Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements (for Louisiana Only)
Retired April 1, 2026

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Instructions for Use
Certain content mandated by Louisiana Department of Health

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Application

This Medical Policy only applies to the state of Louisiana. Portions of the coverage rationale contained in this policy represent Louisiana Medicaid coverage policy and is set forth below in accordance with state requirements.

Coverage Rationale

When determining medical necessity, clinical guidelines will be applied in the following order:
1. Federal, state, and contractual requirements
2. UnitedHealthcare Community Plan Medical Policy
3. InterQual® CP Durable Medical Equipment
4. InterQual® Medicare: Post Acute & Durable Medical Equipment, Ventilators NCD
5. Centers for Medicare & Medicaid Services (CMS) DME Medicare Administrative Contractor (MAC)

Durable Medical Equipment (DME), related supplies, and orthotics are medically necessary when:
- Consistent with the state definition of DME and/or Orthotic; and
- The item(s) meets the plan's definition of medically necessary (refer to the federal, state, or contractual requirements); and
- Ordered by a physician, or ordered by a nurse practitioner, clinical nurse specialist, or physician assistant acting within the scope of practice under state law; and
- The item is not otherwise excluded from coverage

Electric Breast Pump

An electric breast pump is a mechanical device powered by batteries or electricity used by nursing mothers to extract milk from their breasts. Medicaid considers personal-use, double, and electric breast pumps a coverable item for nursing mothers. A new breast pump is covered for each viable pregnancy. The breast pump may be obtained at the gestational age of 32 weeks to expectant mothers who meet the criteria and intend to breastfed their infant.

Note: Single, manual, and hospital-grade breast pumps are not covered items under Louisiana Medicaid.

Equipment Criteria

Electric breast pumps are dispensed to Medicaid beneficiaries who must meet, at a minimum, the below criteria:

- Have an adjustable suction pressure rate with either written instructions or an automatic mechanism to prevent a suction greater than 250 mmHg
- Be adaptable for simultaneous pumping of both breasts (double collection)
- Automatically cycle with an adjustable variable cycling rate, typically 30 to 60 or more cycles per minute
- Include a battery option and adapter to be used as an alternate power source when electricity is not immediately availabl;
- Breast shields (flanges) that are adjustable and flexible, or flanges that are available in several different sizes if rigid, including larger sizes
- Accessories necessary for pumping two breasts simultaneously for electric pumps
- At least two collection bottles with spill-proof standard size caps, which are bisphenol-A (BPA) and DEHP-free; and
- Accessories and supplies must be compatible with the pump provided. Materials must be of durable quality for withstanding repeated boiling, washing, and pumping use

Replacement Criteria

Medicaid will allow replacement of a breast pump older than three years and after expiration of manufacturer's warranty. Replacement and warranty are subject to policy in the Section 18.2 of the Louisiana Medicaid DME Provider Manual.

Electric Breast Pump Supplies

Electric breast pump supplies will be available to the nursing mother once every 180 days. DME providers must obtain a prior authorization for replacement supplies.

(Louisiana Durable Medical Equipment Provider Manual, Chapter 18: Durable Medical Equipment, Section 18.2: Specific Coverage Criteria)

Human Milk Storage Bags

Human milk storage bags are designed to safely store and protect expressed human milk for feeding a child. Medicaid covers 100 human milk storage bags per month for lactating beneficiaries. The Medicaid reimbursement rate on file covers a one-month supply of storage bags.

(Louisiana Durable Medical Equipment Provider Manual, Chapter 18: Durable Medical Equipment, Section 18.2: Specific Coverage Criteria)

Enteral Infusion Pump

A standard enteral infusion pump will be approved only with documented evidence that the pump is medically necessary and that syringe or gravity feedings are not satisfactory due to complications such as aspiration, diarrhea, dumping syndrome, etc. Medicaid will pay for the rental of a standard enteral infusion pump and accessories.

