310-JJ ORTHOTIC AND PROSTHETIC DEVICES

EFFECTIVE DATES: 10/01/17, 10/01/18, 04/01/21

APPROVAL DATES: 07/11/18, 02/11/21

I. PURPOSE

This Policy applies to ACC, ALTCS/EPD, DCS/Comprehensive Health Plan (CHP), DES/DDD (DDD), RBHA Contractors, and Fee-For-Services (FFS) Programs as delineated within this Policy including: Tribal ALTCS, and the American Indian Health Program (AIHP), and all FFS populations, excluding Federal Emergency Services (FES). (For FES, as referred in AMPM Chapter 1100). The purpose of this Policy is to outline coverage responsibilities for medically necessary orthotic and prosthetic devices.

II. DEFINITIONS

ORTHOTIC	Devices that are prescribed by a physician or other licensed practitioner of the healing arts to support a weak or deformed portion of the body, or prevent or correct physical deformity or malfunction, (42 CFR 440.120, A.A.C. R9-22-212).
PROSTHETIC	Devices prescribed by a physician or other licensed practitioner to artificially replace missing, deformed, or malfunctioning portion of the body, such as artificial upper and lower limbs (A.A.C. R9-22-212).

III. POLICY

A. COVERAGE GUIDELINES

1. AHCCCS covers medically necessary orthotic and prosthetic devices, when:
   a. Prescribed by a Primary Care Provider (PCP), attending physician, or practitioner, or
   b. Prescribed by a specialist upon referral from the PCP, attending physician, or practitioner, and
   c. Authorized as required by AHCCCS, Contractor, or Contractor's designee.

2. Orthotic devices are covered for member when medically necessary as specified below:
   a. Orthotics are covered for AHCCCS members under the age of 21 as specified in AMPM Policy 430.
   b. Orthotics are covered for AHCCCS members 21 years of age and older if all of the following apply:
      i. The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare Guidelines,

ii. The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition, and
iii. The orthotic is ordered by a Physician or PCP.

3. Prosthetics are covered when medically necessary within certain limitations as described below:
   a. Prosthetics are covered for AHCCCS members under the age of 21 as specified in AMPM Policy 430, and
   b. Prosthetics are covered for AHCCCS members age 21 and older when medically necessary for rehabilitation, except as specified in Exclusions.

B. COVERAGE DETERMINATIONS

1. The following shall be used in determining coverage of orthotic and prosthetic devices:
   a. Services shall be determined to be medically necessary, cost effective, and federally and state reimbursable, and
   b. Services shall be authorized and maintained to maximize the member's independence and functional level in the most appropriate setting.

2. The Contractor shall make timely determinations of coverage. The Contractor shall not refuse to render a timely determination based on the member's Medicare/Medicaid dual eligibility status or the providers' contract status with the Contractor.

3. Non-Covered prosthetic and orthotic devices are not included when determining whether an inpatient stay qualifies as an outlier. If an inpatient stay does qualify as an outlier without considering charges for non-covered devices, the charges for those devices are not included in the outlier payment calculations.

4. For coverage requirements regarding medical equipment, appliances and supplies under the home health services benefit, as specified in AMPM Policy 310-P.

C. MAINTENANCE AND REPAIR

Maintenance and repair of component parts is covered for Orthotic and Prosthetic devices. Reasonable repairs or adjustments of purchased Orthotics and Prosthetics are covered for all members to make the device serviceable and/or when the repair cost is less than purchasing another unit. Components will be replaced when documentation is provided at the time authorization is sought to establish that the component is not operating effectively.

D. LIMITATIONS

1. The following applies for members 21 years of age and older regarding coverage for lower limb Prosthetics:
   a. Factors for coverage of a lower limb Prosthetic include but are not limited to:
      i. Consideration of the member's:
         1) Past history (including prior Prosthetic use, if applicable),

2) Current condition (including status of the residual limb and the nature of other medical problems), and
3) Degree of motivation to ambulate with a Prosthetic.

ii. Assessment of the member's functional level as described below (note that within the functional classification hierarchy, bilateral amputees often cannot be strictly bound by functional level classifications):

1) Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis. Does not enhance their quality of life or mobility.
2) Level 1: Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
3) Level 2: Has the ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator.
4) Level 3: Has 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.
5) Level 4: Has 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.

b. Limitations (Lower Limb Prosthesis):

i. Lower limb prosthesis is not considered medically necessary for members with a functional level of zero.
ii. If more than one Prosthetic device can meet the member's functional needs, the Prosthetic device that is most cost effective and meets the minimum specifications for the member's needs will be covered.
iii. Microprocessor controlled lower limb or microprocessor-controlled joints for lower limbs are not covered for members 21 years of age and older.

F. EXCLUSIONS

The following services are not covered for individuals 21 years of age or older:

1. Hearing aids.

2. Prescriptive lenses except in situations when they are the sole visual prosthetic device used by the member after a cataract extraction.

3. Bone Anchor Hearing Aid (BAHA) (as of 10/1/2010 as specified in § A.R.S. 36-2907).

4. Cochlear implant (as of 10/1/2010 as specified in § A.R.S. 36-2907).

5. Microprocessor-controlled lower limbs or microprocessor-controlled joints for lower limbs, and

6. Penile implants or vacuum devices.