

Department:	Medical Management	Original Approval:	12/03/2008
Policy #:	MM136	Last Approval:	09/10/2020
Title:	Durable Medical Equipment		
Approved By:	UM Medical Subcommittee		

REQUIRED CLINICAL DOCUMENTATION FOR REVIEW

History and physical exam

Recent (within the past 6 months) chart notes from medical provider and from therapist, as applicable, documenting the need for the Durable Medical Equipment (DME)

List of other DME tried and why it was not appropriate

Details of any specific needs related to risk/trauma/cultural etc.

BACKGROUND

DME items have the following characteristics and must meet all the following criteria in the DME

Definition:

- Is prescribed by a provider (physician (MD, DO, or DPM), advanced registered nurse practitioner, or physician assistant); and
- The order contains the prescriber’s signature or electronic signature, from within the past year; and
- Can withstand repeated use; and
- Is primarily and customarily (traditionally) used to serve a medical purpose; and
- Generally, is not useful for a person in the absence of illness or injury; and
- Is appropriate for use in the client’s place of residence

DEFINITIONS

Durable

Medical equipment considered durable is equipment that can withstand repeated use, such as, the type of item that can 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.

INDICATIONS/CRITERIA

For CHPW **Medicare Advantage** members, if national or local coverage determinations (NCDs, LCDs), as outlined by the Centers for Medicare and Medicaid Services (CMS), are available, then these will be used to determine coverage and criteria to determine medical necessity. If none are available, CHPW uses CHPW Clinical Coverage Criteria and then MCG as noted below.

For **CHNW Cascade Select and CHPW AH-IMC members**: In all cases when available, HCA Health Technology Assessment program determinations are used. For DME not addressed by the HCA HTA Program, CHNW and CHPW use the CHNW/CHPW Coverage Criteria next. For DME not addressed by either, CHNW and CHPW use MCG.

For **Medicare, CHNW Cascade Select, and CHPW AH-IMC Members**, any requests for DME must also meet all the following criteria:

- A current (within 6 months) face-to-face evaluation by the treating physician and therapist, (who are prohibited of being employees of the provider of the item by WAC 182-543-2200), as applicable, showing medical need for the device by the member
- A physical or occupational therapy assessment, including home assessment, if appropriate, to determine the type of device that meets the member's medical needs, is efficacious and safe for the member's use, including during transfers and fits properly in the physical space of the member's home
- Successfully trial by the member of the device or a close simulation of the device
- Results of trials of less expensive devices, if apparently available, and explanation of why these less expensive devices are not appropriate for the member's condition and situation
- CHNW and CHPW consider one piece of mobility/positioning equipment medically necessary, if criteria are met for the equipment. Second items are considered a convenience.
- DME that duplicates equipment that the member already has is not medically necessary

SPECIAL CONSIDERATIONS

Rental of DME

- CHNW and CHPW follows HCA guidelines by applying DME rental fees towards the eventual purchase of a device. (Some DME are for purchase only. Rules regarding rental versus purchase should be checked.)

Repair of DME

- Repair of any DME must meet relevant criteria for medical necessity, including prior authorization if required for similar new equipment.
- Repair is considered only for client-owned equipment after expiration of warranty period.

- It is the expectation of CHNW and CHPW that the provider will have checked for warranty coverage before submitting a request for a DME repair. Warranty coverage will be reviewed, along with repair cost, at the time of assessment for prior authorization.
- Repairs do not require a face to face evaluation with the physician but do require a physician signature on the order.
- CHNW and CHPW do not pay for the repair of equipment, devices, or supplies which have been broken, destroyed, or stolen as a result of the client's carelessness, negligence, recklessness, deliberate intent, or misuse unless:
 - Extenuating circumstances exist that result in a damage or destruction of equipment, devices, or supplies, through no fault of the client that occurred while the client was exercising reasonable care under the circumstances; or
 - Otherwise allowed under specific HCA program rules.

