Clinical Policy: Durable Medical Equipment and Orthotics and Prosthetics Guidelines

Reference Number: LA.CP.MP.107 Coding Implications
Date of Last Revision: 2/22 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

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.

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

Policy/Criteria
It is the policy of Louisiana Healthcare Connections that durable medical equipment, orthotics, and prosthetics are **medically necessary** when the applicable criteria are met.

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AMBULATORY ASSIST PRODUCTS	CRITERIA	HCPCS
Gait trainers	Medically necessary with therapist evaluation and ongoing treatment when *all* of the following criteria are met: A. Moderate to maximum support for walking is required; B. Cleared medically for weight bearing and can physiologically tolerate upright positioning; C. Evaluated with the requested gait trainer, can tolerate the positioning in the device, and has successfully demonstrated proper use; D. The member/enrollee and caregivers have been trained on the gait trainer and are motivated to continue ongoing use. **Codes E8000-E8002 indicate, "includes all accessories and components" as part of the definition of the code. Additional line items under E1399 should not be included with requests for gait trainers.	E8000 E8001 E8002

Standing Frames	Dynamic standing frames are medically necessary when meeting one of the following: A. Initial request, or replacement request due to physiological changes* and all of the following: 1. Age and ambulatory status, one of the following: a. Age ≥ 18 years and nonambulatory or losing the ability to ambulate; b. Age <18 years and preambulatory, nonambulatory, or losing the ability to ambulate, and one of the following: i. Developmental delay in ambulation and ≥ 18 months of age; ii. Documented neurological or neuromuscular impairment and ≥ 1 year of age; 2. Documentation supports all of the following: a. Patient meets height and weight requirements for requested standing frame; b. Alert and responsive to stimuli; c. No contraindications to supported standing program; d. Caregiver trained, available, and able to safely assist patient with use of standing frame; 3. Unable to stand without support due to decreased motor control or abnormal muscle tone; 4. Care managed by a rehabilitation-related specialist or physician; 5. Prescribed for daily home use; 6. Expected use for ≥ 12 months; 7. Demonstrated ability (through a direct trial) to mobilize in and/or operate the dynamic component; 8. Documented functional need for or benefit from the dynamic component of the stander (not for use as exercise equipment or for exercise benefit). B. Replacement request (not due to physiological changes), all of the following: 1. Documentation supports replacement device necessary due to irreparable damage or device exceeds reasonable useful lifetime ≥ 5 years; 2. Physician documentation of proper use and continued benefit; 3. Replacement with identical or nearly identical device; *Changes in physiological condition, such as strength, muscle tone, growth, or weight change, may potentially impact the appropriateness of the standing device currently in use.	E0642 *E1399

AMBULATORY ASSIST PRODUCTS	CRITERIA	HCPCS
	*Line item justification is required for any additional components submitted under the E1399 code.	

BURN GARMENTS	CRITERIA	HCPCS
Burn garments [11]	Medically necessary with associated physical and/or occupational therapy when *all* of 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
Cardiac event recorder, implantable	Medically necessary for evaluation of suspected atrial fibrillation as a cause of cryptogenic stroke who have had a non-diagnostic Holter monitor or 48 hour telemetry Medically necessary for evaluation of recurrent unexplained episodes of pre-syncope, syncope, "seizures", palpitations, or dizziness when both of the following criteria are met: A. A cardiac arrhythmia is suspected as the cause of the symptoms; B. Either of the following criteria are met: 1. Heart failure, prior myocardial infarction (MI) or significant ECG abnormalities (see below): noninvasive ambulatory monitoring, consisting of 30-day pre-symptom external loop recordings or MCT, fails to establish a definitive diagnosis; 2. No heart failure, prior MI or significant ECG abnormalities (see below) and symptoms occur so infrequently and unpredictably (less frequently than once per month) that noninvasive ambulatory monitoring (MCT or external loop recorders) are unlikely to capture a diagnostic ECG. **Significant ECG Abnormalities** • Syncope during exertion or supine • Palpitations at the time of syncope • Family history of SCD • Non-sustained VT	E0616

