 770G System was approved as a supplement to the previously approved MiniMed 670G System.[5] Approval of the MiniMed 770G System expanded the indications for use to users down to two years old and updated the pump communication protocol to Bluetooth. The 770G System is a hybrid closed loop system that measures glucose levels and automatically adjusts insulin delivery by either administering or withholding insulin. The 770G System consists of the MiniMed 770G Insulin Pump, the Guardian Link (3) Transmitter, the Guardian Sensor (3), one-press serter, the Accu-Chek Guide Link blood glucose meter, and the Accu-Chek Guide Test Strips. The system requires a prescription. The 770G System was approved for the following indications:

The MiniMed 770G system is intended for continuous delivery of basal insulin (at user selectable rates) and administration of insulin boluses (in user selectable amounts) for the management of type 1 diabetes mellitus in persons two years of age and older requiring insulin as well as for the continuous monitoring and trending of glucose levels in the fluid under the skin. The MiniMed 770G System includes SmartGuard technology, which can be programmed to automatically adjust delivery of basal insulin based on continuous glucose monitoring (CGM) sensor glucose values and can suspend delivery of insulin when the sensor glucose value falls below or is predicted to fall below predefined threshold values.

The Medtronic MiniMed 770G System consists of the following devices: MiniMed 770G Insulin Pump, the Guardian Link (3) Transmitter, the Guardian Sensor (3), one-press serter, the Accu-Chek Guide™ Link blood glucose meter, and the Accu-Chek Guide™ Test Strips. The system requires a prescription.

The Guardian Sensor (3) has not been evaluated and is not intended to be used directly for making therapy adjustments, but rather to provide an indication of when a fingerstick may be required. All therapy adjustments should be based on measurements obtained using a blood glucose meter and not on values provided by the Guardian Sensor (3).

Per the FDA approval, a prominent boxed warning is included in the labeling regarding use of the 770G System in users with a total daily insulin dose of less than 8 units, “Medtronic performed an evaluation of the 770G closed loop system and determined that it may not be safe for use in patients who require less than a total daily insulin dose of 8 units per day because the device requires a minimum of 8 units per day to operate safely.”

On June 21, 2018, the FDA approved the t:slim X2 Insulin Pump with Basal-IQ Technology (PMA P180008) for individuals who are six years of age and older.[6] The System consists of the t:slim X2 Insulin Pump paired with the Dexcom G5 Mobile CGM (Continuous Glucose
Monitor), as well as the Basal-IQ Technology. The t:slim X2 Insulin Pump is intended for the subcutaneous delivery of insulin, at set and variable rates, for the management of diabetes mellitus in persons requiring insulin. The t:slim X2 Insulin Pump can be used solely for continuous insulin delivery and as part of the System as the receiver for a therapeutic CGM. The t:slim X2 Insulin Pump running the Basal-IQ Technology can be used to suspend insulin delivery based on CGM sensor readings. Introduction into clinical care is planned for summer 2019.

In December 2019, FDA approved the t:slim X2 Insulin Pump with Control-IQ Technology through the De Novo process.\(^7\) The device uses the same pump hardware as the insulin pump component of the systems approved in t:slim X2 Insulin Pump with Basal-IQ Technology (P180008) and P140015. A custom disposable cartridge is motor-driven to deliver patient programmed basal rates and boluses through an infusion set into subcutaneous tissue.

There are many insulin pumps on the market that are approved by the FDA. Insulin infusion pumps that are FDA approved include but are not limited to the Omnipod® System and the Omnipod DASH™ System. FDA 510(k) Product Code: LZG.

**EVIDENCE SUMMARY**

**EXTERNAL INSULIN INFUSION PUMP**

Randomized controlled trials (RCTs) have evaluated insulin pumps with various functionalities including a low glucose suspend (LGS) feature.\(^8\)\(^-\)\(^13\) Results of these studies have demonstrated that insulin infusion pumps may, in carefully selected patient populations, control blood glucose to near-normal levels.

**ARTIFICIAL PANCREAS DEVICE SYSTEMS**

The key clinical outcomes regarding the clinical utility of artificial pancreas device systems (APDSs) relate to their ability to improve morbidity and mortality associated with clinically significant, severe, and acute hypoglycemia or hyperglycemic events.

**Low Glucose Suspend Devices**

**Systematic Review and Technology Assessments**

Alotaibi (2020) published the results of a systematic review with meta-analysis on the efficacy and safety of insulin pump therapy with predictive low glucose suspend (PLGS) features in children and adolescents with type 1 diabetes.\(^14\) RCTs evaluating sensor augmented pump (SAP) with a PLGS feature compared to SAP or insulin pump therapy without SAP in decreasing hypoglycemia in children and adolescents with type 1 diabetes were considered. Although all RCTs with patients aged 2 to 18 years with at least two weeks follow-up were evaluated, only five RCTs with total sample size of 493 children aged 6 to 18 years met inclusion criteria. The risk of bias within studies was low for allocation concealment and random sequence generation was low for most studies. Blinding was not always feasible given the nature of the intervention; three of the studies were open-label, whereas in two of the studies, participants were blinded to the intervention, and in one study the outcome assessors also were blinded to the intervention. Risk of publication bias could not be assessed due to the small number of studies evaluated. Intention-to-treat analysis was used in all studies to...
account for loss of follow-up. Results indicate there is high quality evidence that PLGS is superior to SAP in decreasing percent of time spent in hypoglycemia (sensor glucose [SG] <3.9 mmol/L [<70 mg/dL]/24 h) and nocturnal hypoglycemia (SG <3.9 mmol [<70 mg/dL]/L/night) with an absolute mean difference of 17.4 min/d (95% CI: -19.2, -15.5) and 26.3 min/night (95% CI: -35.5, -16.7), respectively. Percent time spent in hyperglycemia or episodes of diabetic ketoacidosis were not found to be different between groups. The only study with a duration long enough to assess health related quality of life showed no significant difference from baseline to study completion. The authors concluded that among children and adolescents with type 1 diabetes treated with insulin pump therapy, the utilization of PLGS is superior to SAP in decreasing mild to moderate daytime and nocturnal hypoglycemia without increasing the risk of hyperglycemia, but note that future studies evaluating long-term safety and cost-effectiveness are warranted.

A TEC Assessment (2013) reviewed studies that reported on the use of APDSs in patients with type 1 or type 2 diabetes taking insulin who were 16 years and older. It included studies that compared an APDS containing an LGS feature with the best alternative treatment in the above population, had at least 15 patients per arm, and reported on hypoglycemic episodes. A single trial met the inclusion criteria, and the TEC Assessment indicated that, although the trial results were generally favorable, the study was flawed, and further research is needed. Reviewers concluded that there was insufficient evidence to draw conclusions about the impact of an APDS, with an LGS feature, on health outcomes.

Randomized Controlled Trials

Collyns (2021) published the results of a randomized crossover study conducted at two sites comparing the MiniMed Advanced Hybrid Closed-Loop (AHCL) 670G system to sensor-augmented pump therapy with predictive low glucose management (SAP + PLGM) in patients with type 1 diabetes. Of the 60 patients enrolled, 59 completed the study. Patients were naive to automated insulin delivery ranged in age from seven to 80 years (mean age 23.3 ± 14.4 years). The treatment intervention sequence was randomly assigned 1:1 stratified by participants’ age. Each study phase was four weeks, preceded by a two- to four-week run-in and separated by a 2-week washout. Time in target range (TIR, 3.9-10 mmol/L) was higher in the AHCL compared to the SAP + PLGM group (70.4 ± 8.1% vs. 57.9 ± 11.7%, p < 0.001). Mean sensor glucose (SG) at run-in was 9.3 ± 0.9 mmol/L and improved with AHCL (8.5 ± 0.7 mmol/L, p < 0.001) and deteriorated during PLGM (9.5 ± 1.1 mmol/L, p < 0.001). There was one episode of mild diabetic ketoacidosis, which occurred during the SAP + PLGM arm, attributed to an infusion set failure in combination with an intercurrent illness.

Beardsall (2020) published the results of a randomized, open-label, parallel controlled trial in 20 pre-term infants receiving CGM alone supported by a paper algorithm compared to CGM with an additional intervention period of closed-loop CGM. The closed-loop system was comprised of (i) an Enlite CGM sensor, (ii) a laptop computer running a model predictive control algorithm and (iii) two Alaris syringe pumps. All 20 babies remained in the study throughout the intervention period from 48 to 72 hours and the mean (SD) length of glucose data collected in each study arm was 137 (16.4) hours and 136 (8.7) hours for CGM and CGM plus closed loop, respectively. During the intervention period, the median (IQR) time spent in the target range (sensor glucose [SG] 4.0–8.0 mmol/L) was significantly higher in babies in the closed-loop group 91% (78, 99) compared with controls 26% (6-64); p<0.001. In addition, the time spent in the wider target range of 2.6–10.0 mmol/L was higher in the closed-loop group: median 100% compared with control group, median 84%. Lower SG was observed in the
closed-loop group median (IQR) 6.2 (6.1-7.1) mmol/L compared with the control group 8.6 (7.4-11.1) mmol/L (p=0.002). Time spent with SG levels <2.6 mmol/L and glucose variability as measured by the SD of SG were similar between groups. In the postintervention period (post-72 hours), there was qualitatively increased time in both glucose target ranges (4.0–8.0 and 2.6–10.0 mmol/L) in the closed-loop group compared with the control group, but these differences did not reach statistical significance. In the closed-loop study group, two babies had documented episodes of hypoglycemia with blood glucose (BG) <2.6 mmol/L, both associated with a change of maintenance fluids. In the control study group, no babies had a documented BG value <2.6 mmol/L. One baby in the control group had an episode lasting 205 min when the SG fell to <2.6 mmol/L (BG was not checked at this time). Limitations to this study include small sample size, lack of blinding, and short study duration. While Medtronic provided the continuous glucose monitoring systems and sensors, the company had no role in study design, data acquisition, preparation of the manuscript, or decision to publish the study.

Breton (2020) published the results of a multi-site RCT comparing a closed-loop system of insulin delivery (closed-loop group, n=78) and a sensor-augmented insulin pump (control group, n=23) in children 6 to 13 years of age who had type 1 diabetes.[17] The primary outcome was the percentage of time that glucose levels were in the target range of 70 to 180 mg per deciliter, as measured by CGM. The mean (±SD) percentage of time that the glucose level was in the target range over the 16 weeks of treatment increased from 53±17% at baseline to 67±10% in the closed-loop group and from 51±16% to 55±13% in the control group (mean adjusted difference, 11 percentage points [equivalent to 2.6 hours per day]; 95% confidence interval, 7 to 14; p<0.001). The median percentage of time that the system was in the closed-loop mode was 93% (interquartile range, 91 to 95) for patients in the closed-loop group. No episodes of diabetic ketoacidosis or severe hypoglycemia were noted in either study group. Improvements were sustained through 28 weeks in an uncontrolled extension study of 100 children who were enrolled in the RCT (Kanapka 2021).[18] Health-related quality of life and patient satisfaction measures from the RCT and the extension phase were reported by Cobry (2021).[19] Neither children nor their parents in the closed-loop system group reported statistically significant changes in these outcomes compared with the sensor-augmented insulin pump group. The authors concluded that children receiving the closed-loop system did not experience increased burden compared with those using sensor-augmented insulin pump.

