Harvard Pilgrim HealthCare

*Medical Review Criteria*
*Durable Medical Equipment*

# STRIDE[sm] (HMO) MEDICARE ADVANTAGE

**Effective Date: January 1, 2018**

## Subject: Durable Medical Equipment

## Authorization:
Prior authorization is required for any single DME item with a Harvard Pilgrim Stride[SM] (HMO) Medicare Advantage allowable payment amount of $500 or more.

## Policy and Coverage Criteria:
Harvard Pilgrim Stride[SM] (HMO) Medicare Advantage considers Durable Medical Equipment (DME) as reasonable and medically necessary for the treatment of the member's illness or injury, and when documentation confirms All the following indications:

- DME is reasonable and medically necessary based on the member's condition, complexity of requested service(s), and accepted standards of clinical practice;
- DME is considered as an essential part of active treatment of the member's medical condition, and ordered under a plan of care established and reviewed regularly by the attending physician caring for the member; and
- DME will provide therapeutic benefits, improve the functioning of a malformed body part, and/or enable the member to perform tasks that she or he would otherwise be unable to undertake due to his/her medical condition or illness;
- The DME item will be used primarily in the home (but may be transported to other locations);
- DME is furnished by provider(s) with appropriate state licensure, and accreditation/certification from an appropriate accrediting organization (e.g. JCAHO, CMS).

Medicare defines durable medical equipment (DME) as equipment that:

- Can withstand repeated use
- Is primarily and customarily used to serve a medical purpose
- Generally is not useful to a person in the absence of an illness or injury
- Is appropriate for use in the home

All requirements of this definition must be met before an item is considered to be DME.

Examples of equipment that meets the definition of DME include, but are not limited to:

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| • Canes<br>• Crutches<br>• Walkers<br>• Commode chairs | • Home oxygen equipment<br>• Hospital beds<br>• Traction equipment<br>• Wheelchairs |

**Definitions:**

- **Durable:** An item is considered durable if it can withstand repeated use (i.e., the type of item which could normally be rented). *Note: There are items which, while durable, may fall into other benefit categories and are so noted in this policy.*
- **Medical Purpose:** DME is primarily and customarily used for medical purposes, and not generally useful in the absence of illness or injury.
- **Necessary and Reasonable:** DME is necessary when it can be expected to make a meaningful contribution to the treatment of the member's illness or injury or to the improvement of his/her malformed body part.

## Exclusions:

Harvard Pilgrim Stride℠ (HMO) Medicare Advantage considers durable Medical Equipment (DME) as not medically necessary for all other indications. In addition, Harvard Pilgrim Stride℠ (HMO) does not cover:

- Comfort/convenience items (e.g., emesis basins, overbed tables, raised toilet seats, bathtub lifts, stairway elevators, posture chairs)
- Educational/training equipment (e.g., speech teaching machines, Braille training texts)
- Environmental control equipment (e.g., air cleaners, air conditioners, dehumidifiers)
- First-aid equipment
- Hygienic equipment (e.g., bathtub seats, bed baths, incontinence pads)
- Institutional equipment that is inappropriate for home use (e.g., diathermy units, oscillating beds)
- Items that not primarily medical in nature (bed lifters, bed boards, exercise equipment, grab bars, toilet seats)
- Medical supplies of an expendable nature (e.g., incontinent pads, lamb's wool pads, catheters, ace bandages, irrigating kits, sheets).
- Non-reusable disposable supplies (e.g., catheters, irrigation kits)
- Physical fitness equipment (e.g., Exercycle)
- Precautionary-type equipment (e.g., spare oxygen tanks)
- Self-help devices (e.g., grab bars)

**Equipment which is primarily and customarily used for a nonmedical purpose (e.g., equipment used for environmental control, items that serve comfort or convenience functions or are primarily for the convenience of a person caring for the patient, physical fitness equipment, first-aid equipment, and educational/training equipment) is not considered "medical" equipment, even if the item has some remote medically related use.**

**When necessary to determine if a particular item constitutes medical equipment, information on the device and its use should be reviewed on an individual basis.**

**Such review may include an evaluation by UM physicians and/or external specialists; if the equipment is new on the market, it may be necessary to obtain information from the supplier or manufacturer explaining the design, purpose, effectiveness and method of using the equipment in the home as well as the results of any tests or clinical studies that have been conducted.**

## Coding:

**Codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible.**

| Item Billed | Coverage | CMS Determinations and Guidance |
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| **Air-Fluid Bed** | Covered for treatment of pressure sores can be made if such use is reasonable and necessary for the individual patient. | See NCD 280.8 Air-Fluidized Bed |
| **Alternating Pressure Pads and Mattresses:** | Covered if patient has, or is highly susceptible to, decubitus ulcers and the patient's physician specifies that he/she has specified that he will be supervising the course of treatment<br><br>See LCDs for further information on specific pressure reducing surfaces. | See NCD 280.1 Durable Medical Equipment |
| • **Group 1 Support Surface**<br>• Products in this category include mattresses, pressure pads, and mattress overlays (foam, air, water, or gel). | Generally designed to replace a standard hospital or home mattress, or as an overlay placed on top of a standard hospital or home mattress. Covered if the patient is completely immobile. Otherwise, he or she must be partially immobile, or have any stage pressure ulcer and demonstrate one of the following conditions:<br>• Impaired nutritional status<br>• Incontinence<br>• Altered sensory perception<br>• Compromised circulatory status | See Local Coverage Determination for Pressure Reducing Support Surfaces - Group 1 (L33830) |
| • **Group 2 Support Surface**<br>Products in this category include powered air flotation beds, powered pressure reducing air mattresses, and non-powered advanced pressure reducing mattresses. | • Generally designed to replace a standard hospital or home mattress, or as an overlay placed on top of a standard hospital or home mattress.<br>• Covered if the patient has a stage II pressure sore located on the trunk or pelvis, has been on a comprehensive pressure sore treatment program (which has included the use of an appropriate group 1 support surface for at least one month), and has sores which have worsened or remained the same over the past month. A Group 2 support surface is also covered if the patient has large or multiple stage III or IV pressure sores on the trunk or pelvis, or if he or she has had a recent myocutaneous flap or skin graft for a pressure sore on the trunk or pelvis and has been on a group 2 or 3 support surface. | See Local Coverage Determination for Pressure Reducing Support Surfaces - Group 2 (L33642) |

