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

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➲ Instructions for Use

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Related Benefit Interpretation Policy

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

Medical Supplies Grid

Note: This policy is based, in part, upon Medicare DME MAC and/or Medicare criteria.

Item		Coverage	Comments
Abdominal binder	Surgical	Medical Supply*	Only when used as a dressing/holder; also see Dressings, Surgical.
	Non-surgical	Corrective Appliance/ Orthotic	Covered when **all of the following** criteria are met: • Serves a medical purpose and it is only associated with treating an illness, injury or malformed body member • Provides support and counter force (a force in a defined direction of a magnitude at least as great as a rigid or semi-rigid support) on the limb or body part that is being used to brace • Not used to supply compression therapy (e.g. to reduce size, volume, or swelling of a body member or to help circulation) • Not used for convenience or appearance • Not used for cosmetic purposes
Aero Chamber (spacer)		DME	Covered with mask for children 3 years of age through supplemental pharmacy benefit. Or per state law (California Health and Safety Code-Section 1367.06effective 01/01/2005), covered as DME for the management and treatment of pediatric asthma of Dependent children under the age of 19.

Item	Coverage	Comments
Air Conditioner/Air Cleaner/Purifier/ Electrostatic Machines or other Environmental Equipment	Not Covered	Refer to the member's EOC for exclusion details.; Environmental control equipment, not primarily medical in nature

Air-fluidized Bed (Bead), e.g., Clinitron	DME	Coverage criteria apply; refer to the NCD for Air-Fluidized Bed (280.8). (Accessed May 10, 2024)
		
		Home use of an air-fluidized bed **is** recommended when all of the following criteria are met:
		• The member has a stage 3 (full thickness tissue loss) or stage 4 (deep tissue destruction) pressure sore
		• The member is bedridden or chair bound as a result of severely limited mobility
		• The member would require institutionalization in the absence of an air-fluidized bed
		• The air-fluidized bed is ordered in writing by the member's attending physician based upon a comprehensive assessment and evaluation of the member after completion of a course of conservative treatment designed to optimize conditions that promote wound healing
		  ○ The conservative treatment course must have been at least one month in duration without progression toward wound healing. The month of conservative treatment may include some period in an institution as long as there is documentation available to verify that the necessary conservative treatment has been rendered
		  ○ Conservative treatment must include:
		  ▪ Frequent repositioning of the member with particular attention to relief of pressure over bony prominences (usually every 2 hours)
		  ▪ Use of a specialized support surface (Group 2) designed to reduce pressure and shear forces on healing ulcers and to prevent new ulcer formation
		  ▪ Necessary treatment to resolve any wound infection
		  ▪ Optimization of nutrition status to promote wound healing
		  ▪ Debridement by any means (including wet to dry dressings, which does not require an occlusive covering) to remove devitalized tissue from the wound bed
		  ▪ Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering, while the wound heals
		• A trained adult caregiver is available to assist the member with activities of daily living, fluid balance, dry skin care, repositioning, recognition and management of altered status, dietary needs, prescribed treatments, and management and support of the air-fluidized bed system and its problems, such as leakage
		• A physician directs the home treatment regimen and re-evaluates and re-certifies the need for the air-fluidized bed on a monthly basis
		• All other alternative equipment has been considered and ruled out
		
		Home use of an air-fluidized bed **is not** recommended under any of the following circumstances:
		• The member has co-existing pulmonary disease (the lack of firm back support makes coughing ineffective and dry air inhalation thickens pulmonary secretions)
		• The member requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering, such as plastic wrap or other occlusive material

Item	Coverage	Comments
		• The caregiver is unwilling or unable to provide the type of care required by the member on an air-fluidized bed • Structural support is inadequate to support the weight of the air-fluidized bed system, which generally weighs 1,600 pounds or more • Electrical system is insufficient for the anticipated increase in energy consumption
Air Splint	Medical Supply*	Clear plastic splints inflated by air used temporarily on fractured, broken, crushed or burned limbs
Alternating Pressure Pads, Gel Flotation Devices, Lamb's Wool Pads/Sheep Skins (Group 1 pressure reducing support surfaces)	DME	Covered if the member meets: • Criterion 1; or • Criterion 2 or 3; and • At least one of criteria 4-7 **Criteria** 1. Completely immobile - i.e., member cannot make changes in body position without assistance 2. Limited mobility - i.e., member cannot independently make changes in body position significant enough to alleviate pressure 3. Any stage pressure ulcer on the trunk or pelvis 4. Impaired nutritional status 5. Fecal or urinary incontinence 6. Altered sensory perception 7. Compromised circulatory status
Alternating Pressure Pads, Low Air Loss or Powered Flotation without Low Air Loss (Group 2 pressure reducing support surfaces)	DME	Mattresses (Pressure Reducing) **are** recommended if the member meets the following: • Criteria a and b and c; or • Criterion d; or • Criteria e and f **Criteria** 1. Multiple stage II pressure ulcers (see Appendix I for details) located on the trunk or pelvis 2. Member has been on a comprehensive ulcer treatment program for at least the past month, which has included the use of an appropriate Group 1 support surface. The comprehensive treatment should include the following: a. Education of the member and caregiver on the prevention and/or management of pressure ulcers b. Regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a member with a stage III or IV ulcer) c. Appropriate turning and positioning d. Appropriate wound care (for a stage II, III, or IV ulcer) e. Appropriate management of moisture/incontinence f. Nutritional assessment and intervention consistent with the overall plan of care 3. The ulcers have worsened or remained the same over the past month

Item		Coverage	Comments
			4. Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis 5. Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) 6. The member has been on a Group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days) **Note**: If the member is using a Pressure Reducing Mattress, there should be a care plan established by the physician or home care nurse, which includes the elements listed above. The support surface provided for the member should be one in which the member does not "bottom out." Bottoming out is the finding that an outstretched hand can readily palpate the bony prominence (coccyx or lateral trochanter) when it is placed palm up beneath the undersurface of the mattress or overlay and in an area under the bony prominence. The bottoming out criterion should be tested with the member in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the side lying position. **Note**: When a Pressure Reducing Mattress is provided following a myocutaneous flap or skin graft, recommendation generally is limited to 60 days from the date of surgery. **Continued Use** Continued use of a Pressure Reducing Mattress **is** recommended until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show the following: • Other aspects of the care plan are being modified to promote healing, or • The use of the Pressure Reducing Mattress is medically necessary for wound management.
Ambulatory Boot		Corrective Appliance/ Orthotic	Covered when medically necessary. Also known as surgical boot.
Ambulatory Cardiac Event Monitoring (example: Holter Monitor, Event Monitor, Patch-Type Monitor, Zio Patch		Medical Supply*	Refer to the Medical Management Guideline (MMG) titled Cardiac Event Monitoring.
Ankle-Foot Orthosis (AFO)/ Knee-Ankle-Foot Orthosis (KAFO)	**Non-ambulatory** Static or dynamic positioning ankle-foot orthoses (AFO)	Corrective Appliance/ Orthotic	Static or dynamic positioning ankle-foot orthoses (AFO) is covered when criteria are met. Refer to the DME MAC LCD for Ankle-Foot/Knee-Ankle-Foot Orthoses (L33686). (Accessed May 10, 2024) Covered if either all of criteria 1-4 or criterion 5 is met: 1. Plantar flexion contracture of the ankle with a dorsiflexion on passive range of motion testing of at least 10 degrees 2. Reasonable expectation of the ability to correct the contracture 3. Contracture is interfering or expected to interfere significantly with the member's functional abilities

Item		Coverage	Comments
			4. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons 5. Member has plantar fasciitis
	Non-ambulatory foot drop splint	Not Medically Necessary	A foot drop splint/recumbent positioning device and replacement interface will be denied as not medically necessary in a member with foot drop who is non-ambulatory because there are other more appropriate treatment modalities. Refer to the DME MAC LCD for Ankle-Foot/Knee-Ankle-Foot Orthoses (L33686). (Accessed May 10, 2024)
	Ambulatory • Ankle-Foot Orthosis (AFO) • Knee-Ankle-Foot Orthosis (KAFO)/ Ambulatory (e.g., cam walkers, pneumatic splint	Corrective Appliance/ Orthotic	Ankle-foot orthoses (AFO) and knee-ankle-foot orthoses (KAFO) are covered when criteria are met. Refer to the DME MAC LCD for Ankle-Foot/Knee-Ankle-Foot Orthoses (L33686). (Accessed May 10, 2024) Ankle-foot orthoses (AFO) are covered for ambulatory members with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally. Knee-ankle-foot orthoses (KAFO) are covered for ambulatory member for whom an ankle-foot orthosis is covered and for whom additional knee stability is required. AFO, KAFO, and braces for ankle, foot, and knee used solely for athletic sports **are not covered**. AFOs and KAFOs that are molded-to-patient-model are covered for ambulatory member when the basic coverage criteria listed above are met **and** one of the following criteria are met: • The member could not be fit with a prefabricated AFO; or • The condition necessitating the orthosis is expected to be permanent or of long standing duration (more than 6 months), or • There is a need to control the knee, ankle or foot in more than 1 plane; or • There is a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or • The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.
Apnea Monitor Infant or Child)		DME	There must be documentation of sleep apnea by a sleep study and a history of apnea events. Rental only. Not covered for adults.
Artificial Eye		Prosthetic	Covered for member with absence or shrinkage of an eye due to birth defect, trauma or surgical removal. Coverage includes polishing and resurfacing. Orbital implants are reimbursed as surgical implants.
Artificial Larynx or Electronic Speech Aid		Prosthetic	Coverage for member post laryngectomy or permanently inoperative larynx condition; disposable aid not covered. There are two types of speech aids. One operates by placing a vibrating head against the throat; the other amplifies sound waves through a tube which is inserted into the user's mouth. A member who has had radical neck surgery and/or extensive radiation to the anterior part of the neck would

