DURABLE MEDICAL EQUIPMENT, ORTHOTICS, OSTOMY SUPPLIES, MEDICAL SUPPLIES AND REPAIRS/REPLACEMENTS

Guideline Number: CS032.0

Effective Date: June 1, 2019

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Related Community Plan Policies

- Attended Polysomnography For Evaluation of Sleep Disorders
- Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes
- Cochlear Implants
- Electrical and Ultrasound Bone Growth Stimulators
- Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation
- Hearing Aids and Devices Including Wearable, Bone-Anchored and Semi-Implantable
- High Frequency Chest Wall Compression Devices
- Home Traction Therapy
- Mechanical Stretching Devices
- Motorized Spinal Traction
- Obstructive Sleep Apnea Treatment
- Omnibus Codes
- Plagiocephaly and Craniosynostosis Treatment
- Pneumatic Compression Devices
- Prosthetic Devices, Specialized, Microprocessor or Myoelectric Limbs
- Supply Policy

Commercial Policy

- Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies and Repairs/Replacements

Medicare Advantage Coverage Summary

- Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid

APPLICATION

This policy does not apply to the state of Tennessee; refer to the Coverage Determination Guideline titled Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies and Repairs/Replacements (for Tennessee Only).

COVERAGE RATIONALE

Indications for Coverage

Durable Medical Equipment (DME), related supplies, and orthotics are medically necessary when:

- CMS DME Medicare Administrative Contracts (DME MAC) criteria are met (see link below); and
- Consistent with the state definition of DME or Orthotic; and
- Ordered by a physician; and

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• The item is not otherwise excluded from coverage; and
• The item meets the plan’s medically necessary definition [refer to the plan specific document(s)]

In the absence of a related policy above, UnitedHealthcare Community Plan uses available criteria from the DME MAC.

**Cranial Remolding Orthosis**
Cranial molding helmets (cranial remolding orthosis, billed with S1040) used to facilitate a successful post-surgical outcome are covered. For all indications, refer to the Medical Policy titled [Plagiocephaly and Craniosynostosis Treatment](#).

**Note:** A protective helmet (HCPCS code A8000–A8004) is not a cranial remolding device. It is considered a safety device worn to prevent injury to the head rather than a device needed for active treatment.

**Diagnostic or Monitoring Equipment**
Benefits do not include diagnostic or monitoring equipment purchased for home use unless the equipment is identified for coverage by the state contract or state guidelines (e.g., blood pressure monitors, oximeters).

**Lymphedema Stockings for the Arm**
Lymphedema stockings for the arm are covered on an unlimited basis as to number of items and dollar amounts covered as required by the [Women's Health and Cancer Rights Act (WHCRA) of 1998](#).

**Medical Supplies**
Medical Supplies necessary for the use of covered DME are allowed. Other supplies must be identified for coverage by the state contract or state guidelines (e.g., incontinence supplies).

**Mobility Devices**
Mobility Devices include manual wheelchairs, electric wheelchairs, transfer chair, or scooters/power-operated vehicles (POV).

• Proof of the home evaluation is not required at the time of prior authorization. The on-site home evaluation can be performed prior to, or at the time of, delivery of a power Mobility Device. The written report of the home evaluation must be available on request post-delivery.

**Repair and Replacement**
Repair or replacement of DME is covered when the member has a DME benefit and any of the following:

• Repairs are necessary due to routine wear of the equipment and the member still requires the equipment
• Replacement is necessary when the equipment becomes irreparable due to normal wear and tear and the member still requires the equipment
• Replacement of essential accessories, such as hoses, tubes, batteries, etc., for necessary DME are covered when necessary to make the item/device serviceable

**Note:** Vendors/manufacturers are responsible for repairs, replacements, and maintenance for rented equipment and for purchased equipment covered by warranty.

