Clinical Policy: Durable Medical Equipment and Orthotics Guidelines

Reference Number: AR.CP.MP.107 Coding Implications
Date of Last Revision: 1/25 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

DME is defined as equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is appropriate for use in the home, and is generally not useful to a person in the absence of an illness or injury.[1] Orthotic devices are rigid and semi-rigid devices used for the purpose of supporting a weak or deformed body part or restricting or eliminating motion in a disease or injured body part.[2] Prosthetic devices are custom-made artificial limbs or other assistive devices that replace a body part or function as a result of traumatic injuries, vascular disease, diabetes, cancer or congenital disorders.

Policy/Criteria

I. It is the policy of QualChoice that durable medical equipment and orthotics are **medically necessary** when the general and applicable equipment-specific criteria in A and B are met:

A. **General criteria:** Both of the following have been provided to the member/enrollee and/or caregiver, as applicable:

1. Education regarding use of the device, with demonstrated understanding;
2. A trial of the requested device, with demonstrated ability to use it safely and effectively.

Note: *If a medically necessary, lesser cost item exists and will suit the member/enrollee's medical needs, a higher cost item will be denied.*

B. **EQUIPMENT-SPECIFIC CRITERIA**

BURN GARMENTS	CRITERIA	HCPCS
Burn garments [3]	Medically necessary with associated physical and/or occupational therapy when *all* of the following criteria are met: A. At risk of a post-burn contracture; B. The garment and physical and/or occupational therapies are being used with the intent of preventing the need for skin grafting or contractures as a result of hypertrophic scarring; C. Garment is requested by the PCP and/or the treating specialist.	A6501 A6502 A6503 A6504 A6505 A6506 A6507 A6508 A6509 A6510 A6511 A6512 A6513

CARDIAC EQUIPMENT	CRITERIA	HCPCS
Non-wearable external defibrillator with integrated ECG analysis [4]	Considered not medically necessary as it is primarily considered a safety device.	E0617

COMPRESSION THERAPY EQUIPMENT	CRITERIA	HCPCS
Non-pneumatic compression devices [6]	There is insufficient clinical evidence to support the safety and effectiveness of non-pneumatic compression devices over the use of standard pneumatic compression devices.	E0678 E0679

DIABETES CARE EQUIPMENT	CRITERIA	HCPCS
Blood glucose monitor with integrated voice synthesizer [7]	Medically necessary for member/enrollee with diabetes who are legally blind (best corrected visual acuity less than 20/200).	E2100

DIABETIC SHOES & SHOE INSERTS	CRITERIA	HCPCS
	Most benefit plans exclude coverage of orthopedic shoes, foot orthotics or other supportive devices of the feet, except diabetics. (Please refer to your plan documents). For diabetics who have the foot complications: a) Peripheral neuropathy involving the feet; or b) History of pre-ulcerative calluses; or c) History of previous ulceration; or d) Foot deformity; or e) Previous amputation of the foot or part of the foot. There is a limit on the number of foot orthotics that will be covered: **Shoes:** a) Two (2) pairs or a combined total of four (4) units per year if under 18 years of age; b) otherwise, one (1) pair or a combined total of two (2) units per year. **Shoe inserts**: a. Two (2) pairs or a combined total of four (4) units of diabetic custom molded shoe inserts per year. b. In general, the following services will be covered for diabetics, when meeting above medical necessity criteria: c. Diabetic shoes Diabetic Custom Molded Foot Orthotics Custom Molded Orthotics	A5500 A5507 A5510 A5513 L3000 L3003, L3010, L3020 L3030 L3031

HEAT, COLD & LIGHT THERAPY EQUIPMENT	CRITERIA	HCPCS
Ultraviolet panel lights [8, 9]	Medically necessary when meeting both of the following: A. Refractory psoriasis; B. MD justifies treatment at home versus alternate sites (e.g. outpatient department at hospital). Panel lights should be considered, if several discrete body areas can be treated individually. Note: Cabinet style lights should be reserved for extensive involvement of body surface area.	E0691 E0692 E0693 E0694
Cold pad pump [10]	Considered not medically necessary for post-operative management as research does not indicate improved outcomes in pain or edema management with the use of cold compression therapy over the use of other treatments to include conservative treatment, cold therapy alone, compression therapy alone, etc.	E0236