The single trial assessed in the TEC Assessment was the in-home arm of the Automation to Simulate Pancreatic Insulin Response (ASPIRE) trial, reported by Bergenstal (2013).[12] This industry-sponsored trial used the Paradigm Veo insulin pump. A total of 247 patients were randomized to an experimental group, in which a continuous glucose monitor with the LGS feature was used (n=121), or a control group, which used the continuous glucose monitor but not the LGS feature (n=126). Key eligibility criteria were 16-to-70 years old, type 1 diabetes, and HbA1c levels between 5.8% and 10.0%. In addition, patients had to have more than 6 months of experience with insulin pump therapy and at least 2 nocturnal hypoglycemic events (≤65 mg/dL) lasting more than 20 minutes during a 2-week run-in phase. The randomized intervention phase lasted three months. Patients in the LGS group were required to use the feature at least between 10 PM and 8 AM. The threshold value was initially set at 70 mg/dL and could be adjusted to between 70 mg/dL and 90 mg/dL. Seven patients withdrew early from the trial; all 247 were included in the intention-to-treat analysis. The primary efficacy outcome was the area under the curve (AUC) for nocturnal hypoglycemia events. This was calculated by multiplying the magnitude (in milligrams per deciliter) and duration (in minutes) of each qualified hypoglycemic event. The primary safety outcome was change in HbA1c levels.
The primary end point, mean (standard deviation [SD]) AUC for nocturnal hypoglycemic events, was 980 (1200) mg/dL/min in the LGS group and 1568 (1995) mg/dL/min in the control group. The difference between groups was statistically significant (p<0.001), favoring the intervention group.

Similarly, the mean AUC for combined daytime and nighttime hypoglycemic events (a secondary outcome) significantly favored the intervention group (p<0.001). Mean (SD) AUC values were 798 (965) mg/dL/min in the intervention group and 1164 (1590) mg/dL/min in the control group. Moreover, the intervention group experienced fewer hypoglycemic episodes (mean, 3.3 per patient-week; SD=2.0) than the control group (mean, 4.7 per patient-week; SD=2.7; p<0.001). For patients in the LGS group, the mean number of times the feature was triggered per patient was 2.08 per 24-hour period and 0.77 each night (10 PM-8 AM). The median duration of nighttime threshold suspend events was 11.9 minutes; 43% of events lasted for less than five minutes, and 19.6% lasted more than two hours. In both groups, the mean sensor glucose value at the beginning of nocturnal events was 62.6 mg/dL. After four hours, the mean value was 162.3 mg/dL in the LGS group and 140.0 mg/dL in the control group.

Regarding safety outcomes and adverse events, change in HbA1c level was minimal, and there was no statistically significant difference between groups. Mean HbA1c levels decreased from 7.26 to 7.24 mg/dL in the LGS group and from 7.21 to 7.14 mg/dL in the control group. During the study period, there were no severe hypoglycemic events in the LGS group and four events in the control group (range of nadir glucose sensor values in these events, 40-76 mg/dL). There were no deaths or serious device-related adverse events.

Before reporting on in-home findings, the ASPIRE researchers (Garg [2012]) published data from the in-clinic arm of the study[20]. This randomized crossover trial included 50 patients with type 1 diabetes who had at least three months of experience with an insulin pump system. After a 2-week run-in period to verify and optimize basal rates, patients underwent two in-clinic exercise sessions to induce hypoglycemia. The LGS feature on the insulin pump was turned on in one session and off in the other session, in random order. When on, the LGS feature was set to suspend insulin delivery for two hours when levels reached 70 mg/dL or less. The goal of the study was to evaluate whether the severity and duration of hypoglycemia were reduced when the LGS feature was used. The study protocol called for patients to start exercise with glucose levels between 100 mg/dL and 140 mg/dL and to use a treadmill or stationary bicycle until their plasma glucose levels were 85 mg/dL or less. The study outcome (duration of hypoglycemia) was defined as the period of time glucose values were lower than 70 mg/dL and above 50 mg/dL, and hypoglycemia severity was defined as the lowest observed glucose value. A successful session was defined as an observation period of 3 to 4 hours and with glucose levels above 50 mg/dL. Patients who did not attain success could repeat the experiment up to three times.

The 50 patients attempted 134 exercise sessions; 98 of them were successful. Duration of hypoglycemia was significantly shorter during the LGS-on sessions (mean, 138.5 minutes; SD=68) than the LGS-off sessions (mean, 170.7 minutes; SD=91; p=0.006). Hypoglycemia severity was significantly reduced in the LGS-on group. The mean (SD) lowest glucose level was 59.5 (72) mg/dL in the LGS-on group and 57.6 (5.7) mg/dL in the LGS-off group (p=0.015). Potential limitations of the Garg study included evaluation of the LGS feature in a research setting and short assessment period.
A second RCT evaluated the in-home use of the Paradigm Veo System.[8] The trial by Ly (2013) in Australia was excluded from the 2013 TEC Assessment due to the inclusion of children and adults and lack of analyses stratified by age group (the artificial pancreas system approved in the United States at the time of the review was only intended for individuals ≥16 years). The Ly trial included 95 patients with type 1 diabetes between 4 and 50 years of age (mean age, 18.6 years; >30% of sample <18 years old) who had used an insulin pump for at least 6 months. In addition, participants had to have an HbA1c level of 8.5% or less and have impaired awareness of hypoglycemia (defined as a score of at least four on the modified Clarke questionnaire). Patients were randomized to six months of in-home use of the Paradigm Veo System with automated insulin suspension when the glucose sensor reached a preset threshold of 60 mg/dL or to continued use of an insulin pump without the LGS feature. The primary study outcome was the combined incidence of severe hypoglycemic events (defined as hypoglycemic seizure or coma) and moderate hypoglycemic events (defined as an event requiring assistance from another person). As noted, findings were not reported separately for children and adults.

The baseline rate of severe and moderate hypoglycemia was significantly higher in the LGS group (129.6 events per 100 patient-months) than in the pump-only group (20.7 events per 100 patient-months). After 6 months of treatment, and controlling for the baseline hypoglycemia rate, the incidence rate per 100 patient-months was 34.2 (95% confidence interval [CI], 22.0 to 53.3) in the pump-only group and 9.6 (95% CI, 5.2 to 17.4) in the LGS group. The incidence rate ratio was 3.6 (95% CI, 1.7 to 7.5), which was statistically significant favoring the LGS group. Although results were not reported separately for children and adults, the trialists conducted a sensitivity analysis in patients younger than 12 years (15 patients in each treatment group). The high baseline hypoglycemia rates could be explained in part by two outliers (children ages 9 and 10 years). When both children were excluded from the analysis, the primary outcome was no longer statistically significant. The incidence rate ratio for moderate and severe events excluding the two children was 1.7 (95% CI, 0.7 to 4.3). Mean HbA1c levels (a secondary outcome) did not differ between groups at baseline or at 6 months. Change in HbA1c levels during the treatment period was -0.06% (95% CI, -0.2% to 0.09%; p<0.001) in the pump-only group and -0.1% (95% CI, -0.3% to 0.03%) in the LGS group; the difference between groups was not statistically significant.

Prospective Studies

Gómez (2017) published the results of a cohort of 111 type 1 diabetic individuals with documented hypoglycemia and hypoglycemia unawareness who received a sensor-augmented insulin pump with LGS therapy.[21] Participants used a combination system with the Medtronic Paradigm 722 or Paradigm Veo pump connected to the MiniMed CGM device. At a mean follow-up of 47 months (SD=22.7), total daily insulin dose was reduced (mean difference, -0.22 U/kg; 95% CI, -0.18 to -0.26 U/kg; p<0.001). HbA1c levels were reduced from a baseline value of 8.8% (SD=1.9%) to 7.5% (SD=1.0%) at five months (mean difference, -1.3%; 95% CI, -1.09% to -1.50%; p<0.001) and 7.1% (SD=0.8%; mean difference, -1.7%; 95% CI, -1.59% to -1.90%; p<0.001). At baseline, 80% of subjects had had at least one episode of hypoglycemic awareness compared with 10.8% at last follow-up (p<0.001). Episodes of severe hypoglycemia decreased from 66.6% to 2.7% (p<0.001).

Retrospective Studies

August 1, 2022

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Agrawal (2015) retrospectively analyzed use of the threshold suspend feature associated with the Paradigm Veo System in 20,973 patients, most of whom were treated outside of the United States.[22] This noncontrolled descriptive analysis provided information on the safety of the device when used in a practice setting. The threshold suspend feature was enabled for 100% of the time by 14,673 (70%) patients, 0% of the time by 2249 (11%) patients, and the remainder used it intermittently. The mean (SD) setting used to trigger suspension of insulin was a sensor glucose level of 62.8 (5.8) mg/dL. On days when the threshold suspend feature was enabled, there was a mean of 0.82 suspend events per patient day. Of these, 56% lasted for 0 to 5 minutes, and 10% lasted the full two hours. (Data on the length of the other 34% of events were not reported.) On days when the threshold suspend feature was on, sensor glucose values were 50 mg/dL or less 0.64% of the time compared with 2.1% of sensor glucose values 50 mg/dL or less on days when the feature was off. Reduction in hypoglycemia was greatest at night. Sensor glucose percentages equivalent to 17 minutes per night occurred when the threshold suspend feature was on vs glucose percentages equivalent to five minutes per night when the threshold suspend feature was off. Data on the use of the device has suggested fewer and shorter hypoglycemic episodes. The length and severity of hypoglycemic episodes were not fully discussed in this article.

Section Summary

For individuals who have type 1 diabetes who receive an artificial pancreas device system with a low glucose suspend feature, the evidence includes three randomized controlled trials (RCTs) conducted patients six years and older. Relevant outcomes are symptoms, change in disease status, morbid events, resource utilization, and treatment-related morbidity. All of these RCTs reported primary outcomes were favorable for the group using an artificial pancreas system; however, findings from one trial were limited by nonstandard reporting of hypoglycemic episodes, and findings from the other trial were no longer statistically significant when two outliers (children) were excluded from analysis. The RCT limited to adults showed an improvement in the primary outcome (AUC for nocturnal hypoglycemic events). AUC is not used for assessment in clinical practice, but the current technology does allow user and provider review of similar trend data with a CGM.

Results from the ASPIRE study suggested that there were increased risks of hyperglycemia and potential DKA in subjects using the threshold suspend feature. This finding may be related to whether or not actions are taken by the user to assess glycemic status, etiology of the low glucose (activity, diet or medication) and to resume insulin infusion. Both retrospective and prospective observational studies have reported reductions in rates and severity of hypoglycemic episodes in automated insulin delivery system users.

