Quick Reference Guide

Durable Medical Equipment Prior Approval Requirements

2018

DME PA-00-02-031918

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Durable Medical Equipment Coverage Guideline

Durable medical equipment (DME) is any equipment that provides therapeutic benefits to a Member because of certain medical conditions and/or illnesses that can withstand repeated use, is primarily and customarily used to serve a medical purpose, and is appropriate for use in the home.

Prior Approval Requirements

The below listed DME/Supplies require Prior Approval. Please submit a provider prescription and clinical documentation to inform the medical necessity review. Over-the-counter supplies are generally non-covered.

Please note: a separate authorization will be required for conversion from rental of the DME to the purchase of the item.

Lowest Cost Item That Meets Member Needs

Whether the Member rents or buys Durable Medical Equipment (DME), the Plan provides Benefits for the least expensive (and, if applicable, lowest tech) equipment necessary to meet Member's medical needs.

When rented equipment is a covered benefit and medically necessary, Health Options will reimburse only until our share of the reasonable purchase price of the least expensive equipment is paid or until the equipment is no longer necessary, whichever comes first.

Durable Medical Equipment Rentals

Capped rentals – Durable medical equipment that a Member uses continuously over a relatively short period of time, where rental is more appropriate than purchase, as determined by Community Health Options (Health Options). Therefore, capped rental items are reimbursed by Health Options as rentals rather than as purchases. Capped rental payment includes all related costs for the effective use of the equipment by the Member, including equipment, accessories, supplies, delivery, shipping and handling, labor, setup, visits, patient education, maintenance, repairs, and replacement parts of the DME item in question. Please note that in order for DME items to be eligible for reimbursement, the DME supplier must meet eligibility and/or credentialing requirements as defined by Health Options.

Durable Equipment Replacement

Include date of initial purchase and product serial number when submitting a Prior Approval request for previously purchased DME replacement.

Temporary Codes

Temporary codes (S-codes) are a non-covered benefit once CMS assigns another code to the item/service. The provider is required to use a current year HCPCS reference guide for codes and modifiers for billing purposes.

Durable Medical Equipment Abbreviation Legend

Standard Abbreviations Used In This Document			
DME	Durable Medical Equipment	ORTHO	Orthotic, Prosthetic, Bracing Benefit
DISP	Disposable Benefit (Supplies)		

Items	Description	Benefit	Rental/Purchase Guidelines
CARDIAC			
Automated External Defibrillator Components	Coverage Guideline Applies: Wearable Defibrillator Vest. Prior Approval is required prior to hospital discharge and should be included as part of discharge planning coordination.	DME	One month intervals (rental only)
Blood Pressure Monitor	Blood pressure monitors are covered only for Members receiving hemodialysis or peritoneal dialysis in the home. Please refer to home dialysis.	DME	Purchase
COMPRESSION GARMENTS/EQUIPMENT			
Compression Garments	Stockings and Sleeves (not used with pump i.e., Circaids, Ready-Fit) Up to four pairs per year without Prior Approval, additional amounts require Prior Approval. Coverage of a non-elastic gradient compression wrap is limited to one per 6 months per leg. Exception: Lower extremity orthotic not otherwise specified should only be used if a more specific code is not available. Prior Approval required when using the "not otherwise" code Non-covered: Items that do not meet the definition of surgical dressing.	DME	Purchase
Pneumatic Appliances	Segmental/Non-segmental Only covered for the treatment of lymphedema or for the treatment of chronic venous insufficiency with venous stasis ulcers.	DME	6 month rental, then submit request for purchase, if medically necessary
Pneumatic Compressors	Segmental, Non-segmental, Intermittent Limb Only covered for the treatment of the following conditions: ‣ Lymphedema ‣ Chronic venous insufficiency (CVI) with venous stasis ulcers ‣ Deep Vein Thrombosis (DVT) prevention for immobilized individuals	DME	6 month rental, then submit request for purchase, if medically necessary
DIABETES			
Continuous Glucose Monitor- Sensors	Coverage Guideline Applies.	DISP DME	Purchase
Continuous noninvasive glucose monitoring device	Coverage Guideline Applies.	DME	Purchase or 6 month rental
Diabetic Shoes & Diabetic Inserts	Limit one pair per year without Prior Approval. Prior Approval required beyond one pair per year.	Other	Purchase
Insulin Pump	Coverage Guideline Applies. Non-covered: ‣ Fully implantable insulin pump	DME	Purchase or 6 month rental
End Stage Renal Disease (ESRD)/Dialysis			
Dialysis Equipment & Supplies	Coverage Guideline Applies.	DME	Purchase