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| • **Group 3**<br>Complete bed systems, known as air-fluidized beds, which use the circulation of filtered air through silicone beads. | • Covered if the patient meets ALL the following:<br>• Has a stage III or stage IV pressure ulcer<br>• Is bedridden or chair-bound<br>• Would be institutionalized without the use of the group 3 support surface<br>• Is under the close supervision of the patient's treating physician, at least one (1) month of conservative treatment has been administered (including the use of a group 2 support surface), a caregiver is available and willing to assist with patient care, and all other alternative equipment has been considered and ruled out. | See Local Coverage Determination for Pressure Reducing Support Surfaces - Group 3 (L33692) |
| **Ambulatory Blood Pressure Monitoring** | Covered when documentation confirms suspected white coat hypertension defined by ALL the following:<br>• Office blood pressure > 140/90 mm/Hg on 3 separate visits with 2 readings at each visit;<br>• At least 2 documented blood pressure readings taken outside of the medical office which are < 140/90mmHg; and<br>• No evidence of end-organ damage. | See NCD 20.19 Ambulatory Blood Pressure for more detailed information |
| **Ankle-Foot Orthosis (AFO) or Knee-Ankle-Foot Orthosis (KAFO)** | Coverage based on ability to ambulate. See below.<br><br>Elastic pre-fabricated orthoses **ARE NOT** covered as they have been determined to not meet the definition of a brace as they are not rigid or semi-rigid devices. | |
| **AFO**<br>**KFO** | Covered as an appliance/orthotic for ambulatory patients with weakness or deformity of the foot or ankle which requires stabilization to provide the potential to benefit functionally. | See LCD 33686 Ankle-Foot/Knee-Ankle-Foot Orthoses |
| **Orthosis Molded to Patient** | Covered as an appliance/orthotic for ambulatory patients when documentation confirms one of the following: | See LCD 33686 Ankle-Foot/Knee-Ankle-Foot Orthoses |

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| | 1. Patient could not be fit with prefabricated AFOs;<br>2. Condition which necessitates the orthosis is expected to be permanent, or of a duration greater than 6 months;<br>3. There is a need to control the knee, ankle, foot in more than 1 plane;<br>4. Neurological, circulatory, or orthopedic condition which requires custom fabrication over a model to prevent tissue injury;<br>5. The patient has a healing fracture which lacks integrity or anthropometric proportions. | |
| **Non-ambulatory** | Foot drop Splints are not covered for non-ambulatory patients and will be denied as medically not necessary. | See LCD 33686 Ankle-Foot/Knee-Ankle-Foot Orthoses |
| **AFO** | Static or dynamic positioning ankle-foot orthosis) is covered as DME for non-ambulatory patients when criteria are met.<br><br>Covered when documentation confirms criteria 1 - 4 (ALL), **OR** criterion 5 are met:<br>1. Plantar flexion contracture of the ankle (see Diagnosis Codes That Support Medical Necessity Group 1 Codes section) with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a non-fixed contracture); AND<br>2. Reasonable expectation of the ability to correct the contracture; AND<br>3. Contracture is interfering or expected to interfere significantly with the beneficiary's functional abilities; AND<br>4. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons.<br>5. The beneficiary has plantar fasciitis (see Diagnosis Codes That | See LCD 33686 Ankle-Foot/Knee-Ankle-Foot Orthoses |

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| | Support Medical Necessity Group 1 Codes section) | |
| **Artificial Eye (Prosthetic Eye)** | Covered | See Medicare Benefit Policy Manual (100-2), Chapter 15, Subsection 120 (Prosthetic Devices and Subsection 130 leg, Arm, Back and Neck Braces, Trusses and Artificial Legs, Arms and Eyes |
| **Artificial larynx or Electronic Speech Generating Devices** | Covered for members with severe speech impairment and have a medical condition that warrants the use of a device | See NCD (50.1) for Speech Generating Devices<br><br>See also NCD for Speech-Language Pathology Services for the Treatment of Dysphagia (170.3) |
| **Artificial Limbs – Lower Limb**<br>• Standard<br>• C-leg (microprocessor-controlled knee-shin system)<br><br>• Clinical assessments of patient rehabilitation potential must be based on functional levels 0-4 | Covered when the patient will reach or maintain a defined functional state within a reasonable period of time, and is motivated to ambulate.<br><br>A determination of medical necessity for certain components/feature to the prosthesis is based on the patient's potential for functional ability. Functional ability is based on the reasonable expectation that the prosthetist and treating physician, consider factors such as but not limited to:<br>1. The patient's past history (including prior prosthetic use, if applicable);<br>2. The patient's current condition including the status of the residual limb and the nature of the other medical problems;<br>3. The patient's desire to ambulate. | See the Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services. Section 130 - Leg, Arm, Back, and Neck Braces<br><br>See also Local Coverage Determination (LCD) Lower Limb Prostheses (L33787) |
| **Artificial Limbs – Upper Limb** | Covered when criteria are met | See Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services. Section 130 - Leg, Arm, Back, and Neck Braces |
| **Automatic External Defibrillators**<br>• **Wearable AED**<br>• **Non-wearable AED** | Covered as DME when criteria are met. | See Local Coverage Determination (LCD) Automatic External Defibrillators (L33690) |

