



## Medicare Part C Medical Coverage Policy

### Durable Medical Equipment (DME)

**Origination:** March 31, 1993

**Review Date:** June 19, 2019

**Next Review:** June, 2021

**\*\*\*This policy applies to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services.\*\*\***

#### **DESCRIPTION OF PROCEDURE OR SERVICE**

Durable Medical Equipment (DME) is defined as any equipment that provides therapeutic benefits or enables the member to perform certain tasks that he/she is unable to undertake due to certain medical conditions and/or illnesses. DME includes equipment such as wheelchairs, hospital beds, traction equipment, canes, walkers, ventilators, oxygen and other medically needed items. A device is considered DME if it is:

1. approved by the Food and Drug Administration (FDA);
2. can withstand repeated use;
3. is primarily and customarily used to serve a medical purpose;
4. generally is not useful to a person in the absence of an illness or injury; **AND**
5. is appropriate in the home.

Categories of DME include:

- *Monitoring Device: Monitoring equipment that is used by the patient to monitor his/her medical condition is covered as durable medical equipment (DME). The equipment itself does not provide the treatment but rather indicates to the patient the need to seek appropriate medical assistance.*
- *Support Devices: support devices are rigid or semi-rigid devices used to support a weak or deformed body part, or to restrict or eliminate motion in a diseased or injured body part.*
- *Supplies: are eligible for coverage according to the contract limitations when ordered by a plan physician, provided incidental to a physician office visit, provided by a home care agency during covered home care, used to assure the proper functioning of covered DME or prosthetic or if provided by a home infusion company during covered services.*

**POLICY STATEMENT**

Coverage will be provided for durable medical equipment when it is determined to be medically necessary, as outlined in the following guidelines and medical criteria.

**BENEFIT APPLICATION**

Please refer to the member's individual Evidence of Coverage (E.O.C.) for benefit determination. Coverage will be approved according to the E.O.C. limitations if the criteria are met.

Coverage decisions will be made in accordance with:

- The Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD);
- General coverage guidelines included in Original Medicare manuals unless superseded by operational policy letters or regulations; and
- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member's particular Evidence of Coverage (E.O.C.), the E.O.C. always governs the determination of benefits.

**INDICATIONS FOR COVERAGE**

The equipment requested must be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member. The member's diagnosis and condition must warrant the type of equipment or supply being purchased or rented.

A. Individual DME items with a contracted rate  $\leq$  \$1,200 will not require prior authorization if **all** of the following criteria are met:

**HMO Members:**

- 1) the item(s) are prescribed by a Physician who isn't excluded from Medicare **AND**
- 2) are medically necessary; **AND**
- 3) will be provided by or obtained from provider/vendor who is contracted with the Plan; **AND**
- 4) the item is filed with a valid HCPCS code; **AND**
- 5) the item(s) must be for purchase only.

**PPO Members:**

- 1) the item(s) are prescribed by a Physician who isn't excluded from Medicare **AND**
- 2) are medically necessary **AND**
- 3) will be provided by a contracted or a non-contracted vendor, but Medicare-certified vendor **AND**
- 4) the item is filed with a valid HCPCS code **AND**
- 5) the item(s) must be for purchase only.

B. Individual DME items with a contracted rate > \$1,200 require prior authorization.

C. All rental items require prior authorization, including rent-to-purchase items.

D. **All** DME items prescribed by a non-contracting physician require prior authorization. (Applies to HMO members only).

E. Individual support devices require prior approval if the contracted rate is > \$1,200.

F. Individual supplies require prior approval if contracted rate is > \$1,200

**AND** must be:

1. a covered item provided incidental to a physician's office visit **OR**
2. provided by a home care agency during covered home care **OR**
3. used to assure the proper functioning of a covered DME item(s) to achieve a therapeutic benefit from the DME **OR**
4. provided by a home infusion company during covered services.

G. **Replacement DME:** Coverage determination for replacement is made according to the average life of the product as established by the manufacturer. Replacement of lost or stolen equipment and repairs (instead of replacement) of purchased equipment are covered at the discretion of the Plan. DME can be replaced in cases of loss or irreparable damage; i.e., specific accident or a natural disaster.

Requests for replacement DME items are covered when:

1. The request is due to normal wear and tear **OR**
2. A statement from the ordering physician documents a change in the patient's physical condition **AND/OR** the ordering physician's rationale for the replacement DME.

\*\*\*Note: Reasonable useful lifetime (RUL) cannot be less than 5 years.