CARDIAC EQUIPMENT	CRITERIA	HCPCS
	• Bifascicular-block (LBBB or RBBB combined with left anterior or left posterior fascicular block) or other intraventricular conduction abnormalities with QRS duration ≥120 ms • Inadequate sinus bradycardia (<50 bpm) or sinoatrial block in absence of negative chronotropic medications or physical training • Pre-excited QRS complex • Prolonged or short QT interval • RBBB pattern with ST-elevation in leads V1-V3 (Brugada pattern) • Negative T waves in right precordial leads, epsilon waves, and ventricular late potentials suggestive of ARVC	
Non-wearable external defibrillator with integrated ECG analysis	Considered not medically necessary as it is primarily considered a safety Device.	E0617

COMPRESSION THERAPY EQUIPMENT	CRITERIA	HCPCS
Pneumatic compression devices [12]	Not proven safe and effective for lymphedema of the abdomen, trunk, chest, genitals, or neck; and for arterial insufficiency.	E0675

DIABETES CARE EQUIPMENT	CRITERIA	HCPCS
Blood glucose monitor with integrated voice synthesizer [13]	Medically necessary for member/enrollee with diabetes who are legally blind (best corrected visual acuity less than 20/200).	E2100

HEAT, COLD & LIGHT THERAPY EQUIPMENT	CRITERIA	HCPCS
Ultraviolet panel lights	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	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

NEWBORN CARE EQUIPMENT	CRITERIA	HCPCS
Breast pumps	Medically necessary for the following: A. Breast feeding mother if it is a covered benefit in the State B. Less than $250.00 as a purchase C. If >$250 approve as rental up to purchase price then convert to purchase D. Limit one per member/enrollee.	E0604

ORTHOPEDIC CARE EQUIPMENT	CRITERIA	HCPCS
Cervical traction equipment [14]	Medically necessary when all of the following are met: A. The appropriate use of the selected home cervical traction device has been demonstrated and was tolerated; B. One of the following: 1. Diagnosis of temporomandibular joint (TMJ dysfunction and has received treatment for TMJ condition; 2. Distortion of the lower jaw and neck anatomy (e.g. radical neck dissection) such that a chin halter is unable to be utilized; 3. The treating physician orders and/or documents the medical necessity for greater than 20 pounds of cervical traction in the home setting.	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 [4]	Medically necessary when ordered by an orthopedist for treatment of, or postoperatively for: • Total hip arthroplasty; • Slipped capital femoral epiphysis; • Legg-Calvé-Perthes disease; • Hip labral tear; • Hip dysplasia for Charcot-Marie-Tooth disease.	L1640 L1680 L1685 L1686 L1690

ORTHOPEDIC CARE EQUIPMENT	CRITERIA	HCPCS
	Lateral replacements due to growth are considered medically necessary in pediatrics for diagnoses such as hip dysplasia with Charcot-Marie-Tooth disease.	
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 L2627 L2628
Orthopedic footwear, custom	Requests for custom orthotic components will be reviewed using relevant nationally recognized decision support tool criteria for similar codes. 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.	L3230
Shoulder, elbow, wrist, hand, finger orthotics [4]	Medically necessary when ordered immediately post-operative for orthopedic surgeries such as rotator cuff repair, tendon repair, or ORIF. 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.	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, L6714, L6715, L6721, L6722, L6885, L6895, L6900, L6905, L6910, L6915, L6920, L6930, L6940, L6950, L6960, L6965, L6970, L6975,

ORTHOPEDIC CARE EQUIPMENT	CRITERIA	HCPCS
		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 [17,18,19,20,21,22]	Requests will be reviewed by a medical director and/or therapy advisor to determine medical necessity, based on all of the following: A. Standard bed or standard hospital bed must be unable to meet the positioning needs due to disability; 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: 1. Bed rails; 2. Mattress placed on the floor; 3. Removal of all safety hazards; 4. Bed alarms; 5. Video/audio monitors; 6. Child protection devices such as locks on doors, windows, cabinets, furniture anchors, gates at steps and doors; 7. Physician-directed medication to address seizures, behaviors and sleep; 8. Environmental modification to encourage calming behaviors and sleep; 9. Established routines addressing sensory needs and/or behavior modification to assist with improved naptime or night time behaviors and sleep; C. Medical diagnosis to include, but not limited to: 1. Cerebral palsy; 2. Developmental delay; 3. Genetic or neurological disorder that would cause vertigo, disorientation, or uncontrolled movement of the body or extremities; 4. Uncontrolled seizure disorder; 5. Severe behavior disorder; D. Healthcare provider evaluation (typically from an occupational or physical therapist) to include: 1. Specific information on functional status; 2. Documentation of home evaluation; 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; E. Name of and invoice for the bed or enclosure being requested. 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.	E0316 E1399 E0328 or E0329 (when combined with E0316 or E1399)