In addition, one small study reported favorable outcomes for closed-loop systems in pre-term infants, however, this study is limited by very small sample size, lack of blinding, and short study duration.

The evidence is sufficient that the magnitude of reduction for hypoglycemic events in the type 1 diabetes population is likely to be clinically significant. Limitations of the published evidence preclude determining the effects of the technology on overall glycemic control as assessed by HbA1c and other parameters and thus, net health outcomes.

Hybrid Closed-loop Insulin Delivery Systems

Systematic Review
Karageorgiou (2019) published a systematic review and network meta-analysis evaluating the efficacy of closed-loop systems in glycemic control for non-adults with type 1 diabetes mellitus.[23] The meta-analysis included 25 studies (N=504). The closed-loop system group spent a significantly higher percentage of time in a target glycemic range and the mean glucose was also decreased in the closed-loop system group (MD: 3.01%, 95% CI [1.68-4.34%]). Overall the closed-loop system showed better outcomes compared to standard insulin pumps for non-adults.

Prospective Studies

Bergenstal (2016) published a prospective single-arm study on the safety of the hybrid closed-loop system in patients with type 1 diabetes.[24] It included 124 patients ages 14-to-75 years old who had type 1 diabetes for at least two years, had HbA1c levels less than 10.0%, and who had used an insulin pump for at least six months. There was an initial run-in period at baseline for patients to learn how to use the device followed by a 3-month period of device use. The study period included a 6-day hotel stay with a 1-day period of frequent sampling of venous blood glucose levels to verify device accuracy. The primary safety end points were the incidence of severe hypoglycemia and diabetic ketoacidosis and the incidence of device-related and serious adverse events.

There were no episodes of severe hypoglycemia or ketoacidosis during the study. A total of 28 device related adverse events occurred, all of which could be resolved at home. There were four serious adverse events, one case each of appendicitis, bacterial arthritis, worsening rheumatoid arthritis, and Clostridium difficile diarrhea. There were also a number of predefined descriptive end points (but no statistically powered efficacy end points). The device was in the closed-loop mode for a median of 97% of the study period. Mean (SD) HbA1c levels were 7.4% (0.9%) at baseline and 6.9% (0.6%) at the end of the study, and the percentage of sensor glucose values within the target range was 66.7% at baseline and 72.2% at the end of the study.

A multicenter pivotal trial published by Garg (2017) evaluated the safety of Medtronic’s hybrid closed-loop system, using methods similar to those of Bergenstal (NCT02463097) and employing the same device (MiniMed 670G).[25] Of 129 subjects, 124 completed the trial; 30 were adolescents (age range, 14-21 years) and 94 were adults (age range, 22-75 years), all of whom had type 1 diabetes for at least two years before the study, and used insulin pump therapy for six months or more. A three-month study period was preceded by a run-in period for subjects to be more familiar with the equipment, and the sensor glucose values were confirmed by an extended hotel stay (6-day/5-night with daily exercise). In both the adolescent and adult cohorts, the trial found improvements during the study phase over the run-in phase, with an increased percentage of glucose values in the favorable range (for adults, a mean improvement of 68.8% to 73.8%; for adolescents, a mean improvement of 60.4% to 67.2%; p<0.001 for both cohorts). Similarly, the authors reported a decrease in the percentage of values outside of the target range (<70 mg/dL or >180 mg/dL): for adults, time spent below the target range decreased from 6.4% to 3.4% (p<0.001); time above the range decreased from 24.9% to 22.8% (p=0.01). For both cohorts, HbA1c levels showed a significant reduction between baseline and the end of study: for adults, the mean decreased from 7.3% to 6.8% (p<0.001), while for adolescents, the mean decreased from 7.7% to 7.1% (p<0.001).

Secondary outcomes, which included a reduction of nocturnal hyperglycemia and hypoglycemia, increase in mean overall body weight, and a reduction of basal insulin, were favorable for the study phase, compared with the run-in phase; measurements from the hotel...
stay verified the in-home glucose values. However, there were several limitations in the trial, including its nonrandomized design, the exclusion of individuals who had recently experienced diabetic ketoacidosis or severe hypoglycemia, and the interaction between subjects and site personnel. Additionally, most of the adult cohort were already using CGM, and baseline HbA1c levels were lower than average for both cohorts; both baseline characteristics potentially limit the generalizability of the results.

One type of hybrid insulin delivery system employs a predictive algorithm to keep the patient’s glucose levels within a specific range or zone, only increasing or decreasing insulin levels if the device detects that glucose levels are going to fall outside the defined zone. Forlenza (2017) published a randomized controlled crossover trial comparing the efficacy of a zone model predictive control algorithm with that of sensor-augmented pump therapy; the trial included 20 subjects (19 completed), all with type 1 diabetes and having at least three months treatment with a subcutaneous insulin infusion pump.[26] The six week, in-home study was divided into 2-week blocks, with two randomized groups alternating treatment between an artificial pancreas system (DiAs web monitoring) or sensor-augmented pump therapy (Dexcom Share); subjects in both arms reported glucose values and, if applicable, sensor failure. For several primary end points, which included percentage of time in the target glucose range (70-180 mg/dL) and reduction in hypoglycemia (<70 mg/dL), the algorithm-controlled artificial pancreas system was found to be superior to the sensor-augmented pump therapy (71.6 vs 65.2%, p=0.008; 1.3 vs 2%, p= 0.001, respectively); however, while the mean glucose value was lower in the artificial pancreas system than in the control group, the difference between them was not significant (p=0.059). Measurements of nocturnal hypoglycemia were consistent with day-to-day findings. For the secondary end point (safety of both systems after extended wear), the study found that the mean glucose did not change between the first and seventh day of wear. A limitation of the trial was its use of remote monitoring of subjects; also, the trialists noted that, given the marked difference in outcomes between responders and nonresponders, an error might have occurred in setting basal rates. The remainder of the review is focused on additional studies that recently evaluated HCL systems in children and adolescents with type 1 diabetes.

The RCT by Tauschman (2018) evaluated individuals with uncontrolled type 1 diabetes as reflected in mean Hb1c <8 %.[27] Approximately, 50% of the subjects were between 6-21 years of age and 25% are 6-12 years old. Both groups achieved a reduction in HbA1c but were statistically greater in the HCL group compared to the control group. The investigators reported that the HbA1c improvements were not different among children, adolescents, and adults (data not shown in tables). No severe hypoglycemic events were reported consistent with decrease in time spent with glucose <70mg/dl.

Abraham (2018) reported the results of a six month, multicenter, RCT in children and adolescents with type 1 diabetes comparing use of an insulin pump with suspend before low or predictive low-glucose management (PLGM) with sensor-augmented insulin pump therapy (SAPT) alone.[28] At six months, significant reductions were seen in day and night hypoglycemia and number of hypoglycemic events <63mg/dl lasting longer than 20 minutes. There were no differences in HbA1c at six months in either group. A follow-up analysis in 140 participants evaluated the effect of percentage time of sensor use on glycemic control in individuals on SAPT with and without PLGM.[29] The mean ± SD age of the cohort was 13.4 ± 2.8 years, duration of diabetes was 7.1 ± 3.7 years and HbA1c was 7.5 ± 0.8%. The sensor use was calculated as a percentage; the number of sensor glucose recordings was compared to the number of expected total recordings, which was then categorized into four groups <40%, 40 to <60%, 60 to <80% and ≥80%. The frequency of sensor use was 7.86% (n = 11) in <40%,

August 1, 2022

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24.29% (n = 34) in 40 to <60%, 36.43% (n = 51) in 60 to <80% and 31.43% (n = 44) in ≥80%.

With every 10% increase in sensor use in participants in the SAPT group, mean reduction of HbA1c was −0.14% [−0.25 to −0.04] (p = 0.007) while in the PLGM group, the mean reduction was −0.04% [−0.15 to 0.06] (p = 0.361). These results indicate that improvement in glycemic control is dependent on frequency of sensor use, with higher sensor uptake corresponding to improved glycemic outcomes.

Forlenza (2019) reported the data and analysis of the supplemental information filed with the FDA to support the expanded indication for the MiniMed 670G system to children 7-13 years of age.[30] The nonrandomized, single arm multicenter study reported the day and night use of the automated insulin delivery and PLGM for three months in the home setting. There were no serious adverse events and use of the system was associated with reduction in HbA1c and increased time in target glucose range.

Wood (2018) reported an in-clinic evaluation of a 7-13 year-old cohort of the 670G pivotal trial that was designed to evaluate the performance characteristics of the device when activity induced hypoglycemic patterns were used to set individual device parameters for ongoing use by the study participant.[31] The suspend before low prevention capability was confirmed in 97.5% of patients experiencing a sensor glucose of ≤ 55mg/dl.

Messer (2018) reported on a subanalysis of the adolescent and young adult participants in the 670G pivotal trial to better characterize the carbohydrate input and insulin bolus determination features of the device over a three-month period.[32] Participants successfully utilized the device without significant changes in total daily dose of insulin but improved percentage time in range (70-180 mg/dl).

Section Summary

For individuals who have type 1 diabetes who receive an artificial pancreas device system with a hybrid closed-loop insulin delivery system, the evidence includes a multicenter pivotal trial using devices cleared by the Food and Drug Administration, supplemental data and analysis for expanded indications and more recent studies focused on children and adolescents. Three crossover RCTs using a similar first-generation device approved outside the United States have been reported. Relevant outcomes are symptoms, change in disease status, morbid events, resource utilization, and treatment-related morbidity. Of the three crossover RCTs assessing a related device conducted outside the United States, two found significantly better outcomes (ie, time spent in nocturnal hypoglycemia and time spent in preferred glycemic range) with the device than with standard care and the other had mixed findings (significant difference in time spent in nocturnal hypoglycemia and no significant difference in time spent in preferred glycemic range). For the US regulatory registration pivotal trial, the primary outcomes were safety and not efficacy. Additional evidence from device performance studies and clinical studies all demonstrate reductions in time spent in various levels of hypoglycemia, improved time in range (70-180mg/dl), rare diabetic ketoacidosis and few device-related adverse events. The evidence is sufficient that the magnitude of reduction for hypoglycemic events in the type 1 diabetes population is likely to be clinically significant. The variation in the definition of primary and secondary outcomes in the study design and conduct of the published evidence are limitations that preclude determining the effects of the technology on net health outcomes. Reduction in the experience of hypoglycemia and inappropriate awareness of hypoglycemia and glycemic excursions were identified as important acute clinical outcomes in children, adolescents and adults and are related to the future risk for end organ complications.
PRACTICE GUIDELINE SUMMARY

AMERICAN DIABETES ASSOCIATION

The 2021 American Diabetes Association Standards of Medical Care in Diabetes provides the following recommendations on controlling type 1 diabetes:[33]

- Use of technology should be individualized based on a patient’s needs, desires, skill level, and availability of devices. (Level of Evidence E)

- Sensor-augmented pump therapy with automatic low glucose suspend may be considered for adults and youth with diabetes to prevent/mitigate episodes of hypoglycemia. (Level of Evidence B)

- Automated insulin delivery systems may be considered in youth and adults with type 1 diabetes to improve glycemic control. (Level of Evidence A)

- Individual patients may be using systems not approved by the U.S. Food and Drug Administration, such as do-it-yourself closed-loop systems and others; providers cannot prescribe these systems but should provide safety information/troubleshooting/backup advice for the individual devices to enhance patient safety. (Level of Evidence E)

AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS AND THE AMERICAN COLLEGE OF ENDOCRINOLOGY

The American Association of Clinical Endocrinologists and American College of Endocrinology (2018) published a joint position statement on the integration of insulin pumps and continuous glucose monitoring in patients with diabetes.[34] The statement emphasized the use of continuous glucose monitoring and insulin pump therapy for type 1 diabetes patients who are not in glycemic target ranges despite intensive attempts at self-blood glucose monitoring and multiple insulin injection therapy.