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| **Back Brace** | See Spinal Orthosis | |
| **Bi-level Positive Airway Pressure (BiPAP)** | Covered with Criteria | See NCD for Continuous Positive Airway (CPAP Therapy for Obstructive Sleep Apnea (OSA) 240.4<br><br>See also National Coverage Determination (NCD) for Home Use of Oxygen in Approved Clinical Trials (240.2.1) |
| **Blood Glucose Monitors** | **See Harvard Pilgrim Stride℠ (HMO) Medicare Advantage Medical Review Criteria for Continuous Glucose Monitoring Systems.** | See NCD 40.2 Home Blood Glucose Monitors<br><br>See also LCD 33822 for Glucose Monitors |
| **Blood Pressure Monitor (Sphygmomanometer)** | Covered ONLY for members on home dialysis.<br><br>Note: Fully or semi-automatic portable monitors (member activated) are not covered. | See Medicare Benefit Policy Manual, Chapter 11, Section 50.5 - Coverage of Home Dialysis Supplies |
| **Bone Stimulator (Ultrasonic or Electronic)** | Covered with Criteria – See NCD for Criteria | See NCD 150.2 Osteogenic Stimulators |
| **Braces** | See AFO/KAFO or Spinal Orthosis or Knee Orthosis | |
| **Bras (post-surgical)** | Covered with limits. (Two covered initially, with replacements thereafter due to normal wear and tear)<br><br>Coverage includes custom fittings. | See Medicare Benefit Policy Manual (100-2), Chapter 15, §120 - Prosthetic Devices |
| **Breast Prosthesis (non-implanted)** | Covered for members post-mastectomy or lumpectomy.<br><br>One prosthesis per side is initially allowed.<br><br>Replacement with the same type of prosthesis (silicone, fiber, foam or fabric) is covered at any time when the prosthesis is lost or irreparably damaged. | See Medicare Benefit Policy Manual (100-2), Chapter 15, §120 - Prosthetic<br><br>See also Local Coverage Determination (LCD) for Breast Prostheses (L33317) |
| **Canes (Quad or Straight)** | Covered when member meets the Mobility Assistive Equipment criteria. | See NCD for Durable Medical Equipment Reference List (280.1) |

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| **White canes not covered, not primarily medical in nature, not considered Mobility Assistive Equipment.** | | See also National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE) (280.3)<br><br>See also Local Coverage Determination (LCD) Canes and Crutches (L33733) |
| **Catheters and Related Supplies**<br>• **External Urinary Collection Devices**<br>• **Foley or Indwelling Catheter**<br>• **Leg Drainage Bag** | Covered as Prosthetics. | See Local Coverage Determination (LCD) Urological Supplies (L33803) |
| **Chair (adjustable)** | Covered only for members on home dialysis. | See Medicare Benefit Policy Manual, Chapter 11, Section 50.5 - Coverage of Home Dialysis Supplies |
| **Cochlear Implant (External Portion of Device)** | Covered as a Prosthetic when criteria are met. | See Criteria at National Coverage Determination (NCD) for Cochlear Implantation (50.3) |
| **Collagen Implant** | Covered as Prosthetic for member with stress urinary incontinence who meets criteria. | See Criteria at National Coverage Determination (NCD) for Incontinence Control Devices (230.10) |
| **Colostomy Bag** | Ostomy bags and necessary accouterments required for attachment are covered as prosthetic devices. | See LCD L33828 for Ostomy Supplies |
| **Commode (Bedside)** | Covered when medical record documentation confirms member is physically incapable of utilizing a regular toilet facility, including ANY of the following:<br>1. Member is confined to a single room;<br>2. Member is confined to one level of the home and there is no toilet on that level;<br>3. Member is confined to the home and there are no toilet facilities in the house. | See Local Coverage Determination for Commodes (L33736) |
| **Contact Lens, Hydrophilic Soft (external)** | Coverage criteria apply | See NCD for Hydrophilic Contact Lens for Corneal Bandage (80.1)<br><br>See also NCD for Hydrophilic Contact Lens (80.4) |

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| **Continuous Glucose Monitoring Device/System** | **Covered when criteria are met. See separate Harvard Pilgrim Stride[SM] (HMO) Medicare Advantage Medical Review Criteria.** | |
| **Continuous Pass Motion Devices (CPM)** | Covered as DME for members who have received a total knee replacement. Use of the CPM device must commence within 2 days following surgery. Coverage is limited to the portion of the 3-week period following surgery during which the device is used in the home. | See National Coverage Determination (NCD) for Durable Medical Equipment Reference List (280.1) |
| **Continuous Positive Airway Pressure Devices (CPAP)** | Coverage criteria apply. | See criteria at National Coverage Determination (NCD) for Continuous Positive Airway Pressure (CPAP) Therapy For Obstructive Sleep Apnea (OSA) (240.4) |
| **Cough Assist Devices (Mechanical In/ex-sufflation devices)** | Mechanical in/ex-sufflation devices are covered as DME for members who meet criteria as follows:<br>1. Member has a neuromuscular disease, **and**<br>2. The condition causing significant impairment of chest wall and/or movement of the diaphragm is such that it results in an inability to clear retained secretions | See Local Coverage Determination for Mechanical In-exsufflation Devices (L33795) |
| **Crutches, Crutch Tips and Handles** | Covered as DME when medical record documentation confirms ALL the following:<br>1. Member has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living;<br>2. The mobility limitation is one that prevents the member from accomplishing the MRADL, or places him/her at reasonably determined heightened risk of morbidity/mortality secondary to the attempts to perform an MRADL, or prevents him/her from | See also Local Coverage Determination (LCD) Canes and Crutches (L33733) |