OTHER EQUIPMENT	CRITERIA	HCPCS
Positioning seat	Requests should have a physician or therapy advisor review to determine medical necessity. Medically necessary with therapist evaluation and ongoing treatment and *all* of the following criteria are met: A. Commercial device must be unable to meet the positioning needs due to height, weight, or disability; B. Other positioning devices in the home must be reviewed to ensure a duplication of devices is not already in place;	T5001 E1399
Specialized supply or equipment	Requests for not otherwise specified supplies or miscellaneous equipment codes will have a physician or therapy advisor review to determine medical necessity.	T2028 T2029 K0108 (For wheelchair seating refer to LA.CP.MP.99) K0739 E1399

PUMPS	CRITERIA	HCPCS
Ambulatory infusion pump	Medically necessary when used for one of the following indications: A. Iron Poisoning: administration of deferoxamine for the treatment of acute iron poisoning and iron overload; 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; C. With opioid drugs when used for intractable pain caused by cancer. D. To administer a drug considered reasonable and necessary by either: 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 2. Intermittent infusion, each episode of infusion lasting less than 8 hours, and both of the following criteria: a. Does not require the return to the physician's office prior to the beginning of each infusion. 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	E0780 E0781
Gastric suction pump, home model [15]	Medically necessary for home use for gastric suction due to inability to empty gastric secretions through normal gastrointestinal functions.	E2000
Implantable infusion pumps [2]	Medically necessary when meeting both of the following: A. One of the following indications:	E0782 E0783

PUMPS	CRITERIA	HCPCS
	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; 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: a. A 6-week trial of noninvasive methods, such as oral anti-spasmodic drugs, that failed to adequately control the spasticity or produced intolerable side effects; b. Prior to pump implantation, there has been a favorable response to a trial of intrathecal dose of the anti-spasmodic drug; 3. Opioid drugs for treatment of chronic intractable pain- see LA.CP.MP.173 Implantable Intrathecal Pain Pumps; 4. Other uses when all of the following are met: a. The drug is reasonable and necessary for the treatment of the individual; 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; B. None of the following contraindications to implantation of an infusion pump: 1. Known allergy or hypersensitivity to the drug being used (e.g., oral baclofen, morphine, etc.); 2. Active infection; 3. Body size insufficient to support the weight and bulk of the device; 4. Presence of another implanted programmable device; 5. Heparin or insulin is the drug intended for administration.	E0785 E0786
Male vacuum erection device [1,3]	A vacuum erection device (VED) and tension ring are medically necessary for the treatment of erectile dysfunction when prescribed by a physician.	L7900 L7902
Parenteral pump for medication administration	Medically necessary for uninterrupted parenteral administration of medication via pump.	K0455

RESPIRATORY EQUIPMENT	CRITERIA	HCPCS
Nebulizer, ultrasonic	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

RESPIRATORY EQUIPMENT	CRITERIA	HCPCS
Oximeter [16]	Medically necessary when used as a monitoring and alarm device for any of the following: A. To monitor individuals on a home ventilator or with a tracheostomy B. To determine appropriate home oxygen requirements C. To wean an individual from home oxygen D. To monitor an unstable respiratory condition Not medically necessary when used for any of the following: A. Oximetry when used as a diagnostic procedure B. Monitoring of a stable respiratory condition C. Asthma management D. Other conditions not listed above	E0445
Oxygen tent	Medically necessary when the ability to breathe is impaired and for whom supplemental oxygen is required.	E0455
Invasive ventilator (For non-invasive home ventilators, see LA.*CP.MP.184*)	Medically necessary for a long-term/chronic condition or disease affecting the ability to effectively maintain adequate respiratory status. Examples of conditions may include neuromuscular disease, thoracic restrictive disease, or chronic respiratory failure following COPD.	E0465
Second or backup invasive home ventilator	A second or backup invasive ventilator is considered medically necessary for the following indications: A. A second ventilator to serve a different purpose from the first ventilator, based on medical needs. For example, two different types of ventilators are needed for each day, e.g., negative pressure ventilator with chest shell for one indication and a positive pressure ventilator with nasal mask the rest of the day; B. A back-up ventilator for one of the following: 1. Confined to a wheelchair and requires a wheel-chair mounted ventilator during the day and another ventilator of the same type for use while in bed (unable to position the wheelchair-mounted ventilator close enough to the bed for use while sleeping). Without both pieces of equipment, member/enrollee may be prone to medical complications, unable to achieve appropriate medical outcomes, or may not be able to use the equipment effectively; 2. Residence in remote areas with poor emergency access.	

