

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

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Related Policies
<ul style="list-style-type: none"> • Attended Polysomnography for Evaluation of Sleep Disorders • Obstructive Sleep Apnea Treatment • Plagiocephaly and Craniosynostosis Treatment • Preventive Care Services

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

CONDITIONS OF COVERAGE

DME Equipment	DME Rider Required	Covered	Precertification Required****
Purchase: If cost is \$500 or less	**Yes	Yes	*No
Purchase: If cost is greater than \$500	**Yes	Yes	Yes
Rental	**Yes	Yes	Yes
Repair	**Yes	***Yes	***Yes
Replacement	**Yes	***Yes	***Yes

Special Considerations

- *All custom molded or custom made (fabricated) items must be pre-certified. This includes custom molded/custom made or custom fabricated orthotics and custom molded helmets which may require further review by a Medical Director or their Designee.
- **For some Commercial lines of business, DME is covered under base medical and a DME rider is not necessary. Refer to the member specific benefit plan document to determine DME benefit coverage.
- ***Replacement and Repairs are covered when functionally necessary. This includes coverage for the repair or replacement of custom molded/custom made or custom fabricated) and custom molded helmets for children when

growth or change in the member's medical condition make replacement medically necessary. Except as set forth in a member specific benefits plan document, all maintenance and repairs that result from a member's misuse are the member's responsibility.

****Even though certain items do not require pre-certification, they may still be subject to a medical necessity review.

Note: If an authorization is not required, referral guidelines apply in order for a member to receive in-network coverage. A prescription form or provider's medical necessity form may be accepted as a referral for Durable Medical Equipment.

BENEFIT CONSIDERATIONS

Before using this guideline, please check the member specific benefit plan document and any federal or state mandates, if applicable.

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit plan document to determine benefit coverage.

New Jersey Products

Coverage is required for expenses incurred in obtaining an orthotic or Prosthetic Appliance from any Licensed Orthotist or prosthetist, or any Certified Pedorthist as determined medically necessary* by the covered person's physician. Therefore, Oxford cannot conduct medical necessity reviews on these appliances or deny for lack of medical necessity.

Notes:

- Prior notification, precertification, prior authorization, or retrospective review is **not** allowed on these items. All items must be covered as determined Medically Necessary by the covered person's physician.
- Benefits must be provided to the same extent as for any other medical condition under the policy.
- Cost Sharing may be applied:
 - **In-network cost share** (deductible, coinsurance or copayment) may be applied but it should be the same as the cost share applied to a member's primary care physician office visit.
 - **Out of network cost share** (deductible, coinsurance) may be applied as in the same manner that cost sharing is determined for other covered conditions.
- Coverage must be provided for replacement of orthotic or Prosthetic Appliances as long as the replacement is determined to be Medically Necessary by the covered person's physician.

*Refer to the [Definitions](#) section.

Orthotics

Oxford covers custom molded/custom made or custom fabricated orthotics and custom molded helmets based on the following:

- DME benefit is part of the base certificate or as a DME rider; **and**
- Medical necessity; **and**
- Inability of the off-the-shelf orthotic to meet members' specific orthopedic needs.

Medical conditions typically requiring a custom molded/made/fabricated orthotic are listed below.

Medical Condition	Criteria
Spinal Conditions	<ul style="list-style-type: none"> • Condition normally requiring an off-the-shelf/prefabricated orthotic, but in the setting of unusual body habitus, such as obesity or a pendulous abdomen • For the objective correction of a spinal deformity, such as scoliosis • For conditions such as unstable spinal fractures that will be treated non-operatively, when accentuated hydrostatic pressure is required • For conditions of spinal instability or deformity which is to be treated operatively or non-operatively, such as spondylolisthesis or spondylolysis, where rotational and skeletal deformities exist that make the use of an off-the-shelf/prefabricated orthotic unsuitable

Medical Condition	Criteria
Non-Spinal Conditions	<ul style="list-style-type: none"> • Conditions normally requiring an off-the-shelf/ prefabricated orthotic, but in the setting of unusual body habitus, or where injury or therapy has rendered off-the-shelf orthotics unsuitable due to size, shape, or deformity • Congenital musculoskeletal defects, including club foot • Hand splints following hand surgery

Note:

- When a member’s plan includes coverage for orthotics, these items are covered under/as part of a member’s Durable Medical Equipment benefit.
- When a member’s certificate of coverage indicates “orthotics” are excluded from coverage, this refers to shoe inserts (unless there is language within the exclusion clause to indicate otherwise).
- Boots and shoes may be excluded from coverage. Please refer to the member specific benefit plan document for additional information.