In 2014, the American Association of Clinical Endocrinologists and the American College of Endocrinology published a joint position statement for insulin pump management.[35] The consensus statement was developed by evaluating the current evidence, and when evidence from randomized controlled trials lacked, by consensus of a task force of experts. The summary of recommendations states that data support CSII for basal-bolus insulin therapy in patients with type 1 diabetes mellitus (T1DM), when selection is based on a comprehensive evaluation of the patient’s knowledge of diabetes management principles. Specific patient selection recommendations include the ideal CSII candidate as follows:

- A patient with T1DM or intensively managed insulin-dependent type 2 diabetes mellitus
- Currently performing ≥4 insulin injections and ≥4 self-monitored blood glucose (SMBG) measurements daily
- Motivated to achieve optimal blood glucose control
- Willing and able to carry out the tasks that are required to use this complex and time-consuming therapy safely and effectively
- Willing to maintain frequent contact with their health care team

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August 1, 2022
SUMMARY

There is enough research to show that the use of an external insulin infusion pump or FDA-approved automated insulin delivery system (artificial pancreas device) improves health outcomes for select patients with diabetes mellitus or preconception/pregnancy related suboptimal glycemic control. Clinical practice guidelines based on research recommend these devices in certain populations and clinical scenarios. Therefore, the use of an external insulin infusion pump or an FDA-approved automated insulin delivery system (artificial pancreas device) may be considered medically necessary when policy criteria are met.

There is not enough research to show that an insulin pump or FDA-approved automated insulin delivery system (artificial pancreas device) improve health outcomes in all other situations. No clinical practice guidelines based on research recommend these devices for patients not addressed in the policy criteria. Therefore, the use of an external insulin infusion pump or FDA-approved automated insulin delivery system (artificial pancreas device) is investigational when the policy criteria are not met.

All or part of an insulin pump or automated insulin delivery system (artificial pancreas device) may warrant replacement or upgrade when the current device is no longer able to perform its basic function and cannot be repaired or adapted adequately to meet the patient’s medical needs. Therefore, a replacement or upgrade may be considered medically necessary when policy criteria are met. A replacement or upgrade is considered not medically necessary when the device is adequately functioning and can meet the patient’s medical needs.

REFERENCES


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<td>including continuous glucose monitor, blood glucose device, insulin pump and</td>
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<td>computer algorithm that communicates with all of the devices</td>
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**Date of Origin:** September 2000

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Myoelectric Prosthetic and Orthotic Components for the Upper Limb

Effective: September 1, 2021

Next Review: June 2022
Last Review: July 2021

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

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

MEDICAL POLICY CRITERIA

I. Myoelectric upper limb prostheses may be 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; 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 (neuromuscular disease, etc.); and

F. Functional evaluation by a qualified professional (e.g., prosthetist) indicates that with training, use of a myoelectric prosthesis and associated components is necessary to meet the functional needs of the individual (e.g., automatic grasp features, microprocessor control features, or other components to aid 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. Both of the following criteria must be met (1. and 2.):

1. The device is necessary for the patient to perform instrumental activities of daily living including job functioning; and
2. The device is not primarily for the purpose of allowing the patient to perform leisure or recreational activities.

II. The replacement of all or part of an existing myoelectric upper limb prosthesis is considered medically necessary when the existing myoelectric upper limb prosthesis is malfunctioning, cannot be repaired, and is no longer under warranty OR when the current prosthetic can no longer meet the patient’s medical needs due to a significant change in the patient’s physiological condition.

III. Replacement of all or part of an existing myoelectric upper limb prosthesis is considered not medically necessary when Criterion II. is not met.

IV. Myoelectric upper limb prosthetic components are considered not medically necessary under all other conditions.

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

VI. Myoelectric controlled upper-limb orthoses are considered investigational.

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.

LIST OF INFORMATION NEEDED FOR REVIEW

It is critical that the list of information below is submitted for review to determine if the policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome.

- History and Physical/Chart Notes
- Documentation of amputation or missing limb at the wrist or above
- Documentation that standard body-powered devices can’t be used or are not efficient including the ADLs that cannot be accomplished currently
- Documentation that the remaining musculature in the limb contains the minimum microvolt threshold to allow operation of the device including a functional test using a physical or computer model prosthesis

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• Documentation the patient is cognitively and neurologically able to operate the prosthetic
• Documentation the patient doesn’t have any comorbidities that might interfere with the use of the prosthetic
• An evaluation by a qualified professional such as a prosthетist that show the patient will be able to use the prosthetic for ADLs including the patient’s ability to control, maintain, function, and use the prosthetic including why it is necessary for the patient to perform ADLs or job functions and evidence it is not being requested only for leisure or recreational activities
• Documentation that the prosthetic is not being requested to replace a functioning prosthetic

CROSS REFERENCES
1. Powered Knee Prosthesis, or Powered Ankle-Foot Prosthesis, and Microprocessor-Controlled Ankle-Foot Prosthesis, DME, Policy No. 81
2. Powered Exoskeleton for Ambulation, DME, Policy No. 89

BACKGROUND

Upper limb prostheses are used following amputation at any level from the hand to the shoulder. The need for a prosthesis can occur for a number of reasons, including trauma, surgery, or congenital anomalies. The primary goals of the upper limb prosthesis are to restore natural appearance and function. 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 as the level of amputation (digits, hand, wrist, elbow, and shoulder), and thus the complexity of joint movement, increases.

Upper limb prostheses are classified based on the means of generating movement at the joints as follows:

PASSIVE PROSTHESIS:

• The lightest weight upper extremity prosthesis
• Patients generally describe this as the most comfortable of the three types
• Must be repositioned manually, typically by moving it with the opposite arm
• Cannot restore function.

BODY-POWERED PROSTHESIS

• Uses 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 PROSTHESIS

Uses muscle activity from the remaining limb for the control of joint movement.
Electromyographic (EMG) 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.

Implantable EMG sensors with wireless signal transmission (e.g., Implantable Myoelectric Sensors [IMES®]) are being studied as alternatives to surface electrodes to improve prosthetic hand function. These implantable sensors may eliminate the limitations inherent in surface electrodes such as issues related to poor skin contact (e.g., skin sweating) and the ability to detect signals only from superficial muscles.

Although upper arm movement may be slow and limited to one 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.

Patient dissatisfaction with myoelectric prostheses includes the increased cost, maintenance (particularly for the glove), and weight.

Examples of available technologies:

- The SensorHand™ by Advanced Arm Dynamics, which is described as having an AutoGrasp feature, an opening/closing speed of up to 300 mm/second, and advanced EMG signal processing.
- The Utah Arm 3 by Motion Control has a microprocessor interface that allows individualized adjustments to achieve maximum performance.
- The i-LIMB™ hand (Touch Bionics), sometimes referred to as the bionic hand, is the first commercially available myoelectric hand prosthesis with individually powered digits.
- ProDigits™, also from Touch Bionics, are prosthetic digits for one or more fingers in patients with amputation at a transmetacarpal level or higher.
- Otto Bock has a number of myoelectric hand and elbow prostheses including the AutoGrasp feature, the Michelangelo® Hand, and the Electrohand 2000 designed for children.
- LTI Boston Digital Arm™ System by Liberating Technologies Inc. is marketed as having greater torque than any other powered prosthetic elbows
- These devices may be covered by LIVINGSKIN™, a high-definition silicone prosthesis created to resemble a patient's natural skin.

**SENSOR AND MYOELECTRIC PROSTHESIS**

The LUKE Arm (previously known as the DEKA Arm System) can perform complex tasks with multiple simultaneous powered movements (e.g., movement of the elbow, wrist, and hand at the same time). In addition to the EMG electrodes, the LUKE Arm contains a combination of mechanisms including switches, movement sensors, and force sensors. The Luke Arm is the same shape and weight as an adult arm.

**HYBRID SYSTEM, A COMBINATION OF BODY-POWERED AND MYOELECTRIC COMPONENTS**

- May be used for high-level amputations (at or above the elbow).
- Allows control of two joints at once (i.e., one body-powered and one myoelectric)
- Generally lighter weight and less expensive than a prosthesis composed entirely of myoelectric components.
An example of a hybrid system is the ErgoArm by Otto Bock which has a myoelectric hand and a cable-controlled elbow joint.

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 (DARPA), 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 re-innervation 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.

**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 prosthetist/orthoptist 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.

**Regulatory Status**

Prostheses are class I devices that are exempt from U.S. Food and Drug Administration (FDA) marketing clearance, but manufacturers must register prostheses with the restorative devices branch of the FDA and keep a record of any complaints.

Examples of available myoelectric devices are listed above.

The MyoPro® (Myomo) is registered with the FDA as a class 1 limb orthosis.

**EVIDENCE SUMMARY**

In evaluating the effects of the increased sophistication of myoelectric upper limb prostheses compared with body-powered prostheses, passive prostheses, or no prosthesis, the most informative data are from prospective comparative studies with objective and subjective measures that directly address function and health-related quality of life.

In light of the magnitude of functional loss in upper extremity amputation, evaluation of the evidence is based on two assumptions:

1. Use of any prosthesis confers clinical benefit, and
2. Self-selected use is an acceptable measure of the perceived benefit (combination of utility, comfort, and appearance) of a prosthesis for that individual.

It should be considered that the upper limb amputee’s needs may depend on their situation. For example, increased functional capability may be needed with heavy work or domestic duties, while a more natural appearing prosthesis with reduced functional capability may be acceptable for an office, school, or another social environment.
MYOELECTRIC UPPER LIMB PROSTHESIS

Systematic Reviews

A 2015 systematic review (SR) by Carey evaluated differences between myoelectric and body-powered prostheses. The SR included 31 studies.\(^1\) The evidence was conflicting for functional performance between the two prostheses. The authors concluded that there is insufficient evidence to show that one system provides a significant advantage over the other and that prosthetic selection should be based on patient preference and functional needs.