Replacement of DME

- Replacement of any DME must meet relevant criteria for medical necessity, including prior authorization if required for similar new equipment.
- Any requests for DME replacement must include documentation of a current (within 6 months) face-to-face evaluation by the treating physician and therapist, as applicable, showing medical need for the device by the member.
- CHNW and CHPW do not pay for the replacement of equipment, devices, or supplies which have been sold, gifted, lost, broken, destroyed, or stolen as a result of the client's carelessness, negligence, recklessness, deliberate intent, or misuse unless:
 - Extenuating circumstances exist that result in a loss or destruction of equipment, devices, or supplies, through no fault of the client that occurred while the client was exercising reasonable care under the circumstances; or
 - Otherwise allowed under specific HCA program rules.

Loaner DME

For Medicare – members needing loaner DME, due to the current item (purchase or rental) being repaired, would meet for medical necessity.

For CHNW Cascade Select and CHPW AH-IMC: CHNW and CHPW do not rent equipment during the time that a request for similar purchased equipment is being assessed, when authorized equipment is on order, or while the client-owned equipment is being repaired and/or modified. The vendor of service is expected to supply the client with an equivalent loaner.

ADDITIONAL DME CRITERIA:

PLEASE SEE ALSO MM162 “MEDICAL APPROPRIATENESS FOR SERVICE” POLICY, WHICH APPLIES TO ALL DME.

Per MM162, for a service to be medically appropriate, the following criteria must be met:

- Consistent with standards of good medical practice and supported by evidence- based medicine;
- Medically necessary is defined as “a term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of

conditions in the enrollee that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee requesting the service. For the purpose of this section, ‘course of treatment’ may include mere observation or, where appropriate, no medical treatment at all.” (WAC 182-500-0070);

- Consistent with the symptoms, diagnosis, treatment and plan of care of the enrollee’s condition;
- Not solely for the convenience of the enrollee, the enrollee’s family, or the provider of service; and,
- Delivered in the least intensive and most appropriate delivery setting.

EQUIPMENT	CRITERIA
ACTIVITY CHAIR	For CHNW Cascade Select and CHPW AH-IMC members: An activity chair is medically necessary for a member if both the following criteria are met: <ul style="list-style-type: none"> • The member has a significant neurologic impairment that causes inability to control trunk position; and • Does not already have a mobility or positioning device (such as wheelchair, gait trainer, or other prescribed supportive seating)
AFO/KAFO/ORTHOTICS	See CHPW policy MM158
BONE GROWTH STIMULATORS	For Medicare members: CMS Coverage Criteria in Noridian LCD L33796 For CHNW Cascade Select and CHPW AH-IMC members medical necessity criteria for bone growth stimulators are found in: WA HTA 20090828B: Bone Growth Stimulation, 10/30/2009 CMS NCD criteria referenced by the HTA 20090828B: National Coverage Determination (NCD) for Osteogenic Stimulators (150.2)
CHEST COMPRESSION DEVICES	For Medicare Members: Noridian LCD L33785 : High Frequency Chest Wall Oscillation Devices For CHNW Cascade Select and CHPW AH-IMC members: Chest Compression device is medically necessary in addition to chest physiotherapy where there is documented failure of standard treatments to adequately mobilize retained secretions with at least 1 of the following conditions: <ul style="list-style-type: none"> A. Bronchiectasis, confirmed by CT scan, characterized by daily productive cough for at least 6 continuous months or by frequent (i.e., more than 2 times/year) exacerbations requiring antibiotic therapy; <i>or</i>