Newborn Care Equipment	Criteria	HCPCS
Breast pumps	Medically necessary for the following: A. Breast/chest feeding member if it is a covered benefit in the State B. Less than $250.00 as a purchase C. If >$250 approve as rental up to purchase price then convert to purchase D. Limit one per member/enrollee.	E0604

Other Equipment	Criteria	HCPCS
Enclosed Beds [13, 14, 15, 16]	Requests will be reviewed by a medical director and/or therapy advisor to determine medical necessity, based on all of the following: A. Standard bed or standard hospital bed must be unable to meet the positioning needs due to disability; B. Less intensive alternatives to improve the member's/enrollee's safety have been tried and ruled out (to include documentation of why they could not meet medical needs). Considerations include, but are not limited to: 1. Bed rails; 2. Mattress placed on the floor; 3. Removal of all safety hazards; 4. Bed alarms; 5. Video/audio monitors; 6. Child protection devices such as locks on doors, windows, cabinets, furniture anchors, gates at steps and doors; 7. Physician-directed medication to address seizures, behaviors and sleep; 8. Environmental modification to encourage calming behaviors and sleep; 9. Established routines addressing sensory needs and/or behavior modification to assist with improved naptime or night time behaviors and sleep; C. Medical diagnosis to include, but not limited to: 1. Cerebral palsy; 2. Developmental delay; 3. Genetic or neurological disorder that would cause vertigo, disorientation, or uncontrolled movement of the body or extremities; 4. Uncontrolled seizure disorder; 5. Severe behavior disorder; D. Healthcare provider evaluation (typically from an occupational or physical therapist) to include: 1. Specific information on functional status; 2. Documentation of home evaluation; 3. Documentation of education provided to caregivers on proper use of a bed enclosure, noting: they are to be used for medical	E0316 E1399 E0328 or E0329 (when combined with E0316 or E1399)

OTHER EQUIPMENT	CRITERIA	HCPCS
	support, improved safety transitioning in and out of the bed, and improved safety while sleeping; E. Name of and invoice for the bed or enclosure being requested. Note: • Enclosed beds should not be used as a discipline measure or as a restraint during times of high agitation or aggression. To limit sensory deprivation, enclosed beds should be used at night for sleeping and only for short rests or naps during the day. • When the above criteria is met, only basic beds will be considered medically necessary. Upgrades for aesthetic purposes or upgrades that do not meet the rules for durable medical equipment (DME) would not be covered as part of an enclosed bed purchase. This includes but is not limited to any of the following: • Special lights, sounds, fans, cameras, two way talk monitors, vibration pads weighted blankets; • Custom wood types, finishes or engravings, special coverings on the outside of the bed; • Custom upgrades where lower cost alteratives are readily available.	
Positioning seat	Requests should have a physician or therapy advisor review to determine medical necessity. Medically necessary with therapist evaluation and ongoing treatment and *all* of the following criteria are met: A. Commercial device must be unable to meet the positioning needs due to height, weight, or disability; B. Other positioning devices in the home must be reviewed to ensure a duplication of devices is not already in place.	T5001 E1399
Specialized supply or equipment	Requests for not otherwise specified supplies or miscellaneous equipment codes will have a physician or therapy advisor review to determine medical necessity.	E0240 T2028 T2029 K0108 K0739 E1399 (For wheelchair seating refer to CP.MP.99)
ROMTech® PortableConnect® Device [17]	Not medically necessary, as there is insufficient evidence in published peer-reviewed literature to support the use of this technology over currently available alternatives.	E1399, A9900