Item		Coverage	Comments
			generally be able to use only the "oral tube" model or one of the more sensitive and more expensive "throat contact" devices.
Artificial Extremities – Lower Extremities	Standard	Prosthetic	Covered when medical criteria are met; Refer to the InterQual® Client Defined CP: Durable Medical Equipment, Prosthetics, Lower Extremities (Custom) – UHG. Click here to view the InterQual® criteria.
	Bionic	Prosthetic	**Note**: Members may have coverage for this item under the prosthetic benefit in some plans. Refer to the member's EOC/SOB or contact the Customer Service Department to determine coverage eligibility.
	C-leg (microprocessor-controlled knee-shin system)		
	Myoelectric		
Artificial Extremities – Upper Extremities	Standard	Prosthetic	A determination of the medical necessity for the prosthesis is based on the member's potential functional abilities. Potential function ability is based on the reasonable expectations of the prosthetist and treating physician, considering factors including, but not limited to the following: • The member's past history (including prior prosthetic use if applicable); and • The member's current condition including the status of the residual limb and the nature of the other medical problems; and • The member's desire to use a prosthesis. **Body Powered Prostheses – Upper Limb** Upper limb functional body-powered prostheses are powered and controlled by gross body movements, a harness, and cable system. The following are basic requirements necessary for a member to be a candidate for a body-powered prosthesis: • Sufficient residual limb length • Sufficient musculature • Sufficient range of motion A member must possess at least one more of the following gross body movements to be able to control a body-powered prosthesis: • Glenohumeral flexion • Scapular abduction or adduction • Chest expansion • Shoulder depression and elevation
	Myoelectric	Not Covered	**Note**: Members may have coverage for this item under the prosthetic benefit in some plans. Refer to the member's EOC/SOB or contact the Customer Service Department to determine coverage eligibility.
Back Brace		Corrective Appliance/ Orthotic	See Spinal Orthosis.
Back Support (posture chair)		Not Covered	Not primarily medical in nature

Item		Coverage	Comments
Bath Accessories	Bath Tub Lifts and Seats	Not Covered	Not primarily medical in nature
	Transfer Bench	Not Covered	Not primarily medical in nature
Beds and Accessories	Hospital, fixed height	DME	NCD for Hospital Beds (280.7) (Accessed May 10, 2024) Member must meet **one or more** of the following criteria: • Requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed • Require positioning of the body in ways not feasible with an ordinary bed, for alleviation of pain • Require the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or problems with aspiration (pillows or wedges should be considered first) • Require traction equipment that can only be attached to a hospital bed
	Hospital, variable height	DME	Member must meet one of the criteria for the fixed height bed (as listed above) and must require a bed height different than a fixed height bed in order to permit transfer to a chair, wheelchair or standing position; **and** Variable height feature of a hospital bed is covered for one of the following conditions: • Severe arthritis and other injuries to lower extremities; e.g., fractured hip. The condition requires the variable height feature to assist the member to ambulate by enabling the member to place his or her feet on the floor while sitting on the edge of the bed; • Severe cardiac conditions. For those cardiac members who are able to leave bed, but who must avoid the strain of "jumping" up or down; • Spinal cord injuries, including quadriplegic and paraplegic, member's multiple limb amputee and stroke members. For those members who are able to transfer from bed to a wheelchair, with or without help; or • Other severely debilitating diseases and conditions, if the variable height feature is required to assist the member to ambulate.
	Hospital, semi-electric	DME	Member must meet one of the criteria for the fixed height bed (as listed above) and must require frequent or immediate changes in body position.
	Hospital, total electric	Not Covered	The electric height adjustment feature is a convenient item therefore does not meet the definition of DME.
	Hospital, heavy duty extra wide	DME	Recommended for member meeting criteria for a fixed height hospital bed and the member's weight is more than 350 pounds, but does not exceed 600 pounds.
	Hospital, extra heavy duty	DME	Recommended for member's meeting criteria for a fixed height hospital bed and the member's weight exceeds 600 pounds.
	Lounge (power or manual)	Not Covered	Not primarily medical in nature.
	Mattress	DME	Only when part of a hospital bed; dry pressure pad is covered.

Item		Coverage	Comments
	Oscillating	Not Covered	Institutional equipment; inappropriate for home use. Does not meet the definition of DME.
	Over Bed Tables	Not Covered	Not primarily medical in nature.
	Pressure Reducing	DME	Mattresses (Pressure Reducing) **are** recommended if the member meets the following: • Criteria **1 and 2 and 3**, or • Criterion **4**, or • Criteria **5 and 6** **Criteria** 1. Multiple stage II pressure ulcers (see Appendix I for details) located on the trunk or pelvis 2. Member has been on a comprehensive ulcer treatment program for at least the past month, which has included the use of an appropriate Group 1 support surface. The comprehensive treatment should include the following: a. Education of the member and caregiver on the prevention and/or management of pressure ulcers b. Regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a member with a stage III or IV ulcer) c. Appropriate turning and positioning d. Appropriate wound care (for a stage II, III, or IV ulcer) e. Appropriate management of moisture/incontinence f. Nutritional assessment and intervention consistent with the overall plan of care 3. The ulcers have worsened or remained the same over the past month 4. Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis 5. Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) 6. The member has been on a Group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days) **Note**: If the member is using a Pressure Reducing Mattress, there should be a care plan established by the physician or home care nurse, which includes the elements listed above. The support surface provided for the member should be one in which the member does not "bottom out." Bottoming out is the finding that an outstretched hand can readily palpate the bony prominence (coccyx or lateral trochanter) when it is placed palm up beneath the undersurface of the mattress or overlay and in an area under the bony prominence. The bottoming out criterion should be tested with the member in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the side lying position. **Note**: When a Pressure Reducing Mattress is provided following a myocutaneous flap or skin graft, recommendation generally is limited to 60 days from the date of surgery.

Item		Coverage	Comments
			Continued Use Continued use of a Pressure Reducing Mattress **is** recommended until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show the following: • Other aspects of the care plan are being modified to promote healing, or • The use of the Pressure Reducing Mattress is medically necessary for wound management
	Side rails	DME	Only if part of hospital bed and member's condition requires bed side rails
Bed Baths (home type)		Not Covered	Not primarily medical in nature
Bed Board		Not Covered	Not primarily medical in nature
Bed Lifter (bed elevator)		Not Covered	Not primarily medical in nature
Bed Cradle		DME	Covered when necessary to prevent contact with the bed coverings.
Bed Pan (autoclavable, hospital type)		DME	If member is bed bound
Bed Specs (prism glasses)		Not Covered	Not primarily medical in nature
Bed Wetting Alarms		Not Covered	Not primarily medical in nature
Bilevel Positive Airway Pressure (BiPAP)		DME	Coverage criteria apply; refer to the MMG titled Obstructive and Central Sleep Apnea Treatment
Bili-lights/ Bili-blankets (phototherapy)		DME	Covered when medically necessary for treatment of jaundice in newborns
Blood Glucose Analyzer-reflectance Colorimeter		Not Covered	Unsuitable for home use. Does not meet the definition of DME
Blood Pressure Monitor/ Sphygmomanometer		DME	Only for members on home dialysis; fully and semi-automatic (member activated) portable monitors are not covered.
Bone Stimulator also known as Osteogenic Stimulator (Electronic or Ultrasonic)		DME	Criteria apply; refer to the MMG titled Electrical and Ultrasound Bone Growth Stimulators.
Braces		Corrective Appliance/ Orthotic	Excludes orthodontic braces; also see AFO/KAFO or Knee Orthosis or Spinal Orthosis (body jacket) or Back Brace.
Braille Teaching Text		Not Covered	Educational, not primarily medical in nature
Bras/ Brassieres(post-surgery)		Prosthetic	Required to hold a breast prosthesis (up to 3 every 12 months).
Breast Prosthesis (external)		Prosthetic	Covered for members who have had a mastectomy or lumpectomy. Refer to Benefit Interpretation Policy (BIP) titled Post Mastectomy Surgery. Initial prosthesis is covered for the useful lifetime of the prosthesis, with replacements thereafter due to normal wear and tear. Replacement of the same type is covered at any time when it's lost or irreparably damaged. The **useful lifetime expectancy** for silicone breast prostheses is 2 years. The useful lifetime expectancy for nipple prosthesis is 3 months. For fabric, foam, or fiber filled breast prostheses, the

Item		Coverage	Comments
			useful lifetime expectancy is 6 months. Replacement sooner than the useful lifetime because of ordinary wear and tear will be denied as non-covered.
Breast-feeding Support, Supplies and Counseling		DME	Refer to the MMG titled Preventive Care Services.
Cam Walkers (also known as Walking Boot)		Corrective Appliance/ Orthotic	See Ankle Foot Orthosis (AFO)/ Knee Ankle Foot Orthosis (KAFO).
Canes	Quad or Straight	DME	Covered when member meets the Mobility Assistive Equipment clinical criteria. Refer to the • NCD for Durable Medical Equipment Reference List (280.1) • NCD for Mobility Assistive Equipment (280.3) • DME MAC LCD for Canes and Crutches (L33733) (Accessed May 10, 2024)
	White	Not Covered	Not primarily medical in nature
Car Seats		Not Covered	Not primarily medical in nature
Casts (e.g., plaster, fiberglass)		Medical Supply*	Used to reduce fractures or dislocations.
Cervical Collar	Semi-rigid	Corrective Appliance/ Orthotic	Provides increased cervical support over foam.
	Soft	Corrective Appliance/ Orthotic	Minimal cervical support for sprains/strains
	Rigid	Corrective Appliance/ Orthotic	Covered post-surgery
Cervical Pillow		Not Covered	Not primarily medical in nature
Cervical Thoracic Lumbar Sacral Orthoses (CTLSO)		Corrective Appliance/ Orthotic	See Spinal Orthosis. Also see Scoliosis Orthosis.
Chair (adjustable)		DME	Only for members on home dialysis; Refer to the BIP titled Dialysis Services.
Chemical Test Strips		Pharmacy	Refer to the BIP titled Diabetic Management, Services and Supplies.
Clavicle Support/Splint		Corrective Appliance/ Orthotic	Used to keep the clavicle in position following acute injury or post-operative care
Cleft Palate Prosthesis		Prosthetic	Only for cleft lip and palate deformities as a result of congenital malformation