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| | completing MRADL within a reasonable time frame;<br>3. Member is able to safely use the crutch, and the functional mobility deficit can be sufficiently resolved by use of the device. | |
| **Deep Brain Stimulation:** | Covered as a Prosthetic for the treatment of essential tremor (ET) and/or Parkinson's related tremor when criteria are met. | See criteria National Coverage Determination (NCD) for Deep Brain Stimulation for Essential Tremor and Parkinson's Disease (160.24) |
| **Diabetic Shoes / Footwear** | | See LCD L33369 for Therapeutic Shoes for Persons with Diabetes |
| **Dialysis Home Kit for Peritoneal Dialysis** | Cover as DME for members on home dialysis. | See Medicare Benefit Policy Manual, Chapter 11, Section 50.5 - Coverage of Home Dialysis Supplies |
| **Surgical Dressings** | Covered as DME when ordered by the treating provider for the patient's home use in conjunction with durable medical equipment.<br><br>Covered as a **Prosthetic** when order by the treating provider for use in the patient's home as a dressing for surgical wounds or for wound debridement or in conjunction with as a prosthetic device (e.g. a tracheostomy). | Medicare Benefit Policy Manual, Chapter 15, Section 110.3 - Coverage of Supplies and Accessories<br><br>See also Local Coverage Determination for Surgical Dressings (L33381)<br><br>See also Medicare Benefit Policy Manual, Chapter 15, Section 120 (D) Supplies, Repairs, Adjustments, and Replacement |
| **Egg Crate** | See Alternating Pressure Pads, Mattresses and Pressure Reducing Support Surfaces | |
| **Electrical Stimulation Devices** | | |
| **Transcutaneous Electrical Nerve Stimulator (TENS) Unit** | Covered as DME with Criteria | See National Coverage Determination (NCD) for Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy (160.7.1)<br><br>National Coverage Determination (NCD) for Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain (10.2) |

| Item Billed | Coverage | CMS Determinations and Guidance |
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| | | Local Coverage Determination for Transcutaneous Electrical Joint Stimulation Devices (TEJSD) (L34821)<br><br>For Related Supplies See National Coverage Determination (NCD) for Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES) (160.13) |
| **Neuromuscular Electrical Stimulator (NMES)** | Covered as DME with Criteria<br><br>Related Supplies | See Criteria National Coverage Determination (NCD) for Neuromuscular Electrical Stimulation (NMES) (160.12)<br><br>For Related Supplies See National Coverage Determination (NCD) for Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES) (160.13) |
| **Electronic Speech Aid** | See Artificial Larynx | |
| **Enuresis Training Item** | Prosthetic | See Medicare Benefit Policy Manual (Pub.100-2) Chapter 15, Section 120 Prosthetic Devices |
| **Facial Prosthesis** | Prosthetic | Covered when there is loss or absence of facial tissue. See Local Coverage Determination for Facial Prostheses (L33738) |
| **Flutter Device** | See Oscillatory Positive Expiratory Device | |
| **Foot Cradle** | See Hospital Beds and Accessories | |
| **Formula (Enteral feedings)** | Prosthetic | See National Coverage Determination (NCD) for Enteral and Parenteral Nutritional Therapy (180.2) |
| **Heat Lamp** | Covered as DME if condition exists for which the application of heat is therapeutically effective. | See NCD 280.1 Durable Medical Equipment |
| **Heating Pads, Hot Packs** | See Subsections below | |
| **Electrical or non-electrical** | Covered as DME Covered if condition exists for which the application of heat is therapeutically effective. | See National Coverage Determination (NCD) for Infrared Therapy Devices (270.6) |

| Item Billed | Coverage | CMS Determinations and Guidance |
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| | | NCD 280.1 Durable Medical Equipment |
| **Helmets** | See subsections below | |
| **Cranial Orthosis** | Corrective Appliance/Orthotic. Covered with criteria for members with head injuries or reconstructive plating. | See Medicare Benefit Policy Manual (100-2), Chapter 15, § 130 - Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes |
| **Heparin or Saline flushes** | Covered as DME if **patient meets the homebound** status **and** the flush is necessary to maintain patency of an inserted/implanted venous access.<br><br>**While heparin is a Part D drug, it is covered as DME when used to maintain patency of a line.** | See Medicare Part B versus Part D Coverage Issues in the Medicare Prescription Drug Benefit Manual, Chapter 6, Appendix C |
| **High Frequency Chest Wall Oscillation Devices (e.g. ThAIRapy Vest and others)** | Covered as DME when criteria are met | See Local Coverage Determination for High Frequency Chest Wall Oscillation Devices (L33785) |
| **Holter Monitor (Cardiac Event Monitor)** | Covered as Medical Supply only when incident to a physician's professional services **and** furnished as an integral, although incidental, part of those services in the course of diagnosis or treatment of an injury or illness | See National Coverage Determination (NCD) for Electrocardiographic Services (20.15) |
| **Home Prothrombin Time International Normalized Ratio (INR) Monitoring** | Medical Supply and covered only for chronic, oral anticoagulation management for patients with mechanical heart valves, chronic atrial fibrillation or venous thromboembolism on warfarin when incident to a physician's professional services **and** furnished as an integral, although incidental, part of those services in the course of diagnosis or treatment of an injury or illness. | See National Coverage Determination (NCD) for Home Prothrombin Time/International Normalized Ratio (PT/INR) Monitoring for Anticoagulation Management (190.11) |
| **Hospital Beds and Accessories** | Coverage criteria apply. See subsections below. | |
| **Hospital bed, fixed height** | Covered as DME when member meets ANY of the following:<br>1. Requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does | See National Coverage Determination (NCD) for Hospital Beds (280.7) |

