DURABLE MEDICAL EQUIPMENT (DME), PROSTHETICS, CORRECTIVE APPLIANCES/ORTHOTICS (NON-FOOT ORTHOTICS) AND MEDICAL SUPPLIES

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Effective Date:  March 1, 2019

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Covered benefits are listed in three (3) Sections - A, B and C. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations and exclusions as stated in the member’s Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member’s EOC/SOB, the member’s EOC/SOB provision will govern.

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 document to determine benefit coverage.

A. FEDERAL/STATE MANDATED REGULATIONS

California Health and Safety Code-Section 1367.06
a) A health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2005, that covers outpatient prescription drug benefits shall include coverage for inhaler spacers when medically necessary for the management and treatment of pediatric asthma.
b) If a subscriber has coverage for outpatient prescription drugs, a health care service plan contract, except a specialized health care service plan contract, that is issued, amended,
delivered, or renewed on or after January 1, 2005, shall include coverage for the following equipment and supplies when medically necessary for the management and treatment of pediatric asthma:
1. Nebulizers, including face masks and tubing
2. Peak flow meters.

c) The quantity of the equipment and supplies required to be covered pursuant to subdivisions (a) and (b) may be limited by the health care service plan if the limitations do not inhibit appropriate compliance with treatment as prescribed by the enrollee's physician and surgeon. A health care service plan shall provide for an expeditious process for approving additional or replacement inhaler spacers, nebulizers, and peak flow meters when medically necessary for an enrollee to maintain compliance with his or her treatment regimen. The process required by Section 1367.24 may be used to satisfy the requirements of this section for an inhaler spacer.

d) Education for pediatric asthma, including education to enable an enrollee to properly use the device identified in subdivisions (a) and (b), shall be consistent with current professional medical practice.

e) The coverage required by this section shall be provided under the same general terms and conditions, including copayments and deductibles, applicable to all other benefits provided by the plan.

f) A health care service plan shall disclose the benefits under this section in its evidence of coverage and disclosure forms.

g) A health care service plan may not reduce or eliminate coverage as a result of the requirements of this section.

h) Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter, if a plan provides coverage for prescription drugs.

California Health and Safety Code-Section 1367.18:

(a) Every health care service plan, except a specialized health care service plan, that covers hospital, medical, or surgical expenses on a group basis shall offer coverage for orthotic and prosthetic devices and services under the terms and conditions that may be agreed upon between the group subscriber and the plan. Every plan shall communicate the availability of that coverage to all group contract holders and to all prospective group contract holders with whom they are negotiating. Any coverage for prosthetic devices shall include original and replacement devices, as prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license. Any coverage for orthotic devices shall provide for coverage when the device, including original and replacement devices, is prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license, or is ordered by a licensed health care provider acting within the scope of his or her license. Every plan shall have the right to conduct a utilization review to determine medical necessity prior to authorizing these services.

(b) Notwithstanding subdivision (a), on and after July 1, 2007, the amount of the benefit for orthotic and prosthetic devices and services shall be no less than the annual and lifetime benefit maximums applicable to the basic health care services required to be provided under Section 1367. If the contract does not include any annual or lifetime benefit maximums applicable to basic health care services, the amount of the benefit for orthotic and prosthetic devices and services shall not be subject to an annual or lifetime maximum benefit level. Any copayment, coinsurance, deductible, and maximum out-of-pocket amount applied to the benefit for orthotic and prosthetic devices and services shall be no more than the most common amounts applied to the basic health care services required to be provided under Section 1367.

B. STATE MARKET PLAN ENHANCEMENTS

None
C. COVERED BENEFITS

IMPORTANT NOTE: Covered benefits are listed in Sections A, B and C. Always refer to Sections A and B for additional covered benefits not listed in this Section.

Note: Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) to determine the coverage eligibility and any additional services that might be covered.

1. See the Benefit Interpretation Policy titled Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics and Medical Supplies Grid for the list of covered items and specific coverage criteria.