Item		Coverage	Comments
Cochlear Implant (External Component of Device)		Prosthetic	Considered as high-end prosthetic device. Criteria apply. Refer to the BIP titled Hearing Services. Also refer to the MMG titled Cochlear Implants.
Cold Therapy • Cold Packs /Cool Jackets • Water circulating cold pad with pump (e.g., Polar Units)		Not Covered	Not medically necessary; alternative therapy available with the same outcomes
Collagen Implant		Prosthetic	Coverage criteria apply. Refer to the NCD for Incontinence Control Devices (230.10). (Accessed May 10, 2024)
Colostomy Bag		Prosthetic	See Ostomy Supplies item.
Commode (without wheels only)	Bedside	DME	Covered when member is physically incapable of utilizing regular toilet facilities. This would occur when (1) member is confined to a single room, or (2) member is confined to one level of the home environment and there is not toilet on that level, or (3) member is confined to the home and there are no toilet facilities in the home.
	Chair Foot Rest	Not Covered	Not primarily medical in nature
	Elevated Seat (raised toilet seat)	Not Covered	Not primarily medical in nature
Communication Devices (e.g., computers, personal digital assistants, speech generating devices) Except artificial larynxes or electronic speech aid		Not Covered	Refer to the member's EOC for exclusion details. See Artificial Larynx or Electronic Speech Aid.
Compression Burn Garment		DME	Covered when used to reduce hypertrophic scarring and joint contractures following burn injury. See Lymphedema Sleeve/Compression Garments/Bandages (Wrap). Refer to the NCD for Porcine Skin and Gradient Pressure Dressings (270.5). (Accessed May 10, 2024)
Contact Lens, Hydrophilic Soft (external)		Prosthetic	Covered under the medical benefit. Coverage criteria apply. Some plans may cover under Vision Care. Refer to the BIP titled Vision Care and Services.
Continuous Passive Motion (CPM)		DME	Covered for member's who have received a total knee replacement. To qualify for coverage, use of the device must commence within 2 days following surgery. In addition, coverage is limited to that portion of the 3-week period following surgery during which the device is used in the member's home. There is insufficient evidence to justify coverage of these devices for longer periods of time or for other applications
Continuous Positive Airway Pressure (CPAP)		DME	Coverage criteria apply; refer to the MMG titled Obstructive and Central Sleep Apnea Treatment.

Item		Coverage	Comments
Corset		Corrective Appliance/ Orthotic	A hernia support (whether in the form of a corset or truss) which meets the definition of a brace is covered. Refer to the NCD for Corset Used as Hernia Support (280.11). (Accessed May 10, 2024)
Cough Assist Device		DME	Mechanical in-exsufflation devices are covered for member's who meet both of the following criteria: • They have a neuromuscular disease, and • This condition is causing a significant impairment of chest wall and/or diaphragmatic movement, such that it results in an inability to clear retained secretions.
Cranial Band/Helmet(Cranial Orthosis)		Corrective Appliance/ Orthotic	Refer to the MMG titled Plagiocephaly and Craniosynostosis Treatment.
Crutches, Crutch Tips and Handles		DME	Covered when member meets the Mobility Assistive Equipment clinical criteria. Refer to the: • NCD for Mobility Assistive Equipment (MAE) (280.3) • DME MAC LCD for Canes and Crutches (L33733) **Note**: Crutch substitute (HCPCS code E0118) is not covered. There is insufficient published clinical literature demonstrating safety and effectiveness in the Medicare population to establish the medical necessity for this device. Refer to the: • CGS News & Publication-E0118 – Crutch Substitute • Noridian Article E0118 - Crutch Substitute (Accessed May 10, 2024)
Dehumidifier		Not Covered	Refer to the member's EOC for exclusion details. Environmental control equipment, not primarily medical in nature
Diabetic Supplies (e.g., glucometer, lancets, injection aids)			Refer to the BIP titled Diabetic Management, Services and Supplies. **Note**: For United HealthCare Benefits Plan of California: Batteries and Battery Chargers for infusion pumps and home blood glucose monitors are covered if necessary. Supplies or accessories billed separately will be denied.
Dental Splint			See Splints.
Dialysis Home Kit, Peritoneal		DME	Only for members on home dialysis
Diapers/Adult incontinence garments		Prosthetic	Hygienic supplies, non-reusable Only for hospice member's
Disposable Sheets		Medical Supply*	Hygienic item; non-reusable disposable supplies; covered only for hospice members.
Dressings/ Bandages	Non-surgical Dressings/ Bandage (e.g., Ace bandages)	Medical Supply*	Covered only when provided in the physician's office, otherwise considered over the counter
	Surgical Dressings	Medical Supply*	Surgical dressings are limited to primary dressings (therapeutic or protective coverings applied directly to a wound) or secondary dressings (dressings that serve a therapeutic or protective function

Item		Coverage	Comments
		DME Prosthetic	and are needed to secure a primary dressing, e.g., tape, roll gauze, transparent film) that are medically necessary for the treatment of a wound caused by, or treated by, a surgical procedure or wound debridement. Surgical dressings may be covered as: • **Medical supply** when provided the physician's office • **DME** when ordered by the treating physician or other healthcare professional for the member's home use in conjunction with a durable medical equipment (e.g., infusion pumps) • **Prosthetic** when ordered by the treating physician or other healthcare professional for the member's home use as dressing for surgical wound or for wound debridement or in conjunction with a prosthetic device (e.g., tracheostomy)
Easy Stand/Tilt Stand		DME	See Standing Frames.
Egg Crate		Not Covered	See Alternating Pads.
Elbow Orthosis		Corrective Appliance	Used for compression of tissue or to limit motion. Custom molded is covered only when member cannot be fitted with a prefabricated elbow support.
Electrical Stimulation Devices (for chronic pain)	H-wave Stimulation Device	Not Medically Necessary	Insufficient clinical evidence supporting effectiveness
	Interferential Device	Not Medically Necessary	Refer to the MMG titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation.
	Tens Unit	DME	Transcutaneous electrical nerve stimulator (TENS) are covered when coverage criteria are met. Refer to the NCD for Transcutaneous Electrical Nerve Stimulator (TENS) for Acute Post-operative Pain (10.2). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. Refer to the DME MAC LCD - Transcutaneous Electrical Nerve Stimulators (TENS) (L33802) (cms.gov). For coverage of supplies necessary for TENS; refer to the NCD for Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES) (160.13). (Accessed May 10, 2024)
Electrical Stimulation Devices (Neuromuscular, NMES)		DME	Coverage criteria apply; refer to the MMG titled. Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation
Electrical Stimulation Devices or Electromagnetic Therapy for Wound Healing or Diathermy Machines (e.g., Diapulse)		Not Covered	Refer to the MMG titled Electromagnetic Therapy for Wounds.
Electronic Speech Aids		Prosthetic	See Artificial Larynx.
Electric Tumor Treatment Field Therapy (Device used for Cancer Treatment)		DME	Refer to the MMG titled Electric Tumor Treatment Field Therapy.

Item		Coverage	Comments
Elevators		Not Covered	Not primarily medical in nature
Emesis Basin		Not Covered	Not primarily medical in nature
Enuresis Training Item (penile clamp)		Prosthetic	For members with urinary incontinence
Esophageal Dilator		Not Covered	Physician instrument, not appropriate for home use
Exercise Equipment (e.g., barbells, all types of bicycles)		Not Covered	Not primarily medical in nature
Face Masks	Oxygen	DME	Covered if member is on oxygen.
	Surgical	Not Covered	Non-reusable disposable items
Facial Prosthesis		Prosthetic	Facial prostheses **are covered** when there is a loss or absence of facial tissue due to disease, trauma, surgery, or a congenital defect
Fluidic Breathing Assister		DME	See IPPB Machines.
Flutter Device/ Oscillatory Positive Expiratory Pressure Devices		DME	Covered when medically necessary. Refer to MMG titled Airway Clearance Devices.
Foot Cradle		DME	See Bed Cradle.
Foot Orthotics		Corrective Appliances/ Orthotics	For diabetics only when criteria are met; Refer to the BIP titled Shoes and Foot Orthotics.
Formula (enteral feedings)		Medical Supplies*	Coverage criteria apply. Refer to the MMG titled Enteral Nutrition (Oral and Tube Feeding). Also refer to the BIP titled Home Health Care. Also see Pumps.
Gait Belt		Not Covered	Does not meet the definition of DME.
Gait Trainers		DME	A gait trainer (or sometimes referred to as a rollator) is a term used to describe certain devices that are used to support a member during ambulation. Gait trainers are billed using one of the codes for walkers. If a gait trainer has a feature described by one of the walker attachment codes (E0154 - E0157) that code may be separately billed. Other unique features of gait trainers are not separately payable and may not be billed with code E1399. If a supplier chooses to bill separately for a feature of a gait trainer that is not described by a specific HCPCS code, then code A9900 must be used. Refer to the DME MAC LCD for Walkers (L33791). (Accessed May 10, 2024)
Grab Bars (for bath and toilet)		Not Covered	Not primarily medical in nature
Gradient Pressure Stockings (e.g., Jobst stockings)		Prosthetic	See Stockings.
Hearing Aid		Prosthetic	Refer to the BIP titled Hearing Services. Also refer to the MMG titled Hearing Aids and Devices Including Wearable, Bone-Anchored and Semi-Implantable.
Heat Lamp		Not Covered	Not primarily medical in nature
Heater (portable)		Not Covered	Not primarily medical in nature