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| | not usually require the use of a hospital bed;<br>2. Requires positioning of the body in ways not feasible with an ordinary bed, for alleviation of pain;<br>3. Requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or problems with aspiration (pillows or wedges should be considered first);<br>4. Requires traction equipment that can only be attached to a hospital bed. | |
| **Hospital Bed, adjustable height** | • Covered as DME. Variable height feature of a hospital bed is covered for ANY of the following:<br>**1.** Severe arthritis and other injuries to lower extremities; e.g., fractured hip. The condition requires the variable height feature to assist the patient to ambulate by enabling the patient to place his or her feet on the floor while sitting on the edge of the bed;<br>**2.** Severe cardiac conditions. For those cardiac patients who are able to leave bed, but who must avoid the strain of "jumping" up or down;<br>**3.** Spinal cord injuries, including quadriplegic and paraplegic patients, multiple limb amputee and stroke patients. For those patients who are able to transfer from bed to a wheelchair, with or without help;<br>**4.** Other severely debilitating diseases and conditions, if the variable height feature is required to assist the patient to ambulate.<br><br>**ADDITIONALLY: Member must meet one of the criteria outlined** | See National Coverage Determination (NCD) for Hospital Beds (280.7) |

| Item Billed | Coverage | CMS Determinations and Guidance |
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| | **above for a fixed height bed AND must require a bed height different than a fixed height bed in order to permit transfer to a chair, wheelchair or standing position.** | |
| **Hospital Bed, semi-electric** | Covered as DME when criteria are met.<br><br>**Member must meet one of the criteria outlined above for a fixed height bed (as listed above) AND require frequent or immediate changes in body position.** | See National Coverage Determination (NCD) for Hospital Beds (280.7) |
| **Hospital bed, total electric** | Not Covered | Not covered as the height adjustment features is considered a convenience feature. National Coverage Determination (NCD) for Hospital Beds (280.7) |
| **Hospital bed, heavy duty/extra wide** | Covered as DME with criteria. Member must meet criteria for a fixed height hospital bed **AND** weigh more than 350 pounds but not more than 600 pounds. | See National Coverage Determination (NCD) for Hospital Beds (280.7) |
| **Hospital bed, extra heavy duty** | Covered as DME with criteria. Member must meet criteria for a fixed height hospital bed **AND** weigh more than 350 pounds but not more than 600 pounds. | See National Coverage Determination (NCD) for Hospital Beds (280.7) |
| **Bed Cradle** | Covered as DME when necessary to prevent contact with bed coverings. | See National Coverage Determination (NCD) for Hospital Beds (280.7) |
| **Mattress** | Covered as DME ONLY when part of a medical necessary hospital bed. | See National Coverage Determination (NCD) for Hospital Beds (280.7) |
| **Side rails** | Covered as DME only if part of a hospital bed and member's condition requires side rails. | See National Coverage Determination (NCD) for Hospital Beds (280.7) |
| **Humidifier** | See subsections below | |
| **For use with Bi-PAP or C-PAP** | Covered as DME | For coverage criteria see NCD for Continuous Positive Airway (CPAP Therapy for Obstructive Sleep Apnea (OSA) 240.4<br><br>If member is part of a clinical trial, please see CPAP For Obstructive Sleep |

| Item Billed | Coverage | CMS Determinations and Guidance |
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| | | Apnea - Centers for Medicare & Medicaid Services |
| **For Use with Respiratory Assist Devices** | Covered as DME | |
| **For Use with Oxygen Delivery Systems** | Covered as DME | See National Coverage Determination (NCD) for Home Use of Oxygen (240.2) |
| **Independence iBot 4000 Mobility System** | See subsections below. | |
| **Standard** | Covered as DME with criteria. | See criteria for Mobility Assistive Equipment National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE) (280.3) also See National Coverage Determination (NCD) for INDEPENDENCE iBOT 4000 Mobility System (280.15) |
| **4-wheel, Balance, Stair and Remote Functions** | Not Covered | See National Coverage Determination (NCD) for INDEPENDENCE iBOT 4000 Mobility System (280.15) |
| **Incontinence Control Devices** | Covered as Prosthetic for members with permanent neurologic or anatomic dysfunctions of the bladder | See National Coverage Determination (NCD) for Incontinence Control Devices (230.10) |
| **Infusion Pump** | See Pumps | |
| **Insulin Pump (including insulin and supplies)** | Covered as DME | For coverage criteria see National Coverage Determination (NCD) for Infusion Pumps (280.14) and for insulin and supplies see Medicare Prescription Drug Benefit Manual, Chapter 6, Appendix C Medicare Part B versus Part D Coverage Issues |
| **Intermittent Positive Pressure Breathing Machine (IPPB)** | Covered as DME with criteria | See criteria National Coverage Determination (NCD) for Durable Medical Equipment Reference List (280.1) |
| **Knee Orthosis (such as knee immobilizer, range of motion knee orthosis, ACL brace, etc.)** | Corrective Appliance/Orthotic<br><br>Note: Elastic pre-fabricated orthoses are not covered as they have been | |