(Louisiana Durable Medical Equipment Provider Manual, Chapter 18: Durable Medical Equipment, Section 18.2: Specific Coverage Criteria)

Orthotic Devices

Orthotic devices include leg braces, neck braces, knee braces and supports, spinal supports, splints, brace attachments, and repairs. The request for approval should include the following:

- Complete description of special type brace
- Beneficiaries mental and physical ability to use the device
- Whether the device is a replacement
- Whether training is indicated; and
- The plan of training, when indicated

(Louisiana Durable Medical Equipment Provider Manual, Chapter 18: Durable Medical Equipment, Section 18.2: Specific Coverage Criteria)

Equipment Maintenance and Repair

Medicaid will reimburse for the maintenance and repair of equipment only when the following conditions are met:

- Equipment is covered by Medicaid

- Equipment is the personal property of the beneficiary
- Item is still medically necessary
- Equipment is used exclusively by the beneficiary
- No other payment source is available to pay for the needed repairs
- Equipment damage is not due to misuse, abuse, neglect, loss, or wrongful disposition by the beneficiary, the beneficiary's caregiver, or the provider
- Equipment maintenance is performed by a qualified technician
- Maintenance is not currently covered under a manufacturer's or provider's warranty agreement; and
- Maintenance is not performed on a duplicate type of item already being maintained for the beneficiary during the maximum limit period

(Louisiana Durable Medical Equipment Provider Manual, Chapter 18: Durable Medical Equipment, Section 18.2: Specific Coverage Criteria)

Limitations for Replacement of Equipment

Medicaid will not replace equipment that is lost, destroyed, or damaged as a result of misuse, abuse, neglect, loss, or wrongful disposition of equipment by the beneficiary, the beneficiary's caregiver(s), or the provider. At a minimum, examples of equipment misuse, abuse, neglect, loss, or wrongful disposition by the beneficiary, the beneficiary's caregiver, or the provider include but are not limited to the following:

- Failure to clean and maintain the equipment as recommended by the equipment manufacturer; and
- Failure to store the equipment in a secure and covered area when not in use; and
- Loss, destruction, or damage to the equipment caused by the malicious, intentional, or negligent acts of the beneficiary, the beneficiary's caregiver, or the provider

If equipment is stolen or destroyed in a fire, the provider must obtain, in a timely manner, a completed police or insurance report that describes the specific medical equipment that was stolen or destroyed. The police or insurance report must be submitted with the new PA request.

Medicaid may replace equipment when the beneficiary's medical necessity changes. The provider must submit the documentation required to justify the purchase of the replacement equipment.

(Louisiana Durable Medical Equipment Provider Manual, Chapter 18: Durable Medical Equipment, Section 18.1: Services and Limitations)

Artificial Larynxes

An artificial larynx is approved only if the larynx is removed and the beneficiary is unable to use an esophageal voice. Repairs and batteries are included.

(Louisiana Durable Medical Equipment Provider Manual, Chapter 18: Durable Medical Equipment, Section 18.2: Specific Coverage Criteria)

Ventilators and Respiratory Assist Devices (Applies for 2 Years of Age and Older)

For members 2 years of age and older, ventilators are not medically necessary when used only to deliver continuous or intermittent positive airway pressure for adults and children. Any type of ventilator would not be medically necessary when:

- The ventilator is used only in a bi-level PAP (HCPCS codes E0470 and E0471) mode; or
- Used for conditions that qualify for use of a respiratory assistance device (RAD) that are not life-threatening conditions where interruption of respiratory support would quickly lead to serious harm or death; or
- Ventilators, such as Trilogy mechanical ventilators (HCPCS codes E0465 and E0466), used for the treatment of conditions that deliver continuous or intermittent positive airway pressure

Mechanical ventilators (HCPCS codes E0465 and E0466) are considered medically necessary to treat neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease in certain clinical scenarios. For medical necessity clinical coverage criteria, refer to the InterQual® Medicare: Post Acute & Durable Medical Equipment, Ventilators NCD.