ORTHOTICS EQUIPMENT	CRITERIA	HCPCS
Back Braces	The following back braces are covered without preauthorization as outlined below: A) Rib belt with diagnosis of rib fracture(s) (S22.000A S22.9XXS) B) Sacral and Thoracic/Lumbar/Sacral Orthotics with a diagnosis of: • Spinal stenosis (M48.04, M48.05, M48.06, M48.061, M48.062, M48.07, M48.08); • Thoracic vertebral fractures (S22.000A – S22.089S); • Lumbar vertebral fractures (S32.000A – S32.059S); • Sacral fractures (S32.10XA – S32.19XS); • Lumbar spondylolisthesis (M43.16); • Osteomyelitis of lumbar vertebra (M46.26); • Lumbar discitis (M46.46); • Lumbar spine instability (M53.2X6); • Subluxation lumbar spine (M99.13); • Lumbar surgeries: fusion of spine thoracolumbar region (M43.25), lumbar spinal fusion (M43.26), post laminectomy syndrome (M96.3), post-laminectomy lordosis (M96.4) with any diagnosis, and other post-procedural state, lumbar discectomy, lumbar laminectomy (Z98.89); • Any diagnosis code if requested within 10 days post-op for a thoracic and/or lumbar spinal surgery: 63003 – 63012, 63016 – 63017, 63030 – 63035, 63042, 63044, 63046 – 63048, 63085 – 63091, 63101 – 63103, 63170 – 63173, 63185 – 63191, 63197, 63200, 63251 – 63252, 63266 – 63268, 63271 – 63273, 63276 – 63278, 63281 – 63283, 63286 – 63295, 63301 – 63303, 63305 – 63308. C) Scoliosis Orthotics (L1000 – L1290) with a diagnosis of: • Infantile idiopathic scoliosis, cervicothoracic-lumbosacral (M41.03 – M41.07); • Juvenile scoliosis, cervicothoracic-lumbosacral (M41.113 – M41.117); • Adolescent scoliosis, cervicothoracic-lumbosacral (M41.123 – M41.127); • Idiopathic scoliosis, cervicothoracic-lumbosacral (M41.23 – M41.27); • Thoracogenic scoliosis (M41.34 – M41.35); • Neuromuscular cervicothoracic-lumbosacral (M41.43 – M41.47); • Other secondary scoliosis, cervicothoracic-lumbosacral (M41.53 – M41.57); • Other forms of scoliosis, cervicothoracic-lumbosacral (M41.83 – M41.87);	L0220, L0450 L0454, L0626 L0627,L0630 L1000, L1001, L1005, L1010, L1020, L1025, L1030, L1040, L1050, L1060, L1070, L1080, L1085, L1090, L1100, L1110, L1120, L1200, L1210, L1220, L1230, L1240, L1250, L1260, L1270, L1280, L1290
Cervical traction equipment [11]	Medically necessary when all of the following are met: A. The appropriate use of the selected home cervical traction device has been demonstrated and was tolerated; B. One of the following: 1. Diagnosis of temporomandibular joint (TMJ) dysfunction and has received treatment for TMJ condition;	E0849