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| | determined to not meet the definition of a brace as they are not rigid or semi-rigid devices. | |
| **Lifts** | See subsections below | |
| **Hydraulic (Hoyer) Lift/Patient Lift** | Covered as DME if the member's condition results in the need to move periodically to effect improvement or to prevent deterioration of his condition. | |
| **Seat Lift Mechanism** | Covered as DME when ALL the following are met:<br>1. For patients with severe arthritis of the hip or knee, muscular dystrophy, or other neuromuscular diseases;<br>2. Must be part of physician's course of treatment and be prescribed to effect improvement, or arrest or retard deterioration in the member's condition;<br>3. Must be completely incapable of standing up from a regular armchair or any chair in the home;<br>4. Once standing, member must have the ability to ambulate. | See National Coverage Determination (NCD) for Seat Lift (280.4) |
| **Lymphedema Pump** | See Pneumatic Compression Devices | |
| **Lymphedema Sleeve** | Covered as DME if part of the pneumatic compression device, not covered as a separate item. Criteria apply. | See National Coverage Determination (NCD) for Pneumatic Compression Devices (280.6) |
| **Mandibular Device for Sleep Apnea** | Covered as DME when criteria are met. | See Local Coverage Determination for Oral Appliances for Obstructive Sleep Apnea (L33611) |
| **Nebulizers and Supplies** | Covered as DME if patient's ability to breathe is severely impaired.<br><br>See subsections below. | See National Coverage Determination (NCD) for Durable Medical Equipment Reference List (280.1) |
| **Electric – Small volume, non-filtered** | Covered as DME | Covered when medically necessary to deliver appropriate inhalation medications for treatment of COPD, cystic fibrosis, HIV, pneumocystosis, |

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| | | complication of organ transplants or thick/tenacious pulmonary secretions |
| **Electric, small** | Covered as DME | When medically indicated to administer pentamidine to patients with HIV. |
| **Large Volume, Non-Disposable** | Covered as DME | When medically needed to deliver humidity to a member with cystic fibrosis, bronchiectasis, a tracheostomy or tracheobronchial stent with thick/tenacious |
| **Portable (AC or DC)** | Covered as DME | Battery powered portable nebulizers are only covered when medically necessary and not covered for travel, school or recreational purposes. |
| **Medication** | Covered as DME | Covered as part of the nebulizer. See SOB for copayment/coinsurance information. |
| **Nutritional Therapy, Enteral** | Covered as a Prosthetic | See National Coverage Determination (NCD) for Enteral and Parenteral Nutritional Therapy (180.2) |
| **Obturator (palatal)** | Covered as Prosthetic for surgically acquired deformity or trauma and use to fill in a missing palate or portion of the palate. | See Medicare Benefit Policy Manual (100-2), Chapter 15, §120 Prosthetic Devices |
| **Oscillatory positive expiratory pressure device, non-electric (such as a flutter device or Acapella)** | Covered as DME | |
| **Orthopedic Shoes** | Covered as Corrective Appliance/Orthotic only when permanently attached to a brace. | See National Coverage Determination (NCD) for Prosthetic Shoe (280.10) |
| **Ostomy Supplies** | Covered as Prosthetic. Includes irrigation and flushing equipment and supplies directly related to care of the member's ostomy. | |
| **Oxygen and related equipment** | See subsections below | See National Coverage Determination (NCD) for Home Use of Oxygen (240.2) |

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| **Stationary** | Covered as DME | See National Coverage Determination (NCD) for Home Use of Oxygen (240.2) |
| **Portable Regulated** | Covered as DME | See National Coverage Determination (NCD) for Home Use of Oxygen (240.2) |
| **Portable Preset** | Covered as DME | See National Coverage Determination (NCD) for Home Use of Oxygen (240.2) |
| **Oxygen Tent** | Covered as DME | See National Coverage Determination (NCD) for Home Use of Oxygen (240.2) |
| **Pacemaker Monitors (Self-contained with audible/visible signal or digital/electronic** | Covered as DME when prescribed by a provider for a member with a cardiac pacemaker. | See National Coverage Determination (NCD) for Cardiac Pacemakers (20.8)<br><br>National Coverage Determination (NCD) for Cardiac Pacemaker Evaluation Services (20.8.1)<br><br>National Coverage Determination (NCD) for Self-Contained Pacemaker Monitors (20.8.2)<br><br>National Coverage Determination (NCD) for Cardiac Pacemakers: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers (20.8.3)<br><br>National Coverage Determination (NCD) for Transtelephonic Monitoring of Cardiac Pacemakers (20.8.1.1) |
| **Paraffin Bath** | See subsections below | |
| **Portable** | Covered as DME when the patient has had a successful trial of paraffin therapy ordered by a provider and the patient's condition is expected to be relieved by long term use of this treatment modality. | See National Coverage Determination (NCD) for Durable Medical Equipment Reference List (280.1) |
| **Peak Expiratory Flow Meter, hand-held** | Covered as Medical Supply when incident to a provider's professional services | See Medicare Claims Processing Manual, Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies |
| **Penile Prosthesis** | Prosthetic | See National Coverage Determination (NCD) for Diagnosis and Treatment of Impotence (230.4) |

