

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

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[➔ Instructions for Use](#)

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Coverage Rationale

[➔ See Benefit Considerations](#)

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:

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

Breast Pumps

Breast pumps may be covered under the preventive care services benefit. Refer to the Clinical Policy titled [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 are not subject to a plan's contact lens exclusion.

Cranial Remolding Orthosis

Cranial molding helmets (cranial remolding orthosis, billed with HCPCS code S1040) are excluded except when they meet medical criteria. For all indications, refer to the Clinical Policy titled [Plagiocephaly and Craniosynostosis Treatment](#).

Note: A protective helmet (HCPCS codes 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. (Refer to [Benefit Considerations](#)).

Enteral Pumps

Enteral pumps are covered as DME, even when the enteral nutrition formula is not covered. Check the member specific benefit plan document for coverage of enteral pumps. Refer to the Administrative Policy titled [Formula and Specialized Food](#) for information regarding formula.

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: 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, disposable and durable are covered. Refer to the Clinical Policy titled [Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes](#).

Lymphedema Stockings for the Arm

Post-mastectomy lymphedema stockings for the arm are covered on an unlimited basis as to number of items and dollar amounts covered consistent with the requirements of 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).
- Ostomy Supplies are limited to the following:
 - Irrigation sleeves, bags and ostomy irrigation catheters
 - Pouches, face plates and belts
 - Skin barriers

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

- Urinary Catheters:
 - Benefits for external, Indwelling and Intermittent Urinary Catheters for incontinence or retention.
 - Benefits include related urologic supplies for indwelling catheters limited to:
 - Urinary drainage bag and insertion tray (kit)
 - Anchoring device
 - Irrigation tubing set
 - Documentation should include the number and type of catheters that are needed.

Notes:

- Certain plans may exclude coverage for Urinary Catheters (e.g., test, drug, device, or procedure). Refer to the member specific benefit plan document to determine if this exclusion applies.
- Quantity limits may apply.
- For additional supply information, refer to the [Benefit Considerations](#) section.

Orthotic Braces

Orthotic braces that stabilize an injured body part and braces to treat curvature of the spine are considered DME. (Refer to [Benefit Considerations](#)).

Examples of orthotic braces include but are not limited to:

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

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

Repair, Replacement and Upgrade

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

Repair

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.

Replacement

Replacement of DME is for the same or similar type of equipment which is beyond its reasonable useful life span and has become irreparable.

Upgrade

The physician provides documentation that the condition of the member changes (e.g., impaired function necessitates an upgrade to a power wheelchair from a manual one).

General Criteria

- 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
- Unless otherwise stated, DME has a Reasonable Useful Lifetime (RUL) of 5 years
Pediatric DME must allow room for growth adjustments to a minimum of 2 inches in seat and 3 inches of seat depth.

Notes:

- Growth method may not mean ordering equipment that it is too large for current needs.
- A new prescription isn't needed if the needs of the patient are the same.

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

Tracheo-Esophageal and Voice Aid Prosthetics

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

Ventilators and Respiratory Assist Devices (applies for 2 years of age and older)

Ventilators are covered to treat neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease.

For member's 2 years of age and older, ventilators are not covered when used only to deliver continuous or intermittent positive airway pressure for adults and children. Any type of ventilator would not be Medically Necessary when:

- The ventilator is used only in a bi-level PAP (HCPCS codes E0470 and E0471) mode.
- Used for conditions that qualify for use of a-Respiratory Assistance Devices (RAD) that are not life-threatening conditions where interruption of respiratory support would quickly lead to serious harm or death.
- Ventilators, such as Trilogy mechanical ventilators, (HCPCS codes E0465 and E0466) used for the treatment of conditions that deliver continuous or intermittent positive airway pressure are not Medically Necessary.

Bi-level PAP devices (HCPCS codes E0470 and E0471) are considered Medically Necessary in certain clinical scenarios. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Durable Medical Equipment Noninvasive Airway Assistive Devices.

Click [here](#) to view the InterQual® criteria.

