

Clinical Policy: Durable Medical Equipment

Reference Number: TX.CP.MP.552

Last Review Date: 07/20

[Coding Implications](#)

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

Description

Durable medical equipment (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.

This policy applies to the following products: STAR, STAR Health, STAR Kids, STAR+PLUS, and CHIP.

Policy/Criteria

I. It is the policy of Superior HealthPlan that DME is **medically necessary** for the following indications:

A. **Medical Necessity Review:**

1. DME may be medically necessary when there is an expectation that the item requested will make a meaningful contribution to the treatment of the member's illness, injury, or malformation.
2. DME items may not be covered in every instance. Coverage in a particular case is subject to the requirement that the equipment be medically necessary and reasonable for treatment of an illness or injury, or to improve the function. Although a DME item may serve a useful medical purpose, realistically feasible alternatives and equipment that the member currently utilizes must be considered.

Note: Medical supplies are not considered DME per definition above.

B. **Benefit Limitations:**

1. Requests that exceed the benefit allowable will require a medical necessity review by the Plan medical director, unless otherwise specified.
2. Pursuant to the Uniform Managed Care Contract, effective March 1, 2018, requests for Medicaid members over age 20 for DME items via a HCPCS code that is set up as non-covered benefit (NCB) can no longer be denied as a NCB. Rather, a medical necessity review must be performed.

C. **Authorization Requirements for Miscellaneous or Unclassified Procedure Codes:**

1. The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 mandate the use of national coding and transaction standards. Correct coding requires that providers use the most specific code that matches the service being requested, based on the code's description.
2. Services that do not have a unique CPT or HCPCS procedure code may require use of a miscellaneous or unclassified procedure code. Such codes require prior authorization.

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3. Additional documentation requirements for a miscellaneous or unclassified procedure codes:
 - a. Medical records that document the medical necessity of the requested service.
 - b. A clear, concise description of the service.
 - c. The provider's intended fee including the manufacturer suggested retail price (MSRP), average wholesale price (AWP) or other payment documentation, if applicable.

II. Repairs to member-owned equipment may be considered for prior authorization with documentation of **medical necessity**. Documentation should include:

- A. The medical appliance or equipment continues to serve a specific medical purpose
- B. Itemized estimated cost of the repairs
- C. Date of item purchase
- D. Serial number of the item

Note: A repair will be considered based on the age of the item and cost to repair it.

III. Replacement to member-owned equipment is considered **medically necessary** when documentation of **one** of the following substantiates the request:

- A. Decline in functional/medical status of member
- B. Growth features of current equipment have been maximized
- C. Repair/replacement of parts are no longer effective or available
- D. Equipment has been lost, stolen, displaced, or damaged

Note: The Plan may convert an item from rental to purchase. This may be done when an item (HCPCS code) is eligible for purchase and the fee schedule has been met or will be met during the current authorization period.

IV. Clinical Information

Clinical information received must be no older than six months.

V. Change of Provider

The member has the right to choose his/her home health and/or DME provider and to change providers. If the member requests services through a new provider, a change of provider letter with the following must be submitted to the Plan:

- A. Signed and dated by the member, parent or legal guardian
- B. Previous provider's name and effective service end date
- C. Current provider's name and effective service start date

Background

Definitions:

- **Member's Home:** For purposes of rental and purchase of DME, a member's home may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some

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other type of institution. However, an institution may not be considered a member'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 who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Members 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.
- **Healthcare Common Procedure Coding System (HCPCS):** Standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes. The existence of a HCPCS code does not indicate coverage or reimbursement acceptance.
- **Medically Necessary Services:** Services or treatments which are prescribed by an examining provider, or other Licensed Practitioner, and which, pursuant to the EPSDT Program, diagnose or correct or significantly ameliorate defects, physical and mental illnesses, and health conditions, whether or not such services are in the state plan.
- **Physician Signature:** The signature of the MD on a Prescription or Request form must be current, on or before the first date of service and no older than (3) months before the service start date. Stamped signatures and dates are not accepted. Signatures of Nurse Practitioners, Clinical Nurse Specialists, Physician Assistants, or Doctors of Philosophy are not accepted on Authorization Request forms or Prescriptions.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are

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from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. 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.