ORTHOTICS EQUIPMENT	CRITERIA	HCPCS
	2. Distortion of the lower jaw and neck anatomy (e.g. radical neck dissection) such that a chin halter is unable to be utilized; 3. The treating physician orders and/or documents the medical necessity for greater than 20 pounds of cervical traction in the home setting.	
Cervical collar, custom molded	Requests for custom molded cervical collar will be reviewed by a licensed physical or occupational therapist. Documentation accompanying the request must state reason why pre-fabricated collar not adequate.	L0170 L0190 L0200
Hip orthotics	Medically necessary when ordered by an orthopedist for treatment of, or postoperatively for any of the following: A. Total hip arthroplasty; B. Hip labral tear; C. Hip disorders in children when used to stabilize the hip and/or to correct and maintain hip abduction. Lateral replacements due to growth are considered medically necessary in pediatrics for diagnoses such as hip dysplasia with Charcot-Marie-Tooth disease. Requests for hip orthotics for hip osteoarthritis in patients who are not surgical candidates will be reviewed on a case by case basis by a medical director.	L1640 L1680 L1685 L1686 L1690
Legg Perthes orthotics	Medically necessary when ordered by an orthopedist for use in the treatment for Legg-Calvé-Perthes disease in children.	L1700 L1710 L1720 L1730 L1755
Microprocessor-controlled knee-ankle-foot orthoses (KAFO)		L2006
Hip-knee-ankle-foot orthotics (HKAFO)	Requests for orthotics will be reviewed on a case by case basis.	L2050 L2060 L2090
Orthotic components	Requests for orthotic components listed will be reviewed using relevant nationally recognized decision support tool criteria for similar codes.	L2570 L2580 L2627 L2628
Knee Braces	Only specific types of knee braces are covered by QualChoice Requests for custom fabricated knee orthotics require prior authorization and as outlined below: a) Must be submitted by the ordering provider's office (not by the vendor), along with the member's medical records, such as clinic progress notes. Information submitted on a vendor request form will not be accepted.	K0672, L1810, L1812 L1820,L1831 L1834,L1836 L1830,L1832, L1833,L1840 L1843,L1844, L1845, L1846, L1847,L1848,

ORTHOTICS EQUIPMENT	CRITERIA	HCPCS
	The following knee braces are covered by QualChoice as outlined below: 1) Knee orthosis with joints or knee orthosis with condylar pads and joints with or without patellar control is considered medically necessary for: Members who are ambulatory AND have weakness or deformity of the knee AND require stabilization. 2) Knee orthosis with a locking knee joint or a rigid knee orthosis is considered medically necessary for: Flexion or extension contractures of the knee with movement on passive range of motion testing of at least 10 degrees (i.e., a non-fixed contracture). 3) Knee immobilizer without joints , a knee orthosis with adjustable knee joints or a knee orthosis with an adjustable flexion and extension joint that provides both medial–lateral and rotation control), is considered medically necessary for: - A recent (within 3 weeks) injury OR - post-operative surgical procedure on the knee(s). 4) Knee orthosis, Swedish type, prefabricated is covered for: a member who is ambulatory and has knee instability due to genu recurvatum - hyperextended knee. 5) The following knee orthoses require documentation of knee instability and joint laxity on physical examination (e.g., varus/valgus instability, anterior/posterior Drawer test): Knee orthosis with adjustable knee joints, positional orthosis, rigid support, prefabricated item that has been customized to fit the patient by an individual with expertise; Knee orthosis with adjustable knee joints, positional orthosis, rigid support, prefabricated, off-the-shelf; Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, with/without varus/valgus adjustment, prefabricated item that has been customized to fit the patient by an individual with expertise; Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, with/without varus/valgus adjustment, prefabricated item that has been customized to fit the patient by an individual with expertise; Knee orthosis, Swedish type, prefabricated off-the-shelf; Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint, Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, with/without varus/valgus adjustment, prefabricated, off-the-shelf.	L1850, L1851, L1860,L2385 L2780, L2820, L2830, L2850

