

## Clinical Policy: Durable Medical Equipment and Orthotics and Prosthetics Guidelines

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[Coding Implications](#)  
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Policy Statement

In compliance with Ohio Medicaid, Buckeye Health Plan must ensure coverage of medically necessary procedures. The plan covers all the services in the amount, duration, and scope that is no less than that covered by FFS Ohio Medicaid and in accordance with 42 CFR 438.210, with limitations, exclusions, and clarifications provided in the Ohio Medicaid Managed Care Provider Agreement and the Ohio Administrative Code. Buckeye Health Plan will adhere to the following procedures:

- Buckeye Health Plan will use OAC 5160-10 in review of coverage for DME.
- Buckeye Health Plan will not impose hard limits or restrictions on coverage of medically necessary services.
- Buckeye Health Plan will not require any prescribed timeframe for expected use of DME as criteria to determine medical necessity but rather will consider the medical need of the member along with expected outcomes for maintaining or improving health condition.
- Buckeye Health Plan will conduct a medical necessity review for all DME service codes included on the Ohio Department of Medicaid's FFS Fee Schedule.
- Prior to making determinations regarding coverage of services and procedures, Buckeye Health Plan will conduct a medical necessity review for all requests to include non-covered services and any request for services over an established benefit(s).
- Buckeye Health Plan will ensure members under age 21 have access to all services that are available in accordance with federal EPSDT requirements found at 42 U.S.C. 1396d(r). This would include medically necessary services covered by Ohio Medicaid as well as any medically necessary screening, diagnostic and treatment services available to Ohio Medicaid consumers.

### Description

DME is defined as equipment that can stand repeated use, is primarily and customarily used to serve a medical purpose and is generally not useful to a person in the absence of an illness or injury. Orthotic devices are rigid and semi-rigid devices used for the purpose of supporting a weak or deformed body part or restricting or eliminating motion in a disease or injured body part. Prosthetic devices are custom-made artificial limbs or other assistive devices for people who have lost limbs as a result of traumatic injuries, vascular disease, diabetes, cancer or congenital disorders.

### Policy/Criteria

- I. It is the policy of Buckeye Health Plan and health plans affiliated with Centene Corporation<sup>®</sup> that durable medical equipment, orthotics, and prosthetics are **medically necessary** when the general and applicable equipment-specific criteria in A and B are met:
  - A. **General criteria:** Both of the following have been provided to the member/enrollee and/or caregiver, as applicable:

1. Education regarding use of the device, with demonstrated understanding.
2. A trial of the requested device, with demonstrated ability to use it safely and effectively.

**Note:** *If a medically necessary, lesser cost item exists and will suit the member/enrollee's medical needs, a higher cost item will be denied.*

**B. EQUIPMENT-SPECIFIC CRITERIA**

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BURN GARMENTS	CRITERIA	HCPCS
Burn garments	Medically necessary with associated physical and/or occupational therapy when <i>at least one</i> the following criteria are met: A. At risk of a post-burn contracture; B. The garment and physical and/or occupational therapies are being used with the intent of preventing the need for skin grafting or contractures as a result of hypertrophic scarring; C. Garment is requested by the PCP and/or the treating specialist.	A6501 A6502 A6503 A6504 A6505 A6506 A6507 A6508 A6509 A6510 A6511 A6512 A6513

CARDIAC EQUIPMENT	CRITERIA	HCPCS
Non-wearable external defibrillator with integrated ECG analysis	Considered not medically necessary as it is primarily considered a safety device.	E0617

<b>COMPRESSION THERAPY EQUIPMENT</b>	<b>CRITERIA</b>	<b>HCPCS</b>
Pneumatic compression devices <sup>10</sup>	Medically necessary as an accessory for lymphedema of the chest when a primary device (E0650, E0651, E0652) is medically necessary. Not proven safe and effective for lymphedema of the abdomen, trunk, genitals, or neck; and for arterial insufficiency.	E0675
Non-pneumatic compression devices	There is insufficient clinical evidence to support the safety and effectiveness of non-pneumatic compression devices over the use of standard pneumatic compression devices.	K1032 K1033