CPT® Codes	Description
N/A	

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
New Policy	01/14	01/14
Removed E0481 on page 33 since it is not a covered benefit. Updated attached ARQ list and ARQ list with benefit limitations. Updated signatories.	04/14	04/14
Remove PA requirement for Enuresis Alarms. Added PA authorization for Standardized DME list and exception to the PA requirement for incontinence supplies if provided by a DME preferred supplier. Updated References and Signatories. Updated Attachments.	01/15	01/15
Removed work process and imbedded under attachment.	02/15	02/15
Updated coverage criteria for standing table or prone stander, HFCWD, percussor, and total parental pumps. Updated ARQ attachment. Added experimental and investigational verbiage around DME and added experimental definition. Updated References. Removed work process.	08/15	08/15
Removed work process. Removed embedded Excel worksheet – Authorizing Durable Medical Equipment. Updated references and signatories. Grammatical edits. Updated InterQual to 2015 version. Updated definition of HCPCS. Added hospital-grade breast pump (E0604) may be considered for rental, not purchase. Added manual (E0602) and non-hospital-grade electric breast pumps (E0603) may be considered for purchase. Added code S1040 for cranial remolding orthosis. Added E1399, croup tent is not considered medically necessary. Added T5001, position seating (feeder seats, corner chairs, floor sitters and travel chairs) are not considered	08/16	08/16

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medically necessary. Added A8003, protective helmets may be considered medically necessary. Removed RSV or RSV bronchiolitis as an indication for E0575, nebulizer ultrasonic. Removed PT/OT as criteria for considering medical necessity of a heavy duty, multiple breaking system, wheel resistance walker and burn garments. Added oximetry is not a covered benefit for monitoring during seizures. Removed case manager to provide “spot checks” for members on chronic O2 to ascertain the continuing medical necessity for oxygen in the home every 60-90 days. Added CPM device rate is “daily”. Added pulse oximeters are a benefit for members “0-20” and not members over age 21. Removed attachment A (ARQ) and inserted reference ARQ on Prior Authorization SharePoint website. Removed attachment B. Removed T2028 and T2029 – Specialized Supply or Equipment- not a covered benefit. Added E0762- Transcutaneous Electrical Joint Stimulator is a benefit. Removed E0986- Wheelchair Power Drive- not a covered benefit. Removed q4100. Skin substitute. NCB. Added Change of Provider section. Removed CHIP RSA and MRSA from products. Added Authorization Requirements for Unlisted Procedure Codes section. Added STAR Kids to products. Removed Q4100, Q4144, Q4118, and Q4130 as these codes do not pertain to DME.		
Edited references, review date, and grammatical edits.	08/17	08/17
Deleted references to External Ambulatory Insulin Infusion Pump.	04/18	04/18
Edit coverage criteria – change InterQual to TMPPM for semi and fully electric hospital beds.	10/18	10/18
Edit coverage criteria for hospital beds and accessories – changed to TMPPM. Updated InterQual to 2017 version.	11/18	11/18
Removed sections related to ADL equipment, augmentative and alternative communication devices, cochlear implants, compression therapy, CPM equipment, diabetes care, diagnostic equipment, decubitus care, enteral equipment, home apnea monitors, surgical supplies, total parenteral equipment, wheelchairs, and wound care. Updated contents section, definitions, reference, and signatories. Removed columns in the charts titled HCPCS and example of diagnosis. Grammatical edits and formatting changes.	02/19	02/19
Policy formatted to Corporate clinical policy template. Reference number and policy title changed from ‘TX.UM.10.52 Protocol for Authorizing Durable Medical Equipment’ to ‘TX.CP.10.52 Durable Medical Equipment’ Removed reasonable and customary use review under General Criteria sections. Removed over the limit request items, non-covered benefit items, and items reviewed against TMPPM criteria. Sections removed include heat, cold, and light therapy equipment, hospital beds and accessories,	05/19	05/19

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member lifts and devices, newborn care and equipment, other equipment, pumps. Changed ‘Orthopedic Equipment’ to ‘Orthotic Devices’. Added clinical information received must be no older than 6 months. Updated table of contents and references.		
Updated to new template from TX.UM.10.52 (TX.CP.MP.552 nomenclature implementation 09/14/19). Removed DME criteria charts. Added information under section I. B. ‘Benefit Limitation’ noting DME items set up as non-covered benefit (NCB) can no longer be denied as a NCB. Rather, a medical necessity review must be performed. Added sections IV ‘Clinical Information’ and V. ‘Change of Provider’. Updated references.	08/19	08/19
Annual Review. Updated definitions. Updated References.	07/20	07/20

References

1. Texas Medicaid Provider Procedures Manual, Volume 2, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook, June 2020
2. TX.UM.26 Electronic and Verbal Signature Policy
3. Texas Administrative Code, Rule §354.1039, Home Health Services Benefits and Limitations

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. The 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.

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This clinical policy is effective as of the date determined by the 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. This clinical policy is not intended to recommend treatment for members. Members 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 the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members 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 and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, 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.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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