2. DME items, Prosthetic Devices and Corrective Appliances/Orthotics (Non-Foot Orthotics) and medical supplies:
   a. DME items may be rented or purchased and must meet all of the following criteria:
      1) The equipment meets the definition of DME. The equipment is necessary and reasonable for the treatment of the member's illness or injury to improve the functioning of his/her malformed body member.
      2) The equipment is mainly used in the member's home or another location used as the member's home. Home is wherever the Member makes his or her home but does not include acute care, rehabilitation or Skilled Nursing Facilities.
   b. Prosthetic Devices and Corrective Appliances/Orthotics (Non-Foot orthotics) including custom made or custom fitted must meet all of the following criteria:
      1) The item meets the definition of Prosthetic and Corrective Appliances/Orthotics (Non-Foot Orthotics) and is Medically Necessary as determined by the Member’s Network Medical Group or UnitedHealthcare
   Note: Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to loss, misuse, malicious breakage or gross neglect), and services to determine whether the member needs a prosthetic or orthotic device
   c. Supplies for DME items or Prosthetic Devices (e.g., oxygen, batteries for an artificial larynx, stump sock or shrinker) only when they are necessary for the effective use of the item/device
   d. Repairs, replacement and adjustments of DME items, Prosthetic Devices and Corrective Appliances/Orthotics (Non-Foot Orthotics) for owned, purchased or rented equipment. (Note: Repairs, replacement and adjustments for rented items/devices are the contractual responsibility of the item/device provider).
      1) May require pre-certification to be covered (Note: The Market pre-certification process varies)
      2) Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc. The Member’s Network Medical Group or UnitedHealthcare has the option to repair or replace Durable Medical Equipment items.
         a) Extensive adjustment is covered as repair when, based on the manufacturer’s recommendations, the maintenance (e.g., breaking down sealed components, performing tests that require specialized testing equipment not available to the member) is to be performed by an authorized technician
      3) Adjustment of Prosthetic Devices or Corrective Appliances/Orthotics (Non-Foot Orthotics), when required by normal wear and tear or a significant change in the member’s physical condition and ordered by a physician
      4) Replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a significant change in the member’s physical condition occurs. The Member’s Network Medical Group or UnitedHealthcare has the option to repair or replace Durable Medical Equipment items.

3. Medical supplies and materials
   Medical supplies and materials necessary to treat an illness or injury are covered when used or furnished while the Member is treated in the Network Provider’s office, during the course of an illness or injury, or stabilization of an injury or illness, under the direct supervision of the Network...
Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies: Benefit Interpretation Policy (Effective 03/01/2019)

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connection to nerves, muscles or other tissue, prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect.

### F. POLICY HISTORY/REVISION INFORMATION

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<tr>
<th>Date</th>
<th>Action/Description</th>
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| 03/01/2019 | **Federal/State Mandated Regulations**  
- Replaced references to “member” with “enrollee”  
- Updated code title for *California Health and Safety Code*-Section 1367.06; previously titled *California Code*-Section 1367.06  
**Covered Benefits**  
- Replaced references to “Participating Medical Group/Provider” with “Network Medical Group/Provider”  
- Replaced language indicating:  
  - “Adjustment of Prosthetic Devices or Corrective Appliances/Orthotics (Non-Foot Orthotics) [are covered] when required by wear or a significant change in the patient’s condition and ordered by a physician” with “adjustment of Prosthetic Devices or Corrective Appliances/Orthotics (Non-Foot Orthotics) [are covered] when required by normal wear and tear or a significant change in the member’s physical condition and ordered by a physician”  
  - “Replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a significant change in the member’s medical condition occurs” with “replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a significant change in the member’s physical condition occurs”  
**Not Covered**  
- Revised list of non covered services; replaced “additional accessories or attachments” with “optional modifications or attachments”  
**Definitions**  
- Updated definition of “Durable Medical Equipment”  
- Archived previous policy version BIP048,F |