Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid

Policy Number: BIP050.DD
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➲ Instructions for Use

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Related Benefit Interpretation Policy

- Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/ Orthotics (Non Foot Orthotics) and Medical Supplies

Medical Supplies Grid

Note: This policy is based, in part, upon Medicare DME MAC and/or Medicare criteria.

Item	Coverage	Comments
Aero Chamber (Spacer)	DME	Covered with mask for children 3 years of age through supplemental pharmacy benefit. Or per state law (California Health and Safety Code Section 1367.06 effective Jan. 1, 2025), covered as DME for the management and treatment of pediatric asthma of Dependent children under the age of 19.
Air Splint	Medical Supply*	Clear plastic splints inflated by air used temporarily on fractured, broken, crushed, or burned limbs.
Air-Fluidized Bed		Refer to Alternating Pressure Pads and Mattress (Pressure Reducing Support Surfaces)
Alternating Pressure Pads and Mattress (Pressure Reducing Support Surfaces) (Face-to-face requirement may be applicable).	DME	Coverage criteria apply. Refer to the Medical Policy titled Beds and Mattresses.
Ambulatory Boot	Corrective Appliance/ Orthotic	Covered when medically necessary. Also known as surgical boot.
Ambulatory Cardiac Event Monitoring (example: Holter Monitor, Event Monitor, Patch-Type Monitor, Zio Patch	Not Covered	Refer to the Medical Policy titled Implantable Loop Recorders and Wearable Heart Rhythm Monitors.

Item	Coverage	Comments
Ankle-Foot Orthosis (AFO)/Knee-Ankle-Foot Orthosis (KAFO) (Face-to-face requirement may be applicable)	Orthotic	Coverage criteria apply. Refer to the DME MAC LCD for Ankle-Foot/Knee-Ankle-Foot Orthosis (L33686). **Note**: A foot drop splint/recumbent positioning device and replacement interface will be denied as not medically necessary in a patient with foot drop who is non-ambulatory because there are other more appropriate treatment modalities.
Apnea Monitor Infant or Child	DME	There must be documentation of sleep apnea by a sleep study and a history of apnea events. Rental only. Not covered for adults.
Artificial Eye (Eye Prosthesis)	Prosthetic	Covered for member with absence or shrinkage of an eye due to birth defect, trauma, or surgical removal. Coverage includes polishing and resurfacing. Orbital implants are reimbursed as surgical implants. Refer to the: • DME MAC LCD for Eye Prosthesis (L33737). • Medicare Benefit Policy Manual, Chapter 15, §120 – Prosthetic Devices and §130 – Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes.
Artificial Larynx or Electrolarynx (e.g., UltraVoice)	Prosthetic	Covered as prosthetic. Refer to the Medicare Benefit Policy Manual, Chapter 15, §120 – Prosthetic Devices.
Artificial Extremities – Lower Extremities • Standard Microprocessors	Prosthetic	Coverage criteria apply. Refer to the Medical Policy titled Lower Extremity Prosthetics.
Artificial Extremities – Upper Extremities • Standard • Myoelectric	Prosthetic	Coverage criteria apply. Refer to the Medical Policy titled Upper Extremity Prosthetic Devices.
Augmentative Communication Devices		Refer to Speech Generating Devices.
Back Brace/Orthosis		Refer to Spinal Orthosis.
Bead Bed		Refer to Air Fluidized Bed.
Bed Cradle		Refer to Hospital Beds and Accessories
Beds		Refer to Hospital Beds and Accessories
Bi-Level Positive Airway Pressure (BiPAP)	DME	Coverage criteria apply. Refer to the Medical Policy titled Obstructive and Central Sleep Apnea Treatment.
Bili-lights/Bili-blankets (Phototherapy)	DME	Covered when medically necessary for treatment delivered by a healthcare professional of jaundice in newborns.
Blood Glucose Analyzer-reflectance Colorimeter	Not Covered	Unsuitable for home use. Does not meet the definition of DME.
Blood Glucose Monitors	DME	Home blood glucose monitors and supplies (e.g., blood testing strips and lancets) are covered). Coverage criteria apply. Refer to the Benefit Interpretation Policy titled Diabetic Management, Services and Supplies and the Medical Policy titled Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes.
Blood Pressure Monitor/Sphygmomanometer	DME	Only for members on home dialysis; fully and semi-automatic (member activated) portable monitors are not covered. Refer to the Benefit Interpretation Policy titled Dialysis Services.

Item		Coverage	Comments
Bone Stimulator (Face-to-face requirement may be applicable)		DME	Coverage criteria apply. Refer to the Medical Policy titled Electrical and Ultrasound Bone Growth Stimulators.
Braces		Corrective Appliance/ Orthotic	Excludes orthodontic braces; Refer to AFO/KAFO or Knee Orthosis or Spinal Orthosis (body jacket) or Back Brace.
Bras (Mastectomy)		Prosthetic	Refer to Breast Prosthesis.
Breast Prosthesis (External)		Prosthetic	Coverage criteria apply. Refer to the Benefit Interpretation Policy titled Post Mastectomy Surgery and the Medical Policy titled Breast Reconstruction.
Breast-feeding Support, Supplies and Counseling		DME	Refer to the Medical Policy titled Preventive Care Services.
Cam Walkers (also known as Walking Boot)			Refer to AFO/KAFO.
Canes	Quad or Straight	DME	Refer to Mobility Assistive Equipment.
	White	Not Covered	Refer to Mobility Assistive Equipment.
Catheters and Supplies	Closed Drainage Bags		Refer to Urinary Drainage Bags.
	External Urinary Collection Devices (e.g., male external catheters and female pouches/meatal cups)	Prosthetic	Only for members with non-functioning bladder or permanent incontinence when used as an alternative to an indwelling catheter. Male external catheters are limited to no more than 35 per month and female external urinary collection devices are limited to no more than one metal cup per week or one pouch per day. Requests for a greater quantity must be documented by a participating physician as medically necessary. Refer to the DME MAC LCD for Urological Supplies (L33803).
	Foley/Indwelling	Prosthetic	Only for members with non-functioning bladder or permanent incontinence as medically required. Limited to no more than one catheter per month for routine catheter maintenance. Requests for a greater quantity must be documented by a participating physician as medically necessary. Refer to the DME MAC LCD for Urological Supplies (L33803).
	Intermittent Urinary Catheters	Prosthetic	Intermittent catheterization is covered when basic coverage criteria are met and the patient or caregiver can perform the procedure. Refer to the DME MAC LCD for Urological Supplies (L33803). **Notes**: • Any patient who utilizes intermittent catheterization can receive one sterile urological catheter and one packet of lubricant for each catheterization. • Important Points: ○ First, the prescription should reflect the actual number of times that the patient actually catheterizes him/herself per day. For example, if the patient self-catheterizes four times per day, the prescription should be for approximately 120 catheters per month. ○ Although the LCD says that Medicare will cover up to 200 intermittent catheters per month, this is a maximum number and most patients self-catheterize less than 6

Item		Coverage	Comments
Catheters and Supplies (continued)	Intermittent Urinary Catheters (continued)	Prosthetic	times per day. It would be inappropriate to order 200 catheters per month for every patient. The prescription must be individualized for each patient. ○ The second important point is that the provider should clearly document in the chart the number of times per day that the patient performs self-catheterization. Just listing that value on the prescription or on a separate form provided by the supplier is not sufficient. ○ Refer to the Joint DME MAC Letter – Intermittent Urinary Catheterization.
	Leg Drainage Bags	Prosthetic	Only for members with non-functioning bladder or permanent incontinence who is ambulatory or are chair or wheelchair bound. Refer to the DME MAC LCD for Urological Supplies (L33803).
Cervical Collar (Semi-rigid, Soft and Rigid)		Corrective Appliance/ Orthotic	Covered as a brace. Refer to the Medicare Benefit Policy Manual, Chapter 15, §130 – Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes.
Cervical Thoracic Lumbar Sacral Orthosis (CTLSO)		Corrective Appliance/ Orthotic	Refer to Spinal Orthosis.
Chair (adjustable)		DME	Only covered for members on home dialysis. Refer to the Benefit Interpretation Policy titled Dialysis Services.
Chemical Test Strips		Pharmacy	Refer to the Benefit Interpretation Policy titled Diabetic Management, Services and Supplies.
Clavicle Support/Splint		Corrective Appliance/ Orthotic	Used to keep the clavicle in position following acute injury or post-operative care
Cleft Palate Prosthesis		Prosthetic	Only covered for cleft lip and palate deformities as a result of congenital malformation
Cochlear Implant (External Component of Device)		Prosthetic	Coverage criteria apply. Refer to the Benefit Interpretation Policy titled Hearing Services and the Medical Policy titled Cochlear Implants.
Cold Therapy • Cold Packs/Cool Jackets • Water circulating cold pad with pump (e.g., Polar Units)		Not Covered	Not medically necessary. Alternative therapy is available with the same outcomes. Refer to the DME MAC LCD for Cold Therapy (L33735).
Colostomy Bag			Refer to Ostomy Supplies.
Commode, Bedside (without wheels only)		DME	Covered when member is physically incapable of utilizing regular toilet facilities. This would occur when: • The member is confined to a single room; or • The member is confined to one level of the home environment and there is not toilet on that level; or • The member is confined to the home and there are no toilet facilities in the home. Refer to the NCD for Durable Medical Equipment Reference List (280.1) and the DME MAC LCD for Commodes (L33736).
Commode Chair with Seat Lift Mechanism		DME	Coverage criteria apply. Refer to the DME MAC LCD for Commodes (L33736).