Item		Coverage	Comments
Heating and Cooling Plants		Not Covered	Not primarily medical in nature
Helmets (Safety Equipment)		Not Covered	Not primarily medical in nature
Helmets (Cranial Orthosis)		Corrective Appliances/ Orthotics	See Cranial Band/Helmet (Cranial Orthosis).
Heparin/saline flushes		DME	Covered if member meets the homebound status and heparin flush is necessary to maintain patency of the line.
High Frequency Chest Wall Compression Devices (e.g., ThAIRapy® vest)		DME	Refer to the MMG titled Airway Clearance Devices.
Home Prothrombin Time International Normalized Ratio (INR) Monitoring)/ Coagulation Monitor		DME	Refer to the NCD for Home Prothrombin Time/International Normalized Ratio (PT/INR) Monitoring for Anticoagulation Management (190.11) for more detailed benefit information. (This NCD is distinct from, and makes no changes to the clinical laboratory NCD for Prothrombin Time (PT) (190.17)) Also refer to the Medicare Benefit Policy Manual, Chapter 15, §60.1 – Incident To Physician's Professional Services. **Notes**: • Test materials continue to include 4 tests. Frequency of reporting requirements shall remain the same. • Home INR monitoring is not covered for members with porcine valves unless covered by local Medicare contractors. • Refer to the Medicare Claims Processing Manual, Chapter 32, Section 60 – Coverage and Billing for Home Prothrombin Time (PT/INR) Monitoring for Home Anticoagulation Management (Accessed May 10, 2024)
Humidifier	For use with C-PAP or BiPAP (heated or non-heated)	DME	Coverage criteria apply; refer to the MMG titled Obstructive and Central Sleep Apnea Treatment.
	For use with Respiratory Assist Devices	DME	For coverage criteria for Respiratory Assist Devices, see Respiratory Assist Devices.
	For use with Oxygen System	DME	Covered if criteria for oxygen are met. See Oxygen Equipment and Necessary Accessories for additional information.
	Room or Central Heating System Types	Not Covered	Refer to the member's EOC for exclusion details. Environmental control equipment; not medical in nature.
Hydraulic Lifts		DME	See Lifts.
Hypothermic Blankets		Not Covered	Not primarily medical in nature

Item		Coverage	Comments
Immobilizer (extremity)		Corrective Appliance/ Orthotic	See Knee Orthosis.
Incontinence Control Devices (mechanical and hydraulic)		Prosthetic	For members with permanent anatomic and neurologic dysfunction of the bladder
Incontinence Pads		Medical Supplies*	Non-reusable disposable items; only for hospice members
Infusion Pump		DME	See Pumps.
Inhalation Machine		DME	See Nebulizers, or Humidifiers, or IPPB Machines.
Injectors, Jet pressure powered injectors		Not Covered	Refer to the BIP titled Diabetic Management, Services and Supplies.
Insulin pump, including insulin and necessary supplies		DME	Criteria apply; refer to the BIP titled Diabetic Management, Services and Supplies. Also refer to the MMG titled Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes. **Note**: For United HealthCare Benefits Plan of California: Batteries and Battery Chargers are covered for Insulin Pumps.
Intermittent Positive Pressure Breathing (IPPB) Machines		DME	When breathing is severely impaired (includes fluidic breathing assisters)
IV Pole (Intravenous)		DME	Covered when ordered with IV Therapy, tube feeding or other medically necessary indications.
Jacuzzi		Not Covered	Not primarily medical in nature
Knee Orthosis (e.g., knee immobilizer, range of motion knee orthosis, rigid ace design knee orthosis)		Corrective Appliance/ Orthotic	Custom molded covered when member cannot be fitted with prefabricated immobilizer.
Lamb's Wool Pads/Sheep Skins		DME	See Alternating Pressure Pads.
Leotard (pressure garment)		Not Covered	Not primarily medical in nature.
Lifts	Bathtub or Toilet	Not Covered	Not primarily medical in nature
	Hydraulic (Hoyer)	DME	Covered if the member's condition is such that periodic movement is necessary to effect improvement or to arrest or retard deterioration in the member's condition.
	Motorized (electric), Ceiling Modified	Not Covered	Feature is a convenience item, therefore does not meet the definition of DME.

Item		Coverage	Comments
	Seat Lift Mechanism	DME	Covered when criteria are met in the NCD. **Notes**: • Coverage is limited to the seat lift mechanism and installation of the mechanism only. Other related items and services such as costs for the chair or chair upholstery are not covered. • Lift mechanism which operates by spring release with a sudden, catapult-like motion and jolts the member from a seated to a standing position is not covered. Refer to the NCD for Seat Lift (280.4). (Accessed May 10, 2024)
	For Wheelchairs/ Scooters/POVs	Not Covered	Not primarily medical in nature
	Trunk/Vehicle Modification	Not Covered	Not primarily medical in nature
Light Therapy Box (Therapeutic Light Box)		Not Covered	Not primarily medical in nature; therefore does not meet the definition of DME. For the treatment of psoriasis, see Ultraviolet Cabinet.
Lumbar-sacral (LSO)		Corrective Appliance/ Orthotic	See Spinal Orthosis; also see Scoliosis Orthosis.
Lymphedema Pumps (segmental and nonsegmental)		DME	Coverage criteria apply; refer to the MMG titled Pneumatic Compression Device. **Note**: Complex Decongestive Physiotherapy/ CDP is considered a medical treatment rather than part of rehabilitation/therapy, therefore, CDP is neither subject to rehabilitation/therapy copayment, nor benefit maximum.
Lymphedema Sleeve/Compression Garments/Bandages (Wrap)		DME	Covered as part of the pneumatic compression devices, not covered as a separate item. Coverage criteria for pneumatic compression devices apply. See Pneumatic Compression Devices. **Note**: Complex Decongestive Physiotherapy/CDP is considered a medical treatment rather than part of rehabilitation/therapy, therefore, CDP is neither subject to rehabilitation/therapy copayment, nor benefit maximum. **Reference**: • California Health and Safety Code 1300.67.005(d)(9)(B)(iii) • California Health and Safety Code 1367.645
Mandibular Device (for sleep apnea)		DME	Covered when medical criteria are met. Refer to the MMG titled Obstructive and Central Sleep Apnea Treatment.
Massage Devices		Not Covered	Not primarily medical in nature
Mattress		DME	See Beds.
Mobile Stander		DME	See Standing Frames.

Item		Coverage	Comments
Nebulizers and Supplies	Small Volume, electric	DME	Covered for medications approved for delivery by a nebulizer, including nebulized medications for asthma or Per state law (California Health and Safety Code-Section 1367.06effective 1/1/05), covered as DME for the management and treatment of pediatric asthma of Dependent children under the age of 19. Also may be covered when it is medically necessary to administer appropriate inhalation medications for the management of COPD, cystic fibrosis, HIV, pneumocystosis, complications of organ transplants or thick or tenacious pulmonary secretions.
	Large Volume, Non-Disposable	DME	When medically necessary to deliver humidity to a member with thick, tenacious secretions, who has cystic fibrosis, bronchiectasis, a tracheostomy, or a tracheobronchial stent; Not Covered when used predominantly to provide room humidification; Also, per state law (California Health and Safety Code-Section 1367.06effective 01/01/2005) covered as DME for the management and treatment of pediatric asthma of Dependent children under the age of 19. Also covered when medically necessary to deliver humidity to a member with thick, tenacious secretions, who has cystic fibrosis, bronchiectasis, a tracheostomy, or a tracheobronchial stent. Not covered when used predominantly to provide room humidification.
	Large Volume, Disposable	Not Covered	Acceptable alternative available; Not primarily medical in nature; Disposable items are not considered DME by definition.
	Ultrasonic	Not Covered	Offers no proven clinical advantage over a standard nebulizer.
	Portable (AC/DC)	DME	Only one nebulizer is allowed for in home use when Medically Necessary. (Stationary/Portable); Nebulizers are not allowed for out of home use as it does not meet definition of DME.
	Medication		Covered through the member's supplemental pharmacy benefit when listed in the formulary.
Negative Pressure Wound Therapy Pump		DME	See Vacuum Assisted Closure Device.
Neuromuscular Electrical Stimulator (NMES)		DME	See Electrical Stimulation Devices.
Non-contact non thermal Wound Therapy		Not Covered	Refer to the MMG titled Noncontact Warming Therapy, Ultrasound Therapy and Fluorescence Imaging for Wounds
Nutritional Therapy	Enteral	DME	Refer to the MMG titled Enteral Nutrition (Oral and Tube Feeding). Also refer to the BIP titled Home Health Care. Also see Pumps.
	Parenteral	DME	
Obturator, palatal		Prosthetic	Only for surgically acquired deformity or trauma. Used to replace or fill in a missing palate or portion of the palate. Includes the denture when the denture or a portion of denture is an integral part (built-in) of the obturator.
Orthopedic Shoes		Corrective Appliance/ Orthotic	See Shoes.
Ostomy Supplies		Prosthetic	Supplies include but are not limited to irrigation/flushing equipment and other supplies directly related to care of the member's ostomy, such as adhesives; adhesive remover; ostomy belt; hernia

Item		Coverage	Comments
			belts; catheter; skin wash/cleaner; bedside drainage bag and bottle; urinary leg bags; gauze pads; irrigation faceplate; irrigation sleeve; irrigation bag; irrigation cone/catheter; lubricant; urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; gloves; stoma caps; colostomy plug; ostomy inserts; urinary and ostomy pouches; barriers; pouch closures; ostomy rings; ostomy face plates; skin barrier; skin sealant; and waterproof and non-waterproof tape. Ostomy supplies required under this section do not include supplies that are comfort, convenience, or luxury equipment or features.
Oxygen Equipment and Necessary Accessories	Stationary	DME	Covered when medical criteria are met. Refer to the InterQual® CP: Durable Medical Equipment, Home Oxygen Therapy. Click here to view the InterQual® criteria.
	Portable (Regulated) (e.g., Oxylite, includes conserver and tank)	DME	Covered when medical criteria are met. Refer to the InterQual® CP: Durable Medical Equipment, Home Oxygen Therapy. Click here to view the InterQual® criteria.
	Portable (Preset)	Not Covered	First aid or precautionary equipment; essentially not therapeutic in nature. Inappropriate for home use; Does not meet the definition of DME.
	Spare tanks	Not Covered	Considered a convenience item.
	Routine maintenance oxygen therapy, equipment and supplies outside the service area **Note**: This includes travel oxygen supplied by airlines and cruises unless urgently needed.	Not Covered	Refer to the member's EOC for exclusion details.
Pacemaker Monitors (self-contained) • Audible or Visible Signal • Digital Electronic		DME	Member must have cardiac pacemaker. Refer to the BIP titled Cardiac Pacemakers and Defibrillators.
Paraffin Bath Unit	Portable	DME	Covered when the member has undergone a successful trial period of paraffin therapy ordered by a physician and the member's condition is expected to be relieved by a long term use of this modality.
	Standard	Not Covered	Not appropriate for home use.
Parallel Bars		Not Covered	Support exercise equipment; primarily for institutional use
Peak Expiratory Flow Meter, hand-held		DME	For the self-monitoring of members with pure asthma when used as part of a comprehensive asthma management program or per state law (California Health and Safety Code-Section 1367.06 effective