	<p>B. Cystic fibrosis or immotile cilia syndrome; <i>or</i></p> <p>C. The member has one of the following neuromuscular disease diagnoses:</p> <ul style="list-style-type: none"> a. Acid maltase deficiency b. Anterior horn cell diseases, including amyotrophic lateral sclerosis c. Hereditary muscular dystrophy d. Multiple sclerosis e. Myotonic disorders f. Other myopathies g. Paralysis of the diaphragm h. Post-polio i. Quadriplegia regardless of underlying etiology
COMMUNICATION DEVICES (E.G. SPEECH GENERATORS)	See CHPW policy MM167 Speech Generating Devices (Augmentative Communication Devices)
CONTINUOUS PASSIVE MOTION SYSTEM (CPM)	<p>Medicare: National Coverage Determination (NCD) for Durable Medical Equipment Reference List (280.1)</p> <p>Coverage criteria require all of the following:</p> <ul style="list-style-type: none"> 1) Only covered after a total knee replacement 2) Use of the device must commence within 2 days following surgery 3) Coverage is limited to that portion of the 3-week period following surgery during which the device is used in the patient's home <p>There is insufficient evidence to justify coverage of these devices for longer periods of time or for other applications.</p> <p>For CHNW Cascade Select and CHPW AH-IMC members: Up to 10 days rental during any 12-month period, upon hospital discharge, when the client is diagnosed with one of the following:</p> <ul style="list-style-type: none"> 1) Frozen joints 2) Intra-articular tibia plateau fracture 3) Anterior cruciate ligament injury 4) Total knee replacement
COUGH STIMULATING DEVICES	<p>For Medicare Members: Noridian LCD L33795: Mechanical In-exsufflation Devices</p> <p>For CHNW Cascade Select and CHPW AH-IMC members: MCG Guidelines</p>
CPAP/BIPAP	See CHPW Clinical Coverage Criteria MM135
GAIT TRAINERS	MCG Guidelines
HEARING AIDS	see MM168: Hearing Assist Devices
INSULIN PUMPS and CONTINUOUS	<p>For Medicare members: National Coverage Determination (NCD) for Infusion Pumps (280.14) Local Coverage Determination (LCD): Glucose Monitors (L33822)</p>



GLUCOSE MONITORING	<p>For CHNW Cascade Select and CHPW AH-IMC members:</p> <ul style="list-style-type: none">• Initial request: medical necessity criteria are specified in HTA 20180119B Continuous glucose monitoring 03/16/2018 <p>Continuation of CGM or Insulin Pumps for CHPW Medicare, CHPW AH-IMC, and CHNW Cascade Select</p> <ul style="list-style-type: none">- Ongoing request can be approved when there is documented evidence of compliance with use and reporting, and one of the following criteria is met:- There is objective documented evidence of improvement in control of diabetes (specific to baseline status of disease for individual patients), <i>or</i>- There is documented improvement of hypoglycemia, <i>or</i>- The device is malfunctioning and out of warranty <ul style="list-style-type: none">• Ongoing requests are not medically necessary if:<ul style="list-style-type: none">- The use of an external insulin pump for any indication other than those listed above, <i>or</i>- Member was previously pregnant, and this was the only reason CGM was initially approved, however, member is no longer pregnant but still is requesting CGM.
HOSPITAL BEDS	<p>For Medicare Members: Noridian LCD 11572: Hospital Beds And Accessories</p> <p>For CHNW Cascade Select and CHPW AH-IMC members:</p> <p>Hospital beds: WAC 182-543-3000</p> <p>The Medicaid agency covers one hospital bed in a ten-year period, per client, with the following limitations: (Manual Hospital beds are not routinely carried by DME suppliers)</p> <p>A semi-electric hospital bed only when:</p> <ul style="list-style-type: none">• Has a medical condition that necessitates upper body positioning at no less than a thirty-degree angle the majority of time the client is in the bed, or needs to be in Trendelenburg position, or client's medical condition requires immediate position changes, or body positioning that cannot be achieved with a regular bed (such as with neuromuscular disease, stroke, and spinal cord disorders), or the condition requires special equipment that necessitates a hospital bed for use• The client's medical need requires the client to be positioned in a way that is not possible in a regular bed and the position cannot be attained through less costly alternatives (e.g., the use of bedside rails, a trapeze, pillows, bolsters, rolled up towels or blankets);• The client is able to operate the controls independently. <p>Additional criteria for special beds:</p>