Plan Type	Coverage for Orthotics
New Jersey Plans	
New Jersey Small Group Standard Indemnity PPO & POS (B, C, D, E)	<p>The following applies to orthotics:</p> <ul style="list-style-type: none"> • The initial fitting and purchase for braces, trusses, orthopedic footwear and crutches are covered. • Oxford covers Medically Necessary and appropriate replacements or repairs for braces, trusses, orthopedic footwear and crutches.
All Other New Jersey Plans	<ul style="list-style-type: none"> • Oxford covers braces and Orthotic Appliances that are worn externally. The brace or orthotic device must temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. • Orthotic devices must be ordered or provided by, or under the direction of a physician who deems the device to be medically necessary. • Oxford covers Medically Necessary and appropriate replacements or repairs for braces and Orthotic Appliances.
Connecticut and New York Plans	
Connecticut and New York Plans	<p>Custom fitted orthotics (i.e., small, medium or large) are covered.</p> <ul style="list-style-type: none"> • Without pre-certification (*see note above) when: <ul style="list-style-type: none"> ○ DME benefit is part of the base certificate or as a DME rider; and ○ Cost is under \$500.00 • With pre-certification (*see note above) when: <ul style="list-style-type: none"> ○ DME benefit is part of the base certificate or as a DME rider; and ○ Cost is over \$500.00

COVERAGE RATIONALE

Indications for Coverage

Durable Medical Equipment (DME) is a covered health care service when the member has a DME benefit; the equipment is ordered by a physician to treat an injury or sickness (illness) and the equipment is not otherwise excluded in the plan document. DME must be:

- Ordered or provided by a physician for outpatient use primarily in a home setting;
- Used for medical purposes;
- Not consumable or disposable except as needed for the effective use of covered DME; **and**
- Not of use to a person in the absences of a disease or disability.

Breast Pumps

Breast pumps may be covered as DME. Please refer to the [Preventive Care Services](#) policy for breast pump coverage indications.

Contact Lenses & Scleral Bandages (Shells)

Contact lenses or scleral shells that are used to treat an injury or disease (e.g., corneal abrasion, keratoconus or severed dry eye), are not considered DME and may be covered as a therapeutic service. In these situations, contact lenses and scleral shells aren't subject to a plan’s contact lens exclusion.

Cranial Remolding Orthosis

Cranial helmets (cranial remolding orthosis, billed with S1040) used to facilitate a successful post-surgical outcome are covered as DME and are not subject to the orthotic device exclusion. Please refer to policy [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. (Please see [Coverage Limitation and Exclusions](#)).

Enteral Pumps

Enteral pumps are covered as DME, even when the enteral nutrition formula is not covered. Please check the member specific benefit plan document for coverage of enteral pumps.

Implanted Devices

Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body is not covered as DME. (If covered, the device is covered as part of the surgical service.)

Note: Cochlear Implant Benefit Clarification: If benefits exist for a cochlear implant, the external components (i.e., speech processor, microphone, and transmitter coil) and the implantable components are considered under the prosthetic benefit. The member specific benefit plan document must be referenced to determine if there are DME benefits for repair or replacement of external components.

Insulin Pumps

Insulin pumps are considered DME. For state specific information on mandated coverage of diabetes supplies, please check state mandates.

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 that are used with covered DME are covered when the supply is necessary for the effective use of the item/device (e.g., oxygen tubing or mask, batteries for power wheelchairs and prosthetics, or tubing for a delivery pump).