Item		Coverage	Comments
			01/01/2005), covered as DME for the management and treatment of pediatric asthma of Dependent children under the age of 19.
Percussor (Non-Vest type)	Electric or pneumatic, home model	DME	Covered for mobilizing respiratory tract secretions in member's with chronic obstructive lung disease, chronic bronchitis or emphysema, when member or operator of powered percussor has received appropriate training by a physician or therapist, and no one competent to administer manual therapy is available; For ThAIRapy® Vest System, see High Frequency Chest Wall Compression Devices. Refer to the MMG titled Airway Clearance Devices.
	Intrapulmonary Percussive Ventilator (IPV)	Not Covered	No data to support the effectiveness of the device in the home setting. Inappropriate for home use; therefore does not meet the definition of DME.
Personal or Comfort Items		Not Covered	Not primarily medical in nature
Pessary		Medical Supply*	For prolapse of the uterus or nonsurgical treatment of rectocele and cystocele
Pleurx bottles and tubing		DME	Covered as DME for Pleural Infusions.
Pneumatic Compression Devices		DME	Criteria apply; refer to the MMG titled Pneumatic Compression Devices.
Pneumatic Splints		Corrective Appliance/ Orthotic	See Ankle Foot Orthosis (AFO)/Knee-Ankle-Foot Orthosis (KAFO).
Porcine (Pig) Skin Dressings		Medical Supply*	When used as an airtight (occlusive) dressing for burns, donor sites, bedsores (decubiti), and ulcers/wounds
Postural Drainage Boards		DME	For members with chronic pulmonary condition
Power Operated Vehicles (POV)/ Scooters		DME	See Wheelchairs.
Power traction equipment/devices (e.g., VAX-D®, DRX9000, SpineMED™, Spina System™, Lordex® Decompression Unit, DRS System™)		Not Covered	See Traction.
Pulse Oximeter		DME	A pulse oximeter is covered in the home to monitor oxygen saturation when medically necessary for the safe management of a medical diagnosis that would otherwise require treatment at a higher level of care. Coverage requires that an individual be available in the home with the requisite training to interpret and apply pulse oximetry data. Medical conditions that may warrant a home pulse oximeter include, but are not limited to: • Infants with severe chronic lung disease, such as bronchopulmonary dysplasia • Premature infants being actively monitored for apnea • Members who require mechanical home ventilation • Members being weaned off of a home ventilator or oxygen therapy • Members with a tracheostomy who require tracheal suctioning to manage pulmonary secretions

Item		Coverage	Comments
			• Members with a severe cardiopulmonary diagnosis that requires immediate adjustment of oxygen flow rates • Members with a progressive neuromuscular condition that impairs the muscles of respiration (e.g., ALS, Muscular Dystrophy, Myasthenia Gravis) The use of a home pulse oximeter to monitor oxygen saturations in COPD or Asthma is not considered medically necessary in the absence of special circumstances such as those outlined above.
Pumps, including medications and necessary supplies	Enteral	DME	Refer to the MMG titled Enteral Nutrition (Oral and Tube Feeding). Pumps, tubing and supplies necessary to deliver the enteral formula is covered. Also refer to the BIP titled Home Health Care.
	Infusion	DME	Covered when medical criteria are met; Refer to the InterQual® Medicare: Durable Medical Equipment, External Infusion Pumps. Click here to view the InterQual® criteria. External infusion pumps for vancomycin (J3370) are Not Covered. (**Note**: There is insufficient evidence to support the necessity of using an external infusion pump, instead of a disposable elastomeric pump or the gravity drip method, to administer vancomycin in a safe and appropriate manner.) Implantable infusion pumps for infusion of heparin in the treatment of recurrent thromboembolic disease are not covered.
	Insulin, external	DME	Refer to the BIP titled Diabetic Management, Services and Supplies.
	Insulin, implantable	Not Covered	
	Pain Control	DME	Covered when medical criteria are met; refer to the InterQual® Medicare: Durable Medical Equipment, External Infusion Pumps. Click here to view the InterQual® criteria.
	Parenteral	DME	See Nutritional Therapy
	For Erectile Dysfunction	Not Covered	See Vacuum Pump.
Punctal Plug		Medical Supply*	For treatment of dry eyes
PureWick™ Female External Catheter and the PureWick™ Urine Collection System		Not Covered	Refer to the MMG titled Omnibus Codes.
Ramp (wheelchair)		Not Covered	Not primarily medical in nature
Recliner (chair)		DME	Member must be on home dialysis. Refer to the Medicare Benefit Policy Manual, Chapter 11, §20.4 (A)(1) Equipment and Supplies. (Accessed May 10, 2024)
Respiratory Assist Devices		DME	Coverage criteria apply; See Humidifier; Also refer to the MMG titled Obstructive and Central Sleep Apnea Treatment.

Item		Coverage	Comments
Rib Belt		Corrective Appliance/ Orthotic	Covered when **all of the following** criteria are met: • Serves a medical purpose and it is only associated with treating an illness, injury or malformed body member • Provides support and counter force (a force in a defined direction of a magnitude at least as great as a rigid or semi-rigid support) on the limb or body part that is being used to brace • Not used to supply compression therapy (e.g. to reduce size, volume, or swelling of a body member or to help circulation) • Not used for convenience or appearance • Not used for cosmetic purposes
Rolling Chair (Geri Chair)		DME	Covered if member meets Mobility Assistive Equipment clinical criteria. Coverage is limited to those roll-about chairs having casters of at least 5 inches in diameter and officially designed to meet the needs of ill, injured, or otherwise impaired individuals. Not covered for the wide range of chairs with smaller casters as are found in general use in homes, offices, and institutions for many purposes not related to the care/treatment of ill/injured persons. This type is not primarily medical in nature. Refer to the: • NCD for Mobility Assistive Equipment (MAE) (280.3) • NCD for Durable Medical Equipment Reference List (280.1) (Accessed May 10, 2024)
Safety Rollers		DME	See Walkers.
Sauna Baths		Not Covered	Not primarily medical in nature.
Scoliosis Orthosis	Body Jacket Thoracic-lumbar-sacral (TLSO) Cervical-thoracic-lumbar-sacral (CTLSO)	Corrective Appliance/ Orthotic	Coverage criteria apply; Also see Spinal Orthosis. General indications for orthotic treatment in idiopathic scoliosis are as follows: • Skeletally immature member's prior to Risser grade 5 (usually one year post menarche in girls) • Children presenting with curvature of 20 to 30 degrees should also be observed, at least initially. During the observation period, roentgenograms should be obtained at 3 to 6 month intervals and compared with the original films. If the curvature increases by more than 5 degrees in a skeletally immature member ,bracing is recommended • Children presenting with 25 degrees to 39 degrees curvature require prompt treatment. These members are at high risk of progression of curvature • Boys with progressive curvature in excess of 25 degrees, including those presenting at Risser grade 4 • Member's with Scheuermann's Kyphosis including kyphosis of more than 50 degrees. To maintain correction, the brace should be worn until there is improvement in vertebral wedging to roughly 5 degrees. Bracing for longer than 18 months may be necessary to achieve this improvement

Item		Coverage	Comments
			Note: In very young member's bracing may retard progression long enough to allow further trunk growth before the inevitable fusion. Once curvature exceeds 40 degrees, surgical treatment may be the only means of controlling and correcting the deformity. Immediate bracing **is** recommended for the following to allow significant trunk growth prior to surgical intervention: • Skeletally immature member's (at Risser grades 0 to 2) presenting with 30 to 40 degrees curvature • Flaccid paralysis and 20 degrees or more of curvature **Note**: Risser grades are based on the degree of bony fusion of the iliac apophysis, from grade 0 (no ossification) to grade 5 (complete bony fusion) (Reamy and Slakey, 2001). **Note**: The recommended duration of bracing varies from 16 hours/day to 23 hours/day. **Reference**: Article: Schiller JR, Thakur NA, Eberson CP. Brace management in adolescent idiopathic scoliosis. Clin Orthop Relat Res. 2010;468(3):670-678. Scoliosis Research Society: Medical Necessity criteria for Scoliosis Bracing (Milwaukee brace; Wilmington brace; Boston brace; Dynamic Spine-Cor brace; Charleston brace; and Providence brace). http://www.srs.org/ (Accessed May 10, 2024)
Shower/Bath Tub Seat		Not Covered	Not primarily medical in nature
Shower/Bath Tub Walk-In		Not Covered	Not primarily medical in nature
Shoes	Inserts/Orthotics	Corrective Appliance/ Orthotic	Criteria apply. Refer to the BIP titled Shoes and Foot Orthotics.
	Orthopedic	Corrective Appliance/ Orthotic	
	Prosthetic	Prosthetic	
	Therapeutic (e.g., diabetic shoes)	Corrective Appliance/ Orthotic	
Sitz Bath (portable)		DME	Covered if member has an infection or injury of the perineal area and the item has been prescribed by the member's physician as a part of his planned regimen of treatment in the member's home.
Sleep Apnea device		DME	See Mandibular Device.
Slings		Medical Supply*	Used to support and limit motion of an injured upper arm.