Mechanical ventilators (HCPCS codes E0465 and E0466) are considered medically necessary in certain clinical scenarios. For medical necessity clinical coverage criteria, refer to the InterQual® Medicare: Durable Medical Equipment Ventilators.

Click [here](#) to view the InterQual® criteria

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 the following guidelines for medical necessity, applied in the following order:

1. InterQual® CP Durable Medical Equipment
2. InterQual® Medicare Durable Medical Equipment
3. CMS 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
- Criteria are met (see above); and
- The item is not otherwise excluded from coverage.

Definitions

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

Customized: Items which are uniquely constructed or substantially modified for a specific member according to a physician's description and orders.

Conversely, items that:

- Are measured, assembled, fitted, or adapted in consideration of a patient's body size, weight, disability, period of need, or intended use (i.e., custom fitted items); or
- Have been assembled by a supplier, or ordered from a manufacturer, who makes available Customized features, modification or components for wheelchairs that are intended for an individual patient's use in accordance with instructions from the patient's physician do not meet the definition of Customized items. These items are not uniquely constructed or substantially modified. The use of Customized options or accessories or custom fitting of certain parts does not result in a wheelchair or other equipment being considered as Customized.

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

External Urinary Catheter: External urinary collection device.

Indwelling Urinary Catheter: A flexible plastic tube (a catheter) inserted into the bladder that remains there to provide continuous urinary drainage.

Injury: Damage to the body, including all related conditions and symptoms.

Intermittent Urinary Catheter: The use of a flexible plastic tube (a catheter) inserted into the bladder to periodically drain the bladder.

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

Reasonable Useful Lifetime (RUL): RUL is the expected minimum lifespan for the item. It starts on the initial date of service and runs for the defined length of time. The default RUL for Durable Medical Equipment is set at 5 years. RUL is also applied to other non-DME items such as orthoses and prostheses. RUL is not applied to supply items.

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

Oxford 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 Oxford has established the PDAC as a source for correct coding and coding clarification.

Benefit Considerations

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 guideline, 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.

The following services are excluded from coverage:

- Additional accessories to DME items or devices which are primarily for the comfort or convenience of the member are not covered. Examples include but are not limited to:
 - Air conditioners.
 - Air purifiers and filters.
 - Batteries for non-medical equipment (e.g., flashlights, smoke detectors, telephones, watches, weight scales).
 - Humidifiers.
 - Non-medical mobility devices (e.g., commercial stroller). This exclusion does not apply to pediatric wheelchairs.
 - 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).
- Cranial molding helmets and cranial banding except when used to avoid the need for surgery and/or to facilitate a successful surgical outcome.
- Dental braces.
- Devices and computers to assist in communication and speech. However, see Coverage Rationale for information on Dedicated Speech Generating Devices.
- Devices used specifically as safety items or to affect performance in sports-related activities.
- Diagnostic or monitoring equipment purchased for home use (e.g., blood pressure monitor, oximeters) unless otherwise described as a Covered Health Care Service (e.g., oximeter use with a ventilator).
- Elastic splints, sleeves or bandages, unless part of a Covered Health Care Service (e.g., sleeve used in conjunction with a lymphedema pump or bandages used with complex decongestive therapy).
- Oral appliances for snoring.
- Orthotic braces that straighten or change the shape of a body part.
- Personal Care, Comfort and Convenience items and supplies.
- Powered and non-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).
- Replacement of items due to malicious damage, neglect or abuse.
- Replacement of lost or stolen items.
- Routine periodic maintenance (e.g., testing, cleaning, regulating and checking of equipment) for which the owner or vendor is generally responsible.
- The following items and supplies:
 - DME and supplies that are explicitly excluded in the member specific benefit plan document.
 - Medical Supplies (except those described above under [Coverage Rationale](#)). This includes, but is not limited to bandages, gauze, dressings, cotton balls and alcohol wipes.
 - Items and supplies that do not meet the definition of a Covered Health Care Service.
 - Ostomy Supplies unless specifically stated as covered. Refer to the [Coverage Rationale](#).
- The following items are excluded even if prescribed by a physician.
 - Blood pressure cuff/monitor
 - Enuresis alarm
 - Non-wearable external defibrillator
 - Trusses or girdle

- Ultrasonic nebulizers
- Upgrade or replacement of DME when the existing equipment is still functional. Refer to the [Repair, Replacement, and Upgrade](#) section.