Click here to view the InterQual® criteria.

Ventilator Assist Devices

PAP Therapy

For the evaluation of PAP therapy, hypopnea is defined as an abnormal respiratory event lasting at least 20 seconds associated with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4 percent decrease in oxygen saturation.

The apnea-hypopnea index (AHI) is defined as the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of two hours of sleep without the use of a positive airway pressure device, reported by polysomnography using actual recorded hours of sleep (i.e., the AHI may not be extrapolated or projected).

(Louisiana Durable Medical Equipment Provider Manual, Chapter 18: Durable Medical Equipment, Section 18.2: Specific Coverage Criteria)

Bi-level Positive Airway Pressure

The following policy guidelines apply to all ventilator assist devices:

- All equipment needs, including emergency equipment, must be prior authorized. The PAU will act on emergency requests and give a decision within two working days. If not an emergency, the PAU will act on written requests and give a decision within 25 days. Unless the physician can clearly justify purchase of the equipment, a rental trial period of up to three months can be requested to have an adequate trial period to document appropriateness; and
- Other equipment, such as low-pressure alarms, must be separately documented to show medical necessity. Low pressure alarms will be approved for beneficiaries who are ventilator dependent or at risk for a life-threatening event. Pulse oximetry, due to its technology limitations, is not reimbursable for home use; and
- These guidelines exist to assist the physician and the fiscal intermediary to efficiently approve most applications but allow physicians to request consideration for beneficiaries which for unique reasons fall outside criteria. All medical providers are expected to preserve pertinent information which may periodically be surveyed to evaluate these criteria in the future; and
- Non-disposable, reusable supplies should be prescribed, if appropriate, for medical care and economical reasons. Periodic exacerbations may increase supply needs; therefore, an extra prescription should be written. The prescription should be written out “As needed” and not by using the acronym “prn” so it can be used anytime during a several month span; and
- The use of oxygen must be considered for those beneficiaries where these devices fail to adequately improve the beneficiary’s condition. There must be documentation of satisfactory clinical improvement such that mechanical ventilation through a tracheotomy tube is justifiably avoided

(Louisiana Durable Medical Equipment Provider Manual, Chapter 18: Durable Medical Equipment, Section 18.2: Specific Coverage Criteria)

Continuous Positive Airway Pressure

A continuous positive airway pressure (CPAP) machine is used to treat beneficiaries who have moderate to severe obstructive sleep apnea.

A respiratory cycle is defined as an inspiration, followed by expiration. Polysomnography is the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep with physician review, interpretation, and report. It must include sleep staging, which is defined to include a 1-4 lead electroencephalogram (EEG) and electrooculogram (EOG), and a submental electromyogram (EMG).

Polysomnography must also include at least the following additional parameters of sleep: airflow, respiratory effort, and oxygen saturation by oximetry. It may be performed as either a whole night study for diagnosis only or as a split night study to diagnose and initially evaluate treatment. Apnea is defined as the cessation of airflow for at least 10 seconds documented on a polysomnogram.

Criteria for Adults

A single level CPAP device is covered if the beneficiary has a diagnosis of obstructive sleep apnea (OSA), documented by an attended facility-based polysomnogram or a home-based HSAT, and meets either of the following criteria:

- The AHI is greater than or equal to 15 events per hour; or
- The AHI is from 5 to 14 events per hour with documented symptoms of:
  - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or
  - Hypertension, ischemic heart disease, or history of stroke

Polysomnographic studies may be performed in a facility based sleep study laboratory, in the home or in a mobile facility. Sleep study labs must be qualified providers of Medicare or Medicaid services and comply with all applicable state regulatory requirements.