Item		Coverage	Comments
Spinal Orthosis	Cervical-thoracic-lumbar-sacral (CTLSO) Lumbar-sacral (LSO) Thoracic-lumbar-sacral (TLSO)	Corrective Appliance/ Orthotic	Covered when ordered by physician: • To reduce pain by restricting mobility of the trunk; or • To facilitate healing following an injury to the spine or related soft tissues; or • To facilitate healing following a surgical procedure on the spine or related soft tissue; or • To otherwise support weak spinal muscles and/or a deformed spine Also see Scoliosis Orthosis.
Splints	Bi-directional static progressive stretch splinting (e.g., JAS splints, ERMI system)	Not Covered	Refer to the MMG titled Mechanical Stretching Devices.
	Dental Splint (prefabricated, off-the-shelf bite guard; aka night guard appliance)	Not Covered	Dental splint is an off-the-shelf intraoral device that does not require professional fitting or adjustment and is used to prevent damage to teeth caused by bruxism. **Note**: Dental splint does not include oral splints for the treatment of TMJ that require custom fitting and adjustment by a licensed healthcare professional.
	Dynamic (e.g., Dyna Splint)	DME	Refer to the MMG titled Mechanical Stretching Devices.
	Foot (e.g., Dennis-Browne)	Corrective Appliance/ Orthotic	Used as splint/brace to correct rotational anomalies of lower legs; worn during sleep.
	Low-load prolonged-duration stretch devices (LLPS)	DME	Refer to the MMG titled Mechanical Stretching Devices.
	Occlusal Splint (custom fabricated bite plate for TMJ)	Corrective Appliance/ Orthotic	Custom made occlusal splints are removable intraoral appliances fabricated and fitted by a licensed healthcare professional to be worn at night for the treatment of painful temporomandibular joint disease. Refer to the MMG titled Temporomandibular Joint Disorders. For Sleep Apnea device, see Mandibular Device.
	Patient actuated serial stretch (PASS) devices	Not Covered	Refer to the MMG titled Mechanical Stretching Devices.
	Wrist/ Hand/ Finger	Corrective Appliance/ Orthotic	For mild sprains, strains and carpal tunnel conditions. Custom molded covered only when member cannot be fitted with the prefabricated wrist/hand/finger/splint/brace.

Item		Coverage	Comments
Standing Frames/Mobile Stander		DME	Covered if Medically Necessary. Refer to the InterQual® CP: Durable Medical Equipment, Standing Frames. Click here to view the InterQual® criteria. Also refer to the CMS NCD for Mobility Assistive Equipment (MAE) (280.3) and the CMS NCD for Durable Medical Equipment Reference List (280.1). (Accessed May 10, 2024)
Stockings	Gradient Compression Stockings (e.g. Jobst stockings)	Prosthetic	Covered when medical criteria are met. Refer to the InterQual® Medicare: Durable Medical Equipment, Surgical Dressings. Click here to view the InterQual® criteria. Note: If the stockings are specifically for addressing Lymphedema, please see Lymphedema Sleeve/Compression Garments/Bandages (Wrap). **Note**: Coverage is limited to initial 2 pairs of hosiery and replacement of 2 pairs every six month if member is compliant in wearing the hosiery.
	Support Hose (e.g., Ted Hose)	Not Covered	Non-reusable, non-rental item
	Surgical Stockings	Not Covered	Non-reusable, non-rental item
Stump Socks		Medical Supplies*	See Artificial Limb.
Suction Pump or Machine		DME	Covered for members who have difficulty raising and clearing secretions secondary to one of the following: • Cancer or surgery of the throat or mouth • Dysfunction of the swallowing muscles • Unconsciousness or obtunded state • Tracheostomy Must be appropriate for use without professional supervision.
Surgical Boot		Corrective Appliance/ Orthotic	Also known as ambulatory boot.
Syringes	Bulb, Ear	Not Covered	
	Hypodermic	Medical Supply* / Pharmacy	Insulin syringes and pen needles are covered under the pharmacy benefit. All others are covered under the medical benefit. Note: If a member does not have pharmacy benefit, then all syringes / needles are covered under medical.
Telephone Alert System		Not Covered	Not primarily medical in nature
Telephone Arms/Cradle		Not Covered	Not primarily medical in nature

Item		Coverage	Comments
TMJ Splint		Corrective Appliance/ Orthotic	See Occlusal Splint.
ThAIRapy® Vest System		Corrective Appliance/ Orthotic	See High Frequency Chest Wall Compression Devices.
Thoracic Lumbar Sacral Orthoses (TLSO)		Corrective Appliance/ Orthotic	See Spinal Orthosis; also see Scoliosis Orthosis.
Tinnitus Masker		Not Covered	Effectiveness not adequately proven
Toe Filler		Prosthetic	Refer to the BIP titled Shoes and Foot Orthotics.
Toilet Seat, Elevated Bidet		Not Covered	Not primarily medical in nature, not medical equipment
Tracheostomy	Speaking Valve and Tubes	Prosthetic	A trachea tube has been determined to satisfy the definition of a prosthetic device, and the tracheostomy speaking valve is an add-on to the trachea tube which may be considered a medically necessary accessory that enhances the function of the tube, which makes the system a better prosthesis. As such, a tracheostomy speaking valve is covered as an element of the trachea tube which makes the tube more effective.
	Care Kit (Initial and Replacements)	Prosthetic	A tracheostomy care kit is covered for a member following an open surgical tracheostomy which has been open or is expected to remain open for at least 3 months. Replacement kits are covered at one per day only.
Traction Equipment	Cervical (Over-the-Door or Cervical Portable Traction Unit)	DME	Covered if both the following criteria are met • The member has a musculoskeletal or neurologic impairment requiring traction equipment; and, • The appropriate use of a home cervical traction device has been demonstrated to the member and the member tolerated the selected device.
	Cervical, attached to headboard	Not Covered	No proven clinical advantage compared to over-the-door traction mechanism
	Cervical, not requiring additional stand or frame (e.g. Orthotrac Pneumatic Vest or Pronex)	Not Covered	No proven clinical advantage compared to over-the-door traction mechanism
	Freestanding Traction Stand	Not Covered	No proven clinical advantage compared to over-the-door traction mechanism
	Pneumatic Free-Standing Cervical, Stand/ Frame (e.g. Saunders HomeTrac)	DME	Covered if member meets criteria for over-the-door traction unit and one of the following 3 criterion are met: 1. The treating physician orders greater than 20 pounds of cervical traction in the home setting; or, 2. The member has: a. a diagnosis of temporomandibular joint (TMJ) dysfunction; and

Item		Coverage	Comments
			b. received treatment for the TMJ condition; or, 3. The member has distortion of the lower jaw or neck anatomy (e.g., radical neck dissection) such that a chin halter is unable to be utilized. Refer to the MMG titled Home Traction Therapy.
	Power traction equipment/devices (e.g., VAX-D®, DRX9000, AccuSpineMED™ Spina System™, Lordex® Decompression Unit, DRS System™)	Not Covered	Refer to the MMG titled Motorized Spinal Traction.
	Spinal Unloading Devices (includes spinal and axial decompression units, pneumatic vests)	Not Covered	Refer to the MMG titled Motorized Spinal Traction.
	Weights, bags	DME	When used in conjunction with covered traction services
Transfer (Sliding) Board		Not Covered	Not primarily medical in nature
Trapeze Bar		DME	A trapeze bar attached to a bed is covered if the member has a covered hospital bed and the member needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed. Not covered when used on an ordinary bed. A "Free standing" trapeze equipment is covered if the member does not have a covered hospital bed but the member needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed
Treadmill Exerciser		Not Covered	Exercise equipment, not primarily medical in nature
Truss		Prosthetic	Covered as prosthetic when used as a holder for surgical dressings or for lumbar strains, sprains or hernia.
Ultraviolet Cabinet		DME	Covered for members with generalized intractable psoriasis.
Unna Boot/Strapping		Medical Supply*	Generally used to treat chronic ulcers that are usually caused by varicosities of the leg
Urinary Catheters and Supplies/	Closed Drainage Bags	Prosthetic	Only for members with non-functioning bladder or permanent incontinence when used as an alternative to an indwelling catheter. Refer to the DME MAC LCD for Urological Supplies (L33803). (Accessed May 10, 2024)

Item		Coverage	Comments
Urological Supplies	External Urinary Collection Devices (e.g., male external catheters and female pouches/meatal cups)	Prosthetic	Only for members with non-functioning bladder or permanent incontinence when used as an alternative to an indwelling catheter. Refer to the DME MAC LCD for Urological Supplies (L33803). (Accessed May 10, 2024)
	Foley/Indwelling	Prosthetic	Only for members with non-functioning bladder or permanent incontinence as medically required. Refer to the DME MAC LCD for Urological Supplies (L33803). (Accessed May 10, 2024)
	Intermittent Urinary Catheters	Prosthetic	Intermittent catheterization is covered when basic coverage criteria are met and the patient or caregiver can perform the procedure. Refer to the DME MAC LCD for Urological Supplies (L33803). (Accessed May 10, 2024)
	Bedside and Leg Drainage Bags	Prosthetic	Only for members with non-functioning bladder or permanent incontinence who is ambulatory or are chair or wheelchair bound. Refer to the DME MAC LCD for Urological Supplies (L33803). (Accessed May 10, 2024)
	Catheter related supplies	Prosthetic	Only for members with non-functioning bladder or permanent incontinence who is ambulatory or are chair or wheelchair bound. Refer to the DME MAC LCD for Urological Supplies (L33803). (Accessed May 10, 2024) Adhesive catheter skin attachment; catheter insertion trays with and without catheter and bag; male and female external collecting devices; male external catheter with integral collection chamber; irrigation tubing sets; cleaners; skin sealants; bedside bag drainage bottle; catheter leg straps; irrigation tray; irrigation syringe; lubricating gel; sterile individual packets; tubing and connectors; catheter clamp or plug; penile clamp; urethral clamp or compression device; waterproof and non-waterproof tape; and catheter anchoring device are covered.
Urinal (autoclavable)		DME	If member is confined to bed
Vacuum Assisted Closure Device (VAC) or Negative Pressure Wound Therapy Pump		DME	Refer to the MMG titled Negative Pressure Wound Therapy.
Vacuum Pump or Device (e.g., ErecAid)		Not Covered	Some members may have coverage as DME. Refer to the *State Market Plan Enhancements* section of the BIP titled Sexual Dysfunction.
Vaporizers		Not Covered	Not primarily medical in nature
Ventilators (including supplies)		DME	Ventilators (respirators) are recommended for the treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease. This recommendation includes both positive and negative pressure types. If request is related to Obstructive Sleep Apnea. See CPAP section of DME Grid.
Vitrectomy Face Support		DME	Covered following vitrectomy surgery for member's who are required to maintain a face down position in the post-operative period.