Item	Coverage	Comments
Communication Devices (e.g., computers, personal digital assistants, speech generating devices) Except artificial larynxes or electronic speech aid	Not Covered	Refer to the member's EOC for exclusion details. Refer to Artificial Larynx or Electronic Speech Aid or Electrolarynx (e.g., UltraVoice).
Compression Garment/Bandages for Lymphedema	DME	Refer to Lymphedema Compression Treatment Items.
Contact Lens, Hydrophilic Soft (External)	Prosthetic	Covered under the medical benefit. Coverage criteria apply. Some plans may cover under Vision Care. Refer to the Benefit Interpretation Policy titled Vision Care and Services.
Continuous Glucose Monitoring (CGM) Device or System	DME	Coverage criteria apply. Refer to the Benefit Interpretation Policy titled Diabetic Management, Services and Supplies and the Medical Policy titled Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes.
Continuous Passive Motion (CPM) Devices	DME	Covered for member's who have received a total knee replacement. To qualify for coverage, use of the device must commence within 2 days following surgery. In addition, coverage is limited to that portion of the 3-week period following surgery during which the device is used in the member's home. There is insufficient evidence to justify coverage of these devices for longer periods of time or for other applications.
Continuous Positive Airway Pressure (CPAP)	DME	Coverage criteria apply. Refer to the Medical Policy titled Obstructive and Central Sleep Apnea Treatment.
Corset	Corrective Appliance/ Orthotic	A hernia support (whether in the form of a corset or truss) which meets the definition of a brace is covered. Refer to the NCD for Corset Used as Hernia Support (280.11).
Cough Assist Device/Mechanical In-exsufflation Devices	DME	Mechanical in-exsufflation devices are covered for members who meet both of the following criteria: • They have a neuromuscular disease; and • This condition is causing a significant impairment of chest wall and/or diaphragmatic movement, such that it results in an inability to clear retained secretions. • Refer to the DME MAC LCD for Mechanical In-exsufflation Devices (L33795).
Cranial Orthosis	Corrective Appliance/ Orthotic	Refer to the Medical Policy titled Plagiocephaly and Craniosynostosis Treatment.
Crib (Pediatric)	DME	Coverage criteria apply. Refer to Medical Policy titled Beds and Mattresses.
Crutches		Refer to Mobility Assistive Equipment.

Item	Coverage	Comments
Deep Brain Stimulation (DBS) • Unilateral or Bilateral Thalamic Ventralis Intermedius Nucleus (VIM) DBS • Unilateral or Bilateral Subthalamic Nucleus (STN) or Globus Pallidus Interna (GPI) DBS	DME	Coverage criteria apply. Refer to the Medical Policy titled Deep Brain and Cortical Stimulation.
Dental Splint		Refer to Splints.
Diabetic Supplies (e.g., glucometer, lancets, injection aids)		Coverage criteria apply. Refer to the Benefit Interpretation Policy titled Diabetic Management, Services and Supplies. **Note**: For United HealthCare Benefits Plan of California: Batteries and Battery Chargers for infusion pumps and home blood glucose monitors are covered if necessary. Supplies or accessories billed separately will be denied.
Dialysis Home Kit, Peritoneal	DME	Only for members on home dialysis. Refer to the Benefit Interpretation Policy titled Dialysis Services.
Diapers/Adult Incontinence Garments	Medical Supply*	Hygienic supplies, non-reusable. Only covered for hospice members.
Diathermy Machines (Standard Pulses Wave Type, e.g., Diapulse)	DME	Coverage criteria apply. Refer to the Benefit Interpretation Policy titled Rehabilitation Services (Physical, Occupational, and Speech Therapy) and the Medical Policy titled Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech).
Disposable Items	Not Covered	Examples include but are not limited to: • Diapers (Refer to Diapers/Adult Incontinence Garments). • Disposable Sheets and Bags (Refer to Disposable Sheets) • Elastic Stockings • Incontinence Pads • Irrigating Kits • Support Hose/Fabric Support (e.g., Ted Hose) • Surgical Face Mask • Surgical Leggings • Surgical Stockings • Syringes (Ear Bulb) • Wedge Pillow Refer to the: • DME MAC LCD for Urological Supplies (L33803) and the LCA for Urological Supplies (A52521). • NCD for Durable Medical Equipment Reference List (280.1). • Social Security Act §1861(n), Social Security Act §1862(a)(6) and the Medicare Benefit Policy Manual, Chapter 16, §80 – Personal Comfort Items.
Disposable Sheets	Medical Supply*	Hygienic item; non-reusable disposable supplies. Only covered for hospice members.

Item		Coverage	Comments
Dressings/Bandages	Non-surgical Dressings/Bandages (e.g., Ace bandages)	Medical Supply*	Covered only when provided in the physician's office, otherwise considered over the counter. Refer to the Medicare Benefit Policy Manual, Chapter 15, §60.1 – Incident To Physician's Professional Services.
	Surgical Dressings	Medical Supply* DME Prosthetic	Surgical dressings may be covered as: • **Medical supply** when provided the physician's office. Refer to the Medicare Benefit Policy Manual, Chapter 15, §60.1 – Incident To Physician's Professional Services. • **DME** when ordered by the treating physician or other healthcare professional for the patient's home use in conjunction with a Durable Medical Equipment (e.g., infusion pumps). Refer to the Medicare Benefit Policy Manual, Chapter 15, §110.3 - Coverage of Supplies and Accessories. • **Prosthetic** when ordered by the treating physician or other healthcare professional for the patient's home use as dressing for surgical wound or for wound debridement or in conjunction with a Prosthetic Device (e.g., tracheostomy). Refer to the Medicare Benefit Policy Manual, Chapter 15, §120(D) - Supplies, Repairs, Adjustments, and Replacement. Surgical dressings are limited to primary dressings (therapeutic or protective coverings applied directly to a wound) or secondary dressings (dressings that serve a therapeutic or protective function and are needed to secure a primary dressing, e.g., tape, roll gauze, transparent film) that are medically necessary for the treatment of a wound caused by, or treated by, a surgical procedure or wound debridement. Refer to the Medicare Benefit Policy Manual, Chapter 15, §100 - Surgical Dressings, Splints, Casts, and Other Devices Used for Reductions of Fractures and Dislocations. For specific coverage guidelines for surgical dressings, refer to the DME MAC LCD for Surgical Dressings (L33831).
	Porcine Skin Surgical Dressings	Medical Supply* DME	Covered, if reasonable and necessary for the individual patient as an occlusive dressing for burns, donor sites of a homograft, and decubiti and other ulcers. Refer to the NCD for Porcine Skin and Gradient Pressure Dressings (270.5).
	Gradient Pressure Dressings (e.g., Jobst elasticized heavy duty stockings)	Medical Supply* DME	Covered when used to reduce hypertrophic scarring and joint contractures following burn injury. Refer to the NCD for Porcine Skin and Gradient Pressure Dressings (270.5). LCDs/LCAs exist and compliance with these policies is required where applicable. Refer to the DME MAC LCD for Surgical Dressings (L33831).
Egg Crate		Not Covered	Refer to Alternating Pressure Pads and Mattress.
Elbow Orthosis (Face-to-face requirement may be applicable)		Corrective Appliance	Used for compression of tissue or to limit motion. Custom molded is covered only when member cannot be fitted with a prefabricated elbow support. Refer to the Medicare Benefit Policy Manual, Chapter 15, §130 – Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes.
Electrical Stimulation Devices	Interferential Device	Not Covered	Refer to the Medical Policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation.