	<p>Indications for a semi-electric hospital bed must be met.</p> <ul style="list-style-type: none"> • Fully electric bed: brain injury, spinal cord injuries, and/or neurological damage that prevents the member from getting in and out of bed. • Heavy-duty, extra-wide/bariatric bed: member’s weight is more than 350 pounds but less than 600 pounds. • Extra-heavy-duty bed: member’s weight is 600 pounds or more. • Variable height hospital bed: Member needs transfer to chair, wheelchair or standing (such as with hip fracture, neurologic impairment). <p>Rental of bed:</p> <ul style="list-style-type: none"> • The above criteria for the particular bed are satisfied • The patient has less than 12 months length of need • Has a chronic or terminal condition such as chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), lung cancer or cancer that has metastasized to the lungs, or other pulmonary conditions that cause the need for immediate upper body elevation <p>Purchase of bed:</p> <ul style="list-style-type: none"> • The above criteria for the particular bed are satisfied • The patient has 12 months or more length of need • The patient has diagnosis of one of the following: quadriplegia; • tetraplegia; • Duchenne muscular dystrophy; • amyotrophic lateral sclerosis (ALS), • ventilator-dependent; or • COPD or CHF with aspiration risk or shortness of breath that causes the need for a immediate change of upper body positioning of more than thirty degrees.
Hospital bed supplies	<p>For bed accessories such as bed cradle, side rails, trapeze equipment and overlays or mattresses, use:</p> <ol style="list-style-type: none"> 1. Medicaid: MCG latest edition 2. Medicare: use LCD if available, if no LCD is available use MCG latest edition
Mandibular Advancement Devices (MAD)	<p>Medicare Members: Noridian Local Coverage Article: Oral Appliances for Obstructive Sleep Apnea - Policy Article (A52512)</p> <p>CHNW Cascade Select and CHPW AH-IMC members: One custom made (no prefabricated) MAD per client (aged 21 years and older), every five years would be covered with prior authorization under code EO486 when the following criteria are met:</p>

	<p>A. A face to face evaluation with a sleep medicine physician prior to sleep testing is completed in agency-designated center of excellence (COE)</p> <p>B. Sleep testing criteria for CPAP is met</p> <ol style="list-style-type: none"> 1. AHI or RDI \geq 15 per hour with minimum of 30 events OR 2. The AHI or RDI \geq 5 and \leq 14 events per hour with minimum of 10 events and documentation of: <ol style="list-style-type: none"> a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or, b. Hypertension, ischemic heart disease, or history of stroke; or, 3. If the AHI > 30 or the RDI > 30 and meets either of the following (a or b): <ol style="list-style-type: none"> a. The member is not able to tolerate a positive airway pressure (PAP) device; or, b. The treating physician determines that the use of a CPAP device is contraindicated. <p>C. The client has tried and failed the use of CPAP. Documentation of at least a 6-month trial period, describing why CPAP failed, or reason explaining why CPAP is not the appropriate treatment</p> <p>D. Device is ordered by treating provider post review of sleep study</p> <p>E. The device is provided and billed for by a licensed dentist (DDS or DMD).</p> <p>F. The device must be titrated in a sleep center by a qualified provider who has experience in titrating the MAD</p> <p>G. The client must have their own teeth (no dentures or partials)</p> <p>Exclusions Prefabricated (E0485) appliances are not considered reasonable and necessary due to insufficient evidence and are not a covered benefit. Not medically necessary are:</p> <ul style="list-style-type: none"> · Oral occlusal appliances for (TMJ) · Tongue retaining devices used to treat OSA and/or snoring · All oral appliances used only to treat snoring without a diagnosis of OSA · Oral appliances used to treat other dental conditions · Oral appliances that require repeated fitting and/or adjustments, beyond the first 90-days, in order to maintain fit and/or effectiveness
OXYGEN	See CHPW Clinical Coverage Criteria MM144
PATIENT LIFTS	<p>For Medicare members: Local Coverage Determination (LCD): PATIENT LIFTS (L33799)</p> <p>For CHNW Cascade Select and CHPW AH-IMC members: current edition of MCG Guidelines</p>
PROSTHETICS	<p>For Medicare members: Noridian LCDs Consult specific LCD on Noridian index at Local Coverage Determination (LCD): Lower Limb Prostheses (L33787)</p>