Mobility Devices

Mobility Devices (manual wheel chair, electric wheelchairs, transfer chair or scooters) are a covered health care service. Please check the member specific benefit plan document for coverage of Mobility Devices.

Oral Appliances

Oral appliances for snoring are excluded. Coverage may be provided for oral appliances (prefabricated or custom fabricated) for sleep apnea (HCPCS E0485 and E0486). Please refer to policy [Obstructive Sleep Apnea Treatment](#).

- A letter of referral or prescription to the dentist for the appliance must be received from the treating physician; **and**
- A polysomnography must be completed documenting Obstructive Sleep Apnea.

Orthotic Braces

Orthotic braces that stabilize an injured body part and braces to treat curvature of the spine are considered DME. (See [Coverage Limitations and Exclusions](#)). Examples of orthotic braces include but are not limited to:

- Thoracic-lumbar-sacral orthotic (TLSO)
- Lumbar-sacral orthotic (LSO)
- Knee orthotics (KO)
- Ankle Foot Orthotic (AFO)
- Necessary adjustments to shoes to accommodate braces

Note: There are specific codes that are defined by HCPCS as orthotics that Oxford covers as DME.

Ostomy Supplies

Ostomy Supplies. Supplies are limited to the following:

- Pouches, face plates and belts
- Irrigation sleeves, bags and ostomy irrigation catheters
- Skin barriers

- Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above. (Please check the member specific benefit plan document for coverage of ostomy supplies).

Pleurx Bottles and Tubing

Pleurx bottles and tubing are covered as supplies.

Repair and Replacement

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

- The repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are covered when necessary to make the item/device serviceable.
- The physician provides documentation that the condition of the member changes e.g., impaired function necessitates an upgrade to an electric wheelchair from a manual one.
- Routine wear on the equipment renders it non-functional and the member still requires the equipment.
 - Vendors/manufacturers are responsible for repairs, replacements, and maintenance for rented equipment and for purchased equipment covered by warranty.
 - Coverage includes DME obtained in a physician's office, DME vendor, or any other provider authorized to provide/dispense DME.
 - Frequency and timeframe limits for DME repair or replacement are specified in the member specific benefit plan documents.

Speech Generating Devices

Speech Generating Devices are covered as DME when they are not explicitly excluded from coverage in the member specific benefit plan document (COC or SPD) and the treating physician determines that the member suffers from a severe speech impairment and that the medical condition warrants the use of a device based upon the definitions below. The physician attestation must be consistent with and based upon the recommendation of a qualified speech and language pathologist. The speech and language pathology evaluation must reach all of the following conclusions:

- The member's medical condition is one resulting in a severe expressive speech impairment;
- The member's speaking needs cannot be met using natural communication methods;
- Other forms of treatment have been attempted or considered and ruled out. Examples of a Speech Generating Device are:
 - Dynavox
 - Freedom
 - Say-it!

Note: Please check the member specific benefit plan document for coverage of Speech Generating Devices.

Trachea-Esophageal and Voice Aid Prosthetics

Tracheo-esophageal prosthetics and voice aid prosthetics are covered as DME.

Ventilators and Respiratory Assist Devices

For adult or pediatric members, Oxford uses the Medicare policy for coverage determinations for home ventilators. Home ventilators are:

- Not covered for non-life-threatening conditions
- Not covered when used as Respiratory Assistance Devices (RAD)

Regardless of the member's age, any type ventilator would not be eligible for reimbursement for any of the conditions described in the [Medicare RAD criteria](#) even though the ventilator may have the capability of operating in a bi-level PAP (E0470, E0471) mode.

- 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.
- Claims for ventilators, such as Trilogy mechanical ventilators, (E0465, E0466) used for the treatment of conditions described in the Medicare RAD criteria are not covered. Bi-level PAP devices (E0470, E0471) are considered as Medically Necessary in those clinical scenarios.
- 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).

Medical Necessity Plans

In the absence of a related policy or coverage indication from above, Oxford uses available criteria from the [DME MAC](#).