<b>DIABETES CARE EQUIPMENT</b>	<b>CRITERIA</b>	<b>HCPCS</b>
Blood glucose monitor with integrated voice synthesizer <sup>11</sup>	Medically necessary for member/enrollee with diabetes who are legally blind (best corrected visual acuity less than 20/200).	E2100

<b>HEAT, COLD &amp; LIGHT THERAPY EQUIPMENT</b>	<b>CRITERIA</b>	<b>HCPCS</b>
Ultraviolet panel lights <sup>25</sup>	Medically necessary for both of the following: A. Refractory psoriasis; B. MD justifies treatment at home versus alternate sites (e.g. outpatient department at hospital). Panel lights should be considered, if several discrete body areas can be treated individually. Cabinet style should be reserved for extensive involvement > 54% of body surface area.	E0691 E0692 E0693 E0694
Cold pad pump <sup>26</sup>	Considered not medically necessary for post-operative management as research does not indicate improved outcomes in pain or edema management with the use of cold compression therapy over the use of other treatments to include conservative treatment, cold therapy alone, compression therapy alone, etc.	E0236

<b>NEWBORN CARE EQUIPMENT</b>	<b>CRITERIA</b>	<b>HCPCS</b>
Breast pumps	Medically necessary for the following: A. Breast feeding mother. B. Limit one per member/enrollee for rental. Request for more than one pump per calendar year will be reviewed for medical necessity on an individual basis.	E0604

ORTHOPEDIC CARE EQUIPMENT	CRITERIA	HCPCS
Cervical traction equipment <sup>12</sup>	<p>Medically necessary when all of the following are met:</p> <p>A. The appropriate use of the selected home cervical traction device has been demonstrated and was tolerated;</p> <p>B. One of the following:</p> <ol style="list-style-type: none"> <li>1. Diagnosis of temporomandibular joint (TMJ) dysfunction and has received treatment for TMJ condition;</li> <li>2. Distortion of the lower jaw and neck anatomy (e.g. radical neck dissection) such that a chin halter is unable to be utilized;</li> <li>3. The treating physician orders and/or documents the medical necessity for greater than 20 pounds of cervical traction in the home setting.</li> </ol>	E0849
Halo procedure equipment & Fracture Frames	Halo and fracture frame placement is generally performed on an emergent or inpatient basis and will be reviewed at the appropriate level of care using nationally recognized decision support tools.	E0947 E0948 L0810 L0820 L0830 L0859
Cervical collar, custom molded	Requests for custom molded cervical collar will be reviewed by a licensed physical or occupational therapist. Documentation accompanying the request must state reason why pre-fabricated collar not adequate.	L0170 L0190 L0200
Spinal orthotics	Requests for spinal orthotics will be reviewed using relevant nationally recognized decision support tool criteria for similar codes.	L0700 L0710 L0999 L1000 L1001 L1005
Hip orthotics	<p>Medically necessary when ordered by an orthopedist for treatment of, or postoperatively for any of the following:</p> <ol style="list-style-type: none"> <li>A. Total hip arthroplasty;</li> <li>B. Slipped capital femoral epiphysis;</li> <li>C. Legg-Calvé-Perthes disease;</li> <li>D. Hip labral tear;</li> <li>E. Hip dysplasia for Charcot-Marie-Tooth disease.</li> </ol> <p>Lateral replacements due to growth are considered medically necessary in pediatrics for diagnoses such as hip dysplasia with Charcot-Marie-Tooth disease.</p>	L1640 L1680 L1685 L1686 L1690
Legg Perthes orthotics	Medically necessary when ordered by an orthopedist for use in the treatment for Legg-Calvé-Perthes disease in children.	L1700 L1710 L1720 L1730 L1755
Hip-knee-ankle-foot orthotics (HKAFO)	Requests for orthotics will be reviewed on a case by case basis.	L2050 L2060 L2090
Orthotic components	Requests for orthotic components listed will be reviewed using relevant nationally recognized decision support tool criteria for similar codes.	L2570 L2580