	For CHNW Cascade Select and CHPW AH-IMC members: current Edition MCG Guidelines For Ankle Foot Orthotics and Ankle Knee Orthotics, see CHPW Clinical Coverage Criteria MM158 Ankle Foot Orthotics and Ankle Knee Orthotics
Positioning Car Seat For EPSDT children <21 years with special orthopedic or neurologic needs (HCPCS T5001)	For CHNW Cascade Select, positioning car seat is not a covered benefit. For CHPW AH-IMC members: Both of the following criteria are required for approval of a positioning car seat: 1. The patient has a significant physical or neurologic or orthopedic condition including one or more of the following: <ul style="list-style-type: none"> – Significant hypotonicity, hypertonicity, athetosis, ataxia, spasticity, seizure disorder, or muscle spasming which results in uncontrollable movement and position change – Orthopedic disease processes resulting in significant bony fragility – Inability to maintain an unsupported sitting position independently 2. A rear-facing Child Safety Seat (CSS) cannot be used because of one or more of the following: <ul style="list-style-type: none"> – Weight 50 lbs or more – Significant casting (such as spica cast for hip dislocation) – Tracheostomy – Severe hydrocephalus – Requirement of prone or supine positioning after surgery (such as for myelomeningocele) – Significant contractures that would result in an inability to perform postural corrections due to vehicle motion – Severe scoliosis, which interferes with proper positioning <u>According to Child Passenger Safety: American Academy of Pediatrics:</u> Most currently available convertible Child Safety Seats (CSSs) can be used rear facing to 40-50 lbs. All children should be restrained in a rear facing CSS for as long as possible.
STANDING FRAME and SIT TO STAND FRAME	For Medicare Members Medicare does not reimburse for standing frames (HCPCS codes E0637, E0638, E0641, E0642, or wheelchair attachments for standing E2230). For CHNW Cascade Select and CHPW AH-IMC members requesting standing frames (HCPCS codes E0637, E0638, E0641, E0642): <ul style="list-style-type: none"> – MCG current edition: Standing Frame
Specialized Strollers for EPSDT members	For CHNW Cascade Select members: strollers are not a covered benefit For CHPW AH-IMC members: The member meets the applicable criteria from MCG current edition, Wheelchairs, Manual (A-0354) The member does not have a wheelchair or plans for a wheelchair A commercially available (non-DME) stroller will not meet the member’s mobility needs

TENS UNITS	<p>For Medicare members: Noridian LCD L33802: Transcutaneous Electrical Nerve Stimulators (TENS)</p> <p>For CHNW Cascade Select and CHPW AH-IMC members: Electrical Neural Stimulation is not medically necessary outside of medically supervised facility settings and is not medically necessary for home use. This is because according to HTA 20091030A – Electrical Neural Stimulation, ENS showed insufficient evidence to conclude it was effective in reducing pain, increasing patient satisfaction and reducing analgesic consumption</p>
TUMOR-TREATING FIELDS (ALSO CALLED: NOVOCURE, OPTUNE, ALTERNATING ELECTRIC FIELD THERAPY) FOR GLIOBLASTOMA	<p>For Medicare and Local Coverage Determination (LCD): Tumor Treatment Field Therapy (TTFT) (L34823)</p> <p>For CHNW Cascade Select and CHPW AH-IMC members: According to the HTCC 20181116A - Tumor treating fields, (TTF) – re-review, which is based on current evidence, this technology is not medically necessary for the treatment of newly diagnosed or recurrent glioblastoma multiforme or for the treatment of other cancers due to unproven efficacy and less cost-effective than comparators.</p>
VENTILATOR, Invasive or Non-invasive	<p>For Medicare members CHNW Cascade Select and CHPW AH-IMC members:</p> <ul style="list-style-type: none"> • Initial request: Medical Necessity Determination: MCG Guidelines A-0893 • Ongoing use: continuing use is medically necessary when both (A and B) are met: <ul style="list-style-type: none"> A. Documentation of improvement in relevant signs and symptoms due to the device; and B. Documentation of complaint use for at least an average of 4 hours or more hours per 24 hours and the requesting physician document ongoing benefit use.
VENTILATOR, BACK-UP	<p>For Medicare, CHNW Cascade Select and CHPW AH-IMC members, CHNW and CHPW cover a back-up ventilator when both 1 and 2 are met:</p> <ol style="list-style-type: none"> 1. Has met criteria per MCG Guidelines A-0893, and 2. When one or more of the following clinical criteria are met: <ol style="list-style-type: none"> a. The client cannot maintain spontaneous ventilations for four or more consecutive hours; b. The client lives in an area where a replacement ventilator cannot be provided within two hours; c. The client requires mechanical ventilation during mobility as prescribed in their plan of care.
WEARABLE CARDIOVERTER DEFIBRILLATOR	<p>For Medicare members: Local Coverage Determination (LCD): Automatic External Defibrillators (L33690) https://med.noridianmedicare.com/documents/2230703/7218263/Automatic+External+Defibrillators Must be reevaluated after 3 months.</p>