ORTHOTICS EQUIPMENT	CRITERIA	HCPCS
	Custom–fabricated knee braces require prior authorization and are covered as outlined below: Member is ambulatory AND - There is deformity of the leg or knee such that a prefabricated brace cannot be used, AND - Member's exact measurements of thigh and calf are submitted. 7) Additions to the knee braces–straight knee joint, heavy–duty, each joint is considered medically necessary when: - The coverage criteria for the base orthosis code is met AND - The member weighs more than 300lbs. 8) Additions to the custom fabricated knee braces are considered medically necessary when: The member meets the criteria for a custom-fabricated knee brace AND - Either daily activity level requires a brace designed for high impact/high stress activities, OR - The member weighs greater than 250 pounds. 9) The following are examples of non-covered knee orthotics: Knee orthosis, double upright with adjustable joint, with inflatable air support chamber, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise; Knee orthosis, double upright with adjustable joint, with inflatable air support chamber(s), prefabricated, off-the-shelf; 10) The following additions to knee braces are considered part of base orthotic and therefore are not separately payable Addition to lower extremity orthotic, removable soft interface, all components, replacement only, each; - Addition to lower extremity orthotic, noncorrosive finish, per bar; - Addition to lower extremity orthotic, soft interface for molded plastic, below knee section; Addition to lower extremity orthotic, soft interface for molded plastic, above knee section. - Addtn to lower extremity orthotic, tibial length sock, fracture or equal, ea - Addtn to lower extremity orthotic, femoral length sock, fracture or equal, ea Limits QualChoice does not cover ANY knee brace not listed above. The following examples of knee braces and associated accessories are considered not medically necessary and are not covered. This list may not be all-inclusive . 1) Prophylactic knee braces; 2) Functional knee braces utilized solely for participation in sports or to improve athletic performance;	

ORTHOTICS EQUIPMENT	CRITERIA	HCPCS
	3) Patellofemoral knee braces/sleeves for the treatment of postoperative knee effusion or patellofemoral syndrome without subluxation or dislocation; 4) Functional knee braces after successful reconstructive ligament surgery; 5) Socks and brace sleeves used in conjunction with the orthotic device; 6) Additional removable or non-removable interface dispensed with the initial device are not separately reimbursable; 7) Inflatable air bladder incorporated into the design, as it has no proven clinical benefit.	
Shoulder, elbow, wrist, hand, finger orthotics	Medically necessary when ordered immediately post-operative for orthopedic surgeries such as rotator cuff repair, tendon repair, or ORIF. Replacement due to normal wear and tear is considered medically necessary when the item is a lateral purchase and the orthotic is still needed; Coverage is based on contract guidelines for replacement DME.	L3904 L4000 L4010 L4020 L4030 L4205
Breast Prosthetics	Medically necessary post-masectomy or for treatment of gender dysphoria and documentation supports that prefabricated prosthetics will not suffice.	L8030 L8035
MyoPro® Orthosis[33]	Not medically necessary, as there is insufficient evidence in published peer-reviewed literature to support the use of this technology over other technologies and currently available alternatives.	L8701 L8702

PUMPS	CRITERIA	HCPCS
Ambulatory infusion pump [18]	Medically necessary when used for one of the following indications: A. Iron Poisoning: administration of deferoxamine for the treatment of acute iron poisoning and iron overload; B. Chemotherapy for liver cancer: treatment of primary hepatocellular carcinoma or colorectal cancer where this disease is unresectable; OR, where the patient refuses surgical excision of the tumor; C. With opioid drugs when used for intractable pain caused by cancer. D. To administer a drug considered reasonable and necessary by either: 1. Prolonged infusion of at least 8 hours because of proven improved clinical efficacy (i.e., proven or generally accepted to have significant advantages over intermittent bolus	E0780 E0781