Item		Coverage	Comments
Electrical Stimulation Devices (continued)	• Transcutaneous Electrical Nerve Stimulator (TENS) Unit • Neuromuscular Electrical Stimulation (NMES)	DME	Coverage criteria apply. Refer to the Medical Policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation.
Electrical Stimulation Devices or Electromagnetic Therapy for Wound Healing		Not Covered	Refer to the Medical Policy titled Electromagnetic Therapy for Wounds.
Electronic Speech Aids		Prosthetic	Coverage for member post laryngectomy or permanently inoperative larynx condition. Refer to the NCD for Electronic Speech Aids (50.2).
Electric Tumor Treatment Field Therapy (Device used for Cancer Treatment)		DME	Coverage criteria apply. Refer to the Medical Policy titled Electric Tumor Treatment Field Therapy.
Enuresis Training Item (Penile Clamp)		Prosthetic	For members with urinary incontinence.
Eye Prosthesis			Refer to Artificial Eye.
External Breast Prostheses			Refer to Breast Prosthesis.
Face Masks – Oxygen		DME	Covered if oxygen is covered. Coverage criteria for oxygen apply. For coverage criteria, refer to the NCD for Home Use of Oxygen (240.2). Also refer to the DME MAC LCD for Oxygen and Oxygen Equipment (L33797).
Facial Prosthesis		Prosthetic	Facial prostheses are covered when there is a loss or absence of facial tissue due to disease, trauma, surgery, or a congenital defect. Refer to the DME MAC LCD for Facial Prostheses (L33738).
Female External Urine Management Systems (including but not limited to QiVi™ Female External Urine Management System, CareDry® System, PrimaFit External Urine Management Device, PureWick™ System, Versette® external catheter)		Not Covered	Refer to the Medical Policy titled Omnibus Codes.
Fluidic Breathing Assister		DME	Refer to Intermittent Positive Pressure Breathing (IPPB) Machines.
Flutter Device/Oscillatory Positive Expiratory Pressure Devices		DME	Coverage criteria apply. Refer to the Medical Policy titled Airway Clearance Devices.
Foot Cradle			Refer to Bed Cradle.
Foot Orthotics		Corrective Appliances/ Orthotics	For diabetics only when criteria are met. Refer to the Benefit Interpretation Policy titled Shoes and Foot Orthotics.
Formula (Enteral Feedings)		Medical Supplies*	Refer to Nutritional Therapy. Also refer to the Benefit Interpretation Policy titled Home Health Care.

Item		Coverage	Comments
Gait Trainers		DME	Coverage criteria apply. Refer to the Medical Policy titled Walkers.
Gradient Pressure Stockings (e.g., Jobst stockings)		Prosthetic	Refer to Stockings.
Hearing Aid		Prosthetic	Coverage criteria apply. Refer to the Benefit Interpretation Policy titled Hearing Services and the Medical Policy titled Hearing Aids and Devices Including Wearable, Bone-Anchored and Semi-Implantable.
Heat Lamp		DME	Covered if patient's condition is one for which the application of heat in the form of heat lamp is therapeutically effective. Refer to the NCD for Durable Medical Equipment Reference List (280.1).
Heating Pads, Steam Packs or Hot Packs	Electrical or Non-Electrical	DME	Covered if member's medical condition is one for which the application of heat in the form of heat pad is therapeutically effective. Refer to the: • NCD for Durable Medical Equipment Reference List (280.1). • DME MAC LCD for Heating Pads and Heat Lamps (L33784).
	Infrared	Not Covered	Not primarily medical in nature. Refer to the: • NCD for Infrared Therapy Devices (270.6). • DME MAC LCD for Infrared Heating Pad Systems (L33825).
Helmets (Safety Equipment)		Not Covered	Not primarily medical in nature.
Helmets (Cranial Orthosis)			Refer to Cranial Orthosis.
High Frequency Chest Wall Compression Devices (e.g., ThAIRapy® Vest System)		DME	Coverage criteria apply. Refer to the Medical Policy titled Airway Clearance Devices.
Hospital Beds and Accessories (Face-to-face requirement may be applicable)		DME	Coverage criteria apply. Refer to the Medical Policy titled Beds and Mattresses.
Hot Packs			Refer to Heating Pads.
Humidifiers	For use with C-PAP or BiPAP (Heated or Non-Heated)	DME	Coverage criteria apply. Refer to the Medical Policy titled Obstructive and Central Sleep Apnea Treatment.
	For use with Respiratory Assist Devices	DME	For coverage criteria for RADs, refer to the DME MAC LCD for Respiratory Assist Devices (L33800).
	For use with Oxygen System	DME	Coverage criteria for oxygen apply. For coverage criteria, refer to the NCD for Home Use of Oxygen (240.2). Also refer to the DME MAC LCD for Oxygen and Oxygen Equipment (L33797).
	Room or Central Heating System Types	Not Covered	Refer to the member's EOC for exclusion details. Environmental control equipment; not medical in nature.
Hydraulic Lifts			Refer to Lifts.

Item		Coverage	Comments
Immobilizer (Extremity)			Refer to Knee Orthosis.
Incontinence Control Devices (Mechanical and Hydraulic)		Prosthetic	Coverage criteria apply. Refer to the NCD for Incontinence Control Devices (230.10).
Infusion Pump			Refer to Pumps.
Inhalation Machine			Refer to Nebulizers, or Humidifiers, or IPPB Machines.
Insulin Pump, Including Insulin and Necessary Supplies		DME	Coverage criteria apply. Refer to the Benefit Interpretation Policy titled Diabetic Management, Services and Supplies and the Medical Policy titled Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes. **Note**: For United HealthCare Benefits Plan of California: Batteries and Battery Chargers are covered for Insulin Pumps.
Intermittent Positive Pressure Breathing (IPPB) Machines		DME	Covered if patient's ability to breathe is severely impaired. (Includes fluidic breathing assisters.) Refer to the NCD for Durable Medical Equipment Reference List (280.1).
Iron Lungs			Refer to Ventilators.
IV Pole (Intravenous)		DME	Covered when ordered with IV Therapy, tube feeding or other medically necessary indications.
Jaw Motion Rehabilitation System (Passive Rehabilitation Therapy)		Not Covered	Refer to the Medical Policy titled Treatment of Temporomandibular Joint Disorders.
Knee Orthosis (e.g., knee immobilizer, range of motion knee orthosis, rigid ace design knee orthosis anterior cruciate ligament/ACL brace) (Face-to-face requirement may be applicable)		Corrective Appliance/ Orthotic	Coverage criteria apply. Refer to the DME MAC LCD for Knee Orthoses (L33318).
Lamb's Wool Pads/Sheep Skins			Refer to Alternating Pressure Pads and Mattresses.
Lifts	Hydraulic (Hoyer) Lift/ Patient Lift	DME	Covered if the member's condition is such that periodic movement is necessary to effect improvement or to arrest or retard deterioration in the member's condition. Refer to the: • NCD for Durable Medical Equipment Reference List (280.1). • DME MAC LCD for Patient Lifts (L33799).
	Motorized (Electric), Ceiling Modified	Not Covered	Feature is a convenience item, therefore does not meet the definition of DME. Refer to the Medicare Benefit Policy Manual, Chapter 15, §110.2 – Equipment Presumptively Non-Medical. Also refer to the Social Security Act §1861(n) and 1862(a)(6).

Item		Coverage	Comments
Lifts (continued)	Seat Lift Mechanism	DME	Covered when criteria are met. **Notes**: • Coverage is limited to the seat lift mechanism and installation of the mechanism only. Other related items and services such as costs for the chair or chair upholstery are not covered. • Lift mechanism which operates by spring release with a sudden, catapult-like motion and jolts the member from a seated to a standing position is not covered. Refer to the: • NCD for Seat Lift (280.4). • DME MAC LCD for Seat Lift Mechanisms (L33801).
	For Wheelchairs/ Scooters/POVs	Not Covered	Not primarily medical in nature. Refer to the Social Security Act §1861(n), Social Security Act §1862(a)(6) and the Medicare Benefit Policy Manual, Chapter 16, §80 – Personal Comfort Items. Also refer to Wheelchairs.
Light Therapy Box		Not Covered	Not primarily medical in nature; Other devices and equipment used for environmental control or to enhance the environmental setting in which the member is placed are not considered a covered DME. Refer to the Medicare Benefit Policy Manual, Chapter 15, §110.1 – Equipment Presumptively Non-Medical. Also refer to Ultraviolet Cabinet.
Lumbar Orthosis (LO) Lumbar-Sacral Orthosis (LSO)			Refer to Spinal Orthosis.
Lymphedema Compression Treatment Items		DME	Covered as part of the pneumatic compression devices, not covered as a separate item. Coverage criteria for pneumatic compression devices apply. Refer to Pneumatic Compression Devices. **Note**: Complex Decongestive Physiotherapy/CDP is considered a medical treatment rather than part of rehabilitation/therapy, therefore, CDP is neither subject to rehabilitation/therapy copayment, nor benefit maximum. Reference: • California Health and Safety Code 1300.67.005(d)(9)(B)(iii). • California Health and Safety Code 1367.645.
Lymphedema Pumps		DME	Coverage criteria apply. Refer to the Medical Policy titled Pneumatic Compression Device. **Note**: Complex Decongestive Physiotherapy/ CDP is considered a medical treatment rather than part of rehabilitation/therapy, therefore, CDP is neither subject to rehabilitation/therapy copayment, nor benefit maximum. Refer to Pneumatic Compression Devices.
Mandibular Device (for Sleep Apnea)		DME	Coverage criteria apply. Refer to the Medical Policy titled Obstructive and Central Sleep Apnea Treatment.
Mattress			Refer to Hospital Beds and Accessories.