Item		Coverage	Comments

Walkers (standard)	Rigid (pick-up), adjustable or fixed height	DME	Covered when the following criteria are met:
			
			The member has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home. A mobility limitation is one that:
			• Prevents the member from accomplishing the MRADL entirely, or
			• Places the member at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform the MRADL, or
			• Prevents the member from completing the MRADL within a reasonable time frame; and
			  ○ The member is able to safely use the walker; and
			  ○ The functional mobility deficit can be sufficiently resolved with the use of a walker.
			*Baskets are not covered
			
			Refer to the:
			• DME MAC LCD for Walkers (L33791)
			• NCD for Mobility Assistive Equipment (MAE) (280.3)
			(Accessed May 10, 2024)

	Folding (pick-up), adjustable or fixed height		
	Rigid, wheeled, without seat		
	Folding, wheeled, without seat		
Walkers (special types)	Heavy duty, multiple braking system, variable wheel resistance (Safety Rollers)	DME	Covered for members who meet coverage criteria for a standard walker and who are unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand. Refer to the: • DME MAC LCD for Walkers (L33791) • NCD for Mobility Assistive Equipment (MAE) (280.3) (Accessed May 10, 2024)
	Heavy duty		Covered for members who meet the coverage criteria for a standard walker and who weigh more than 300 pounds.
	Leg extensions		Covered only for members 6 feet tall or more.
	With Seat		If medically necessary
	With basket	Not Covered	Additional accessories to DME, corrective appliances or prosthetics which are primarily for the comfort or convenience of the member are not covered
Wearable Cardioverter Defibrillators	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type	DME	Criteria apply. Refer to the Benefit Interpretation Policy titled Cardiac Pacemakers and Defibrillators.

Item		Coverage	Comments
	Replacement garment for use with automated external defibrillator, each	DME	Criteria apply. Refer to the Benefit Interpretation Policy titled Cardiac Pacemakers and Defibrillators.
	Replacement electrodes for use with automated external defibrillator, each	DME	Criteria apply. Refer to the Benefit Interpretation Policy titled Cardiac Pacemakers and Defibrillators.
	Replacement battery for automated external defibrillator, each	Not Covered	
Wedge Pillow		Not Covered	Not primarily medical in nature

Wheelchairs and Accessories		DME	Covered if the member meets Mobility Assistive Equipment clinical criteria documented in the NCD for Mobility Assistive Equipment (AME) (280.3).
			• The following are covered when criteria are met.
			  ○ Standard Wheelchair
			  ○ Lightweight Wheelchair
			  ○ Specially sized Wheelchair
			  ○ Electric Wheelchair
			  ○ High Strength Lightweight Wheelchair
			  ○ Power Mobility Devices (PMD) which include Power operated vehicle (POV), or scooters, and Power motorized wheelchairs
			• Repairs, replacements and maintenance criteria: refer to the Benefit Interpretation Policy titled Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies.
			• Accessories and Options: See the LCD - Wheelchair Options/Accessories (L33792) (cms.gov) for Wheelchair Options/Accessories and for Wheelchair Seating.
			Refer to CMS NCD for Mobility Assistive Equipment (MAE) (280.3).
			(Accessed May 10, 2024)

Whirlpool Bath Equipment (standard)		DME	Medical necessity is determined by the following: • Evidence that a whirlpool bath offers substantial therapeutic benefit for the member's medical condition • Verification that the member is homebound or that treatment in the home is the least costly alternative
Whirlpool Pump (portable)		Not Covered	Not primarily medical in nature
Wig/Hairpiece (cranial prosthesis)		Not Covered	Not primarily medical in nature

Item	Coverage	Comments
Wrist splint	DME	See Splints.

*Medical Supplies are covered only when they are incident to a physician's professional services or authorized home health services and are furnished as an integral, although incidental, part of those services in the course of diagnosis or treatment of an injury or illness.

Policy History/Revision Information

Date	Summary of Changes
07/01/2024	**Medical Supplies Grid** • Updated list of applicable items; replaced: ○ "Artificial *Limbs* – Upper *Limb*" with "Artificial *Extremities* – Lower *Extremities*" ○ "Artificial *Limbs* – Upper *Limb*" with "Artificial *Extremities* – Upper *Extremities*" ○ "Communication Devices (e.g., Computers, Personal Digital Assistants, Speech Generating Devices) Except Artificial Larynxes" with "Communication Devices (e.g., Computers, Personal Digital Assistants, Speech Generating Devices) Except Artificial Larynxes *or Electronic Speech Aid*" ○ "Electric Tumor Treatment Field Therapy" with "Electric Tumor Treatment Field Therapy *(Device Used for Cancer Treatment)"* ○ "Purewick™ Urine Collection System" with "*PureWick™ Female External Catheter and the* PureWick™ Urine Collection System" ○ "TMJ *Device*" with "TMJ *Splint*" ***Air Conditioner/Air Cleaner/Purifier/Electrostatic Machines or Other Environmental Equipment*** • Revised coverage guidelines to indicate items are environmental control equipment and not primarily medical in nature; refer to the member's Evidence of Coverage (EOC) for exclusion details ***Ambulatory Boot*** • Added language to indicate ambulatory boots are covered when medically necessary ***Ankle-Foot Orthosis (AFO)/Knee-Ankle-Foot Orthosis (KAFO), Non-Ambulatory Foot Drop Splint*** • Replaced reference to "patient" with "member" ***Artificial Extremities – Lower Extremities*** Standard Prosthetic • Removed language indicating item is covered when medical criteria are met • Revised language pertaining to medical necessity clinical coverage criteria: ○ Added reference to the InterQual® Client Defined CP: Durable Medical Equipment, Prosthetics, Lower Extremities ○ Removed reference to the InterQual® Client Defined CP: Durable Medical Equipment, Prosthetic Devices, Wigs, Specialized, Microprocessor or Myoelectric Upper Limbs (Custom) – UHG Bionic *and* C-leg (Microprocessor-Controlled Knee-Shin System) • Added language to indicate item is covered as prosthetic ***Artificial Extremities – Upper Extremities, Myoelectric*** • Added language to indicate item is not covered ***Back Brace*** • Added language to indicate item is covered as corrective appliance/orthotic ***Bilevel Positive Airway Pressure (BiPAP)*** • Revised coverage guidelines to indicate coverage criteria apply; refer to the Medical Management Guideline (MMG) titled *Obstructive and Central Sleep Apnea Treatment*

Date	Summary of Changes

	Bili-lights/ Bili-Blankets (Phototherapy)
	• Replaced language indicating "[items are covered] for treatment of jaundice in newborns" to "[items are] covered *when medically necessary* for treatment jaundice in newborns"
	Cam Walkers (also known as Walking Boot)
	• Added language to indicate item is covered as corrective appliance/orthotic
	Canes, Quad or Straight
	• Replaced reference to "patient" with "member"
	Cervical Thoracic Lumbar Sacral Orthoses (CTLSO)
	• Added language to indicate item is covered as corrective appliance/orthotic
	Chemical Test Strips
	• Added language to indicate item is covered as pharmacy
	Collagen Implant
	• Revised language to indicate coverage criteria apply; refer to the *National Coverage Determination (NCD) for Incontinence Control Devices (230.10)*
	Commode (Without Wheels Only)
	• Added language to indicate **chair footrests** and **elevated seats (raised toilet seat)** are not primarily medical in nature
	Communication Devices (e.g., Computers, Personal Digital Assistants, Speech Generating Devices) Except Artificial Larynxes or Electronic Speech Aid
	• Replaced language indicating "[item has an] EOC exclusion" with "*refer to the member's* EOC *for* exclusion *details*"
	• Added instruction to refer to the *Artificial Larynx or Electronic Speech Aid* section of the policy
	Compression Burn Garment
	• Revised coverage guidelines to indicate item is covered when used to reduce hypertrophic scarring and joint contractures following burn injury
	• Added instruction to refer to the:
	  ○ *Lymphedema Sleeve/Compression Garments/Bandages (Wrap)* section of the policy
	  ○ NCD for *Porcine Skin and Gradient Pressure Dressings (270.5)*
	Contact Lens, Hydrophilic Soft (External)
	• Added language to indicate:
	  ○ Item is covered as prosthetic
	  ○ Some plans may cover vision care
	Continuous Positive Airway Pressure (CPAP)
	• Revised coverage guidelines to indicate coverage criteria apply; refer to the MMG titled *Obstructive and Central Sleep Apnea Treatment*
	Corset
	• Revised coverage guidelines to indicate a hernia support (whether in the form of a corset or truss) which meets the definition of a brace is covered; refer to the *NCD for Corset Used as Hernia Support (280.11)*
	Crutches, Crutch Tips and Handles
	• Replaced reference to "patient" with "member"
	• Removed reference link to the Coverage Summary titled *Mobility Assistive Equipment (MAE)*

Date	Summary of Changes
	Dehumidifier • Revised coverage guidelines to indicate items are environmental control equipment and not primarily medical in nature; refer to the member's EOC for exclusion details ***Diabetic Supplies (e.g., Glucometer, Lancets, Injection Aids)*** • Updated notation for United HealthCare Benefits Plan of California to indicate batteries and battery chargers for infusion pumps and home blood glucose monitors *are covered if necessary; supplies or accessories billed separately will be denied* ***Disposable Sheets*** • Revised language to indicate item is covered as medical supplies and are covered only when they are incident to a physician's professional services or authorized home health services and are furnished as an integral, although incidental, part of those services in the course of diagnosis or treatment of an injury or illness ***Dressings/ Bandage, Non-Surgical (e.g., Ace Bandages)*** • Added language to clarify items are *covered* only when provided in the physician's office, otherwise considered over the counter ***Electric Tumor Treatment Field Therapy (Device Used for Cancer Treatment)*** • Added language to indicate item is covered as DME ***Electrical Stimulation Devices (Neuromuscular, NMES)*** • Added reference link to the MMG titled *Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation* ***Electronic Speech Aids*** • Added language to indicate item is covered as a prosthetic ***Fluidic Breathing Assister*** • Added language to indicate item is covered as DME ***Flutter Device/Oscillatory Positive Expiratory Pressure Devices*** • Revised coverage guidelines to indicate item is covered when medically necessary • Added instruction to refer to the MMG titled *Airway Clearance Devices* ***Foot Cradle*** • Added language to indicate item is covered as DME ***Formula (Enteral Feedings)*** • Added language to indicate item is covered as medical supplies and are covered only when they are incident to a physician's professional services or authorized home health services and are furnished as an integral, although incidental, part of those services in the course of diagnosis or treatment of an injury or illness • Added reference link to the MMG titled *Enteral Nutrition (Oral and Tube Feeding)* ***Gait Trainers*** • Added language to indicate item is covered as DME • Replaced reference to "patient" with "member" ***Gradient Pressure Stockings (e.g., Jobst Stockings)*** • Added language to indicate item is covered as prosthetic ***Hearing Aid*** • Added language to indicate item is covered as prosthetic ***Helmets (Cranial Orthosis)*** *(new to policy)* • Added language to indicate item is covered as corrective appliance/orthotic