### **WHEN COVERAGE WILL NOT BE APPROVED**

- 1) Over-the-Counter items;
- 2) Personal comfort or convenience items, e.g. household fixtures and equipment which generally have a non-medical purpose;
- 3) Take home items from the hospital;
- 4) Professional fees directly related to dispensing or customizing of the item (these are payable as part of the overall charge);
- 5) Replacement of damaged equipment when damages are not a result of normal wear and tear of a previously approved purchased piece of equipment (i.e., abuse);
- 6) Sales tax and mailing charges (these are included in the overall charge);
- 7) Professional training in the use of the equipment (this is the responsibility of the vendor).

**LIMITATIONS**

- Refer to the individual member's E.O.C. for limitations and exclusions including but not limited to dollar amounts.

**BILLING/ CODING/PHYSICIAN DOCUMENTATION INFORMATION**

This policy may apply to the following codes. Inclusion of a code in the section does not guarantee reimbursement.

*Applicable codes:*

*A codes- medical/surgical supply*

*B codes- enteral and parenteral therapy*

*E codes- Durable medical equipment*

*K codes- Temporary codes*

*L codes- Related to Orthotics*

*V codes- Vision services*

The Plan may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

**SPECIAL NOTES**

- A. Plan reserves the right, in its sole and absolute discretion to determine, with respect to covered DME, supplies, devices, the model or style of the DME, supplies, or device which will be covered.
- B. Rental is authorized for:
  - 1) equipment used for a limited time;
  - 2) equipment that will require frequent servicing;
  - 3) equipment that requires evaluation by an Episodic Care Manager for potential long-term use versus immediate purchase, (i.e., hospital bed, CPAP, wheelchair, etc.).
- C. Purchase may be authorized if:
  - 1) the equipment is customized; **or**
  - 2) immediate purchase is less expensive and long-term rental is expected; **or**
  - 3) A rental item may be converted to purchase after two (2) months if it will be more cost effective to do so and the member is expected to meet the criteria for coverage long term.
  - 4) Once the equipment is owned by the member, the plan will cover reasonable and necessary repairs provided these are not under warranty. If repairs are authorized, a loaner DME must be provided until the repairs are complete and the DME is returned to the member.
- D. Enteral Therapy and Total Parenteral Nutrition (TPN) are reviewed as DME.

For further information on specific policies, see the CMS DME MAC Jurisdiction C website: <http://www.cgsmedicare.com/jc/coverage/lcdinfo.html>

- Refer to the Evidence of Coverage for rules for ownership of durable medical equipment.

References:

1. Medicare National Coverage Determinations Manual, Chapter 1, Part 4 –Coverage Determinations; Rev.173, 09/4/2014, Section 280.1 Durable Medical Equipment: Accessed via Internet site [www.cms.gov](http://www.cms.gov). Viewed on 06/11/2019.
2. CMS Manual Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, Section 110 Durable Medical Equipment- General, Rev 161, 04/1/2013; Accessed via Internet site [www.cms.gov](http://www.cms.gov); Viewed 09/09/2020.
3. Medicare Claims Processing Manual, Chapter 20; Internet site [www.cms.gov/Manuals/IOMlist.asp](http://www.cms.gov/Manuals/IOMlist.asp); viewed on 06/11/2019.
4. MLN SE1103 Revised. Viewed by internet; <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1103.pdf>; updated on 08/14, 2012; viewed on 03/04/2013.
5. 2017 BCBSNC Evidence of Coverage, Chapter 4. Medical Benefits Chart, Durable Medical Equipment and related supplies. Reviewed on 6/11/19.

Policy Implementation/Update Information:

Revision Dates: March 23, 1998; February 16, 2001; May 29, 2001; June 14, 2001; October 3, 2001; December 8, 2004; June 28, 2006; March 19, 2012.

September 2009: Codes section added to policy

March 2012: Removed reference to prosthetics from the policy.

Revision Dates: April 17, 2013. Updated minor edits to mirror NCD. Added note that enteral therapy and TPN are under the DME benefit.

Revision Dates: May 20, 2015; No CMS updates, minor revisions to policy.

Revision Date: June 21, 2017; Annual Review, No CMS updates. For Staff clarification: Indications for Coverage: A) Separated HMO requirements from PPO requirements.

Revision Date: June 19, 2019; Annual Review. No CMS updates. Minor Revisions Only.

Revision Date: February 20, 2020. DME Threshold change for 2020 from \$600 to \$1200. Indications for Coverage A. Updated to reflect this amount.

Revision Date: April 27, 2020: Update to other references to DME Threshold increase missed in February update.

Revision Date: September 16, 2020; Staff Clarification: Indications for Coverage G. "\*\*\*\*Note: Reasonable useful lifetime (RUL) cannot be less than 5 years."

Approval Dates:

Medical Coverage Policy Committee: September 16, 2020

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