Pediatric Criteria (Under 21 Years of Age)

- A single level CPAP device is covered if the beneficiary has a diagnosis of OSA documented by an attended, facility-based polysomnogram and there is:
  - Documentation of physical exam (including airway) and of any other medical condition, which may be correctable (e.g., tonsillectomy and/or adenoidectomy) prior to the institution of assisted ventilation
  - Documentation of how sleep disturbance reduces the quality of life and affects the activities of daily living
  - Prescription by a physician with training and expertise in pediatric respiratory sleep disorders
  - Documentation of the medical diagnosis, which is known to cause respiratory/sleep disorders
  - Sleep or respiratory study documenting two or more of the following:
    - Oxygen saturation of less than 90 percent pulse oximetry or partial pressure of transcutaneous or arterial of less than 60 mmHg
    - Carbon dioxide greater than 55 mmHg bye end tidal, transcutaneous, arterial, or capillary blood measurement
    - Apnea of 10 to 20 seconds duration on the average of one per hour
- A follow up plan should be submitted identifying the responsible physician or facility, giving data collected to demonstrate the success or failure of intervention, and showing a visit within the first month of use and a second assessment within the first three months of use
- Indication of a responsible, committed home environment and of caregivers properly trained in appropriate respiratory care
- A written plan for home health follow up care

(Louisiana Durable Medical Equipment Provider Manual, Chapter 18: Durable Medical Equipment, Section 18.2: Specific Coverage Criteria)

Medical Supplies

Durable Medical Equipment (DME)/supplies are covered when medical necessity criteria are met for use as part of the medical care of a beneficiary. Refer to the Louisiana Durable Medical Equipment Provider Manual, Chapter 18: Durable Medical Equipment, Section 18.2: Specific Coverage Criteria.

Non-Covered DME Services and Items

A non-covered service, item, or supply is not available for reimbursement. Listed below are items and services that are not reimbursed by Medicaid through the DME program.

- Clinically unproven equipment
- Comfort or convenience equipment
- Dentures
- Disposable supplies customarily provided as part of a nursing or personal care service or a medical diagnostic or monitoring procedure
- Electric lifts (manual lifts are covered)
- Emergency and non-emergency alert devices
- Environmental modifications (e.g., home, bathroom, ramps, etc.)
- Equipment designed for use by a physician or trained medical personnel
- Experimental equipment
- Facilitated communications (FC)
- Furniture and other items which do not serve a medical purpose
- Hand held showers
- Investigational equipment
- Items used for cosmetic purposes
- Personal comfort, convenience, or general sanitation items
- Physical fitness equipment
- Precautionary-type equipment (e.g., power generators, backup oxygen equipment)
- Rehabilitation equipment
- Reimbursement for delivery or delivery mileage of Medical Supplies
- Routine and first aid items
- Safety alarms and alert systems/buttons

- Scooters
- Seat lifts and recliner lifts
- Standard car seats
- Supplies or equipment covered by Medicaid per diem rates (nursing home residents maybe approved for orthotics and prosthetics, but not for DME and supplies)
- Televisions, telephones, VCR machines, and devices designed to produce music or provide entertainment
- Training equipment or self-help equipment
- Van lifts
- Wheelchair lifts
- Wheelchair ramps

Note: This list is not all inclusive.

(Louisiana Durable Medical Equipment Provider Manual, Chapter 18: Durable Medical Equipment, Section 18.1: Services and Limitations)

Definitions

Check the federal, state, or contractual definitions that supersede the definitions below.

Durable Medical Equipment (DME): Medical equipment that is all of the following:
- Suitable for use in any setting in which normal life activities take place
- Can withstand repeated use
- Generally not useful to an individual in the absence of a disability, illness, or injury
- Can be reusable or removable
- Is not implantable within the body
- Primarily and customarily used to serve a medical purpose
- Meets the federal/state definition of DME

Medical Supplies: Supplies are health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medial disability, illness, or injury (CFR § 440.70).