Item		Coverage	Comments
Mechanical In-exsufflation Devices			Refer to Cough Assist Devices.
Mobile Stander		DME	Refer to Standing Frames.
Mobility Assistive Equipment (MAE) Mobility Assistive Equipment (MAE) (continued)	Canes	DME	Coverage criteria apply. Refer to the NCD for Mobility Assistive Equipment (MAE) (280.3). Also refer to the DME MAC LCD for Canes and Crutches (L33733) and the NCD for Durable Medical Equipment Reference List (280.1). White canes are not covered; not primarily medical in nature; not considered Mobility Assistive Equipment. Refer to the NCD for White Cane for Use by a Blind Person (280.2).
	Crutches	DME	Coverage criteria apply. Refer to the NCD for Mobility Assistive Equipment (MAE) (280.3). Also refer to the DME MAC LCD for Canes and Crutches (L33733). **Note**: Crutch substitute (HCPCS code E0118) is not covered. There is insufficient published clinical literature demonstrating safety and effectiveness in the Medicare population to establish the medical necessity for this device. Refer to the Noridian Article E0118 - Crutch Substitute.
	Power Mobility Device (PMDs) [includes Power Wheelchairs and Power Operated Vehicle (also known as POVs or scooters)] (Face-to-face requirement may be applicable)	DME	Coverage criteria apply. Refer to the: • NCD for Mobility Assistive Equipment (MAE) (280.3). • DME MAC LCD for Power Mobility Devices (L33789). For guidelines for repairs, replacements and maintenance, refer to the Medicare Benefit Policy Manual, Chapter 15, §110.2 – Repairs, Replacement and Maintenance and Delivery. • For guidelines for PMD options and accessories, refer to DME MAC LCD for Wheelchair Options/Accessories (L33792). For guidelines for PMD seating, refer to the DME MAC LCD for Wheelchair Seating (L33312). For documentation and face-to-face requirements for PMDs, refer to the: • LCD for Power Mobility Devices (L33789). • MLN Matters SE1112 – Power Mobility Device Face-to-Face Examination Checklist. **Notes**: • Home Assessment: Prior to or at the time of delivery of a POV or PWC, the supplier or practitioner must perform an on-site evaluation of the Member's Home to verify that the member can adequately maneuver the device that is provided considering physical layout, doorway width, doorway thresholds, and surfaces. There must be a written report of this evaluation available on request. Refer to the DME MAC LCD for Power Mobility Devices (L33789). • Battery replacement (purchased equipment) is covered only when the member owns or is purchasing (not renting) the electric wheelchair or POV. Refer to the Medicare Benefit Policy Manual, Chapter 15, §110.3 – Coverage of Supplies and Accessories. Also refer to the DME MAC LCD for Wheelchair Options/Accessories (L33792). The following are not covered:

Item		Coverage	Comments
Mobility Assistive Equipment (MAE) (continued)	Power Mobility Device (PMDs) [includes Power Wheelchairs and Power Operated Vehicle (also known as POVs or scooters)] (Face-to-face requirement may be applicable) (continued)	DME	• POVs for members who are capable of ambulation within the home but require a power vehicle for movement outside of the home. Refer to the DME MAC LCD for Power Mobility Devices (L33789). • POVs that are primarily used to allow the member to perform leisure or recreational activities. Refer to the DME MAC LCD for Power Mobility Devices (L33789). • Replacement of a wheelchair due to malicious damage, neglect, or abuse. Refer to the Medicare Benefit Policy Manual, Chapter 15, §110.2 – Repairs, Replacement and Maintenance and Delivery. • Repairs on rented DME items (DME provider is responsible for such repairs). Refer to the Medicare Benefit Policy Manual, Chapter 15, §110.2 – Repairs, Replacement and Maintenance and Delivery.
	Walkers	DME	Coverage criteria apply. Refer to the NCD for Mobility Assistive Equipment (MAE) (280.3) and DME MAC LCD for Walkers (L33791). **Note**: The medical necessity for a walker with an enclosed frame (E0144) has not been established. Therefore, if an enclosed frame walker is provided, it will be denied as not reasonable and necessary. Refer to the DME MAC LCD for Walkers (L33791).
	Wheelchairs (manual)	DME	Coverage criteria apply. Refer to the NCD for Mobility Assistive Equipment (MAE) (280.3) and DME MAC LCD for Manual Wheelchair Bases (L33788). For guidelines for wheelchair options and accessories, refer to DME MAC LCD for Wheelchair Options/Accessories (L33792). • For guidelines for wheelchair seating, refer to the DME MAC LCD for Wheelchair Seating (L33312). • For guidelines for repairs, replacements and maintenance, refer to the Medicare Benefit Policy Manual, Chapter 15, §110.2 – Repairs, Replacement and Maintenance and Delivery. **Notes**: • Mobile Geriatric Chairs may be covered when criteria are met. Refer to the NCD for Durable Medical Equipment Reference List (280.1). Also refer to the NCD for Mobility Assistive Equipment (MAE) (280.3). • Payment is made for only one wheelchair at a time. Backup chairs are denied as not reasonable and necessary. One month's rental for a standard manual wheelchair is covered if a member-owned wheelchair is being repaired. Refer to the DME MAC LCD for Manual Wheelchair Bases (L33788). The following are not covered: • Ramp for a wheelchair is not covered; not primarily medical in nature. Refer to the Medicare Benefit Policy Manual, Chapter 15, § 110.1 (B)(2) – Equipment Presumptively Non-Medical. • Wheelchair upgrades that are beneficial primarily in allowing the member to perform

Item		Coverage	Comments
Mobility Assistive Equipment (MAE) (continued)	Wheelchairs (manual) (continued)	DME	leisure or recreational activities. Refer to the: ○ Medicare Benefit Policy Manual, Chapter 16, §20 – Services Not Reasonable and Necessary and §10 - General Exclusions from Coverage. ○ DME MAC LCD for Power Mobility Devices (L33789). ○ LCA for Power Mobility Devices - Policy Article (A52498). • Deluxe items or features. Refer to the Medicare Benefit Policy Manual, Chapter 16, §20 – Services Not Reasonable and Necessary and §10 - General Exclusions from Coverage. • Items purchased for comfort or added convenience for the member or the member's caretaker. Refer to the Medicare Benefit Policy Manual, Chapter 16, §20 – Services Not Reasonable and Necessary and §10 - General Exclusions from Coverage. • Replacement of a wheelchair due to malicious damage, neglect, or abuse. Refer to the Medicare Benefit Policy Manual, Chapter 15, §110.2 – Repairs, Replacement, and Maintenance and Delivery. • Repairs on rented DME items (DME provider is responsible for such repairs). Refer to the Medicare Benefit Policy Manual, Chapter 15, §110.2 – Repairs, Replacement, and Maintenance and Delivery.
Myoelectric Arm Orthosis (i.e., MyoPro®)		Not Covered	Refer to the Medical Policy titled Omnibus Codes.
Nebulizers and Supplies	Small Volume, Electric	DME	Covered for medications approved for delivery by a nebulizer, including nebulized medications for asthma or Per state law (California Health and Safety Code-Section 1367.06 effective 1/1/05), covered as DME for the management and treatment of pediatric asthma of Dependent children under the age of 19. Also may be covered when it is medically necessary to administer appropriate inhalation medications for the management of COPD, cystic fibrosis, HIV, pneumocystosis, complications of organ transplants or thick or tenacious pulmonary secretions.
	Large Volume, Non-Disposable	DME	When medically necessary to deliver humidity to a member with thick, tenacious secretions, who has cystic fibrosis, bronchiectasis, a tracheostomy, or a tracheobronchial stent; Not Covered when used predominantly to provide room humidification; Also, per state law (California Health and Safety Code-Section 1367.06 effective 01/01/2005) covered as DME for the management and treatment of pediatric asthma of Dependent children under the age of 19. Also covered when medically necessary to deliver humidity to a member with thick, tenacious secretions, who has cystic fibrosis, bronchiectasis, a tracheostomy, or a tracheobronchial stent. Not covered when used predominantly to provide room humidification.
	Large Volume, Disposable	Not Covered	Acceptable alternative available; Not primarily medical in nature; Disposable items are not considered DME by definition.
	Ultrasonic	Not Covered	Offers no proven clinical advantage over a standard nebulizer.
	Portable (AC/DC)	DME	Only one nebulizer is allowed for in-home use when medically necessary. (Stationary/Portable); Nebulizers are not allowed for out-of-home use as it does not meet definition of DME.
	Medication		Covered through the member's supplemental pharmacy benefit when listed in the formulary.