Items	Description	Benefit	Rental/Purchase Guidelines
HEARING			
Hearing Aids, Fittings, Earmolds	Coverage Guideline Applies. Refer to Member Benefit Agreement for coverage details. Non-Covered: Cochlear implants	DME	Purchase
HOSPITAL BEDS/PATIENT LIFTS			
Hospital Beds	Coverage Guideline Applies. Includes but not limited to: ‣ Fixed Height ‣ Variable Height ‣ Semi-Electric ‣ Heavy Duty ‣ Extra Heavy Duty Non-covered: ‣ Hospital Bed Accessories (i.e., Bed Board, Over-Bed Table) ‣ Fully Electric Hospital Bed	DME	6 month rental; then submit request for purchase, if medically necessary or Purchase without renting, if meets medical necessity
Mattress	Coverage Guideline Applies.Includes but not limited to: ‣ Air Fluidized ‣ Alternating Pressure Pump/Pad ‣ Gel Mattress ‣ Air Pressure Mattress ‣ Water Pressure ‣ Air Power Pressure – Reducing ‣ Powered Overlay ‣ Non-Powered Overlay Replacement Pad ‣ Geomat ‣ Sheepskin ‣ Inner Spring ‣ Foam Rubber ‣ Synthetic Sheepskin ‣ Dry Pressure ‣ Mattress Overlay	DME	6 month rental; then submit request for purchase, if medically necessary or Purchase without renting if meets medical necessity
Patient Lift	Coverage Guideline Applies. Includes but not limited to: ‣ Hydraulic (Hoyer) Sling or Seat ‣ Electrical Multi-positional Patient Support System ‣ Multi-positional transfer system	DME	6 month rental, then submit request for purchase, if medically necessary

Items	Description	Benefit	Rental/Purchase Guidelines
MISCELLANEOUS EQUIPMENT/SUPPLIES			
Breast Pump	Prior Approval required if hospital grade breast pump.	DME	Purchase
Continuous Passive Motion Machine (CPM)	Not covered	DME	Not covered
Gloves- sterile	Sterile gloves are covered only when used by the Member or the Member's caregiver for procedures that need to avoid contamination of the area (sterile technique). Limit – 5 pair per day Non-covered: Non-sterile gloves	DISP	Purchase
Paraffin Bath Unit Paraffin/ Pound	Covered when the Member has undergone a successful trial period of Paraffin therapy ordered by a provider and the Member's condition is expected to be relieved by long-term use of this modality.	DME	6 month rental; then submit request for purchase, if medically necessary
Protime/Coagucheck/ INR Monitors	Coverage Guideline Applies.	DME	6 month rental, then submit request for purchase, if medically necessary
Speech Generating Device (SGD)	Synthesized Speech Augmentive Device w/Display) Prior to the delivery of the SGD, the patient has had a formal evaluation of their cognitive and communication abilities by a speech-language pathologist (SLP). Claims for more than one SGD will be denied as not medically necessary.	DME	Purchase
Ultraviolet Light Therapy System	System and Replacement bulb/lamp.	DME	Not covered
Wigs/Artificial Hair	Coverage limit applies: one wig per year Coverage provided for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata, alopecia totalis, and alopecia medicamentosa resulting from the treatment from any forms of cancer or leukemia, or permanent loss of scalp hair due to injury.	OTHER	Purchase
Wound Care Supplies & Equipment	Coverage Guideline Applies. Includes but not limited to: ‣ Wound Vacuum ‣ Negative Pressure Wound Therapy Pumps (NPWT) Wound care supplies	DME DISP	6 month rental, then submit request for purchase, if medically necessary Purchase
MOBILITY ASSISTANCE			
Crutch substitute	Covered when the individual's condition is such that (s)he is unable to use crutches, standard walkers or other standard ambulatory assist devices.	DME	Purchase
Gait Trainer, Pediatric Size	Coverage Guideline Applies.	DME	Purchase