ORTHOPEDIC CARE EQUIPMENT	CRITERIA	HCPCS
		L2627 L2628
Foot orthotics, custom	<p>Medically necessary for arch, heel, or other foot pain when indicated by at least one of the following:</p> <ul style="list-style-type: none"> <li>A. Diplegic cerebral palsy;</li> <li>B. Juvenile idiopathic arthritis;</li> <li>C. Pes cavus (high arch);</li> <li>D. Rheumatoid arthritis;</li> <li>E. Plantar fasciitis when symptoms have been present for 3 months or more and adjustment of activities, anti-inflammatory medications, prefabricated orthotics, and stretching of calf muscles and plantar surface have failed to improve symptoms;</li> <li>F. Posterior tibial tendon dysfunction in adult, as indicated by one or more of the following:               <ul style="list-style-type: none"> <li>1. Stage I disease (tenosynovitis without deformity);</li> <li>2. Stage II disease (flexible and passively correctable deformity)</li> </ul> </li> </ul>	L3000 L3001 L3002 L3003 L3010 L3020 L3030 L3031 L3070 L3080
Orthopedic footwear, custom	<p>Requests for custom orthotic components will be reviewed using relevant nationally recognized decision support tool criteria for similar codes.</p> <p>In addition to supporting the medical necessity of foot orthotics, information must be provided to indicate why prefabricated devices cannot meet the need/why custom devices are necessary.</p>	L3230
Shoulder, elbow, wrist, hand, finger orthotics	<p>Medically necessary when ordered immediately post-operative for orthopedic surgeries such as rotator cuff repair, tendon repair, or ORIF.</p> <p>Replacement due to normal wear and tear is considered medically necessary when the item is a lateral purchase and the orthotic is still needed; Coverage is based on contract guidelines for replacement DME.</p>	L3904 L4000 L4010 L4020 L4030 L4130 L4205
Prosthetics and additions: Upper Extremity and Myoelectric	Requests for upper extremity and myoelectric prosthetics will be reviewed using relevant nationally recognized clinical decision support tool criteria for similar codes.	L6000, L6010, L6020, L6026, L6050, L6055, L6100, L6110, L6120, L6130, L6200, L6205, L6250, L6300, L6310, L6320, L6350, L6360, L6370, L6380, L6382, L6384, L6386, L6388, L6400, L6450, L6500, L6550, L6570, L6580, L6582, L6584, L6586, L6588, L6590, L6623, L6624, L6625, L6628, L6638, L6646, L6647, L6648, L6689, L6690, L6692, L6693, L6704, L6707, L6708, L6709, L6711, L6712, L6713,

ORTHOPEDIC CARE EQUIPMENT	CRITERIA	HCPCS
		L6714, L6715, L6721, L6722, L6885, L6895, L6900, L6905, L6910, L6915, L6920, L6930, L6940, L6950, L6960, L6965, L6970, L6975, L7040, L7170, L7185, L7186, L7405, L7499
Prosthetics and additions: Lower Extremity	Requests for these prosthetics and additions will be reviewed by a licensed physical or occupational therapist.	L5990

OTHER EQUIPMENT	CRITERIA	HCPCS
Enclosed Beds <sup>15,16,17,18,19,20</sup>	<p>Requests will be reviewed by a medical director and/or therapy advisor to determine medical necessity, based on all of the following:</p> <p>A. Standard bed or standard hospital bed must be unable to meet the positioning needs due to disability;</p> <p>B. Less intensive alternatives to improve the member's/enrollee's safety have been tried and ruled out (To include documentation of why they could not meet medical needs). Considerations include, but are not limited to:</p> <ol style="list-style-type: none"> <li>1. Bed rails;</li> <li>2. Mattress placed on the floor;</li> <li>3. Removal of all safety hazards;</li> <li>4. Bed alarms;</li> <li>5. Video/audio monitors;</li> <li>6. Child protection devices such as locks on doors, windows, cabinets, furniture anchors, gates at steps and doors;</li> <li>7. Physician-directed medication to address seizures, behaviors and sleep;</li> <li>8. Environmental modification to encourage calming behaviors and sleep;</li> <li>9. Established routines addressing sensory needs and/or behavior modification to assist with improved naptime or night time behaviors and sleep;</li> </ol> <p>C. Medical diagnosis to include, but not limited to:</p> <ol style="list-style-type: none"> <li>1. Cerebral palsy;</li> <li>2. Developmental delay;</li> <li>3. Genetic or neurological disorder that would cause vertigo, disorientation, or uncontrolled movement of the body or extremities;</li> <li>4. Uncontrolled seizure disorder;</li> <li>5. Severe behavior disorder;</li> </ol> <p>D. Healthcare provider evaluation (typically from an occupational or physical therapist) to include:</p>	E0316 E1399 E0328 or E0329 (when combined with E0316 or E1399)