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| **Percussor (Non-vest type)** | See subsections below | |
| **Pneumatic or electric, home models** | Covered as DME when used for mobilizing respiratory tract secretions in patients with chronic obstructive lung disease, chronic bronchitis, or emphysema, when patient or operator of powered percussor receives appropriate training by a physician or therapist, and no one competent to administer manual therapy is available. | See National Coverage Determination (NCD) for Durable Medical Equipment Reference List (280.1) |
| **Pneumatic Compression Device** | See subsections below | |
| **To treat lymphedema or chronic venous insufficiency** | Covered as DME with criteria. | See National Coverage Determination (NCD) for Pneumatic Compression Devices (280.6) |
| **Porcine (Pig) Skin Dressings** | Covered as Medical Supply if reasonable and necessary for individual member's condition. | See National Coverage Determination (NCD) for Porcine Skin and Gradient Pressure Dressings (270.5) |
| **Power Mobility Devices** | See Wheelchairs | |
| **Pumps, including medications and supplies** | See subsections below | |
| **Enteral** | Prosthetic coverage | See criteria National Coverage Determination (NCD) for Enteral and Parenteral Nutritional Therapy (180.2) |
| **Infusion** | Covered as DME | See National Coverage Determination (NCD) for Infusion Pumps (280.14) |
| **Insulin (external)** | Covered as DME | See National Coverage Determination (NCD) for Infusion Pumps (280.14) |
| **Lymphedema** | Covered as DME | See National Coverage Determination (NCD) for Pneumatic Compression Devices (280.6) |
| **Pain Control** | Covered as DME | See National Coverage Determination (NCD) for Infusion Pumps (280.14) |

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| **Parenteral** | Covered as Prosthetic | See National Coverage Determination (NCD) for Enteral and Parenteral Nutritional Therapy (180.2) |
| **Erectile Dysfunction** | See Vacuum Pump | |
| **Recliner Chair** | Covered as DME for members on home dialysis. | See Medicare Benefit Policy Manual, Chapter 11- End Stage Renal Disease (ESRD). Section 20.4 (A)(1)- Equipment and Supplies |
| **Refractive Lenses** | Covered as DME with criteria (See subsections below) | |
| **Aphakic** | The following lenses or combinations of lenses are covered when determined to be medically necessary for members who are aphakic (i.e., who have had a cataract removed but do not have an implanted intraocular lens, or who have congenital absence of the lens):<br>1. Bifocal lenses in frames;<br>2. Lenses in frames for far vision and lenses in frames for near vision;<br>3. When a contact lens(es) for far vision is prescribed (including cases of binocular and monocular aphakia), payment will be made for the contact lens(es), and lens(es) in frames for near vision to be worn at the same time as the contact lens(es) and lenses in frames to be worn when the contacts have been removed.<br>4. For aphakic members (i.e., those who do not have an implanted intraocular lens), replacement lenses are covered when they are medically necessary. | See Local Coverage Determination for Refractive Lenses (L33793) |
| **Pseudophakic** | | See Local Coverage Determination for Refractive Lenses (L33793) |
| **Respirators** | See Ventilators | |
| **Respiratory Assist Device** | Covered as DME | |

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| **Rib Belt, Custom made (thoracic)** | Corrective Appliance/Orthotic when ALL the following are met:<br>1. Serves a medical purpose and it is only associated with treating an illness, injury or malformed body member;<br>2. Provides support and counter force (a force in a defined direction of a magnitude at least as great as a rigid or semi-rigid support) on the limb or body part that is being used to brace;<br>3. Not used to supply compression therapy (e.g. to reduce size, volume, or swelling of a body member or to help circulation);<br>4. Not used for convenience or appearance;<br>5. Not used for cosmetic purposes | |
| **Rolling Chair (Geriatric Chair)** | Covered as DME if member meets Mobility Assistive Equipment clinical criteria. | See National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE) (280.3)<br><br>National Coverage Determination (NCD) for Durable Medical Equipment Reference List (280.1) |
| **Scleral Shell** | Scleral shell or shield may be covered as prosthetic when used as follows:<br>1. In combination with artificial tears for the treatment of dry eye; **OR**<br>2. As an artificial eye when the eye has become sightless and shrunken by inflammatory disease. | See National Coverage Determination (NCD) for Scleral Shell (80.5) |
| **Shoes**<br>• **Orthotics or inserts**<br>• **Therapeutic (such as diabetic shoes)**<br>• **Prosthetic**<br>• **Orthopedic** | Covered as corrective appliance / orthotic | See National Coverage Determination (NCD) for Prosthetic Shoe (280.10) |
| **Sleep Apnea Device** | Covered as DME with Criteria | See Criteria Local Coverage Determination for Oral Appliances for Obstructive Sleep Apnea (L33611) |
| **Speech Generating Device** | See Artificial larynx or Electronic Speech-Generating Devices | |

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| **Spinal Orthosis**<br>• **Thoracic-lumbar –sacral orthosis**<br>• **Cervical-thoracic-lumbar-sacral orthosis**<br>• **Lumbar orthosis**<br>• **Lumbar-sacral orthosis** | Corrective Appliance/Orthotic covered when prescribed for ANY of the following:<br>1. To facilitate healing following an injury to the spine or related soft tissue;<br>2. To reduce pain by restricting motion of the trunk;<br>3. To facilitate healing following a surgical procedure on the spine or related soft tissue;<br>4. To otherwise support weak spinal muscles and/or a deformed spine | |
| **Stair Lift** | See Lifts | |
| **Stump Sock** | See artificial limbs | |
| **Suction Pump or Machine** | Covered as DME for members who have difficulty clearing secretions due to ANY of the following:<br>1. Cancer or surgery of the throat or mouth;<br>2. Unconsciousness of obtunded state;<br>3. Dysfunction of muscles of swallowing;<br>4. Tracheostomy | |
| **Sykes Hernia Control Device** | Corrective Appliance/Orthotic | See criteria: National Coverage Determination (NCD) for Sykes Hernia Control (280.12) |
| **TENS Unit/Muscle Stimulator** | See Electrical Stimulation Device | |
| **Toe Filler** | Prosthetic | See Medicare Benefit Coverage Manual (Pub. 100-2), Chapter 15, Section 140 Therapeutic Shoes for Individuals with Diabetes. |
| **Tracheostomy** | See subsections below | |
| **Speaking Valve and Tube** | Covered as prosthetic | See National Coverage Determination (NCD) for Tracheostomy Speaking Valve (50.4) |
| **Care Kit (Initial and replacements)** | Covered as prosthetic | See Local Coverage Determination for Tracheostomy Care Supplies (L33832) |
| **Traction Equipment** | See subsections below | See National Coverage Determination (NCD) for Durable Medical Equipment Reference List (280.1) |