DME, Related Supplies, and Orthotics are Medically Necessary when:

- Ordered by a physician; and
- The item(s) meets the plans Medically Necessary definition (refer to the plan specific document(s)); and
- CMS DME MAC criteria are met (see above link); and
- The item is not otherwise excluded from coverage.

Coverage Limitations and Exclusions

- When more than one piece of DME can meet the member's functional needs, benefits are available only for the item that meets the minimum specifications for member needs. Examples include but are not limited to: standard electric wheelchair vs. custom wheelchair; standard bed vs semi-electric bed vs fully electric or flotation system. This limitation is intended to exclude coverage for deluxe or additional components of a DME item which are not necessary to meet the member's minimal specifications to treat an Injury or Sickness.
- When the member rents or purchases a piece of DME that exceeds this policy, the member will be responsible for any cost difference between the piece he/she rents or purchases and the piece we have determined is the most cost-effective.
- Additional accessories to DME items or devices which are primarily for the comfort or convenience of the member are not covered. Examples include but not limited to:
 - Air conditioners
 - Humidifiers
 - Air purifiers and filters
 - Remodeling or modification to home or vehicle to accommodate DME or patient condition (e.g, Ramps, stair lifts and stair glides, wheelchair lifts, bathroom modifications, door modifications)
 - Batteries for non-medical equipment (e.g., flashlights, smoke detectors, telephones, watches, weight scales)
- Upgrade or replacement of DME when the existing equipment is still functional is not covered.
- Replacement of items due to malicious damage, neglect or abuse is not covered.
- Replacement of lost or stolen items is not covered.
- Routine periodic maintenance (e.g., testing, cleaning, regulating and checking of equipment) for which the owner or vendor is generally responsible is not covered.
- DME and supplies that are explicitly excluded in the member specific benefit plan document are not covered.
- Elastic splints, sleeves or bandages **unless part of a covered health service**, e.g., sleeve used in conjunction with a lymphedema pump or bandages used with complex decongestive therapy are not covered.
- Devices used specifically as safety items or to affect performance in sports-related activities are not covered.
- Diagnostic or monitoring equipment purchased for home use unless otherwise described as a covered health care service (e.g. blood pressure monitor, oximeters).
- The following items are excluded even if prescribed by a physician. Please refer to the member specific benefit plan document.
 - Blood pressure cuff/monitor
 - Enuresis alarm
 - Non-wearable external defibrillator
 - Trusses or girdle
 - Ultrasonic nebulizers
- Devices and computers to assist in communication and speech are not covered. However, see Indications for Coverage for information on Speech Generating Devices.
- Oral appliances for snoring are not covered. See [Indications for Coverage](#) for oral appliances for sleep apnea.

- Personal Care, Comfort and Convenience items and supplies (Please check the member specific benefit plan document for the list of excluded items).
- Dental braces are also excluded from coverage. (Please check the member specific benefit plan document and State Mandates).
- Ostomy Supplies are not covered unless specifically stated as covered. Please check the member specific benefit plan document. See [Indications For Coverage](#).
- Medical Supplies (except those described above under Indications for Coverage) are excluded. This includes, but is not limited to bandages, gauze, dressings, cotton balls and alcohol wipes.
- Urinary catheters are excluded unless specifically stated as covered. Please check the member specific benefit plan document.
- Cranial helmets used for other indications other than those above under the [Indications for Coverage](#) are excluded from coverage under the orthotics exclusion.
- Powered exoskeleton devices.
- Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes (e.g. Smart phone applications, software applications).

DEFINITIONS

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

Certified Pedorthist (NJ Only): A person certified by the American Board for Certification in Pedorthics, or its successor, in the design, manufacture, fit and modification of shoes and related foot appliances from the ankle and below as prescribed by a licensed doctor of medicine or podiatric medicine for the amelioration of painful or disabling conditions of the foot.

Custom Fitted Orthotic: (i.e., small, medium or large) which may or may not need heat to fit to patient.

Custom Molded Orthotic (Custom Made or Custom Fabricated): Custom molded to fit patient. Needs to be measured to specifically fit an individual.