OTHER EQUIPMENT	CRITERIA	HCPCS
	<ol style="list-style-type: none"> <li>1. Specific information on functional status;</li> <li>2. Documentation of home evaluation;</li> <li>3. Documentation of education provided to caregivers on proper use of a bed enclosure, noting: they are to be used for medical support, improved safety transitioning in and out of the bed, and improved safety while sleeping;</li> </ol> <p>E. Name of and invoice for the bed or enclosure being requested.</p> <p>Note: Enclosed beds should not be used as a discipline measure or as a restraint during times of high agitation or aggression. To limit sensory deprivation, enclosed beds should be used at night for sleeping and only for short rests or naps during the day.</p>	
Positioning seat	<p>Requests should have a physician or therapy advisor review to determine medical necessity.</p> <p>Medically necessary with therapist evaluation and ongoing treatment and <i>all</i> of the following criteria are met:</p> <ol style="list-style-type: none"> <li>A. Commercial device must be unable to meet the positioning needs due to height, weight, or disability;</li> <li>B. Other positioning devices in the home must be reviewed to ensure a duplication of devices is not already in place;</li> </ol>	T5001 E1399
Specialized supply or equipment	<p>Requests for not otherwise specified supplies or miscellaneous equipment codes will have a physician or therapy advisor review to determine medical necessity.</p>	T2028 T2029 K0108 K0739 E1399

PUMPS	CRITERIA	HCPCS
Ambulatory infusion pump <sup>2</sup>	<p>Medically necessary when used for one of the following indications:</p> <ol style="list-style-type: none"> <li>A. Iron Poisoning: administration of deferoxamine for the treatment of acute iron poisoning and iron overload;</li> <li>B. Chemotherapy for liver cancer: treatment of primary hepatocellular carcinoma or colorectal cancer where this disease is unresectable; OR, where the patient refuses surgical excision of the tumor;</li> <li>C. With opioid drugs when used for intractable pain caused by cancer.</li> <li>D. To administer a drug considered reasonable and necessary by either: <ol style="list-style-type: none"> <li>1. Prolonged infusion of at least 8 hours because of proven improved clinical efficacy (i.e., proven or generally accepted to have significant advantages over intermittent bolus administration regimens or infusions lasting less than 8 hours) or</li> <li>2. Intermittent infusion, each episode of infusion lasting less than 8 hours, and both of the following criteria:</li> </ol> </li> </ol>	E0780 E0781