Reasonable Useful Lifetime: RUL is the expected minimum lifespan for the item. It starts on the initial date of service and runs for the defined length of time. The default RUL for Durable Medical Equipment is 5 years. RUL is also applied to other non-DME items such as orthoses and prostheses. RUL is not applied to supply items.

Applicable Codes

UnitedHealthcare has adopted the requirements and intent of the National Correct Coding Initiative. The Centers for Medicare & Medicaid Services (CMS) has contracted with Palmetto to manage Pricing, Data and Coding (PDAC) for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). This notice is to confirm UnitedHealthcare has established the PDAC as a source for correct coding and coding clarification.

Benefit Considerations

Contact Lenses & Scleral Bandages (Shells)

Contact lenses or scleral shells that are used to treat an injury or disease (e.g., corneal abrasion, keratoconus, or severe dry eye) are not considered DME and may be covered as a therapeutic service. Refer to the federal, state, or contractual requirements for coverage.

Cranial Remolding Orthosis

Cranial molding helmets (cranial remolding orthosis, billed with HCPCS code S1040) are covered when they meet medical criteria. For all indications, refer to the Medical Policy titled Plagiocephaly and Craniosynostosis Treatment (for Louisiana Only).

Note: A protective helmet (HCPCS codes A8000–A8004) is not a cranial remolding device. It is considered a safety device worn to prevent injury to the head rather than a device needed for active treatment.

Implanted Devices

Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body is not covered as DME. (If covered, the device is covered as part of the surgical service.)

Cochlear Implant Benefit Clarification: The external components (i.e., speech processor, microphone, and transmitter coil) are considered under the DME benefit, and the implantable components are considered under the medical-surgical benefit. Refer to the federal, state, or contractual requirements to determine if there are DME benefits for repair or replacement of external components.

Diabetic Supplies and Equipment

Insulin pumps requiring tubing and supplies are covered through the Durable Medical Equipment, prosthetics, orthotics, and supplies (DMEPOS) program. All reservoirs and canisters will be covered through the DMEPOS program. All other diabetic supplies and equipment are covered through the Louisiana Medicaid Pharmacy Program.

External insulin pumps (e.g., Cequr Simplicity, Omnipod and V-Go) will be reimbursed as a pharmacy benefit only (Louisiana Department of Health Informational Bulletin 23-11, 2024).

Continuous Subcutaneous Insulin External Infusion Pumps

A continuous subcutaneous insulin external infusion pump is a portable insulin pump. It is about the size and weight of a small pager. The pump delivers a continuous basal infusion of insulin. Insulin pumps can be automatically programmed for multiple basal rates over a 24-hour time period. This can be useful for such situations as nocturnal hypoglycemia, the dawn phenomenon, and to assist with tight glycemic control.

Before meals or at other times (e.g., hyperglycemia after unanticipated caloric intake), the pump can be set to deliver a bolus of insulin, similar to taking an injection of pre-meal regular insulin for someone using multiple daily injections.

Payment for a continuous subcutaneous insulin external infusion pump and related supplies will be authorized for treatment of Type I diabetes. Beneficiaries must meet either Criterion A or B as follows:

- **Criterion A**: The beneficiary has completed a comprehensive diabetes education program and, for at least six months prior to initiation of the insulin pump, has been on a program of multiple daily injections of insulin (at least three injections per day) with frequent self-adjustments of insulin dosages; and has documented an average frequency of glucose self-testing of at least four times per day during the two months prior to initiation of the insulin pump; and meets **two or more** of the following criteria while on the multiple daily injection regimen:
  - Glycosylated hemoglobin level (HbAlc) greater than 7.0 percent
  - History of recurring hypoglycemia
  - Wide fluctuations in blood glucose levels (regardless of A1C)
  - Demonstrated microvascular complications
  - Recurrent severe hypoglycemia
  - Suboptimal diabetes control (A1C exceeds target range for age)
  - Adolescents with eating disorders
  - Pregnant adolescents
  - Ketosis-prone individual
  - Competitive athletes; and
  - Extreme sensitivity to insulin in younger children
- **Criterion B**: The beneficiary with Type I diabetes has been on a pump prior to enrollment in Medicaid and has documented an average frequency of glucose self-testing of at least four times per day during the month prior to Medicaid enrollment.