A 2007 SR by Biddis of 40 articles published over the previous 25 years assessed upper limb prosthesis acceptance and abandonment.\(^2\) For pediatric patients the mean rejection rate was 38\% for passive prostheses (one study), 45\% for body-powered prostheses (three studies), and 32\% for myoelectric prostheses (12 studies). For adults there was considerable variation between studies, with mean rejection rates of 39\% (six studies), 26\% (eight studies), and 23\% (10 studies) for passive, body-powered and myoelectric prostheses, respectively. The authors found no evidence that the acceptability of passive prostheses had declined over the period from 1983 to 2004, “despite the advent of myoelectric devices with functional as well as cosmetic appeal.” Body-powered prostheses were also found to have remained a popular choice, with the type of hand-attachment being the major factor in acceptance. Body-powered hooks were considered acceptable by many users, but body-powered hands were frequently rejected (80\% to 87\% rejection rates) due to slowness in movement, awkward use, maintenance issues, excessive weight, insufficient grip strength, and the energy needed to operate. Rejection rates of myoelectric prostheses tended to increase with longer follow-up. There was no evidence of a change in rejection rates over the 25 years of study, but the results are limited by sampling bias from isolated populations and the generally poor quality of the studies included.

Randomized Controlled Trials

In comparative studies of prostheses, subjects served as their own control. Since these studies included use by all subjects of both a myoelectric and a body-powered prosthesis, randomization was directed at the order in which each amputee used the prostheses. Two trials were found in which a total of 196 children used both a myoelectric and a body-powered hand prosthesis, in randomized order, for a period of three months each.\(^3, 4\) No clinically relevant objective or subjective difference was found between the two types of prostheses.

Nonrandomized Studies

A number of small (n<50) non-randomized case series\(^5-7\) and online, telephone, or mailed surveys\(^8-12\) were found, but few studies directly addressed whether myoelectric prostheses improved function and health-related quality of life. Most of the studies identified described amputees’ self-selected use or rejection rates. The results were usually presented as hours worn at work or school, hours worn at home, and hours worn in social situations. Amputees’ self-reported reasons for use and abandonment were also frequently reported. The limited evidence available suggests that, in comparison with body-powered prostheses, myoelectric components may improve range of motion to some extent, have similar capability for light work, but may have reduced performance under heavy working conditions. The literature also indicated that the percentage of amputees who accepted use of a myoelectric prosthesis was about the same as those who prefer to use a body-powered prosthesis, and that self-selected use depended at least in part on the individual’s activities of daily living. Appearance was most
frequently cited as an advantage of myoelectric prostheses. Nonuse of any prosthesis was associated with lack of functional need, discomfort (excessive weight and heat), and impediment to sensory feedback.

**Section Summary: Myoelectric Upper-Limb Prosthesis**

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 the percentage of amputees who accept 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. When compared with body-powered prostheses, myoelectric components possess similar capability to perform light work, and myoelectric components may improve range of motion. The literature has also indicated that 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.

**SENSOR AND MYOELECTRIC UPPER LIMB COMPONENTS**

Investigators from three Veterans Administration medical centers and the Center for the Intrepid at Brooke Army Medical Center published a series of reports on home use of the LUKE prototype (DEKA Gen 2 and DEKA Gen 3) in 2017 and 2018.[13-17] Participants were included in the in-laboratory training if they met criteria and had sufficient control options (e.g., myoelectric and/or active control over one or both feet) to operate the device. In-lab training included a virtual reality training component. At the completion of the in-lab training, the investigators determined, using a priori criteria, which participants were eligible to continue to the 12-week home trial. The criteria included the independent use of the prosthesis in the laboratory and community setting, fair, functional performance, and sound judgment when operating or troubleshooting minor technical issues.

One of the publications (Resnick, 2017) reported on the acceptance of the LUKE prototype before and after a 12-week trial of home use.[15] Of 42 participants enrolled at the time, 32 (76%) participants completed the in-laboratory training, 22 (52%) wanted to receive a LUKE Arm and proceeded to the home trial, 18 (43%) completed the home trial, and 14 (33%) expressed a desire to receive the prototype at the end of the home trial. Over 80% of those who completed the home trial preferred the prototype arm for hand and wrist function, but as many preferred the weight and look of their own prosthesis. One-third of those who completed the home training thought that the arm was not ready for commercialization. Participants who completed the trial were more likely to be prosthesis users at study onset (p=0.03), and less likely to have musculoskeletal problems (p=0.047).[13] Reasons for attrition during the in-laboratory training were reported in a separate publication by Resnik and Klinger (2017).[16] Attrition was related to the prosthesis entirely or in part by 67% of the participants, leading to a recommendation to provide patients with an opportunity to train with the prosthesis before a final decision about the appropriateness of the device.

Functional outcomes of the Gen 2 and Gen 3 arms, as compared with participants’ prostheses, were reported by Resnick et al (2018).[14] At the time of the report, 23 regular prosthesis users had completed the in-lab training, and 15 had gone on to complete the home use portion of the study. Outcomes were both performance-based and self-reported measures. At the end of the lab training, dexterity was similar, but performance was slower with the LUKE prototype than...
with their conventional prosthesis. At the end of the home study, activity speed was similar to the conventional prostheses, and one of the performance measures (Activities Measure for Upper-Limb Amputees) was improved. Participants also reported that they were able to perform more activities, had less perceived disability, and less difficulty in activities, but there were no differences between the two prostheses on many of the outcome measures including dexterity, prosthetic skill, spontaneity, pain, community integration, or quality of life. Post hoc power analysis suggested that evaluation of some outcomes might not have been sufficiently powered to detect a difference.

In a separate publication, Resnick (2017) reported that participants continued to use their prosthesis (average, 2.7 h/d) in addition to the LUKE prototype, concluding that availability of both prostheses would have the greatest utility. This conclusion is similar to those from earlier prosthesis surveys, which found that the selection of a specific prosthesis type (myoelectric, powered, or passive) could differ depending on the specific activity during the day. In the DEKA Gen 2 and Gen 3 study reported here, 29% of participants had a body-powered device, and 71% had a conventional myoelectric prosthesis.

**Section Summary: Sensor and Myoelectric Upper-Limb Components**

The LUKE Arm was cleared for marketing in 2014 and is now commercially available. The prototypes for the LUKE Arm, the DEKA Gen 2 and Gen 3, were evaluated by the U.S. military and Veteran’s Administration in a 12-week home study, with study results reported in a series of publications. Acceptance of the advanced prosthesis in this trial was mixed, with one-third of enrolled participants desiring to receive the prototype at the end of the trial. Demonstration of improvement in function has also been mixed. After several months of home use, activity speed was shown to be similar to the conventional prosthesis. There was an improvement in the performance of some, but not all, activities. Participants continued to use their prosthesis for part of the day, and some commented that the prosthesis was not ready for commercialization. There were no differences between the LUKE Arm prototype and the participants’ prostheses for many outcome measures. Study of the current generation of the LUKE Arm is needed to determine whether the newer models of this advanced prosthesis lead to consistent improvements in function and quality of life.

**MYOELECTRIC ORTHOTIC**

Page (2020) compared the efficacy of a myoelectric orthosis combined with repetitive task-specific practice to repetitive task-specific practice alone in improving performance for subjects with post-stroke upper extremity hemiparesis. A total of 34 patients with chronic, moderate, stable, post-stroke, upper extremity hemiparesis were randomly assigned to Myomo + repetitive, task-specific practice; repetitive, task-specific practice only; or Myomo only. The primary outcome was the upper extremity section of the Fugl-Meyer Impairment Scale and the secondary outcome was the Arm Motor Activity Test. The groups all increased on the Fugl-Meyer Impairment Scale and the Arm Motor Activity Test, with no significant differences between groups.

Peters (2017) evaluated the immediate effect (no training) of a myoelectric elbow-wrist-hand orthosis on paretic upper-extremity impairment. Participants (n=18) were stable and moderately impaired with a single stroke 12 months or later before study enrollment. They were tested using a battery of measures without, and then with the device; the order of testing was not counterbalanced. The primary measure was the upper-extremity section of the Fugl-
Meyer Assessment, a validated scale that determines active movement. Upper-extremity movement on the Fugl-Meyer Assessment was significantly improved while wearing the orthotic (a clinically significant increase of 8.71 points, p<0.001). The most commonly observed gains were in elbow extension, finger extension, grasping a tennis ball, and grasping a pencil. The Box and Block test (moving blocks from one side of a box to another) also improved (p<0.001). Clinically significant improvements were observed for raising a spoon and cup, and there were significant decreases in the time taken to grasp a cup and gross manual dexterity. Performance on these tests changed from unable to able to complete. The functional outcome measures (raising a spoon and cup, turning on a light switch, and picking up a laundry basket with two hands) were developed by the investigators to assess these moderately impaired participants. The authors noted that performance on these tasks was inconsistent, and proposed a future study that would include training with the myoelectric orthosis before testing.

Page (2013) compared the efficacy of a myoelectric orthosis combined with repetitive task-specific practice to repetitive task-specific practice alone in improving performance following stroke. Sixteen subjects at a mean of 75 months post-stroke were divided into two groups. Both groups received therapist-supervised repetitive task-specific practice for three days a week for eight weeks. One group used the orthotic during practice. After intervention, there was no significant difference between groups in Fugl-Meyer score increases, six measures of the Stroke Impact Scale, or Canadian Occupational Performance Measure Performance. There was a significant difference in the Stroke Impact Scale Total (p=0.027).

Section Summary: Myoelectric Orthotic

The largest study identified tested participants with and without the orthosis. This study evaluated the function with and without the orthotic in stable poststroke participants who had no prior experience with the device. Outcomes were inconsistent. Studies are needed that show consistent improvements in relevant outcome measures. Results should also be replicated in a larger number of patients.

PRACTICE GUIDELINE SUMMARY

No practice guidelines identified.

SUMMARY

There is enough research to show that myoelectric upper limb prostheses improve health outcomes for people with an amputation or missing limb at the wrist or above when the medical policy criteria are met. Therefore, myoelectric upper limb prostheses may be considered medically necessary when policy criteria are met.

In certain situations, a myoelectric upper limb prosthesis may no longer be able to perform its basic function due to damage or wear. When it is out of its warranty period and cannot be repaired adequately to meet the patient’s medical needs, replacement of the device may be medically appropriate. Therefore, replacement of all or part of a myoelectric upper limb prosthesis may be considered medically necessary when device replacement Criteria are met.

When a myoelectric upper limb prosthesis is in its warranty period or can be repaired or adapted adequately to meet the patient’s medical needs, replacement of the device is not

August 1, 2022

These criteria do not imply or guarantee approval. Please check with your plan to ensure coverage.