Item		Coverage	Comments
Negative Pressure Wound Therapy Pump			Refer to Vacuum Assisted Closure Device.
Non-Contact Normothermic Wound Therapy (NNWT)		Not Covered	Refer to the Medical Policy titled Noncontact Warming Therapy, Ultrasound Therapy and Fluorescence Imaging for Wounds.
Nutritional Therapy	Enteral	DME	Coverage criteria apply. Refer to the Medical Policy titled Enteral Nutrition (Oral and Tube Feeding).
	Parenteral	DME	
Obturator, palatal		Prosthetic	Only for surgically acquired deformity or trauma. Used to replace or fill in a missing palate or portion of the palate. Includes the denture when the denture or a portion of denture is an integral part (built-in) of the obturator.
Orthopedic Shoes			Refer to Shoes.
Ostomy Supplies		Prosthetic	Colostomy (and other ostomy) bags and necessary accouterments required for attachment are covered as Prosthetic Devices. This coverage also includes irrigation and flushing equipment and other items and supplies directly related to ostomy care, whether the attachment of a bag is required. Refer to the Medicare Benefit Policy Manual, Chapter 15, § 120 – Prosthetic Devices. For coverage guidelines, refer to the DME MAC LCD for Ostomy Supplies (L33828).
Other Non-Covered Items		Not covered	Examples of items that are not primarily medical in nature, does not meet the definition of DME, and/or are personal comfort items, include but are not limited to: • Air Cleaner/Purifier • Air Conditioner Bathtub Lifts and Seats • Bed Baths (home type) • Bed Boards • Bed Lifter (bed elevator) • Bed Specs • Braille Teaching Text • Car Seats • Carafes • Commode - elevated seat (raised toilet seat) • Dehumidifier (room or central heating system type) • Electrostatic Machines • Elevators • Emesis Basin • Esophageal Dilator • Exercise Equipment (e.g., barbells, all types of tricycles) • Grab Bars (for bath and toilet) • Heat and Massage Foam Cushion Pads • Heater (Portable Room Heater) • Heating and Cooling Plants • Helmet (Safety Equipment) • Injectors (Hypodermic Jet Pressure Powered Injectors

Item	Coverage	Comments
Other Non-Covered Items (continued)	Not covered	• Leotard (Pressure Garment) • Massage Devices • Parallel Bars • Pulse Tachometer • Sauna Baths • Stair Lifts/Stair Elevator • Shower/Bathtub Seat • Speech Teaching Machines • Standing Tables • Telephone Alert System • Toilet Seat, Elevated Bidet • Treadmill Exerciser • Wedge Pillow • Back Support (posture chair) • Bed Wetting Alarm • Breast Pump (Electric or Manual) • Commode - Chair Foot Rest • Gait Belt • Spirometer • Vitrectomy Face Support (Positioning Pillow) • Whirlpool Pump (portable) • Wig/Hairpiece • Jacuzzi • Hypothermic Blanket • Personal or Comfort Items • Telephone Arms/Cradle • Transfer Bench (for tub or toilet) • Vehicle/Trunk Modification • Walk-in bathtub/showers Refer to the: • Medicare Benefit Policy Manual, Chapter 15, §110.1 – Definition of DME. • Medicare Benefit Policy Manual, Chapter 16, §80 – Personal Comfort Items. • NCD for Durable Medical Equipment Reference List (280.1).
Oxygen and Oxygen Equipment	DME	Coverage criteria apply. Refer to the NCD for Home Use of Oxygen (240.2). Also refer to the DME MAC LCD for Oxygen and Oxygen Equipment (L33797).
Pacemaker Monitors (self-contained) • Audible or Visible Signal • Digital Electronic	DME	Member must have cardiac pacemaker. Refer to the Benefit Interpretation Policy titled Cardiac Pacemakers and Defibrillators.

Item		Coverage	Comments
Paraffin Bath Unit Paraffin Bath Unit (continued)	Portable	DME	Covered when the member has undergone a successful trial period of paraffin therapy ordered by a physician and the member's condition is expected to be relieved by a long-term use of this modality. Refer to the NCD for Durable Medical Equipment Reference List (280.1).
	Standard	Not Covered	Institutional equipment; not appropriate for home use. Refer to the NCD for Durable Medical Equipment Reference List (280.1).
Patient Lift			Refer to Lifts.
Peak Expiratory Flow Meter, hand-held		DME	For the self-monitoring of members with pure asthma when used as part of a comprehensive asthma management program or per state law (California Health and Safety Code-Section 1367.06 effective 01/01/2005), covered as DME for the management and treatment of pediatric asthma of Dependent children under the age of 19.
Penile Prosthesis		Prosthetic	Coverage criteria apply. Refer to the NCD for Diagnosis and Treatment of Impotence (230.4).
Percussor (Non-Vest Type)	Electric or Pneumatic, Home Model	DME	Covered for mobilizing respiratory tract secretions in member's with chronic obstructive lung disease, chronic bronchitis, or emphysema, when member or operator of powered percussor has received appropriate training by a physician or therapist, and no one competent to administer manual therapy is available. For ThAIRapy® Vest System, refer to High Frequency Chest Wall Compression Devices. Refer to the Medical Policy titled Airway Clearance Devices.
	Intrapulmonary Percussive Ventilator (IPV)	Not Covered	Refer to the Medical Policy titled Airway Clearance Devices.
Pessary		Medical Supply*	Covered when performed as part of the physician services. Refer to the Medicare Benefit Policy Manual, Chapter 15, §60.1 – Services and Supplies Incident To Physician's Professional Services.
Pleurx bottles and tubing		DME	Covered as DME for Pleural Infusions.
Pneumatic Compression Devices - For the prevention of illnesses/disease including deep vein thrombosis (DVT)		DME	Coverage criteria apply. Refer to the Medical Policy titled Pneumatic Compression Devices.
Pneumatic Compression Devices - For the treatment of lymphedema or chronic venous insufficiency with venous stasis ulcer		DME	Coverage criteria apply. Refer to the Medical Policy titled Pneumatic Compression Devices.
Pneumatic Compression Devices - For the treatment of peripheral arterial disease		Not Covered	Refer to the Medical Policy titled Pneumatic Compression Devices.
Pneumatic Splints			Refer to AFO/KAFO.
Postural Drainage Boards		DME	For members with chronic pulmonary condition. Refer to the NCD for Durable Medical Equipment Reference List (280.1).
Power Mobility Devices			Refer to Mobility Assistive Equipment.
Power Operated Vehicles (POV)/Scooters			Refer to Mobility Assistive Equipment.

Item		Coverage	Comments
Power Traction Equipment/Devices (e.g., VAX-D®, DRX9000, SpineMED™, Spina System™, Lordex® Decompression Unit, DRS System™)			Refer to Traction Equipment.
Protector, heel, or elbow		Medical Supply*	Not covered as DME; billed as part of an inpatient hospital or SNF care or as incident to a physician's service.
Pulse Oximeter		Not Covered	Oximeters (E0445) and replacement probes (A4606) will be denied as non-covered because they are monitoring devices that provide information to physicians to assist in managing the member's treatment. Refer to the DME MAC LCD for Oxygen and Oxygen Equipment (L33797).
Pumps, including Medications and Necessary Supplies	Enteral		Refer to Nutritional Therapy (Enteral).
	Infusion (e.g., HCPCS code E0784)	DME	Coverage criteria apply. Refer to the Benefit Interpretation Policy titled Diabetic Management, Services and Supplies.
	Insulin, External	DME	External continuous subcutaneous insulin infusion (CSII) pump and related drugs and supplies are covered when coverage criteria are met. Refer to the Benefit Interpretation Policy titled Diabetic Management, Services and Supplies.
	Insulin, Implantable	Not Covered	
	Lymphedema	DME	Coverage criteria apply. Refer to the Medical Policy titled Pneumatic Compression Device.
	Parenteral		Refer to Nutritional Therapy.
	Negative Pressure Wound		Refer to Vacuum Assisted Closure Device.
	For Erectile Dysfunction		Refer to Vacuum Pump.
Recliner (chair)		DME	Member must be on home dialysis. Refer to the Benefit Interpretation Policy titled Dialysis Services.
Reflectance Colorimeters			Refer to Blood Glucose Analyzer-reflectance Colorimeter.
Respirators			Refer to Ventilators.
Rib Belt		Corrective Appliance/ Orthotic	Covered when Medically Necessary.
Rolling Chair/Roll-about Chair (Geriatric Chair)		DME	Covered if member meets Mobility Assistive Equipment clinical criteria. Coverage is limited to those roll-about chairs having casters of at least 5 inches in diameter and officially designed to meet the needs of ill, injured, or otherwise impaired individuals. Not covered for the wide range of chairs with smaller casters as are found in general use in homes, offices, and institutions for many purposes not related to the care/treatment of ill/injured persons. This type is not primarily medical in nature. Refer to the: • NCD for Mobility Assistive Equipment (MAE) (280.3).