Date	Summary of Changes
	• Added instruction to refer to the *Cranial Band/Helmet (Cranial Orthosis)* section of the policy ***Humidifier*** For Use with C-PAP or BiPAP (Heated or Non-Heated) • Revised coverage guidelines to indicate coverage criteria apply; refer to the MMG titled *Obstructive and Central Sleep Apnea Treatment* For Use with Respiratory Assist Devices • Added language to indicate item is covered as DME For Use with Oxygen System • Added instruction to refer to the *Oxygen Equipment and Necessary Accessories* section of the policy Room or Central Heating System Types • Added instruction to refer to the member's EOC for exclusion details ***Hydraulic Lifts*** • Added language to indicate item is covered as DME ***Immobilizer (Extremity)*** • Added language to indicate item is covered as corrective appliance/orthotic ***Incontinence Pads*** • Revised language to indicate item is covered as medical supplies and are covered only when they are incident to a physician's professional services or authorized home health services and are furnished as an integral, although incidental, part of those services in the course of diagnosis or treatment of an injury or illness ***Inhalation Machine*** • Added language to indicate item is covered as DME ***Injectors, Jet Pressure Powered Injectors*** • Added language to indicate item is not covered ***IV Pole (Intravenous)*** • Revised language to indicate item is covered when ordered with IV therapy, tube feeding, or other medically necessary indications ***Lamb's Wool Pads/Sheep Skins*** • Added language to indicate item is covered as DME ***Leotard (Pressure Garment)*** • Removed language indicating item does not meet definition of DME ***Lifts*** Motorized (Electric), Ceiling Modified • Added language to indicate feature is a convenience item and therefore does not meet the definition of DME Seat Lift Mechanism • Replaced reference to "patient" with "member" ***Lymphedema Sleeve/Compression Garments/Bandages (Wrap)*** • Revised language to indicate item is covered as DME • Revised coverage guidelines to indicate item is covered as part of the pneumatic compression devices, not covered as a separate item ○ Coverage criteria for pneumatic compression devices apply

Date	Summary of Changes
	○ Refer to the *Pneumatic Compression Devices* section of the policy ***Mattress*** • Added language to indicate item is covered as DME ***Nebulizers and Supplies; Small Volume, Electric and Large Volume, Non-Disposable*** • Removed language indicating: ○ A specific percentage of cost copayment applies ○ Benefits do not apply to the annual DME benefit maximum ○ Refer to the member's Schedule of Benefits ***Negative Pressure Wound Therapy Pump*** • Added language to indicate item is covered as DME ***Neuromuscular Electrical Stimulator (NMES)*** • Added language to indicate item is covered as DME ***Non-Contact Non-Thermal Wound Therapy*** • Added language to indicate item is not covered ***Nutritional Therapy*** • Added reference link to the MMG titled *Enteral Nutrition (Oral and Tube Feeding)* Enteral • Added language to indicate item is covered as DME ***Orthopedic Shoes*** • Added language to indicate item is covered as corrective appliance/orthotic ***Oxygen Equipment and Necessary Accessories; Routine Maintenance Oxygen Therapy, Equipment and Supplies Outside the Service Area*** • Updated notation to indicate covered items include travel oxygen supplied by airlines and cruises unless urgently needed • Added instruction to refer to the member's EOC for exclusion details ***Peak Expiratory Flow Meter, Hand-Held*** • Removed language indicating: ○ A specific percentage of cost copayment applies ○ Benefits do not apply to the annual DME benefit maximum ○ Refer to the member's Schedule of Benefits ***Percussor (Non-Vest Type), Electric or Pneumatic, Home Model*** • Added reference link to the MMG titled *Airway Clearance Devices* ***Pleurx Bottles and Tubing*** • Added language to clarify item is covered as DME *for pleural infusions* ***Pneumatic Splints*** • Added language to indicate item is covered as corrective appliance/orthotic ***Power Traction Equipment/Devices (e.g., VAX-D®, DRX9000, SpineMED™, Spina System™, Lordex® Decompression Unit, DRS System™)*** • Added language to indicate items are not covered ***Pumps, Including Medications and Necessary Supplies***

Date	Summary of Changes

	Enteral
	• Added language to indicate items are covered as DME
	• Added reference link to the MMG titled *Enteral Nutrition (Oral and Tube Feeding)*
	Parenteral
	• Added instruction to refer to the *Nutritional Therapy* section of the policy
	For Erectile Dysfunction
	• Added language to indicate item is not covered
	PureWick™ Female External Catheter and the PureWick™ Urine Collection System
	• Added language to indicate the item is not covered
	Recliner (Chair)
	• Added instruction to refer to the *Medicare Benefit Policy Manual, Chapter 11, §20.4 (A)(1) Equipment and Supplies*
	Safety Rollers
	• Added language to indicate item is covered as DME
	Shoes
	• Added language to indicate criteria apply
	Sitz Bath (Portable)
	• Replaced references to "patient" with "member"
	Sleep Apnea Device
	• Added language to indicate item is covered as DME
	Splints
	Bi-Directional Static Progressive Stretch Splinting (e.g., JAS Splints, ERMI System)
	• Added language to indicate items is not covered
	Low-Load Prolonged-Duration Stretch Devices (LLPS) *(new to policy)*
	• Added language to indicate Item is covered as DME
	• Added reference link to the MMG titled *Mechanical Stretching Devices*
	Patient Actuated Serial Stretch (PASS) Devices *(new to policy)*
	• Added language to indicate item is not covered
	• Added reference link to the MMG titled *Mechanical Stretching Devices*
	Stockings, Gradient Compression (e.g., Jobst Stockings)
	• Added language to indicate if the stockings are specifically for addressing Lymphedema, refer to the *Lymphedema Sleeve/Compression Garments/Bandages (Wrap)* section of the policy
	Stump Socks
	• Added language to indicate item is covered as medical supplies and are covered only when they are incident to a physician's professional services or authorized home health services and are furnished as an integral, although incidental, part of those services in the course of diagnosis or treatment of an injury or illness
	Syringes, Hypodermic
	• Added language to indicate:
	  ○ Items are covered as pharmacy
	  ○ Insulin syringes and pen needles are covered under the pharmacy benefit; all others are covered under the medical benefit

Date	Summary of Changes
	○ If a member does not have pharmacy benefit, then all syringes/needles are covered under medical ***TMJ Splint*** • Added language to indicate item is covered as corrective appliance/orthotic ***ThAIRapy® Vest System*** • Added language to indicate item is covered as corrective appliance/orthotic ***Thoracic Lumbar Sacral Orthoses (TLSO)*** • Added language to indicate item is covered as corrective appliance/orthotic ***Traction Equipment*** • Added language to indicate power traction equipment/devices (e.g., VAX-D®, DRX9000, AccuSpineMED™ Spina System™, Lordex® Decompression Unit, DRS System™) and spinal unloading devices (includes spinal and axial decompression units, pneumatic vests) are not covered ***Ultraviolet Cabinet*** • Replaced language indicating "covered for *selected* members with generalized intractable psoriasis" with "covered for members with generalized intractable psoriasis" ***Urinary Catheters and Supplies/Urological Supplies*** • Added reference link to the DME MAC LCD for Urological Supplies (L33803) Closed Drainage Bags *and* External Urinary Collection Devices • Revised coverage guidelines to indicate items are covered only for members with non-functioning bladder or permanent incontinence when used as an alternative to an indwelling catheter Foley/Indwelling • Revised coverage guidelines to indicate items are covered only for members with non-functioning bladder or permanent incontinence as medically required Intermittent Urinary Catheters • Revised coverage guidelines to indicate intermittent catheterization is covered when basic coverage criteria are met and the patient or caregiver can perform the procedure Bedside and Leg Drainage Bags • Revised coverage guidelines to indicate item is covered only for members with non-functioning bladder or permanent incontinence who are ambulatory or are chair or wheelchair bound Catheter Related Supplies • Added language to indicate item is covered only for members with non-functioning bladder or permanent incontinence who are ambulatory or are chair or wheelchair bound ***Walkers (Standard)*** • Removed reference link to the Coverage Summary titled *Mobility Assistive Equipment (MAE)* ***Walkers, Heavy Duty, Multiple Braking System, Variable Wheel Resistance*** • Removed reference link to the Coverage Summary titled *Mobility Assistive Equipment (MAE)* ***Wearable Cardioverter Defibrillators*** • Revised coverage guidelines for automatic external defibrillator, with integrated electrocardiogram analysis, garment type; replacement garment for use with automated external defibrillator, each; and replacement electrodes for use with automated external defibrillator, each, to indicate criteria apply ○ Refer to the Benefit Interpretation Policy titled *Cardiac Pacemakers and Defibrillators*

Date	Summary of Changes
	Wheelchairs and Accessories • Replaced language indicating "[items are] *recommended* if the member meets mobility assistive equipment clinical criteria" with "[items are] *covered* if the member meets mobility assistive equipment clinical criteria *documented in the NCD for Mobility Assistive Equipment (AME) (280.3)*" • Removed language indicating wheelchairs are covered only if the member has a DME benefit ***Wrist Splint*** • Added language to indicate item is covered as DME **Supporting Information** • Archived previous policy version BIP050.BB

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. 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.