Preauthorization requirements are only valid for the month published. They may have changed from previous months and may change in future months.
medically appropriate. Therefore, replacement of all or part of a myoelectric upper limb prosthesis is considered not medically necessary when device replacement Criteria are not met.

There is enough research to show that myoelectric upper limb prostheses do not improve health outcomes when policy criteria are not met. Therefore, myoelectric upper limb prostheses, under all other conditions including but not limited to replacement of an existing functioning prostheses are considered not medically necessary when policy criteria are not met.

There is not enough research to show that upper-limb prosthetic components with both sensor and myoelectric control improve health outcomes compared with conventional prostheses. Therefore, upper-limb prosthetic components with both sensor and myoelectric control are considered investigational.

There is not enough research to show that myoelectric controlled upper-limb orthoses improve health outcomes for people with upper limb weakness or paresis. Only two comparative studies have been published examining myoelectric orthoses. They had small sample sizes and demonstrated inconsistent performance. Therefore, myoelectric controlled upper-limb orthoses are considered investigational.

REFERENCES

2. EA Biddiss, TT Chau. Upper limb prosthesis use and abandonment: a survey of the last 25 years. Prosthet Orthot Int. 2007;31(3):236-57. PMID: 17979010


17. L Resnik, F Acluche, S Lieberman Klinger, M Borgia. Does the DEKA Arm substitute for or supplement conventional prostheses. *Prosthet Orthot Int.* 2017;309364617729924. PMID: 28905665


## CODES

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*Date of Origin: June 2010*
**Powered and Microprocessor-Controlled Knee and Ankle-Foot Prostheses and Microprocessor-Controlled Knee-Ankle-Foot Orthoses**

**Effective:** December 1, 2021

**Next Review:** September 2022
**Last Review:** October 2021

**IMPORTANT REMINDER**

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

**DESCRIPTION**

Microprocessor-controlled prostheses and orthoses use feedback from sensors to adjust joint movement on a real-time as-needed basis and powered prostheses are designed to replace muscle activity in the affected limb.

**MEDICAL POLICY CRITERIA**

I. Microprocessor-controlled knee may be considered **medically necessary** in amputees when all of the following criteria are met (A. – E.):

   A. At least one of the following criteria are met:

      1. Demonstrated need for ambulation at variable rates or for long distances such that the patient would benefit from a device that may reduce energy consumption. (Use of the limb only in the home and/or for basic community ambulation does not establish medical necessity of the computerized limb over standard limb applications); or

      2. Demonstrated daily activities or job tasks that do not permit full focus of concentration on knee control and stability, including but not limited to
ambulation on uneven terrain, curbs, ramps, regular use on stairs or repetitive lifting and/or carrying. (Use of the limb for limited stair climbing in the home or employment environment does not establish medical necessity of the computerized limb over standard prosthetic application).

B. All of the following criteria must be met to demonstrate adequate physical ability:
   1. Adequate cardiovascular and pulmonary reserve for ambulation at faster than normal walking speed; and
   2. Adequate stride strength and balance to activate the knee unit; and
   3. Classified as one of the following Medicare Functional Levels:
      a. Select Level K2—Patients capable of limited community ambulation, but only if improved stability in stance permits increased independence, decreased risk of falls, and potential to advance to a less restrictive walking device. The microprocessor is required to enable fine-tuning and adjustment of the hydraulic mechanism to accommodate the unique motor skills and demands of the functional level K2 ambulator; or
      b. Level K3—Patients who have the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion; or
      c. Level K4—Patients who have the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.
   C. Adequate cognitive ability to master use and care requirements for the technology; and
   D. Patients with amputation from hemi-pelvectomy through knee-disarticulation level including bilateral lower extremity; and
   E. All of the following criteria must also be met:
      1. Stable or absent wound; and
      2. The request is for either a microprocessor-controlled knee or a non-microprocessor-controlled mechanical prosthesis but not both for a single knee; and
      3. Adequate socket fitting with the potential to return to active lifestyle.

II. The replacement of all or part of an existing microprocessor-controlled knee is considered **medically necessary** when either of the following are met:
   A. The existing microprocessor-controlled knee is malfunctioning, cannot be repaired, and is no longer under warranty; or
   B. The current prosthetic can no longer meet the patient’s medical needs due to a significant change in the patient’s physiological condition.
III. Replacement of all or part of an existing microprocessor-controlled knee is considered not medically necessary when Criterion II. is not met.

IV. A microprocessor-controlled knee is considered not medically necessary when Criterion I. is not met or when any of the following apply:
   A. Medicare Functional Levels K0, K1, and the subset of K2 patients capable of limited community ambulation who do not have the cardiovascular reserve, strength, and balance to improve stability in stance to permit increased independence, decreased risk of falls and potential to advance to a less restrictive walking device
   B. When the primary benefit is to allow the patient to perform leisure or recreational activities
   C. Inability to tolerate the weight of the prosthesis
   D. Significant hip flexion contracture (over 20 degrees)
   E. Patient falls outside of recommended weight or height guidelines of manufacturer

V. A powered knee or ankle-foot is considered investigational.

VI. A microprocessor-controlled ankle-foot prosthesis or knee-ankle-foot orthosis is considered investigational.

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.

LIST OF INFORMATION NEEDED FOR REVIEW

It is critical that the list of information below is submitted for review to determine if the policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome.

- History and Physical/Chart Notes
- Documentation of need at variable rates or for long distance ambulation from a device that reduces energy consumption
- Documentation of specific ADLS including job tasks that call do not permit full focus of concentration on knee control and stability
- Documentation of adequate ability to ambulate faster than normal walking speed including cardiovascular/pulmonary reserve, stride length, balance, Medicare Functional Level, and cognitive ability
- Type of amputation
- Wound status if applicable
- If a replacement is requested, documentation that the device is malfunctioning, cannot be repaired, and is no longer under warranty OR documentation of a significant change in the patient’s physiological condition that makes the current prosthetic no longer able to meet the patient’s medical needs

CROSS REFERENCES

1. Myoelectric Prosthetic Components for the Upper Limb, DME, Policy No. 80
2. Powered Exoskeleton for Ambulation, DME, Policy No. 89
MICROPROCESSOR-CONTROLLED PROSTHETIC KNEES

Microprocessor-controlled prosthetic knees have been developed, including the Intelligent Prosthesis (IP) (Blatchford, England), the Adaptive (Endolite, England), the Rheo Knee® (Össur, Iceland), the C-Leg®, Genium™ Bionic Prosthetic System, and the X2 and X3 prostheses (Otto Bock Orthopedic Industry, Minneapolis, MN), and Seattle Power Knees (3 models include Single Axis, 4-bar and Fusion, from Seattle Systems). These devices are equipped with a sensor that detects when the knee is in full extension and adjusts the swing phase automatically, permitting a more natural walking pattern of varying speeds. For example, the prosthetist can specify several different optimal adjustments that the computer later selects and applies according to the pace of ambulation. In addition, these devices (with the exception of the IP) use microprocessor control in both the swing and stance phases of gait. (The C-Leg Compact provides only stance control). By improving stance control, they may provide increased safety, stability, and function. For example, the sensors are designed to recognize a stumble and stiffen the knee, thus avoiding a fall. Other potential benefits of microprocessor-controlled knee prostheses are improved ability to navigate stairs, slopes, and uneven terrain and reduction in energy expenditure and concentration required for ambulation. The C-Leg was cleared for marketing in 1999 through the 510(k) process of the U.S. Food and Drug Administration (FDA; K991590). Next-generation devices such as the Genium Bionic Prosthetic system and the X2 and X3 prostheses utilize additional environmental input (e.g., gyroscope and accelerometer) and more sophisticated processing that is intended to create more natural movement. One improvement in function is step-over-step stair and ramp ascent. They also allow the user to walk and run forward and backward. The X3 is a more rugged version of the X2 that can be used, for example, in water, sand, and mud. The X2 and X3 were developed by Otto Bock as part of the Military Amputee Research Program.

MICROPROCESSOR-CONTROLLED ANKLE-FOOT PROSTHESES

Microprocessor-controlled ankle-foot prostheses are being developed for transtibial amputees. These include the Proprio Foot® (Össur), the iPED (developed by Martin Bionics and licensed to College Park Industries), and the Elan Foot (Endolite). With sensors in the feet that determine the direction and speed of the foot’s movement, a microprocessor controls the flexion angle of the ankle, allowing the foot to lift during the swing phase and potentially adjust to changes in force, speed, and terrain during the step phase. The intent of the technology is to make ambulation more efficient and prevent falls in patients ranging from the young active amputee to the elderly diabetic patient. The Proprio Foot™ and Elan Foot are microprocessor-controlled foot prostheses that are commercially available and considered class I devices that are exempt from 510(k) marketing clearance. Information on the Össur website indicates use of the Proprio Foot™ for low- to moderate-impact for transtibial amputees who are classified as level K3 (i.e., community ambulatory, with the ability or potential for ambulation with variable cadence). The Meridium and Empower are microprocessor ankle-feet available from Otto Bock, and the Kinnex is a microprocessor ankle-foot available from Freedom Innovations.

POWERED PROSTHESES

In development are lower-limb prostheses that also replace muscle activity in order to bend and straighten the prosthetic joint. For example, the PowerFoot BiOM® (developed at the Massachusetts Institute of Technology and licensed to iWalk) is a myoelectric prosthesis for transtibial amputees that uses muscle activity from the remaining limb for the control of ankle
movement. This prosthesis is designed to propel the foot forward as it pushes off the ground during the gait cycle, which in addition to improving efficiency, has the potential to reduce hip and back problems arising from an unnatural gait with use of a passive prosthesis. This technology is limited by the size and the weight required for a motor and batteries in the prosthesis. The Power Knee™ (Össur), which is designed to replace muscle activity of the quadriceps, uses artificial proprioception with sensors similar to the Proprio Foot in order to anticipate and respond with the appropriate movement required for the next step.

REGULATORY STATUS

Microprocessor-controlled prostheses are categorized as class I, exempt devices. Manufacturers must register prostheses with the restorative devices branch of FDA and keep a record of any complaints but do not have to undergo a full FDA review. FDA product codes include ISW and KFX.

EVIDENCE SUMMARY

Evaluating the effects of the increased sophistication of powered knee, powered ankle-foot, and microprocessor-controlled ankle-foot prostheses requires comparison with body-powered prostheses, passive prostheses, or no prosthesis. The most informative data are prospective comparative studies with objective measures that directly address function, safety, and health-related quality of life.

The evidence review below does not address microprocessor-controlled knees, which have been shown to improve function measures and decrease the cognitive burden associated with monitoring the prosthesis.