Item	Coverage	Comments
Rolling Chair/Roll-about Chair (Geriatric Chair) (continued)	DME	• NCD for Durable Medical Equipment Reference List (280.1).
Safety Rollers		Refer to Mobility Assistive Equipment.
Scleral Shell	Prosthetic	Scleral shell (or shield) is a catchall term for different types of hard scleral contact lenses. Scleral shell may be covered as prosthetic when: • Used as an artificial eye when the eye has been rendered sightless and shrunken by inflammatory disease; or • Used in combination with artificial tears in the treatment of "dry eye" of diverse etiology. Refer to the NCD for Scleral Shell (80.5).
Scoliosis Orthosis		Refer to Spinal Orthosis/CTLSO and TLSO.
Shoes • Inserts/Orthotics • Orthopedic • Prosthetic • Therapeutic (e.g., diabetic shoes)	Corrective Appliance /Orthotic	Coverage criteria apply. Refer to the Benefit Interpretation Policy titled Shoes and Foot Orthotics.
Sitz Bath (Portable)	DME	Covered if member has an infection or injury of the perineal area and the item has been prescribed by the member's physician as a part of his planned regimen of treatment in the member's home. Refer to the NCD for Durable Medical Equipment Reference List (280.1).
Sleep Apnea Device		Refer to Mandibular Device.
Slings	Medical Supply*	Used to support and limit motion of an injured upper arm. Refer to the Medicare Benefit Policy Manual, Chapter 15, §60.1 – Incident To Physician's Professional Services.
Speech Generating Device	DME	Coverage criteria apply. Refer to the NCD for Speech Generating Devices (50.1). LCDs/LCAs exist and compliance with these policies is required where applicable. Refer to the DME MAC LCD for Speech Generating Devices (SGD) (L33739).
Spinal Orthosis (Body Jacket) • Cervical-Thoracic-Lumbar Sacral Orthosis (CTLSO) • Lumbar Orthosis (LO) • Lumbar-Sacral Orthosis (LSO) • Thoracic-Lumbar-Sacral Orthosis (TLSO) (Face-to-face requirement may be applicable)	Corrective Appliance/ Orthotic	Coverage criteria apply. Refer to the DME MAC LCD for Spinal Orthoses: TLSO and LSO (L33790).

Item		Coverage	Comments
Splints	• Bi-Directional Static Progressive Stretch Splinting • Static progressive (SP) stretch (splinting) devices, e.g., Joint Active Systems (JAS) • Patient-actuated serial stretch (PASS), e.g., ERMI system	Not Covered	For coverage guidelines, refer to the Medical Policy titled Mechanical Stretching Devices.
	Dental Splint (prefabricated, off-the-shelf bite guard; aka night guard appliance)	Not Covered	Dental splint is an off-the-shelf intraoral device that does not require professional fitting or adjustment and is used to prevent damage to teeth caused by bruxism. **Note**: Dental splint does not include oral splints for the treatment of TMJ that require custom fitting and adjustment by a licensed healthcare professional.
	Dynamic (e.g., Dyna Splint)	DME	For coverage guidelines, refer to the Medical Policy titled Mechanical Stretching Devices.
	Foot (e.g., Denis-Browne)	Corrective Appliance/ Orthotic	Used as splint/brace to correct rotational anomalies of lower legs; worn during sleep. Refer to the Benefit Interpretation Policy titled Shoes and Foot Orthotics.
	Low-Load Prolonged-Duration Stretch (LLPS) Devices such as the Dynasplint System	DME	For coverage guidelines, refer to the Medical Policy titled Mechanical Stretching Devices.
	Occlusal Splint (custom fabricated bite plate for TMJ)	Not Covered	For coverage guidelines, refer to the Medical Policy titled Treatment of Temporomandibular Joint Disorders.
	Patient actuated serial stretch (PASS) devices	Not Covered	For coverage guidelines, refer to the Medical Policy titled Mechanical Stretching Devices.
	Wrist/Hand/Finger	Corrective Appliance/ Orthotic	For mild sprains, strains, and carpal tunnel conditions. Custom molded covered only when member cannot be fitted with the prefabricated wrist/hand/finger/splint/brace.
Standing Frames/Mobile Stander		DME	Covered when medically necessary.
Steam Packs			Refer to Heating Pads (Covered under the same condition as heating pads).

Item		Coverage	Comments
Stockings	Gradient Compression Stockings, Below Knee	Prosthetic	Covered when used to secure a primary dressing over an open venous stasis ulcer that has been treated by a physician or other healthcare professional requiring medically necessary debridement or treatment of a wound caused by, or treated by, a surgical procedure. Refer to the: • DME MAC LCD for Surgical Dressings (L33831). • Medicare Benefit Policy Manual, Chapter 15, §100 – Surgical Dressings, Splints, Casts, and Other Devices Used for Reductions of Fractures and Dislocations.
Suction Pump or Machine		DME	Covered for members who have difficulty raising and clearing secretions secondary to one of the following: • Cancer or surgery of the throat or mouth. • Dysfunction of the swallowing muscles. • Unconsciousness or obtunded state. • Tracheostomy. Must be appropriate for use without professional supervision. Refer to the: • DME MAC LCD for Suction Pumps (L33612). • NCD for Durable Medical Equipment Reference List (280.1).
Sykes Hernia Control		Corrective Appliance/ Orthotic	Coverage criteria apply. Refer to the NCD for Sykes Hernia Control (280.12).
Syringes	Hypodermic	Medical Supply*/ Pharmacy	Insulin syringes and pen needles are covered under the pharmacy benefit. All others are covered under the medical benefit. Refer to Diabetic Supplies.
TMJ Splint			Refer to Occlusal Splint.
TENS Unit/Muscle Stimulator			Refer to Electrical Stimulation Devices.
ThAIRapy® Vest System			Refer to High Frequency Chest Wall Compression Devices.
Thoracic Lumbar Sacral Orthoses (TLSO)			Refer to Spinal Orthosis.
Toe Filler		Prosthetic	Refer to the Benefit Interpretation Policy titled Shoes and Foot Orthotics.
Tracheostomy	Speaking Valve and Tubes	Prosthetic	A trachea tube has been determined to satisfy the definition of a prosthetic device, and the tracheostomy speaking valve is an add-on to the trachea tube which may be considered a medically necessary accessory that enhances the function of the tube, which makes the system a better prosthesis. As such, a tracheostomy speaking valve is covered as an element of the trachea tube which makes the tube more effective. Refer to the NCD for Tracheostomy Speaking Valve (50.4).
	Care Kit (Initial and Replacements)	Prosthetic	A tracheostomy care or cleaning started kit is covered for a member following an open surgical tracheostomy up to 2 weeks post-operatively. Replacement kits are covered at one per day only. Refer to the DME MAC LCD for Tracheostomy Care Supplies (L33832).

Item		Coverage	Comments
Traction Equipment	General Coverage Guidelines	DME	Covered if member has orthopedic impairment requiring traction equipment that prevents ambulation during the period of use (Consider covering devices usable during ambulation; e.g., cervical traction collar, under the brace provision). Refer to the NCD for Durable Medical Equipment Reference List (280.1).
	Cervical (Over-the-Door or Cervical Portable Traction Unit)	DME	Covered if both the following criteria are met: • The member has a musculoskeletal or neurologic impairment requiring traction equipment; and • The appropriate use of a home cervical traction device has been demonstrated to the member and the member tolerated the selected device. Refer to the DME MAC LCD for Cervical Traction Devices (L33823).
	Cervical, Attached To Headboard	Not Covered	No proven clinical advantage compared to over-the-door traction mechanism. Refer to the DME MAC LCD for Cervical Traction Devices (L33823).
	Cervical, Not Requiring Additional Stand or Frame (e.g., Orthotrac Pneumatic Vest or Pronex)	Not Covered	No proven clinical advantage compared to over-the-door traction mechanism. Refer to the DME MAC LCD for Cervical Traction Devices (L33823).
	Freestanding Traction Stand	Not Covered	No proven clinical advantage compared to over-the-door traction mechanism. Refer to the DME MAC LCD for Cervical Traction Devices (L33823).