	<p>For CHNW Cascade Select and CHPW AH-IMC members: Current edition MCG Guidelines A-0566 Must be reevaluated after 3 months.</p>
<p>WHEELCHAIRS (AND ACCESSORIES) AND SCOOTERS</p>	<p>For Medicare members: Manual Wheelchairs: Noridian LCD L33788 https://med.noridianmedicare.com/documents/2230703/7218263/Manual+Wheelchair+Bases+LCD+and+PA</p> <p>Power mobility devices: Noridian LCD L33789: https://med.noridianmedicare.com/documents/2230703/7218263/Power+Mobility+Devices</p> <p>Wheelchair Options and Accessories: Noridian LCD L33792 https://med.noridianmedicare.com/documents/2230703/7218263/Wheelchair+Options+Accessories+LCD</p> <p>For CHNW Cascade Select and CHPW AH-IMC members use MCG for medical necessity including the below specific requirement. This applies to both Rental/Purchase wheelchairs: MCG current edition: Power Wheelchair, Manual Wheelchair, or Scooter</p> <p>A standard lightweight wheelchair if the client's medical condition does not allow the client to use standard weight wheelchair because of one of the following:</p> <ul style="list-style-type: none"> • The client cannot self-propel a standard weight wheelchair. • Custom modifications cannot be provided on a standard weight wheelchair <p>A high-strength lightweight wheelchair for a client who meets one of the following:</p> <ul style="list-style-type: none"> • Whose medical condition doesn't allow the client to self-propel a lightweight or standard weight wheelchair • Requires custom modifications that cannot be provided on a standard weight or lightweight wheelchair <p>A heavy-duty wheelchair for a client who requires a specifically manufactured wheelchair designed to meet one of the following:</p> <ul style="list-style-type: none"> • Support a person weighing 300 pounds and over • Accommodate a seat width up to 22 inches wide (not to be confused with custom heavy-duty wheelchairs)
<p>WOUND VAC SYSTEMS:</p>	<p>For Medicare members:</p>

	<p>Noridian LCD 11489 Negative Pressure Wound Therapy Pumps https://med.noridianmedicare.com/documents/2230703/7218263/Negative+Pressure+Wound+Therapy+Pumps+LCD+and+PA/21a6cc9a-7d71-4b36-9445-6d7585c4eac9</p> <p>For CHNW Cascade Select and CHPW AH-IMC members, medical necessity criteria are specified in: WA HTA 20161118A: Negative pressure wound therapy for home use (NPWT) 01/20/2017</p>
--	---

LIMITATIONS/EXCLUSIONS

Please refer to a product line’s certificate of coverage for benefit limitations and exclusions for these services:

PRODUCT LINE	LINK TO CERTIFICATE OF COVERAGE
CHPW Medicare Advantage	https://medicare.chpw.org/chpw-washington-state-medicare-advantage-plans/all-medicare-plans-2020/
CHPW Apple Health Integrated Managed Care	https://www.chpw.org/for-members/benefits-and-coverage-imc/
CHNW Cascade Select	

Citations & References

CFR	
WAC	WAC 284-43-2050 , WAC 182-552-1000 , WAC 182-501-0050 ; WAC 182-543-1000 ; WAC 182-543-7100 ; WAC 182-543-2200 ; WAC 284-43-5642
RCW	
Contract Citation	<input checked="" type="checkbox"/> CHPW AH-IMC <ul style="list-style-type: none"> 1.82 Durable Medical Equipment (DME) definition 11.2 Utilization Management General Requirements 11.3 Medical Necessity Determination 17.1: The Contractor shall provide the following services, as medically necessary: 17.1.21: Durable Medical Equipment (DME) and Supplies

		17.1.30.2 Pursuant to WAC 182-501-0050, the Contractor shall review any request for a non-covered service to determine the medical necessity of the service, -- unless it is specifically excluded by this Contract or prohibited by federal rules. 17.15.3: (Clinical practice guidelines shall) Be the basis for and are consistent with decisions for utilization management
	<input checked="" type="checkbox"/> CHPW MA	Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Effective January 1, 2020 Medicare Claims Processing Manual Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) 100.2.1 - Completion of Certificate of Medical Necessity Forms Physician Signature and Date - -- the treating physician must sign and date the CMN (certificate of medical necessity)". "The treating physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable."
	CHNW Cascade Select	<u>WAC 284-43-5642 Essential health benefit categories</u> Requirement to align coverage criteria to Health Technology Clinical Committee (HTCC) decisions
CHPW Clinical Practice Guidelines	Child Passenger Safety: American Academy of Pediatrics	
Other Requirements		
NCQA Elements		
References	MCG Guidelines	