MICROPROCESSOR-CONTROLLED ANKLE-FOOT PROSTHESES

Systematic Reviews

A 2004 Cochrane review of ankle-foot prostheses (updated in 2008 with search dates through June 2006) concluded that there is insufficient evidence from high quality comparative studies to determine the overall superiority of any individual type of prosthetic ankle-foot mechanism.[1] The review included 26 cross-over studies with 3 to 16 participants in each study (n=245). Only one study was considered to be of high methodological quality while the remainders were considered of moderate quality. The vast majority of clinical studies on human walking have used standardized gait assessment protocols (e.g., treadmills) with limited “ecological validity”. The authors recommended that for future research, functional outcomes should be assessed for various aspects of mobility such as making transfers, maintaining balance, level walking, stair climbing, negotiating ramps and obstacles, and changes in walking speed.

Randomized Controlled Trials

Gailey published a 2012 randomized, within-subject crossover study that compared self-reported and objective performance outcomes for four types of prosthetic feet, including the SACH (solid ankle cushion heel), SAFE (stationary attachment flexible endoskeletal), Talux mechanical foot, and the Proprio Foot microprocessor-controlled ankle prosthesis.[2] Ten patients with transtibial amputation were tested with their own prosthesis and then, in random order, each of the other prostheses after training and a two week acclimation period. No differences between prostheses were detected for the following measures:
• Prosthesis Evaluation Questionnaire (PEQ) (self-reported subjective rating of ease of use, social and emotional issues, and function over different surfaces)
• Locomotor Capabilities Index (self-reported subjective rating of capability to perform certain activities such as walking in various environments on various surfaces, sitting, standing, bending)
• Six-minute walk test (objective distance measurement)
• Steps per day
• Hours of daily activity

In 2014, the same investigators reported the effects of these prosthetic feet on ramp ambulation in 10 unilateral transtibial amputees. Higher symmetry was reported with the Talux mechanical foot and the Proprio Foot during ramp descent, while no significant difference was found between the prostheses during ramp ascent.

Due to the limited sample sizes in these studies, conclusions cannot be reached about the comparisons between the various types of foot prostheses.

Nonrandomized Comparative Studies

Riveras (2020) reported on minimum toe clearance and tripping probability in 13 transtibial amputees using three prosthetic ankle-foot designs. The participants tested a non-articulating ankle (NAA), an articulating hydraulic ankle (AHA), and an articulating hydraulic ankle with microprocessor (AHA-MP). Statistically significant differences were found for minimum toe clearance for ramp ascending ($p \leq 0.001$) and descending ($p=0.003$), with larger median values in the prosthetic limb when using the AHA-MP. The coefficient of variation was also significantly lower on the prosthetic limb for both types of articulating hydraulic ankle compared to the non-articulating ankle during ramp descent ($p=0.014$). The lowest tripping probability was reported for the AHA-MP.

Two comparative trials of the microprocessor-controlled ankle from the same investigators investigated the Proprio Foot. Its use was evaluated in 16 transtibial amputees during stair ascent and descent or while walking up and down a ramp. These studies were limited to the effect of flexion angles (flexion versus neutral angle). Healthy controls were also used for comparison. The outcomes of these studies were mixed. For example, the adapted mode (ankle flexion) resulted in more normal gait analysis results during ramp ascent but not during descent; however, some patients reported feeling safer with the adaptive mode ankle than with the Proprio Foot. Other small studies have reported on ankle flexion using individuals as their own comparison group. A within-subject study of six patients reported no benefit of an active Proprio Foot compared with the same prosthesis turned off with level walking or with slope ascent or descent. An additional study reported a lower energy cost of floor walking with the Proprio Foot compared with a dynamic carbon fiber foot in 10 transtibial amputees.

Section Summary

These studies do not permit conclusions about the clinical benefits and risks of the microprocessor-controlled foot compared with mechanical prostheses due to methodological limitations. These limitations included, among others, the small sample size, which limits the ability to rule out chance as an explanation of the study findings.

POWERED KNEE AND/OR ANKLE-FOOT PROSTHESES
Kim (2021) reported results of a randomized trial of twelve participants that compared the BiOM powered ankle prosthesis with the participants’ prescribed, unpowered prostheses. Seven participants were randomly allocated to the powered prosthesis first group and five to the unpowered prosthesis first. Ten participants completed the study. No significant differences were identified in metabolic costs (p=0.585), daily step count (p=0.995), walking speed in-lab (p=0.145) and in daily life (p=0.226), or perception of mobility between prostheses (p≥0.058).

Ferris compared the BiOM powered ankle-foot prosthesis with an energy-storing and – returning (ESR) foot in 11 transtibial amputees. These results were also compared with 11 matched controls with intact limbs. Compared with the ESR foot, the powered ankle-foot increased walking speed, but there were no significant differences in physical performance measure or conditions on the PEQ. Compared with the intact limb, the powered ankle-foot had increased step length and greater ankle peak power, but had reduced range of motion. There appeared to be an increase in compensatory strategies at proximal joints with the powered prosthesis; the authors noted that normalization of gait kinematics and kinetics may not be possible with a uniarticular device. Seven patients preferred the PowerFoot BiOM and four preferred the ESR prosthesis.

In another small study of seven amputees and seven intact controls, Herr (2012) reported gross metabolic cost and preferred walking speed to be more similar to non-amputee controls with the powered foot than with the ESR prosthesis.

Mancinelli (2011) compared the PowerFoot BiOM with a passive-elastic foot in five transtibial amputees. At the time of this study the powered prosthesis was a prototype and subjects’ exposure to the prosthesis was limited to the laboratory. Laboratory assessment of gait biomechanics showed an average increase of 54% in the peak ankle power generation during late stance. Metabolic cost measured by oxygen consumption while walking on an indoor track was reduced by an average of 8.4% (p=0.06). This study did not report the impact of these measurements on patient function.

Section Summary

The current evidence is insufficient to permit conclusions about the benefits of powered lower extremity prostheses compared with other prostheses. These small studies mainly report on the feasibility of various prototypes. Larger, higher quality studies are needed to determine the impact of these devices on functional outcomes with greater certainty.

MICROPROCESSOR-CONTROLLED ORTHOSES

Randomized Controlled Trials

A randomized crossover trial of a microprocessor swing- and stance-controlled knee-ankle-foot orthosis was reported by Deems-Dluhy in 2021. A total of 18 community-dwelling adults were assigned to receive a C-brace orthosis and a stance-control-orthosis in a randomized order. The C-brace controls with a microprocessor-controlled knee throughout stance and swing phases of gait. All participants received six sessions of training over a one-month period. Statistically significant differences were reported between post-microprocessor orthosis and post-stance-control orthosis in the six-minute walk test, with longer times post-microprocessor orthosis. Higher quality of life scores were reported in the Modified Falls Efficacy Scale, Orthotic and Prosthetic User’s Survey (OPUS) (p=0.02) and physical health domain of the World Health Organization Quality of Life (WHOQOL-BREF) (p=0.037) after using the...
microprocessor-controlled orthosis. There were also fewer participant-reported falls when wearing the microprocessor-controlled orthosis versus a stance-control-orthosis or locked knee-ankle-foot orthosis.

**Nonrandomized Comparative Studies**

Pröbsting (2017) reported results of a questionnaire filled out by 13 patients at baseline (regarding their current locked knee ankle foot orthosis or stance control orthosis) and following use of a microprocessor stance and swing control orthosis.[15] The patients completed the Orthosis Evaluation Questionnaire, a new self-reported outcome measure created by modifying the Prosthesis Evaluation Questionnaire for use in lower limb orthotics and the Activities of Daily Living Questionnaire. There were statistically significant differences in the total score and the domains of ambulation (p=0.001), paretic limb health (p=0.04), sounds (p =0.02), and well-being (p=0.01), with superior results reported for the microprocessor orthosis.

**Section Summary**

The current evidence is insufficient to permit conclusions about the benefits of microprocessor-controlled lower extremity orthoses compared with other orthoses. These limitations include, among others, the small sample size. Larger, higher quality studies are needed to determine the impact of these devices on functional outcomes with greater certainty.

**PRACTICE GUIDELINE SUMMARY**

A 2017 clinical practice guideline from the Department of Veterans Affairs and the Department of Defense (VA/DoD) included the following recommendation with a weak strength of evidence:[16]

We suggest offering microprocessor knee units over non-microprocessor knee units for ambulation to reduce risk of falls and maximize patient satisfaction. There is insufficient evidence to recommend for or against any particular socket design, prosthetic foot categories, and suspensions and interfaces.

The VAs’ Prosthetic and Sensory Aids Strategic Healthcare Group was directed by the Under Secretary for Health to establish a Prosthetic Clinical Management Program to coordinate the development of clinical practice recommendations for prosthetic prescriptive practices. The following are guidelines from the Veterans Health Administration Prosthetic Clinical Management program:[17]

A. Contraindications for use of the microprocessor knee should include:
   - Any condition that prevents socket fitting, such as a complicated wound or intractable pain which precludes socket wear.
   - Inability to tolerate the weight of the prosthesis.
   - Medicare Level K 0—no ability or potential to ambulate or transfer.
   - Medicare Level K 1—limited ability to transfer or ambulate on level ground at fixed cadence.
   - Medicare Level K 2—limited community ambulator that does not have the cardiovascular reserve, strength, and balance to improve stability in stance to permit increased independence, less risk of falls, and potential to advance to a less-restrictive walking device.
   - Inability to use swing and stance features of the knee unit.

These criteria do not imply or guarantee approval. Please check with your plan to ensure coverage. Preauthorization requirements are only valid for the month published. They may have changed from previous months and may change in future months.
Poor balance or ataxia that limits ambulation.
• Significant hip flexion contracture (over 20 degrees).
• Significant deformity of remaining limb that would impair ability to stride.
• Limited cardiovascular and/or pulmonary reserve or profound weakness.
• Limited cognitive ability to understand gait sequencing or care requirements.
• Long distance or competitive running.
• Falls outside of recommended weight or height guidelines of manufacturer.
• Specific environmental factors—such as excessive moisture or dust, or inability to charge the prosthesis.
• Extremely rural conditions where maintenance ability is limited.

B. Indications for use of the microprocessor knee should include:
• Adequate cardiovascular and pulmonary reserve to ambulate at variable cadence.
• Adequate strength and balance in stride to activate the knee unit.
• Should not exceed the weight or height restrictions of the device.
• Adequate cognitive ability to master technology and gait requirements of device.
• Hemi-pelvectomy through knee-disarticulation level of amputation, including bilateral; lower extremity amputees are candidates if they meet functional criteria as listed
• Patient is an active walker and requires a device that reduces energy consumption to permit longer distances with less fatigue.
• Daily activities or job tasks that do not permit full focus of concentration on knee control and stability—such as uneven terrain, ramps, curbs, stairs, repetitive lifting, and/or carrying.
• Medicare Level K 2—limited community ambulator, but only if improved stability in stance permits increased independence, less risk of falls, and potential to advance to a less restrictive walking device, and patient has cardiovascular reserve, strength, and balance to use the prosthesis. The microprocessor enables fine-tuning and adjustment of the hydraulic mechanism to accommodate the unique motor skills and demands of the functional level K2 ambulator.
• Medicare Level K 3—unlimited community ambulator.
• Medicare Level K 4—active adult, athlete who has the need to function as a K 3 level in daily activities.
• Potential to lessen back pain by providing more secure stance control, using less muscle control to keep knee stable.
• Potential to unload and decrease stress on remaining limb.
• Potential to return to an active lifestyle.