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 [MP.009.25]

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Women's Health and Cancer Rights Act of 1998. Available at: https://www.cms.gov/ccio/programs-and-initiatives/other-insurance-protections/whcra_factsheet.html. Accessed April 11, 2022.

Policy History/Revision Information

Date	Summary of Changes
03/01/2023	<p>Coverage Rationale</p> <ul style="list-style-type: none"> ● Removed content addressing: <ul style="list-style-type: none"> ○ Mobility Devices ○ Oral Appliances ○ Pleurx Bottles and Tubing ● Removed instruction to refer to state mandates for state specific information on mandated coverage of diabetes supplies <p>Medical Supplies</p> <ul style="list-style-type: none"> ● Replaced language indicating “[there are] benefits for Indwelling and Intermittent Urinary Catheters for incontinence or retention” with “[there are] benefits for <i>External</i> Indwelling and Intermittent Urinary Catheters for incontinence or retention” ● Added language to indicate quantity limits may apply for Urinary Catheters <p>Ventilators and Respiratory Assist Devices (applies for 2 years of age and older)</p> <ul style="list-style-type: none"> ● Revised coverage guidelines to indicate: <ul style="list-style-type: none"> ○ Ventilators are covered to treat neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease ○ For member’s 2 years of age and older, ventilators are not covered when used only to deliver continuous or intermittent positive airway pressure for adults and children; any type of ventilator would not be medically necessary when: <ul style="list-style-type: none"> ▪ The ventilator is used only in a bi-level PAP (HCPCS code E0470 or E0471) mode ▪ Used for conditions that qualify for use of a respiratory assistance devices (RAD) that are not life-threatening conditions where interruption of respiratory support would quickly lead to serious harm or death ▪ Ventilators such as Trilogy mechanical ventilators (HCPCS codes E0465 and E0466) used for the treatment of conditions that deliver continuous or intermittent positive airway pressure are not medically necessary

Date	Summary of Changes
	<ul style="list-style-type: none"> ○ Bi-level PAP devices (HCPCS codes E0470 and E0471) are considered medically necessary in certain clinical scenarios; for medical necessity clinical coverage criteria, refer to the InterQual® CP: Durable Medical Equipment, Noninvasive Airway Assistive Devices ○ Mechanical ventilators (E0465, E0466) are considered medically necessary in certain clinical scenarios; for medical necessity clinical coverage criteria, refer to the InterQual® Medicare: Durable Medical Equipment, Ventilators <p>Medical Necessity Plans</p> <ul style="list-style-type: none"> ● Revised language pertaining to medical necessity clinical coverage criteria; added reference to the: <ul style="list-style-type: none"> ○ InterQual® CP: Durable Medical Equipment ○ InterQual® Medicare: Durable Medical Equipment ● Replaced language indicating “DME, related supplies, and orthotics are medically necessary when <i>CMS DME MAC</i> criteria are met” with “DME, related supplies, and orthotics are medically necessary when criteria <i>[in the policy]</i> are met” <p>Definitions</p> <ul style="list-style-type: none"> ● Added definition of: <ul style="list-style-type: none"> ○ External Urinary Catheter ● Removed definition of: <ul style="list-style-type: none"> ○ Behavioral Management Program ○ Covered Health Care Service(s) ○ Medically Necessary ○ Mental Illness ○ Mobility Device ○ Obstructive Sleep Apnea ○ Sickness ○ Speech Generating Device <p>Supporting Information</p> <ul style="list-style-type: none"> ● Updated <i>Benefit Considerations</i> and <i>References</i> sections to reflect the most current information ● Archived previous policy version DME 039.27

Instructions for Use

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. 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.