Revision History

Revision Date	Revision Description	Revision Made By
12/03/2008	Approval	MMLT
12/08/2010	Approval	MMLT
02/11/2011	Added sentence on current evaluation for replacement	Lucy Sutphen, MD, FACP
12/14/2011	Approval	MMLT
11/21/2012	Updated DME prior authorization requirements	Lucy Sutphen, MD, FACP
11/28/2012	Approval	MMLT
03/31/2014	References updated with active links	Kate Brostoff MD

MM136_CCC_Durable Medical Equipment

13 of 17

DATA CONTAINED IN THIS DOCUMENT IS CONSIDERED CONFIDENTIAL AND PROPRIETARY INFORMATION AND ITS DUPLICATION USE OR DISCLOSURE IS PROHIBITED WITHOUT PRIOR APPROVAL OF COMMUNITY HEALTH PLAN OF WASHINGTON.

06/20/2014	Updated DME prior authorization requirements	Kate Brostoff MD
06/23/2014	Approval	MMLT
06/15/2015	References updated with active links	Kate Brostoff MD
06/23/2015	Approval	MMLT
08/08/2016	References updated with active links	Cyndi Stilson, RN
08/08/2016	Updated links and MCG reference	Jane Daughenbaugh, RN
08/09/2016	Reviewed – no changes	Victor Collymore, MD
08/09/2016	Approval	MMLT
09/19/2016	Added criteria for high risk fractures per HCA request	Cyndi Stilson, RN
09/27/2016	Approved	MMLT
05/31/2017	Changed 'VENTILATORS' criteria to MCG. Links checked and updated	Cyndi Stilson, RN
06/01/2017	Approved	MMLT
03/26/2018	Changed from UM006	Cindy Bush
04/05/2018	Transferred to new template	Cindy Bush
05/02/2018	Updated and corrected links. Corrected links to HTA for insulin pumps and CGM and for negative pressure wound vac. Corrected bone growth stimulation to reference WA HTA. Corrected speech generating device and cough stimulating devices guidelines for Medicare members. Removed summary for bone growth stimulation because the linked guidelines are clear. Removed erroneous information about rental caps.	LuAnn Chen, MD
5/30/2018	Approved	UM Medical Subcommittee
06/18/2018	Added characteristics for DME per AHMC contract 1.55 DME; Added definition; Removed box under indications/criteria "Medicaid Members" and "Medicare Members" – no information	Yves Houghton, RN
06/22/2018	Approval	UM Committee
07/19/2018	Added CMS information about respiratory assist devices. Added WAC requirements for ventilators, (home, pressure, back-up). Added limitations on replacement due to client's recklessness etc as per WAC 182-501-0050.	LuAnn Chen, MD
08/02/2018	Additional information added for communication devices. Added details regarding semi electric hospital beds	LuAnn Chen, MD
08/14/2018	Approval	UM Medical Subcommittee



09/06/2018	Added criteria for positional car seats and clinical practice guidelines related to child passenger safety. Added criteria for Continuous Passive Motion System. Need to remove SGD and hearing aids since new policies are being created.	LuAnn Chen, MD
9/20/18	Added criteria for electric bed, heavy-duty, extra-wide/bariatric bed and extra-heavy-duty bed	Yves Houghton RN
09/20/2018	Approval	UM Medical Subcommittee
09/26/2018	Approval	UM Committee
10/12/2018	Clarified that prosthetics criteria: MCG AFO/KAFO/orthotics: MM158. Need to remove speech devices when the new policy is posted. Bathroom DME will be separate policy.	LuAnn Chen, MD
10/18/2018	Removed criteria for speech devices and posted the reference to CHPW policy MM167 Speech Generating Devices (Augmentative Communication Devices).	LuAnn Chen, MD
10/19/2018	Approval	UM Medical Subcommittee
11/14/2018	Added indications for Chest compression devices for EPSDT children	LuAnn Chen, MD
11/15/2018	Approved	UM Medical Subcommittee
12/07/2018	Removed reference to non-covered DME items (TENS) for Apple Health, due to CMS requirement.	LuAnn Chen, MD
12/07/2018	Approved	UM Medical Subcommittee
12/18/2018	Added Mandibular Advancement Devices	LuAnn Chen, MD
12/20/2018	Approved	UM Medical Subcommittee
01/04/2019	Added requirement for physician signature	LuAnn Chen, MD
01/04/2019	Approved	UM Medical Subcommittee
01/11/2019	Expanded Chest compression criteria for AH members to include adults	LuAnn Chen, MD
01/15/2019	Approval	UM Committee
1/29/2019	Updated Patient Lifts to use MCG guidelines and removed criteria for hearing aids	Yves Houghton
02/01/2019	Approval	UM Committee
02/27/2019	Requirement for submitting results of trials with similar devices, and home assessment. Removed requirement for physician visit prior to DME repair. Physician signature not	LuAnn Chen, MD