	Pneumatic Free-Standing Cervical, Stand/Frame. Applying traction force to other than mandible (e.g., Saunders HomeTrac)	DME	Covered if member meets criteria for over-the-door traction unit and one of the following 3 criteria are met:
			• The treating physician orders greater than 20 pounds of cervical traction in the home setting; or
			• The member has:
			  ○ A diagnosis of temporomandibular joint (TMJ) dysfunction; and
			  ○ Received treatment for the TMJ condition; or
			• The member has distortion of the lower jaw or neck anatomy (e.g., radical neck dissection) such that a chin halter is unable to be utilized.
			Refer to the Medical Policy titled Home Traction Therapy.

	Power Traction Equipment/Devices (e.g., VAX-D®, DRX9000, AccuSpineMED™ Spina System™, Lordex® Decompression Unit, DRS System™)	Not Covered	Refer to the Medical Policy titled Motorized Spinal Traction.
	Weights, bags	DME	When used in conjunction with covered traction services.
Transfer (Sliding) Board		DME	Covered when part of an authorized treatment plan is necessary to treat an illness or injury.

Item	Coverage	Comments
Trapeze Bar	DME	A trapeze bar attached to a bed is covered if the member has a covered hospital bed and the member needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed. Not covered when used on an ordinary bed. Refer to the NCD for Durable Medical Equipment Reference List (280.1). Also refer to Hospital Beds and Accessories.
Truss	Prosthetic	Covered as prosthetic when used as a holder for surgical dressings or for lumbar strains, sprains, or hernia. Refer to the: • Medicare Benefit Policy Manual, Chapter 15, §120 – Prosthetic Devices and §130 Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes. • NCD for Corset Used as Hernia Support (280.11).
Ultraviolet Cabinet	DME	Covered for selected members with generalized intractable psoriasis. Using appropriate consultation, the contractor should determine whether medical and other factors justify treatment at home rather than at alternative sites, e.g., outpatient department of a hospital. Refer to the NCD for Durable Medical Equipment Reference List (280.1).
Unna Boot/Strapping	Medical Supply*	Generally used to treat chronic ulcers that are usually caused by varicosities of the leg. Refer to the DME MAC LCD for Surgical Dressings (L33831).
Urinal (Autoclavable)	DME	If member is confined to bed. Refer to the NCD for Durable Medical Equipment Reference List (280.1).
Urinary Drainage Bags	Prosthetic	Urinary collection and retention system that replace bladder function in the case of permanent urinary incontinence are covered as Prosthetic Devices. There is insufficient evidence to support the medical necessity of a single use system bag rather than the multi-use bag. Therefore, a single use drainage system is subject to the same coverage parameters as the multi-use drainage bags. Refer to the NCD for Urinary Drainage Bags (230.17).
Urological Supplies		Refer to Catheters and Supplies.
Vacuum Assisted Closure Device (VAC) or Negative Pressure Wound Therapy Pump	DME	Coverage criteria apply. Refer to the Medical Policy titled Negative Pressure Wound Therapy.
Vacuum Pump or Device (e.g., ErecAid)	Not Covered	Some members may have coverage as DME. Refer to the State Market Plan Enhancements section of the Benefit Interpretation Policy titled Sexual Dysfunction.
Vaporizers	DME	Only for members with a respiratory illness. Refer to the NCD for Durable Medical Equipment Reference List (280.1).
Ventilators (including Supplies)	DME	Covered for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease. Includes both positive and negative pressure types. If request is related to Obstructive Sleep Apnea, refer to CPAP section of DME Grid.
Walkers	DME	Refer to Mobility Assistive Equipment.

Item		Coverage	Comments
Wheelchairs (Manual, Motorized, Power Operated, Scooters, POVs, Specially Sized) (Face-to-face requirement may be applicable)	General Coverage Guidelines	DME	Refer to Mobility Assistive Equipment.
	Ramp for Wheelchair	Not Covered	Refer to Mobility Assistive Equipment.
	Seat Elevator for PWC	DME	Coverage criteria apply for Group 2 power wheelchair with power options that can accommodate rehabilitative features (for example, tilt in space) or Group 3 power wheelchair. Refer to the NCD for Seat Elevation Equipment (Power Operated) on Power Wheelchairs (280.16).
Wearable Cardioverter Defibrillators	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type	DME	Coverage criteria apply. Refer to the Benefit Interpretation Policy titled Cardiac Pacemakers and Defibrillators.
	Replacement garment for use with automated external defibrillator, each	DME	Coverage criteria apply. Refer to the Benefit Interpretation Policy titled Cardiac Pacemakers and Defibrillators.
	Replacement electrodes for use with automated external defibrillator, each	DME	Coverage criteria apply. Refer to the Benefit Interpretation Policy titled Cardiac Pacemakers and Defibrillators.
	Replacement battery for automated external defibrillator, each	Not Covered	Refer to the Benefit Interpretation Policy titled Cardiac Pacemakers and Defibrillators.
Whirlpool Bath Equipment (Standard/ Non-Portable))		DME	Covered if member is homebound and has a (standard) condition for which the whirlpool bath can be expected to provide substantial therapeutic benefit justifying its cost. Where member is not homebound but has such a condition, payment is restricted to the cost of providing the services elsewhere; e.g., an outpatient department of a participating hospital, if that alternative is less costly. In all cases, refer claim to medical staff for a determination. Refer to the NCD for Durable Medical Equipment Reference List (280.1).
Wrist splint		DME	Refer to Splints.

*Medical Supplies are covered only when they are incident to a physician's professional services or authorized home health services and are furnished as an integral, although incidental, part of those services in the course of diagnosis or treatment of an injury or illness.

Policy History/Revision Information

Date	Summary of Changes
01/01/2026	**Medical Supplies Grid** • Updated list of applicable items; replaced: ○ "Air-Fluidized Bed *(Bead), e.g., Clinitron*" with "Air-Fluidized Bed" ○ "Alternating Pressure Pads, *Gel Flotation Devices, Lamb's Wool Pads/Sheep Skins (Group 1 pressure reducing support surfaces)*" and "Alternating Pressure Pads, *Low Air Loss or Powered Flotation without Low Air Loss (Group 2 pressure reducing support surfaces)*" with "Alternating Pressure Pads *and Mattress (Pressure Reducing Support Surfaces)*" ○ "Artificial Eye" with "Artificial Eye *(Eye Prosthesis)*" ○ "Artificial Larynx *or Electronic Speech Aid*" with "Artificial Larynx *or Electrolarynx (e.g., UltraVoice)*" ○ "Back Brace" with "Back Brace*/Orthosis*" ○ "Beds and Accessories" with "*Hospital* Beds and Accessories" ○ "Bi-directional static progressive stretch splinting *(e.g., JAS splints, ERMI system)*" with "Bi-Directional Static Progressive Stretch Splinting" ○ "Bone Stimulator *also known as Osteogenic Stimulator (Electronic or Ultrasonic)*" with "Bone Stimulator" ○ "Bras/ Brassieres(post-surgery)" with "Bras (mastectomy)" ○ "Compression *Burn* Garment" with "Compression Garment/*Bandages for Lymphedema*" ○ "Continuous Passive Motion (CPM)" with "Continuous Passive Motion (CPM) *Devices*" ○ "Cough Assist Device" with "Cough Assist Device/*Mechanical In-exsufflation Devices*" ○ "*Cranial Band/Helmet* (Cranial Orthosis)" with "Cranial Orthosis" ○ "Crutches, *Crutch Tips and Handles*" with "Crutches" ○ "Electrical Stimulation Devices *(for chronic pain)*" with "Electrical Stimulation Devices" ○ "Electrical Stimulation Devices or Electromagnetic Therapy for Wound Healing *or Diathermy Machines (e.g., Diapulse)*" with "Electrical Stimulation Devices or Electromagnetic Therapy for Wound Healing" ○ "Gradient Compression Stockings *(e.g., Jobst stockings)*" with "Gradient Compression Stockings, *Below Knee"* ○ "Hydraulic (Hoyer) Lift" with "Hydraulic (Hoyer)*/Patient Lift*" ○ "Infusion Pumps" with "Infusion Pumps *(e.g., HCPCS code E0784)*" ○ "Knee Orthosis (e.g., Knee Immobilizer, Range of Motion Knee Orthosis, Rigid Ace Design Knee Orthosis" with "Knee Orthosis (e.g., Knee Immobilizer, Range of Motion Knee Orthosis, Rigid Ace Design Knee Orthosis, *Anterior Cruciate Ligament/ACL Brace)*" ○ "Light Therapy Box *(Therapeutic Light Box)*" with "Light Therapy Box" ○ "Low-Load Prolonged-Duration Stretch Devices (LLPS)" with "Low-Load Prolonged-Duration Stretch (LLPS) Devices *such as the Dynasplint System*" ○ "Lumbar-Sacral Orthosis(LSO)" with "*Lumbar Orthosis (LO)*/Lumbar-Sacral Orthosis (LSO)" ○ "Lymphedema *Sleeve/Compression Garments/Bandages (Wrap)*" with "Lymphedema *Compression Treatment Items*" ○ "Lymphedema Pumps *(segmental and nonsegmental)*" with "Lymphedema Pumps" ○ "Oxygen Equipment *and Necessary Accessories*" with "*Oxygen and* Oxygen Equipment" ○ "PureWick™ Female External Catheter and the PureWick™ *Urine Collection* System" with "Female External *Urine Management Systems (including but not limited to QiVi™ Female External Urine Management System, CareDry® System, PrimaFit External Urine Management Device,* PureWick™ System, *Versette® External Catheter)*" ○ "Rolling Chair (Geri Chair)" with "Rolling Chair/*Roll-about Chair* (Geriatric Chair)" ○ "Spinal Orthosis" with "Spinal Orthosis *(Body Jacket)*" ○ "Whirlpool Bath Equipment (standard)" with "Whirlpool Bath Equipment (Standard/*Non-Portable*)