Durable Medical Equipment: Medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use primarily in a home setting
- Used for medical purposes
- Not consumable or disposable except as needed for the effective use of covered DME
- Not of use to a person in the absence of a disease or disability
- Serves a medical purpose for the treatment of a Sickness or Injury
- Primarily used within the home

Licensed Orthotist (NJ Only): Any person who practices orthotics and who represents himself to the public by title or by description of services, under any title incorporating such terms as "orthotics," "orthotists," "orthotic," or "L.O." or any similar title or description of services, provided that the individual has met the eligibility requirements contained in section 11 of this act and has been duly licensed under this act.

Licensed Prosthetist (NJ Only): A person who practices prosthetics and who represents himself to the public by title or by description of services, under any title incorporating such terms as "prosthetics," "prosthetist," "prosthetic," or "L.P." or any similar title or description of services, provided that the individual has met the eligibility requirements contained in section 11 and has been duly licensed under this act.

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

Medically Necessary: Health care services for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, disease, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by Oxford.

- In accordance with generally accepted standards of medical practice

- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms
- Not mainly for patient convenience or that of the patient's doctor or other health care provider
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms

Medically Necessary (for NJ Products Only): A health care service that a health care provider, exercising his prudent clinical judgement, (sic) would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is in accordance with the generally accepted standards of medical practice:

- Clinically appropriate, in terms of type, frequency, extent site (sic) and duration, and considered effective for the covered person's illness, injury or disease
- Not primarily for the convenience of the covered person or the health care provider
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury or disease

Mobility Device: A manual wheelchair, electric wheelchair, transfer chair or scooter.

Obstructive Sleep Apnea (OSA): The American Academy of Sleep Medicine (AASM) defines obstructive sleep apnea as a sleep related breathing disorder that involves a decrease or complete halt in airflow despite an ongoing effort to breathe.

OSA severity is defined as:

- Mild for AHI or RDI ≥ 5 and < 15
- Moderate for AHI or RDI ≥ 15 and ≤ 30
- Severe for AHI or RDI > 30 /hr

Orthotic Appliance (NJ Only): A brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

Prosthetic Appliance (NJ Only): Any artificial device that is not surgically implanted and that is used to replace a missing limb, appendage, or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs, or other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

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

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

Speech Generating Devices are not:

- Devices 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 is not considered a Speech Generating Device

APPLICABLE CODES

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

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare Coverage Determination Guideline (CDG) that was researched, developed and approved by the UnitedHealthcare Coverage Determination Committee [CDG.009.11]

Centers for Medicare and Medicaid Services (CMS), Correct Coding and Coverage of Ventilators” dated January 1, 2016; available at https://www.dmepdac.com/resources/articles/2015/12_15_15.html. Accessed November 7, 2016.

Centers for Medicare and Medicaid Services (CMS). Medicare Benefit Policy Manual, Pub. 100-2, Chapter 14, §10, Coverage of Medical Devices.

Centers for Medicare and Medicaid Services (CMS). Medicare Benefit Policy Manual, Pub. 100-2, Chapter 15, §110 Durable Medical Equipment – General.

Centers for Medicare and Medicaid Services (CMS). Medicare Benefit Policy Manual, Pub. 100-2, Chapter 15, §110.4 Repairs, Maintenance, Replacement, and Delivery.

Centers for Medicare and Medicaid Services (CMS). Medicare National Coverage Determinations Manual (Pub. 100-3), Chapter 1, Part 4 (Sections 200 – 310.1), § 280.

Medical and Surgical Supplies Coverage Determinations Medicare Coverage Issues Manual, Pub. 6, §60-9.

NJ Insurance Law (N.J.S.A. 17B:27-46.1ff).

NJ Law P.L. 2007, c.345.

Oxford Certificates of Coverage and Member Handbooks.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
07/01/2018	<ul style="list-style-type: none">Updated list of related policies; added reference link to the policy titled <i>Attended Polysomnography for Evaluation of Sleep Disorders</i>Revised coverage rationale/indications for coverage; added language pertaining to the evaluation of PAP therapy to indicate 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 arousalArchived previous policy version DME 039.12 T0