In addition to meeting Criterion A or B above, the beneficiary with diabetes must be insulinopenic per the updated fasting C-peptide testing requirement, or must be autoantibody positive [e.g., islet cell autoantibodies (ICA), glutamic acid decarboxylase (GAD65), the 40K fragment of tyrosine phosphatase (IA2), insulin autoantibodies (IAA), or zinc transporter 8 autoantibodies (ZnT8)].

Updated fasting C-peptide testing requirement:

- Insulinopenia (defined as fasting C-peptide level less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method); and

- Fasting C-peptide levels will only be considered valid with a concurrently obtained fasting glucose of less than 225 mg/dl
  Note: Levels only need to be documented once in the medical record.

The pump must be ordered by a physician who has familiarity with continuous subcutaneous insulin infusion (CSII) and who works closely with a team of nurses, diabetes educators, and dietitians who are knowledgeable in the use of CSII; the follow-up care of the beneficiary must be managed by a physician meeting these same requirements.

(Louisiana Durable Medical Equipment Provider Manual, Chapter 18: Durable Medical Equipment, Section 18.2: Specific Coverage Criteria)

Lymphedema Stockings for the Arm

Post-mastectomy lymphedema stockings for the arm are considered DME. For state specific information on mandated coverage, refer to the state or contractual requirements.

References

Centers for Disease Control and Prevention. https://www.cdc.gov/growthcharts/clinical_charts.htm. Accessed July 22, 2024.

Code of Federal Regulations (CFR). Home health services. 42 CFR 440.70. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.70. Accessed July 22, 2024.

Louisiana Department of Health Durable Medical Equipment Provider Manual. Chapter Eighteen of the Medicaid Services Manual. Issued September 1, 2010. https://www.lamedicaid.com/provweb1/Providermanuals/manuals/DME/DME.pdf. Accessed July 2, 2025.

Louisiana Department of Health Informational Bulletin 23-11. Diabetic Supplies Coverage as a Pharmacy Benefit. Issued January 26, 2024.

Policy History/Revision Information

Date	Summary of Changes
04/01/2026	• Retired policy; Louisiana plan membership disenrolled on Apr. 1, 2026
01/01/2026	**Coverage Rationale** ***Electric Breast Pump*** • Revised list of equipment criteria for electric breast pumps dispensed to Medicaid beneficiaries; replaced "*all* accessories necessary for pumping two breasts simultaneously for electric pumps" with "accessories necessary for pumping two breasts simultaneously for electric pumps" ***Continuous Positive Airway Pressure (CPAP)*** Criteria for Adults • Replaced language indicating: ○ "A single level CPAP device is covered if the beneficiary has a diagnosis of obstructive sleep apnea (OSA), documented by an attended facility-based polysomnogram, and meets the [listed] criteria" with "a single level CPAP device is covered if the beneficiary has a diagnosis of obstructive sleep apnea (OSA), documented by an attended facility-based polysomnogram *or a home-based home sleep apnea test (HSAT)*, and meets the [listed] criteria" ○ "Polysomnographic studies *must* be performed in a facility-based sleep study laboratory, *and not* in the home or in a mobile facility; *these* labs must be qualified providers of Medicare or Medicaid services and comply with all applicable state regulatory requirements" with "polysomnographic studies *may* be performed in a facility-based sleep study laboratory, in the home, or in a mobile facility; *sleep study* labs must be qualified providers of Medicare or Medicaid services and comply with all applicable state regulatory requirements • Removed language indicating polysomnographic studies may not be performed by a DME provider **Supporting Information** • Archived previous policy version CS032LA.T

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.