C. Physical and Functional Fitting Criteria for New Amputees:
• New amputees may be considered if they meet certain criteria as outlined above.
• Premorbid and current functional assessment important determinant.
• Requires stable wound and ability to fit socket.
• Immediate postoperative fit is possible.
• Must have potential to return to active lifestyle.
SUMMARY

Research has shown that microprocessor-controlled knees improve function for some amputees and decrease the cognitive burden associated with monitoring the prosthesis. Those considered most likely to benefit from these prostheses have both the potential and need for frequent movement at a variable pace, uneven ground, or on stairs. Therefore, a microprocessor-controlled knee may be considered medically necessary when policy criteria are met.

In certain situations, a microprocessor-controlled knee may no longer be able to perform its basic function due to damage or wear or because of a change in the patient’s physiological condition. When this occurs, replacement of the device may be medically appropriate. Therefore, replacement of all or part of a microprocessor-controlled knee may be considered medically necessary when device replacement Criteria are met.

When a microprocessor-controlled knee is in its warranty period or can be repaired or adapted adequately to meet the patient’s medical needs, replacement of the device is not medically appropriate. Therefore, replacement of all or part of a microprocessor-controlled knee is considered not medically necessary when device replacement Criteria are not met.

There is not enough research to show if or how well microprocessor-controlled knees improve health outcomes when criteria are not met. Therefore, microprocessor-controlled knees are not medically necessary when policy criteria are not met.

There is not enough research to show that there are improved health outcomes for microprocessor-controlled ankle-foot prostheses compared with conventional prostheses. Therefore, microprocessor-controlled ankle-foot prostheses are considered investigational.

There is not enough research to evaluate the health benefits and risks of powered lower limb prostheses. Therefore, powered knee and/or powered ankle-foot prostheses are considered investigational.

There is not enough research to show that microprocessor-controlled knee-ankle-foot orthoses improve health outcomes compared with conventional orthoses. Therefore, microprocessor-controlled knee-ankle-foot orthoses are considered investigational.

REFERENCES


August 1, 2022

These criteria do not imply or guarantee approval. Please check with your plan to ensure coverage. Preauthorization requirements are only valid for the month published. They may have changed from previous months and may change in future months.


<table>
<thead>
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<th>Codes</th>
<th>Number</th>
<th>Description</th>
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<tr>
<td>HCPCS</td>
<td>K1014</td>
<td>Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control</td>
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<td>L2006</td>
<td>Knee ankle foot device, any material, single or double upright, swing and/or stance phase microprocessor control with adjustability, includes all components (e.g., sensors, batteries, charger), any type activation, with or without ankle joint(s), custom fabricated</td>
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<td>L5857</td>
<td>;swing phase only, includes electronic sensor(s), any type</td>
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<tr>
<td></td>
<td>L5858</td>
<td>;stance phase only, includes electronic sensor(s), any type</td>
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<tr>
<td></td>
<td>L5859</td>
<td>Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered</td>
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<td>L5969</td>
<td>Addition, endoskeletal ankle-foot or ankle system, power assist, includes any type motor(s)</td>
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<td>Endoskeletal ankle foot system, microprocessor controlled feature, dorsiflexion and/or plantar flexion control, include power source</td>
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<tr>
<td></td>
<td>L5999</td>
<td>Lower extremity prosthesis, not otherwise specified</td>
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*Date of Origin: May 2010*
Noninvasive Ventilators in the Home Setting

Effective: October 1, 2021

Next Review: July 2022
Last Review: August 2021

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Noninvasive ventilation (NIV) assistance or noninvasive positive pressure ventilation (NPPV) uses a nasal mask, face mask, or mouthpiece, connected to a ventilator to provide ventilation support during sleep or intermittently throughout the day.

MEDICAL POLICY CRITERIA

Notes: This policy only addresses home ventilators with a noninvasive interface (HCPCS code E0466). It does not address the use of other types of home ventilators, including those with an invasive interface (HCPCS E0465) or a multi-function home ventilator (HCPCS E0467).

I. Use of a noninvasive ventilator in the home setting may be considered medically necessary when both of the following criteria are met (A. and B.):

A. The device is being requested to treat any of the following indications:
   1. Neuromuscular disease, or
   2. Thoracic restrictive disease, or
3. Chronic respiratory failure consequent to chronic obstructive pulmonary disease.

   B. There is sufficient documentation in the medical record to support the condition is life-threatening where interruption of respiratory support would quickly lead to serious harm or death.

II. Use of a noninvasive ventilator in the home setting is considered **not medically necessary** when Criterion I. is not met, including but not limited to the following situations:

   A. The patient’s condition is such that treatment may be adequately provided by a bilevel positive airway pressure device; or
   
   B. Severity of the patient’s condition is not severe and life-threatening.

*NOTE:* A summary of the supporting rationale for the policy criteria is at the end of the policy.

**POLICY GUIDELINES**

**VENTILATOR WITH NONINVASIVE INTERFACES**

The Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations Manual (Internet-Only Manual, Publ. 100-03) in Chapter 1, Part 4, Section 280.1 stipulates that ventilators (E0465, E0466) are covered for the following conditions:[1]

“[N]euromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease.”

Each of these disease categories are comprised of conditions that can vary from severe and life-threatening to less serious forms. These ventilator-related disease groups overlap conditions described in this Respiratory Assist Devices LCD used to determine coverage for bilevel PAP devices. Each of these disease categories are conditions where the specific presentation of the disease can vary from patient to patient. For conditions such as these, the specific treatment plan for any individual patient will vary as well. Choice of an appropriate treatment plan, including the determination to use a ventilator vs. a bi-level PAP device, is made based upon the specifics of each individual beneficiary's medical condition. In the event of a claim review, there must be sufficient detailed information in the medical record to justify the treatment selected.

Ventilators fall under the Frequent and Substantial Servicing (FSS) payment category, and payment policy requirements preclude FSS payment for devices used to deliver continuous and/or intermittent positive airway pressure, regardless of the illness treated by the device. (Social Security Act 1834(a)(3)(A)) This means that products currently classified as HCPCS code E0465 or E0466 when used to provide CPAP or bi-level PAP (with or without backup rate) therapy, regardless of the underlying medical condition, shall not be paid in the FSS payment category. A ventilator is not eligible for reimbursement for any of the conditions described in this RAD LCD even though the ventilator equipment may have the capability of operating in a bi-level PAP (E0470, E0471) mode. Claims for ventilators used to provide CPAP or bi-level CPAP therapy for conditions described in this RAD policy will be denied as not reasonable and necessary.

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August 1, 2022

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Preauthorization requirements are only valid for the month published. They may have changed from previous months and may change in future months.
General principles of correct coding require that products assigned to a specific HCPCS code only be billed using the assigned code. Thus, using the HCPCS codes for CPAP (E0601) or bi-level PAP (E0470, E0471) devices for a ventilator (E0465, E0466) used to provide CPAP or bi-level PAP therapy is incorrect coding. Claims for ventilators billed using the CPAP or bi-level PAP device HCPCS codes will be denied as incorrect coding.

**LIST OF INFORMATION NEEDED FOR REVIEW**

**REQUIRED DOCUMENTATION:**

The information below must be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome.

- All chart notes and medical records pertinent to the request (e.g., supporting documentation of neuromuscular disease, thoracic restrictive disease, and/or chronic respiratory failure consequent to COPD).
- Documentation must demonstrate that the condition is life-threatening where interruption of respiratory support would quickly lead to serious harm or death.

**CROSS REFERENCES**

1. Phrenic Nerve Stimulation for Central Sleep Apnea, Surgery, Policy No. 212

**BACKGROUND**

This policy is based on the Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations Manual (Internet-Only Manual, Publ. 100-03) in Chapter 1, Part 4, Section 280.1; and Local Coverage Determination (LCD): Respiratory Assist Devices (L33800).[1, 2]

**NONINVASIVE VENTILATORS**

Ventilators, also known as respirators, are medical devices used to mechanically assist with a patients’ breathing. Mechanical ventilation is often categorized by the interface used, such as a tracheostomy tube for invasive ventilation, or a mask for non-invasive ventilation. Non-invasive ventilation (NIV) assistance or non-invasive positive pressure ventilation (NPPV) uses a nasal mask, face mask, or mouthpiece, connected to a ventilator to provide ventilation support during sleep or intermittently throughout the day. In the hospital setting, a trial of NPPV may be attempted prior to invasive treatment. Ventilation support rests the lung muscles and improves breathing performance during the day. At night, ventilation may be used to treat sleep-associated hypoventilation. If use is at night only, this is referred to as nocturnal NPPV. If use is intermittent, this may be referred to as “Mouthpiece” or “Sip and Puff” ventilation. Supplemental oxygen may also be added to this type of system.

In recent decades, NPPV has been used for treatment in the home setting. BPAP are portable pressure-limited ventilators, which are more commonly used than portable volume-limited ventilators. In some populations, efficacy is similar with both types of devices according to comparative studies, thus the portable pressure-limited ventilators are usually preferred over portable volume-limited ventilators, because of lower cost, better portability, and often greater comfort.[3]
REGULATORY STATUS

The U.S. Food and Drug Administration (FDA) has approved numerous portable home ventilators through the 510(k) process. A non-exhaustive list of examples includes the following:

- Trilogy™ (Philips Respironics)
- Newport® (Newport Medical Instruments)
- IVent (GE Healthcare)
- Puritan™ (Covidien)
- LTV® (Carefusion)

FDA Product Code: CBK.

SUMMARY

There is enough research to show that use of a noninvasive ventilator in the home setting improves health outcomes for patients with neuromuscular disease, thoracic restrictive disease, or chronic respiratory failure consequent to chronic obstructive pulmonary disease. Clinical guidelines based on research recommend noninvasive ventilators for use in the home setting for these populations. Therefore, the use of a noninvasive ventilator in the home setting may be considered medically necessary when policy criteria are met.

In all other situations, the use of a noninvasive ventilator in the home setting is not associated with improvements in health outcomes. Therefore, the use of a noninvasive ventilator in the home setting is considered not medically necessary when policy criteria are not met.

REFERENCES


**CODES**

**NOTE:** Home ventilator codes requiring prior authorization are listed on the “Commercial Pre-authorization List” web page. Home ventilators not listed on the pre-authorization website do not require prior approval. There may be codes related to home ventilator systems that are not included in this medical policy.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Number</th>
<th>Description</th>
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<td>CPT</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>HCPCS</td>
<td>E0466</td>
<td>Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)</td>
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_Date of Origin: July 2019_