PUMPS	CRITERIA	HCPCS
	administration regimens or infusions lasting less than 8 hours) or 2. Intermittent infusion, each episode of infusion lasting less than 8 hours, and both of the following criteria: a. Does not require the return to the physician's office prior to the beginning of each infusion. b. Strictly controlled rate of infusion is necessary because systemic toxicity or adverse effects of the drug are unavoidable without infusing it at a controlled rate as indicated in the Physician's Desk Reference, or the U.S. Pharmacopeia Drug Information	
Gastric suction pump, home model [19]	Medically necessary for home use for gastric suction due to inability to empty gastric secretions through normal gastrointestinal functions.	E2000
Implantable infusion pumps [18]	Medically necessary when meeting both of the following: A. One of the following indications: 1. Chemotherapy for liver cancer: primary hepatocellular carcinoma or Duke's Class D colorectal cancer, in which the metastases are limited to the liver and where either the disease is unresectable, or the patient refuses excision of the tumor; 2. Anti-spasmodic drugs for severe spasticity: administered intrathecal to treat chronic intractable spasticity in patients unresponsive to less invasive medical therapy including both of the following: a. A 6-week trial of noninvasive methods, such as oral anti-spasmodic drugs, that failed to adequately control the spasticity or produced intolerable side effects; b. Prior to pump implantation, there has been a favorable response to a trial of intrathecal dose of the anti-spasmodic drug; 3. Opioid drugs for treatment of chronic intractable pain- see CP.MP.173 Implantable Intrathecal Pain Pumps; 4. Other uses when all of the following are met: a. The drug is reasonable and necessary for the treatment of the individual; b. It is medically necessary that the drug be administered by an implanted infusion pump. The infusion pump has been FDA-approved for the drug being administered and the purpose for which it is being administered; B. None of the following contraindications to implantation of an infusion pump: 1. Known allergy or hypersensitivity to the drug being used (e.g., oral baclofen, morphine, etc.); 2. Active infection; 3. Body size insufficient to support the weight and bulk of the device; 4. Presence of another implanted programmable device; 5. Heparin or insulin is the drug intended for administration.	E0782 E0783 E0785 E0786

PUMPS	CRITERIA	HCPCS
Parenteral pump for medication administration [20]	Medically necessary for uninterrupted parenteral administration of medication via pump.	K0455
Vacuum erection device [21, 22]	A vacuum erection device (VED) and tension ring are medically necessary for the treatment of erectile dysfunction when prescribed by a physician.	L7900 L7902

RESPIRATORY EQUIPMENT	CRITERIA	HCPCS
Nebulizer, ultrasonic [23]	Not medically necessary, as it provides no clinical advantage over use of a small-volume nebulizer (E0574) and compressor.	E0575
IPPB & supplies	Medically necessary for member/enrollee with respiratory disease when an incentive spirometer is ineffective.	E0500 E0550
Oximeter [24]	Medically necessary when used as a monitoring and alarm device for any of the following: A. To monitor individuals on a home ventilator or with a tracheostomy B. To determine appropriate home oxygen requirements C. To wean an individual from home oxygen D. To monitor an unstable respiratory condition Not medically necessary when used for any of the following: A. Oximetry when used as a diagnostic procedure B. Monitoring of a stable respiratory condition C. Asthma management D. Other conditions not listed above	E0445
Oxygen tent [24]	Medically necessary when the ability to breathe is impaired and for whom supplemental oxygen is required.	E0455
Intrapulmonary percussive ventilation devices (Volara™, Percussionaire-TRUE-IPV®)[25, 26, 27, 28]	Current evidence does not support the effectiveness of intrapulmonary percussive ventilation (IPV).	E1399

SURGICAL SUPPLIES	CRITERIA	HCPCS
Other surgical supplies	These items are used as part of a surgical procedure and will be reviewed according to the relevant surgical procedure or level of care.	L8040, L8041, L8042, L8043, L8044, L8045, L8046, L8047, L8499, L8600, L8609, L8610, L8612, L8615, L8631, L8659

WALKERS	CRITERIA	HCPCS
Walker, standard [29]	Requests for standard walkers are considered medically necessary when meeting all of the following: A. Mobility-related activities of daily living (MRADLs) in the home cannot be met due to mobility limitation; B. Walker is able to be safely used by member/enrollee; C. Functional mobility deficit will be sufficiently resolved with the use of a walker.	E0130 E0135 E0141 E0143
Walker, heavy duty [29]	Requests for heavy duty walkers (E0148, E0149) are considered medically necessary when meeting the above standard walker criteria and the member/enrollee weighs more than 300 pounds. Requests for heavy duty, multiple braking system, variable wheel resistance walkers (E0147) are considered medically necessary when meeting the above standard walker criteria and the member/enrollee is unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand.	E0148 E0149 E0147