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| **Cervical (Over-the-door), or Cervical Portable Traction Unit** | Covered as DME when medical record documentation confirms ALL the following:<br>1. Appropriate use of the device has been demonstrated to the patient and the patient tolerated the device;<br>2. Patient has a musculoskeletal or neurological impairment requiring such equipment. | |
| **Pneumatic, Free Standing Cervical or Free-Standing Stand/Frame for applying cervical traction without placing force on the mandible (e.g., Saunders Home Trac)** | Covered as DME if the member meets ALL the following:<br>1. Has received treatment for TMJ conditions, or has a diagnosis of TMJ dysfunction;<br>2. Treating provider orders greater than 20 pounds of cervical traction in the home setting;<br>3. Member has anatomic distortion of the lower jaw or neck such that a chin halter is unable to be used. | |
| **Transfer (Slide) Board** | Covered as DME when part of a prescribed treatment plan necessary to treat an illness or injury. | |
| **Trapeze Bar** | Covered as DME when ALL the following are met:<br>1. Member has a covered hospital bed;<br>2. Device is needed to allow the member to sit up, change body position or to get out of bed.<br>Note – Not covered when used with an ordinary bed. | See National Coverage Determination (NCD) for Durable Medical Equipment Reference List (280.1)<br><br>Note – Also see Hospital Bed and Accessories |
| **Ultraviolet Cabinet** | Covered as DME for member with generalized intractable psoriasis if treatment at home is medically necessary rather than at an outpatient treatment center. | See National Coverage Determination (NCD) for Durable Medical Equipment Reference List (280.1) |
| **Vacuum Assisted Closure Device (VAC) and Negative Pressure Wound Therapy pumps** | Covered as DME | |
| **Vaporizers** | Covered as DME | Covered for members with a respiratory illness. See National |

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| | | Coverage Determination (NCD) for Durable Medical Equipment Reference List (280.1) |
| **Ventilators (and related supplies)** | Covered as DME. Both negative and positive pressure types are covered for members with neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure due to chronic obstructive pulmonary disease (COPD). | See National Coverage Determination (NCD) for Durable Medical Equipment Reference List (280.1) |
| **Walkers (Also see Special Type Walkers below)** | Covered as DME if the member has a mobility limitation which significantly impairs his or her ability to participate in one or more mobility-related activity of daily living (MRADL) AND:<br>1. Prevents the member from accomplishing the MRADL entirely; **OR**<br>2. Places a patient at risk of morbidity or mortality secondary to attempting to perform the MRADL; **OR**<br>3. Prevents the patient from completing the activity within a reasonable time frame.<br>The member must also be able to safely use the walker and the mobility deficit can be sufficiently resolved with the use of a walker. | See National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE) (280.3) |
| **Walkers –Multiple Braking Systems/Variable Wheel Resistance (AKA Safety Rollers)** | Covered as DME | Covered for patient who meet coverage criteria and who are unable to use a standard walker due to condition resulting in restricted use of one hand. |
| **Walkers – Heavy Duty** | Covered as DME | Covered for members who meet coverage criteria for a standard walker AND who weigh more than 300 pounds. |
| **Walker with Leg Extensions** | Covered as DME | Covered for members who meet coverage criteria for a standard walker AND who are 6 feet tall or more |
| **Walker with Seat** | Covered as DME | Covered for member who meets coverage criteria for a standard walker and who need to sit frequently based on a medical condition |

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| **Wheelchairs (manual, motorized, power, scooters, POVs, specialty and oversized) – See subsections below** | Covered as DME | Covered when member meets criteria: Local Coverage Determination for Manual Wheelchair Bases (L33788) **and see** Local Coverage Article for Power Mobility Devices - Policy Article - Effective January 2015 **and see** Local Coverage Determination for Power Mobility Devices (L33789)**and see** National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE) (280.3) |
| **Whirlpool Bath Equipment** | Covered as DME when member has a condition for which a whirlpool bath can be expected to provide substantial therapeutic benefit, AND meets ANY of the following:<br>• Is homebound; **OR**<br>• If not homebound, the cost of providing the services elsewhere (such as an outpatient setting) is costlier. | |
| **Wig or Hairpiece** | Although not covered by national Medicare, Harvard Pilgrim Stride℠ (HMO) Medicare Advantage covers one wig or hairpiece every 12 months when the following criteria are met:<br>1. Must be medically necessary as determined by the members treating physician; AND<br>2. The qualifying condition must not be normal male pattern baldness, normal female pattern baldness or premature hair loss. | |

Refer to Attachments A1 and A2 for lists of codes for items that are considered DME and may be covered if other requirements are met.

Attachment A1
Attachment A2

Refer to Attachment B for a list of codes for items that are not covered and, therefore, not eligible for reimbursement consideration because they do not meet Medicare's definition of DME or are excluded from coverage by Medicare.

Attachment B

**Summary of Changes:**

| Date | Revision |
|---|---|
| **10/17** | **Updated formatting, updated hyperlinks for NCD and LCD online documents, update list of DME coding attachment A1 and A2** |
| **10/12/16** | Language and formatting changes including deleting Face to Face language, updating exclusions, adding hyperlinks to lists of codes for items that are and are not considered DME. |

**Approved by UMCPC: 9/13/17**
**Initiated: 8/26/15 (effective 1/1/16)**