PUMPS	CRITERIA	HCPCS
	<ul style="list-style-type: none"> <li>a. Does not require the return to the physician's office prior to the beginning of each infusion.</li> <li>b. Strictly controlled rate of infusion is necessary because systemic toxicity or adverse effects of the drug are unavoidable without infusing it at a controlled rate as indicated in the Physician's Desk Reference, or the U.S. Pharmacopeia Drug Information</li> </ul>	
Gastric suction pump, home model <sup>13</sup>	Medically necessary for home use for gastric suction due to inability to empty gastric secretions through normal gastrointestinal functions.	E2000
Implantable infusion pumps <sup>2</sup>	<p>Medically necessary when meeting both of the following:</p> <p>A. One of the following indications:</p> <ul style="list-style-type: none"> <li>1. Chemotherapy for liver cancer: primary hepatocellular carcinoma or Duke's Class D colorectal cancer, in which the metastases are limited to the liver and where either the disease is unresectable, or the patient refuses excision of the tumor;</li> <li>2. Anti-spasmodic drugs for severe spasticity: administered intrathecal to treat chronic intractable spasticity in patients unresponsive to less invasive medical therapy including both of the following: <ul style="list-style-type: none"> <li>a. A 6-week trial of noninvasive methods, such as oral antispasmodic drugs, that failed to adequately control the spasticity or produced intolerable side effects;</li> <li>b. Prior to pump implantation, there has been a favorable response to a trial of intrathecal dose of the antispasmodic drug;</li> </ul> </li> <li>3. Opioid drugs for treatment of chronic intractable pain- see <a href="#">CP.MP.173</a> Implantable Intrathecal Pain Pumps;</li> <li>4. Other uses when all of the following are met: <ul style="list-style-type: none"> <li>a. The drug is reasonable and necessary for the treatment of the individual;</li> <li>b. It is medically necessary that the drug be administered by an implanted infusion pump. The infusion pump has been FDA-approved for the drug being administered and the purpose for which it is being administered;</li> </ul> </li> </ul> <p>B. None of the following contraindications to implantation of an infusion pump:</p> <ul style="list-style-type: none"> <li>1. Known allergy or hypersensitivity to the drug being used (e.g., oral baclofen, morphine, etc.);</li> <li>2. Active infection;</li> <li>3. Body size insufficient to support the weight and bulk of the device;</li> <li>4. Presence of another implanted programmable device;</li> <li>5. Heparin or insulin is the drug intended for administration.</li> </ul>	E0782 E0783 E0785 E0786
Vacuum erection device <sup>1,3</sup>	A vacuum erection device (VED) and tension ring are medically necessary for the treatment of erectile dysfunction when prescribed by a physician.	L7900 L7902

<b>PUMPS</b>	<b>CRITERIA</b>	<b>HCPCS</b>
Parenteral pump for medication administration	Medically necessary for uninterrupted parenteral administration of medication via pump.	K0455

<b>RESPIRATORY EQUIPMENT</b>	<b>CRITERIA</b>	<b>HCPCS</b>
Nebulizer, ultrasonic <sup>27</sup>	Not medically necessary, as it provides no clinical advantage over use of a small-volume nebulizer (E0574) and compressor.	E0575
IPPB & supplies	Medically necessary for member/enrollee with respiratory disease when an incentive spirometer is ineffective.	E0500 E0550
Oximeter <sup>14</sup>	<p>Medically necessary when used as a monitoring and alarm device for any of the following:</p> <ul style="list-style-type: none"> <li>A. To monitor individuals on a home ventilator or with a tracheostomy</li> <li>B. To determine appropriate home oxygen requirements</li> <li>C. To wean an individual from home oxygen</li> <li>D. To monitor an unstable respiratory condition</li> </ul> <p>Not medically necessary when used for any of the following:</p> <ul style="list-style-type: none"> <li>A. Oximetry when used as a diagnostic procedure</li> <li>B. Monitoring of a stable respiratory condition</li> <li>C. Asthma management</li> <li>D. Other conditions not listed above</li> </ul>	E0445
Oxygen tent	Medically necessary when the ability to breathe is impaired and for whom supplemental oxygen is required.	E0455
Intrapulmonary percussive ventilation devices (Volara™, Percussionaire-TRUE-IPV®) <sup>22, 23, 24</sup>	Plan provides access with case-by-case review for medical necessity for HCPCS code E0469 and supply kits A7021.	E1399

<b>SURGICAL SUPPLIES</b>	<b>CRITERIA</b>	<b>HCPCS</b>
Other surgical supplies	These items are used as part of a surgical procedure and will be reviewed according to the relevant surgical procedure or level of care.	L8035, L8040, L8041, L8042, L8043, L8044, L8045, L8046, L8047, L8499, L8600, L8609, L8610, L8612, L8615, L8631, L8659