	needed for certain DME or DME ordered for SNF members (can be signed for by ARNP or PA)	
02/28/2019	Approved	UM Medical Subcommittee
03/18/2019	Added criteria for standing frames and sit to stand frames. Change face to face requirement to be 6 months instead of 3 months	LuAnn Chen, MD
04/05/2019	Approval	UM Medical Subcommittee
09/19/2019	Added criteria for Tumor-Treating Fields	LuAnn Chen, MD
10/11/2019	Approval	UM Medical Subcommittee
11/08/2019	Corrected links for Insulin pumps and CGM for Medicare members. Corrected Tumor-Treating Fields criteria to align with the HTA. Corrected link to LCD for Patient Lifts. Corrected lower limb prosthesis LCD link.	LuAnn Chen, MD
11/15/2019	Approval	UM Medical Subcommittee
01/03/2020	Clarified definition of DME and requirement for all DME to have physician signature.	LuAnn Chen, MD
1/10/2020	Added criteria for continued use of CGM	Yves Houghton, RN
01/14/2020	Added criteria for hospital bed for AH members who need body positioning that cannot be achieved with a regular bed and criteria for variable height bed. Combined Ventilator Home, with Ventilator Invasive and Non-invasive, update criteria to use MCG for both LOBs. Updated Ventilator Back up criteria to use MCG for both LOBs.	LuAnn Chen, MD and Yves Houghton, RN
01/21/2020	Approval	UM Medical Subcommittee
02/12/2020	WAH-IMC and MA Contract Citations updated	LuAnn Chen, MD
02/19/2020	Added definition of physician to include MD, DO, DPM. Medicare Claims Processing Manual Chapter 20 referenced.	LuAnn Chen, MD
02/20/2020	Approval	UM Medical Subcommittee
03/04/2020	Clarified definition of DME. Criteria added for activity chair. Added Loaner DME criteria. Added criteria on medical appropriateness. Clarified that CHPW considers one piece of mobility/positioning equipment medically necessary, if criteria are met for the equipment. Second items	LuAnn Chen, MD Yves, Houghton, RN



	are considered a convenience. And that DME that duplicates equipment that the member already has is not medically necessary. Added citation of WAC 182-543-7100 and WAC 182-543-2200 .	
03/12/2020	Approval	UM Medical Subcommittee
04/02/2020	Clarified that Medicare does not reimburse for standing frame. Specified MCG as criteria for AH members for standing frame.	LuAnn Chen, MD
04/03/2020	Approval	UM Medical Subcommittee
06/29/2020	Clarified need for records from within the past 6 months. Clarified that CHPW does not pay for repair of damage to DME caused by neglect or intentional destruction. Clarified criteria for ongoing approval of CGM.	LuAnn Chen, MD
6/29/2020	Added criteria for ongoing ventilator use	Yves Houghton, RN BSN
07/21/2020	Approval	UM Medical Subcommittee
08/03/2020	Corrected link to Medicare CGM criteria. Clarified that ENS is not medically necessary for home use based on HTA. The HTAs on negative pressure wound therapy for home use and the HTA on Bone Growth Simulators supplies medical necessity criteria for these devices. Added criteria for CHNW Cascade Select. Added exception to physician signature for the COVID-19 PHE.	LuAnn Chen, MD
09/10/2020	Approval	UM Medical Subcommittee