Repair or replacement of DME is not covered for the following:

• Repairs, replacements and maintenance for items/devices required during a rental period or a Maintenance & Service agreement. These are the contractual responsibility of the item/device provider.
• Replacement and repairs of items are required due to malicious damage, neglect or abuse

**Equipment Upgrades**

• A change in the member’s medical condition and equipment needs requires the same documentation as a new request
• Equipment upgrades are equivalent to a new service
• Repairs of DME are for like components of the primary device which are necessary to restore its function
• Replacement of DME is for the same or similar type of equipment

**Ventilators and Respiratory Assist Devices**
For adult or pediatric members, home ventilators are:

• Not covered for non-life-threatening conditions
• Not covered when used as respiratory assist devices (RAD)
Regardless of the member’s age, any type of ventilator would not be eligible for reimbursement for any of the conditions described in the DME Medicare Administrative Contracts (DME MAC) RAD criteria even though the ventilator may have the capability of operating in a bi-level PAP (E0470, E0471) mode.

- Claims for ventilators, such as Trilogy mechanical ventilators (E0465, E0466), used for the treatment of conditions described in the DME MAC RAD criteria are not covered. Bi-level PAP devices (E0470, E0471) are considered as medically necessary in those clinical scenarios.
- The conditions that qualify for use of a RAD are not life-threatening conditions where interruption of respiratory support would quickly lead to serious harm or death.
- Ventilators must not be billed using codes for CPAP (E0601) or bi-level PAP (E0470, E0471, E0472). The use of CPAP or bi-level PAP HCPCS codes to bill a ventilator is incorrect coding, even if the ventilator is only being used in CPAP or bi-level mode.

PAP Therapy

Note: For the evaluation of PAP therapy, hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds associated with at least a 30% reduction in airflow and with at least a 3% decrease in oxygen saturation from pre-event baseline or the event is associated with an arousal (AASM Scoring Manual, 2017).

DEFINITIONS

Please check the definitions within the member benefit plan document that supersede the definitions below.

**Durable Medical Equipment (DME):** Medical equipment that is all of the following:

- Can withstand repeated use
- Is generally not useful to a person in the absence of a sickness, injury or their symptoms
- Is not disposable
- Is not implantable within the body
- Is used to serve a medical purpose with respect to treatment of a sickness, injury or their symptoms
- Meets the state definition of DME

**Medical Supplies:** Expendable items required for care related to a medical illness or dysfunction.

**Mobility Device:** A manual wheelchair, electric wheelchair, transfer chair, scooter, gait trainer, walker, crutch or cane.

**Speech Generating Device:** Speech Generating Devices are characterized by the following:

- Are of use only by an individual who has severe speech impairment
- May be software that allows a laptop computer, desktop computer or personal digital assistant (PDA) to function as a Speech Generating Device
- May have digitized speech output, using pre-recorded messages, greater than 8 minutes recording time
- May have digitized speech output, using pre-recorded messages, less than or equal to 8 minutes recording time
- May have synthesized speech output, which permits multiple methods of message formulation and multiple methods of device access
- May have synthesized speech output, which requires message formulation by spelling and device access by physical contact with the device-direct selection techniques

Speech Generating Devices are not:

- Devices that are capable of running software for purposes other than for speech generation, e.g., devices that can also run a word processing package, an accounting program, or perform other non-medical function
- Laptop computers, desktop computers, or PDAs which may be programmed to perform the same function as a Speech Generating Device
- Useful to someone without severe speech impairment

**Women's Health and Cancer Rights Act of 1998, § 713 (a):** "In general - a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a Mastectomy shall provide, in case of a participant or beneficiary who is receiving benefits in connection with a Mastectomy and who elects breast reconstruction in connection with such Mastectomy, coverage for (1) reconstruction of the breast on which the Mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce symmetrical appearance; and (3) prostheses and physical complications all stages of Mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient.”
APPLICABLE CODES

UnitedHealthcare has adopted the requirements and intent of the National Correct Coding Initiative. The Centers for Medicare & Medicaid Services (CMS) has contracted with Palmetto to manage Pricing, Data and Coding (PDAC) for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). This notice is to confirm UnitedHealthcare has established the PDAC as its definitive source for correct coding and coding clarification.

REFERENCES


State Medicaid contracts.


GUIDELINE HISTORY/REVISION INFORMATION

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<td>o Simplified and relocated Instructions for Use</td>
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INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this guideline, please check the federal, state or contractual requirements for benefit plan coverage.

UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The UnitedHealthcare Coverage Determination Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.