



MEDICAL COVERAGE POLICY

SERVICE: Durable Medical Equipment

Policy Number: 028

Effective Date: 04/01/2023

Last Review: 03/30/2023

Next Review Date: 03/30/2024

Important note:

Unless otherwise indicated, this policy will apply to all lines of business.

Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

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PRIOR AUTHORIZATION: **Varies by product line.** See "Prior Authorization List."

POLICY: Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for coverage details.

For Medicare plans, please refer to appropriate Medicare NCD (National Coverage Determination) or LCD (Local Coverage Determination). If there is no applicable NCD or LCD, use the criteria set forth below.

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid TMPPM.

In order for durable medical equipment to be covered, the request must meet the requirements set forth in the Evidence of Coverage (EOC), must not be excluded from coverage in the EOC, and must be medically necessary. Each EOC contract will define the maximum benefit allowed. Items must be prescribed by a physician or other authorized clinician and not available to the general public as "over the counter," unless required by mandate (e.g. diabetic supplies). The following criteria, as defined by CMS, must be met:

- Can withstand repeated use; i.e., could normally be rented and used by successive patients;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of illness or injury; and,
- Is appropriate for use in a patient's home.
- Has an expected lifetime of at least 3 years

Medical necessity determination generally makes use of a review tool, e.g., InterQual®, or applicable Medicare NCD/LCD. Medically necessary DME is a covered benefit, up to any maximum allowable per the member's EOC. BSWHP only covers equipment necessary to restore or support the usual basic functions of daily living in the home. Purchase or rental of DME will be at the discretion of BSWHP. Replacement, repair, and modification of DME will **ONLY** be covered for a material change in clinical status or customary wear and tear; duplicates are not a covered benefit.



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Durable Medical Equipment miscellaneous (E1399):

HCPCS code E1399 is used for DME that does not have a separate identifiable code. As such, there are specific situations where the following rules will apply:

- E1399 for the Volara® device – see medical policy 236 – “Medications, Services & Supplies NOT Medically Necessary”
- E1399 for Vaginal/rectal probe sensors (Promethous: Pathway Vaginal EMG/Stimulation Sensor, and others). When this device is being used as a biofeedback tool, and if biofeedback is a benefit for the member’s plan, use Interqual® criteria subset “Biofeedback Therapy,” the “Medicare Procedures” product, and “Novitas Solutions,” to evaluate for medical necessity.
- When E1399 is used for wheelchair parts and accessories, medical review may NOT be required.

Exclusions: The following items are examples of services which are not considered covered

DME: Household equipment which has a customary purpose other than medical such as, but not limited to:

- exercise cycles,
- air purifiers,
- air conditioners,
- water purifiers,
- allergenic pillows,
- mattresses and water-beds
- household fixtures including, but not limited to, escalators, elevators, saunas, swimming pools, ramps, stairs, and bathroom modifications.
- Miscellaneous items including, but not limited to dentures, hearing aids, eyeglasses, and corrective lenses (unless covered by rider).

OVERVIEW: Durable medical equipment (DME) must be able to withstand repeated use. DME must be primarily and customarily used to serve a medical purpose, rather than being for patient comfort or convenience. It must be medically necessary for one or more activities of daily living (ADL). DME should be appropriate for use in the home. DME should not be useful to a person without injury or illness. CMS defines DME at this location: <https://www.medicare.gov/coverage/durable-medical-equipment-coverage.html>

MANDATES: There are no mandated benefits or regulatory requirements for BSWHP to provide coverage for these services with the exception of diabetic supplies.

CODES:

Important note:

***CODES:** Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.*

CPT Codes:	
CPT Not Covered	
ICD-10 Codes:	



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ICD-10 Not Covered	
HCPCS Codes	A, B, E, K, L codes

POLICY HISTORY:

Status	Date	Action
New	08/1/2010	New policy
Reviewed	10/18/2011	Reviewed.
Reviewed	12/6/2011	Reviewed.
Reviewed	10/25/2012	Reviewed.
Reviewed	10/3/2013	No changes
Reviewed	07/24/2014	Added CMS definition
Reviewed	08/11/2015	No changes.
Reviewed	08/18/2016	No changes.
Reviewed	07/18/2017	No changes.
Reviewed	05/29/2018	Clarified language in the policy statement.
Reviewed	08/22/2019	No changes.
Reviewed	09/24/2020	Reformatted for SWHP/FirstCare
Reviewed	09/23/2021	No changes
Reviewed	03/24/2022	Added specific information regarding E1399
Reviewed	03/30/2023	Added another E1399 item

REFERENCES: The following scientific references were utilized in the formulation of this medical policy. BSWHP will continue to review clinical evidence surrounding acupuncture with and without electrical stimulation and may modify this policy at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to BSWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order

- Centers for Medicare and Medicaid Services (CMS). National Coverage Determination (NCD) for Durable Medical Equipment Reference List (280.1). Effective 5/5/2005.
- U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA). Definition of durable medical equipment. Medicare Carriers Manual §2100.1. Baltimore, MD: HCFA; 1999.
- Medicare Definition of DME. <https://www.medicare.gov/coverage/durable-medical-equipment-coverage.html> Accessed 7/7/2017

Note: Health Maintenance Organization (HMO) products are offered through Scott and White Health Plan dba Baylor Scott & White Health Plan, and Scott & White Care Plans dba Baylor Scott & White Care Plan. Insured PPO and EPO products are offered through Baylor Scott & White Insurance Company. Scott and White Health Plan dba Baylor Scott & White Health Plan serves as a third-party administrator for self-funded employer-sponsored plans. Baylor Scott & White Care Plan and Baylor Scott & White Insurance Company are wholly owned subsidiaries of Scott and White Health Plan. These companies are referred to collectively in this document as Baylor Scott & White Health Plans.

RightCare STAR Medicaid plans are offered through Scott and White Health Plan in the Central Managed Care Service Area (MRSA) and STAR and CHIP plans are offered through



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SHA LLC dba FirstCare Health Plans (FirstCare) in the Lubbock and West MRSAs. Individual HMO plans are offered through FirstCare in West Texas.