Items	Description	Benefit	Rental/Purchase Guidelines
Manual Wheelchair	Coverage Guideline Applies. ‣ Standard ‣ Hemi ‣ Fully Reclining ‣ Extra Heavy Duty ‣ High Strength ‣ Lightweight ‣ Heavy Duty ‣ Lightweight ‣ Ultra-Lightweight Pediatric	DME	6 month rental, then submit request for purchase, if medically necessary
Power Wheelchair Base	Coverage Guideline Applies. Lowest cost wheelchair, to include manual wheelchair if applicable, that meets Member needs.	DME	6 month rental, then submit request for purchase, if medically necessary
Rollabout Wheelchair (Geri Chair)	Coverage Guideline Applies.	DME	6 month rental, then submit request for purchase, if medically necessary
Wheelchair Accessories	Coverage Guideline Applies. Coverage applies to accessories that meet immediate Member needs. Non-covered but not limited to: ‣ Power seat elevation feature ‣ Power standing feature ‣ Stair climbing ‣ Electronic balance ‣ Ability to elevate seat by balancing on two wheels ‣ Remote Operation ‣ A9270- Non-covered items/service	DME	6 month rental, then submit request for purchase, if medically necessary or may purchase without renting if meets medical necessity
NERVE/BONE STIMULATORS AND BIOFEEDBACK			
Bone Growth Stimulator	Coverage Guideline Applies. Spinal bone growth stimulator authorization requests are processed through eviCore. All non-spinal bone growth stimulator authorization requests are processed through Health Options.	DME	Purchase
Functional Electrical Stimulators (FES)	Coverage Guideline Applies.	DME	6 month rental, then submit request for purchase, if medically necessary
Nerve Stimulator	Coverage Guideline Applies. Treatment of nausea/vomiting (Vagus Nerve Stimulator)	DME	Purchase

Items	Description	Benefit	Rental/Purchase Guidelines
Neuromuscular Stimulator	May be medically necessary for disuse atrophy where the nerve supply to the muscle is intact and the Member has non-neurological reasons for disuse atrophy.	DME	6 month rental, then submit request for purchase, if medically necessary
Pelvic Floor Stimulator	Electrical muscle stimulators may be medically necessary DME for the management of urinary incontinence. Member has tried/failed pelvic floor exercises (Kegel exercises).	DME	Purchase
Transcutaneous Electrical Joint Stimulation Device System (i.e., BioniCare)	Considered experimental and investigational for the treatment of osteoarthritis because its effectiveness has not been established. Clinical review required.	DME	6 month rental, then submit request for purchase, if medically necessary
Transcutaneous Electrical Nerve Stimulator (TENS)	Transcutaneous Electrical Nerve Stimulator (TENS) is covered with a detailed written order for the treatment of Members with chronic, intractable pain or acute post- operative pain who meet the coverage rules.	DME	6 month rental, then submit request for purchase, if medically necessary
ORTHOTICS/ORTHOPEDIC DEVICES			
Orthopedic Devices: Dynamic Splinting Devices	Coverage Guideline Applies.	ORTHO	Purchase
Orthopedic Footwear	Coverage Guideline Applies.	ORTHO	Purchase.
Orthosis	Coverage Guideline Applies. Additions to lower extremity orthosis. Generally no Prior Approval required for Orthosis; however, Prior Approval is required for lower extremity, not otherwise specified. Additions to Ankle Foot Orthotics (AFOs) and Knee Ankle Foot Orthotics (KAFOs) will be denied as not medically necessary if either the base orthosis is not medically necessary or the specific addition is not medically necessary.	ORTHO	Purchase
Orthosis	Coverage Guideline Applies. Other Scoliosis Procedures. Generally no Prior Approval required for Orthosis; however, Prior Approval is required for, spinal orthotic not otherwise specified. Considered medically necessary in the treatment of congenital defects. Replacement braces are medically necessary when the Member has outgrown the previous brace or because his/her condition has changed such as to make the previous brace unusable. This includes scoliosis braces.	ORTHO	Purchase
Orthotics Repairs for orthotic devices	An estimate of the cost (supplies and labor) and what is being repaired will be required. Repairs will be approved only when the orthotic device meets the coverage guideline for the purchase of Orthotic Footwear.	ORTHO	Purchase
Traction Cervical Extremity Fracture Frame Pelvic	Coverage Guideline Applies.	DME	6 month rental, then submit request for purchase, if medically necessary
PROSTHETICS			
Prosthesis	Repairs for prosthetic devices: requires submission of an estimate of the cost (supplies and labor) and what is being repaired.	ORTHO	Purchase
Prosthetic Implants	Coverage Guideline Applies. Includes but not limited to: Artificial Larynx, Tracheostomy Speaking Valve Implantable neurostimulator, pulse generator, any type	ORTHO	Purchase