SURGICAL SUPPLIES	CRITERIA	HCPCS
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

WHEELCHAIRS	CRITERIA	HCPCS
Manual wheelchair	Initial request is medically necessary for when meeting all of the following: A. Mobility-related activities of daily living (MRADLs) in the home cannot be met due to mobility limitation, all of the following: 1. Mobility limitation cannot be met with a cane or walker; 2. Mobility limitation can be met with a manual wheelchair; 3. Home provides adequate access and maneuvering space for requested manual wheelchair; 4. Willingness to use a manual wheelchair in the home; B. 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; C. Wheelchair use will significantly improve MRADLs. Replacement is medically necessary when meeting all of the following: A. Documentation supports at least one of the following: 1. Growth features of current wheelchair have been maximized; 2. Repair or replacement of parts no longer effective; 3. Current wheelchair in use ≥ 5 years; 4. Change in functional status of patient documented; B. Mobility-related activities of daily living (MRADLs) in the home cannot be met due to mobility limitation, all of the following: 1. Mobility limitation cannot be met with a cane or walker; 2. Mobility limitation can be met with a manual wheelchair; 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.	E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0009, 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

WHEELCHAIRS	CRITERIA	HCPCS
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).	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 and may not support medical necessity. 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's/Enrollee's Home
For purposes of rental and purchase of DME, a member's/enrollee's home may be his/her 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's/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, to 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.

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Converted corporate to local policy.	12/20	
Added criteria for enclosed beds to "Other Equipment" section of policy. Added references and codes E0316, E1399 and E0328 or E0329 (when combined with E0316 or E1399) for enclosed beds. Replaced "investigational" with "not proven safe and effective" in the following sections: Pnuematic compression devices, neuromuscular stimulator, and peroneal nerve stimulators. Updated policy to remove neuromuscular stimulator, fuctional neuromuscular stimulator, and peroneal nerve stimulator, which was transferred to CP.MP.48 Neuromuscular Electrical Stimulation (NMES). Replaced existing Standing Frames criteria with new initial request and replacement request criteria. Revised section on pneumatic compression devices to state that they are not proven safe and effective for lymphedema of the abdomen, trunk, chest, genitals, or neck; and for arterial insufficiency. Added criteria for Wheelchair-mounted Assistive Robotic Arm (JACO). Changed "review date" in the header to "date of last revision" and "date" in the revision log header to "revision date." Added "and may not support medical necessity" to coding implications" Reorganized Standing Frame criteria and required that replacement requests also meet existing criteria for the initial request. For initial request under 18, added "and one of the following: Developmental delay in ambulation and ≥ 18 months of age; Documented neurological or neuromuscular impairments and ≥ 1 year of age." Required that documentation supports meeting height and weight requirements, alert and responsive to stimuli, no contraindications to standing program, and caregiver trained, available, and able to safely assist. Removed requirement for "able to tolerate upright position." Added informational note. Removed requirement for replacement requests not due to physiological changes to meet existing criteria and reformatted criteria. Contents table renumbered. References reviewed and updated. Added burn garment HCPCS codes A6502, A6503, A6504, A6505, A6506, A6508, A6509, A6510, A6512 and A6513 to policy. Made note for HCPCS code K0108 to refer to CP.MP.99 for wheelchair seating in Specialized supply or Equipment section.	5/21	4/14/22

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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. LHCC 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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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 LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This clinical policy is the property of LHCC. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.