WALKERS	CRITERIA	HCPCS
Walker, standard <sup>29</sup>	<p>Requests for standard walkers are considered medically necessary when meeting all of the following:</p> <ul style="list-style-type: none"> <li>A. Mobility-related activities of daily living (MRADLs) in the home cannot be met due to mobility limitation;</li> <li>B. Walker is able to be safely used by member/enrollee;</li> <li>C. Functional mobility deficit will be sufficiently resolved with the use of a walker.</li> </ul>	<p>E0130 E0135 E0141 E0143</p>
Walker, heavy duty <sup>29</sup>	<p>Requests for heavy duty walkers (E0148, E0149) are considered medically necessary when meeting the above standard walker criteria and the member/enrollee weighs more than 300 pounds.</p> <p>Requests for heavy duty, multiple braking system, variable wheel resistance walkers (E0147) are considered medically necessary when meeting the above standard walker criteria and the member/enrollee is unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand.</p>	<p>E0148 E0149</p> <p>E0147</p>

WHEELCHAIRS	CRITERIA	HCPCS
Manual wheelchair <sup>28</sup>	<p>Initial request is medically necessary when meeting all of the following:</p> <ul style="list-style-type: none"> <li>A. Mobility-related activities of daily living (MRADLs) in the home cannot be met due to mobility limitation, all of the following: <ul style="list-style-type: none"> <li>1. Mobility limitation cannot be met with a cane or walker;</li> <li>2. Mobility limitation can be met with a manual wheelchair;</li> <li>3. Home provides adequate access and maneuvering space for requested manual wheelchair;</li> <li>4. Willingness to use a manual wheelchair in the home;</li> </ul> </li> <li>B. One of the following: <ul style="list-style-type: none"> <li>1. Caregiver is available and willing to assist with wheelchair use;</li> <li>2. Manual wheelchair can be safely and efficiently propelled by user;</li> </ul> </li> <li>C. Wheelchair use will significantly improve MRADLs.</li> </ul> <p>Replacement is medically necessary when meeting all of the following:</p> <ul style="list-style-type: none"> <li>A. Documentation supports at least one of the following: <ul style="list-style-type: none"> <li>1. Growth features of current wheelchair have been maximized;</li> <li>2. Repair or replacement of parts no longer effective;</li> <li>3. Current wheelchair in use <math>\geq</math> 5 years;</li> <li>4. Change in functional status of patient documented;</li> </ul> </li> <li>B. Mobility-related activities of daily living (MRADLs) in the home cannot be met due to mobility limitation, all of the following: <ul style="list-style-type: none"> <li>1. Mobility limitation cannot be met with a cane or walker;</li> <li>2. Mobility limitation can be met with a manual wheelchair;</li> </ul> </li> </ul>	<p>E1229, E1231, E1232, E1233, E1234, E1235, E1037, E1050, E1060, E1070, E1083, E1084, E1085, E1086, E1087, E1088, E1089, E1090, E1091, E1092, E1093, E1100, E1110, E1130, E1140, E1150, E1160, E1170, E1171, E1172, E1180, E1190, E1195, E1200, E1221, E1222, E1223, E1224, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295, E1236, E1237, E1238, K0009</p>

WHEELCHAIRS	CRITERIA	HCPCS
	3. Home provides adequate access and maneuvering space for requested manual wheelchair; 4. Willingness to use a manual wheelchair in the home; C. One of the following: 1. Caregiver is available and willing to assist with wheelchair use; 2. Manual wheelchair can be safely and efficiently propelled by user; D. Wheelchair use will significantly improve MRADLs.	
Power seat elevator on power wheelchair	Medically necessary as a component on a power wheelchair when all of the following are met: A. A licensed, certified medical professional (i.e. physical or occupational therapist) is involved with the assessment, prescription, trials and training of equipment; B. Adequate cognitive function to safely use the seat elevating feature; C. A clear functional need for the feature is indicated; D. Provision of the feature will improve functional independence with an activity, such as but not limited to: facilitating reach for the completion of ADLs or IADLs or improving transfer biomechanics and safety.	E2300
Robotic Arm, Wheelchair-mounted (JACO)	There is insufficient clinical evidence to support safety and improved health outcomes of the JACO Assistive Robotic Arm (Kinova, Inc.) over other technologies.	E1399
Rollabout chair	Medically necessary when used in lieu of a wheelchair for those who would qualify for a wheelchair (except for the ability to self-propel a manual wheelchair).	E1031
Wheelchair repair	Requests for wheelchair repairs specifically using codes K0108, K0739, or E1399, are medically necessary when reviewed by a physician or therapy advisor and when meeting the following criteria: A. Wheelchair is less than 5 years old (as evident by the age/date of purchase information provided); B. Cost of repairs is less than the cost of replacement; C. Information is provided to support the need for repairs due to normal wear and tear, as opposed to abuse/misuse or overutilization (as based on review of previous repair history, age and overall condition).  One month's rental for a standard manual wheelchair is considered medically necessary if a member/enrollee owned wheelchair is being repaired. <sup>28</sup>	K0108 K0739 E1399
WOUND CARE	CRITERIA	HCPCS
Whirlpool tub	Considered not medically necessary.	E1310