Prosthetics	Coverage Guideline Applies. Includes but not limited to: ‣ Lower limb, upper limb, external power Non-covered: ‣ High tech, athletic performance, titanium options when lower cost prosthetic meets Member's medical needs. ‣ Penile prosthetic	ORTHO	Purchase
Prosthetics	Socks excluding "fracture socks" do not require Prior Approval. Prior Approval required for miscellaneous prosthetic services.	ORTHO	Purchase
REPAIRS			
DME Labor (repair)	Repair or non-routine service for durable medical equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes. Repair or non-routine service for oxygen equipment requiring the skill of a technician, labor component, per 15 minutes. A prescription will be required along with a statement of what is being repaired. An estimate of the cost (supplies and labor) is required.	OTHER	Labor Cost
RESPIRATORY			
Apnea Monitor (With or Without Kit)	Covered for infants less than 12 months of age with documented apnea or who have known risk factors for life threatening apnea.	DME	6 month rental, then submit request for continued rental (maximum 12 months), if medically necessary
BiPAP	Coverage Guideline Applies. For treatment other than obstructive sleep apnea (OSA).	DME	6 month rental, then submit request for purchase, if medically necessary
CPAP/BiPAP	Coverage Guideline Applies. For treatment of obstructive sleep apnea (OSA). Rental period is limited to 60-day intervals with a compliance report due at each rental renewal and upon purchase request. CPAP- Continuous positive airway pressure BiPAP- Bi-level positive airway pressure The Member has a face-to-face clinical evaluation by the treating provider prior to the sleep test to assess the Member for OSA. Polysomnograph results and a detailed written order are required for rental. The BiPAP/CPAP Questionnaire is required for purchase. A bi-level respiratory assist device (BiPAP) is covered when the Member with OSA has met medical necessity criteria AND a CPAP device has been tried and proven ineffective based on a therapeutic trial conducted in either a facility or in the home. Non-covered: Oral appliances for Sleep Apnea.	DME	6 month rental, then submit request for purchase, if medically necessary
Cough Stimulating Device	Coverage Guideline Applies.	DME	6 month rental or purchase

Items	Description	Benefit	Rental/Purchase Guidelines
High Frequency Chest Wall Oscillation Devices (HFCWO) Air-Pulse Generator System/ Vest Clearance Airway System	Coverage Guideline Applies. There must be well documented failure of standard treatments to adequately mobilize retained secretions. It is not medically necessary for a member to use both an HFCWO device and a mechanical in/exsufflation device.	DME	6 month rental, then submit request for purchase, if medically necessary
IPPB Machine IPPB Humidifier	Coverage Guideline Applies. Used to treat respiratory diseases. Rental only.	DME	12 months (rental only)
Oxygen	Coverage Guideline Applies. Emergency or stand-by oxygen systems will be denied as not medically necessary since they are precautionary and not therapeutic in nature. Community Health Options covers rental of oxygen equipment. Includes but not limited to: ‣ Concentrator ‣ Gaseous Portable ‣ Stationary ‣ Liquid Portable ‣ Vapor Enriching System ‣ Contents	OXYGEN	12 months (rental only)
Pulse Oximeter and Probes	Coverage Guideline Applies. Pulse Oximeter Pulse Oximeter Probes	 DME DISP	 6 month rental, then submit request for purchase, if medically necessary Purchase
Ventilator	Coverage Guideline Applies. Includes but not limited to: ‣ Volume Control ‣ Negative Pressure ‣ Pressure Support ‣ Chest Shell ‣ Chest Wrap	DME	12 months (rental only)