WHEELCHAIRS	CRITERIA	HCPCS
Power seat elevator on power wheelchair [31]	Medically necessary as a component on a power wheelchair when all of the following are met: A. A licensed, certified medical professional (i.e. physical or occupational therapist) is involved with the assessment, prescription, trials and training of equipment; B. Adequate cognitive function to safely use the seat elevating feature; C. A clear functional need for the feature is indicated; D. Provision of the feature will improve functional independence with an activity, such as but not limited to: facilitating reach for the completion of ADLs or IADLs or improving transfer biomechanics and safety.	E2298
Robotic Arm, Wheelchair-mounted (JACO) [32]	There is insufficient clinical evidence to support safety and improved health outcomes of the JACO Assistive Robotic Arm (Kinova, Inc.) over other technologies.	E1399
Rollabout chair	Medically necessary when used in lieu of a wheelchair for those who would qualify for a wheelchair (except for the ability to self-propel a manual wheelchair).	E1031

WOUND CARE	CRITERIA	HCPCS
Whirlpool tub	Considered not medically necessary.	E1310

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Background
DME items have the following characteristics:

- The equipment is prescribed by a physician;
- The equipment meets the definition of DME;
- The equipment is necessary and reasonable for the treatment of an illness or injury;
- The equipment is manufactured primarily for use in the home environment, but is not limited to use in the home.

Member/Enrollee's Home
For purposes of rental and purchase of DME, a member/enrollee's home may be their own dwelling, an apartment, a relative's home, a home for the aged or some other type of institution. However, an institution may not be considered a member/enrollee's home if the following are met:

- Meets at least the basic requirement in the definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians, inpatient, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or
- Meets at least the basic requirement in the definition of a skilled nursing facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for members/enrollees who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Members/enrollees who have been permanently admitted to an inpatient skilled nursing facility or inpatient hospice and who have changed their home address to that of the SNF or hospice will have the SNF or hospice defined as their home.

Products
Products is defined as a listing of the most common items, or group of items, that are or may be perceived as home medical equipment. This listing, while reasonably complete, is not intended to quantify the entire spectrum of products that may be considered DME either now or in the future.

Durability
An item is considered durable if it can withstand repeated use, i.e., the type of item that could normally be rented. Medical supplies of an expendable nature, such as incontinence pads, lamb's wool pads, catheters, ace bandages, elastic stockings, surgical facemasks, sheets and bags are not considered "durable" within the meaning of the definition. There are other items that although durable in nature, may fall into other coverage categories such as supplies and orthotics and prosthetics. Orthotics and Prosthetics items include, but are not limited to, braces, artificial limbs and eyes.

Medical Equipment
Medical equipment is defined as equipment primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury. In most instances, no documentation will be needed to support whether a specific item of equipment is medical in nature. However, some cases will require documentation to determine whether the item

constitutes medical equipment. This documentation would include the advice of local medical organizations and facilities and specialists in the field of physical medicine and rehabilitation. If the equipment is new on the market, it may be necessary, prior to seeking professional advice, 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.

Personal computers or mobile technology such as iPads, smart phones, iPods, personal digital assistants, etc., may be considered as medical equipment when used for the purpose of speech generating equipment when other non-medical functions are limited or disabled and that device is used as the primary source of communication for those qualifying for a speech generating device.

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy created	06/09	06/09
Modified corporate policy. Changes for initial approval incorporating policies	10/24	10/24
Annual review. Minor rewording to description with no clinical significance. Replaced codes K1032 and K1033 with E0678 and E0679 under non-pneumatic compression devices. Added additional note to enclosed bed section. Removed halo procedure and equipment criteria due to no prior auth. Updated criteria under hip orthotics. Added section and code L2006 for microprocessor-controlled knee-ankle-foot orthoses (KAFO). Removed code L4130 under shoulder, elbow, wrist, hand, finger orthotics. Updated code E2300 to E2298 under power seat elevator on power wheelchair.	1/25	1/25

References

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.