**Coding Implications**

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

### **Background**

DME items have the following characteristics:

- The equipment is prescribed by a physician;
- The equipment meets the definition of DME;
- The equipment is necessary and reasonable for the treatment of an illness or injury;
- The equipment is manufactured primarily for use in the home environment, but is not limited to use in the home.

#### *Member/Enrollee's Home*

For purposes of rental and purchase of DME, a member/enrollee's home may be their own dwelling, an apartment, a relative's home, a home for the aged or some other type of institution. However, an institution may not be considered a member/enrollee's home if the following are met:

- Meets at least the basic requirement in the definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians, inpatient, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or
- Meets at least the basic requirement in the definition of a skilled nursing facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for members/enrollees who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Members/enrollees who have been permanently admitted to an inpatient skilled nursing facility or inpatient hospice and who have changed their home address to that of the SNF or hospice will have the SNF or hospice defined as their home.

#### *Products*

Products is defined as a listing of the most common items, or group of items, that are or may be perceived as home medical equipment. This listing, while reasonably complete, is not intended to quantify the entire spectrum of products that may be considered DME either now or in the future.

#### *Durability*

An item is considered durable if it can withstand repeated use, i.e., the type of item that could normally be rented. Medical supplies of an expendable nature, such as incontinence pads, lamb's wool pads, catheters, ace bandages, elastic stockings, surgical facemasks, sheets and bags are not considered "durable" within the meaning of the definition. There are other items that although durable in nature, may fall into other coverage categories such as supplies and orthotics and prosthetics. Orthotics and Prosthetics items include, but are not limited to, braces, artificial limbs and eyes.

*Medical Equipment*

Medical equipment is defined as equipment primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury. In most instances, no documentation will be needed to support whether a specific item of equipment is medical in nature. However, some cases will require documentation to determine whether the item constitutes medical equipment. This documentation would include the advice of local medical organizations and facilities and specialists in the field of physical medicine and rehabilitation. If the equipment is new on the market, it may be necessary, prior to seeking professional advice, to obtain information from the supplier or manufacturer explaining the design, purpose, effectiveness and method of using the equipment in the home as well as the results of any tests or clinical studies that have been conducted.

Personal computers or mobile technology such as iPads, smart phones, iPods, personal digital assistants, etc., may be considered as medical equipment when used for the purpose of speech generating equipment when other non-medical functions are limited or disabled and that device is used as the primary source of communication for those qualifying for a speech generating device.

<b>Reviews, Revisions, and Approvals</b>	<b>Revision Date</b>	<b>Approval</b>
Original Policy created and approved	06/09	06/09
Centene Policy <a href="#">CP.MP.107</a> updated with OH Addendum	02/23	02/23
Policy moved to Ohio Specific template and Addendum language integrated into policy template as Policy Statement. References reviewed and updated. No material change in review criteria.	07/23	07/23
Annual Review. Review references. Update to breast pump section and Intrapulmonary percussive ventilation device.	02/25	02/25

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## Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. Buckeye Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by Buckeye Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional

medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom Buckeye Health Plan has no control or right of control. Providers are not agents or employees of Buckeye Health Plan.

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**Note: For Medicaid members/enrollees**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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