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	• Removed coverage guidelines for:
	  ○ Abdominal binder
	  ○ Air conditioner/air cleaner/purifier/electrostatic machines or other environmental equipment
	  ○ Bed pan (autoclavable, hospital type)
	  ○ Casts (e.g., plaster, fiberglass)
	  ○ Cervical pillow
	  ○ Collagen implant
	  ○ Easy stand/tilt stand
	  ○ Face masks, surgical
	  ○ Heparin/saline flushes
	  ○ H-wave stimulation device
	  ○ Home prothrombin time international normalized ratio (INR) monitoring)/coagulation monitor
	  ○ Incontinence pads
	  ○ Porcine (pig) skin dressings
	  ○ Pumps, including Medications and necessary supplies, for pain control
	  ○ Punctal plug
	  ○ Ramp (wheelchair)
	  ○ Respiratory assist devices
	  ○ Support hose (e.g., Ted hose)
	  ○ Surgical boot
	  ○ Surgical stockings
	  ○ Syringes, bulb, ear
	  ○ Tinnitus masker
	  ○ Toilet lifts
	  ○ Traction equipment, spinal unloading devices (includes spinal and axial decompression units, pneumatic vests)
	  ○ Urinary catheter related supplies
	Air-Fluidized Bed
	• Replaced coverage guidelines with instruction to refer to the *Alternating Pressure Pads and Mattress (Pressure Reducing Support Surfaces)* section of the policy
	Alternating Pressure Pads and Mattress (Pressure Reducing Support Surfaces) (Face-to-Face Requirement May Be Applicable)
	• Revised coverage guidelines to indicate:
	  ○ Face-to-face requirement may be applicable
	  ○ Coverage criteria apply; refer to the Medical Policy titled *Beds and Mattresses*
	Ambulatory Cardiac Event Monitoring (e.g., Holter Monitor, Event Monitor, Patch-Type Monitor, Zio Patch)
	• Added language to indicate item is not covered
	• Removed language indicating item is covered as medical supply
	Ankle-Foot Orthosis (AFO)/Knee-Ankle-Foot Orthosis (KAFO)
	• Revised language to indicate:
	  ○ Face-to-face requirement may be applicable
	  ○ Item is covered as orthotic
	  ○ Coverage criteria apply; refer to the *DME MAC LCD for Ankle-Foot/Knee-Ankle-Foot Orthosis (L33686)*

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	○ A foot drop splint/recumbent positioning device and replacement interface will be denied as not medically necessary in a patient with foot drop who is non-ambulatory because there are other more appropriate treatment modalities ***Artificial Eye (Eye Prosthesis)*** • Added reference link to the: ○ *DME MAC LCD for Eye Prosthesis (L33737)* ○ *Medicare Benefit Policy Manual, Chapter 15, §120 Prosthetic Devices* and *Section 130 Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes* ***Artificial Larynx or Electrolarynx (e.g., UltraVoice)*** • Revised language to indicate item is covered as prosthetic; refer to the *Medicare Benefit Policy Manual, Chapter 15, §120 Prosthetic Devices* ***Artificial Extremities – Lower Extremities, Standard and Microprocessor*** • Revised coverage guidelines to indicate prosthetic coverage criteria apply; refer to the Medical Policy titled *Lower Extremity Prosthetics* ***Artificial Extremities – Upper Extremities, Standard and Myoelectric*** • Revised coverage guidelines to indicate prosthetic coverage criteria apply; refer to the Medical Policy titled *Upper Extremity Prosthetic Devices* ***Augmentative Communication Devices*** • Added instruction to refer to the *Speech Generating Devices* section of the policy ***Bead Bed*** • Added instruction to refer to the *Air-Fluidized Beds* section of the policy ***Bed Cradle*** • Removed language indicating item is covered when necessary to prevent contact with the bed coverings • Added instruction to refer to the *Hospital Beds and Accessories* section of the policy ***Beds*** • Added instruction to refer to the *Hospital Beds and Accessories* section of the policy ***Bili-Lights/Bili-Blankets (Phototherapy)*** • Replaced language indicating "item is covered when medically necessary for treatment of jaundice in newborns" with "item is covered when medically necessary for treatment *delivered by a healthcare professional* of jaundice in newborns" ***Blood Glucose Monitors*** • Added language to indicate: ○ Home blood glucose monitors and supplies (e.g., blood testing strips and lancets) are covered ○ DME coverage criteria apply ○ Refer to the Benefit Interpretation Policy titled *Diabetic Management, Services and Supplies* and the Medical Policy titled *Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes* ***Blood Pressure Monitor/Sphygmomanometer*** • Added reference link to the Benefit Interpretation Policy titled *Dialysis Services* ***Bras (Mastectomy)*** • Removed language indicating item is required to hold a breast prosthesis (up to 3 every 12 months) • Added instruction to refer to the *Breast Prosthesis* section of the policy

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	Breast Prosthesis (External) • Revised coverage criteria to indicate prosthetic coverage criteria apply; refer to the Benefit Interpretation Policy titled *Post Mastectomy Surgery* and the Medical Policy titled *Breast Reconstruction* ***Cam Walkers (Also Known As Walking Boot)*** • Removed language indicating item is covered as corrective appliance/orthotic ***Canes, Quad or Straight* and *Canes, White*** • Replaced coverage guidelines with instruction to refer to the *Mobility Assistive Equipment* section of the policy ***Catheters and Supplies*** • Revised coverage guidelines (relocated from the *Urinary Catheter and Supplies/Urological Supplies* section of the policy) to indicate: Closed Drainage Bags ○ Refer to the *Urinary Drainage Bags* section of the policy Leg Drainage Bags ○ Only for members with non-functioning bladder or permanent incontinence who is ambulatory or are chair or wheelchair bound; refer to the *DME MAC LCD for Urological Supplies (L33803)* External Urinary Collection Devices (e.g., Male External Catheters and Female Pouches/Meatal Cups) ○ Only for members with non-functioning bladder or permanent incontinence when used as an alternative to an indwelling catheter ○ Male external catheters are limited to no more than 35 per month and female external urinary collection devices are limited to no more than one metal cup per week or one pouch per day ○ Requests for a greater quantity must be documented by a participating physician as medically necessary ○ Refer to the *DME MAC LCD for Urological Supplies (L33803)* Foley/Indwelling ○ Only for members with non-functioning bladder or permanent incontinence as medically required ○ Limited to no more than one catheter per month for routine catheter maintenance ○ Requests for a greater quantity must be documented by a participating physician as medically necessary ○ Refer to the *DME MAC LCD for Urological Supplies (L33803)* Intermittent Urinary Catheters ○ Intermittent catheterization is covered when basic coverage criteria are met and the patient or caregiver can perform the procedure; refer to the *DME MAC LCD for Urological Supplies (L33803)* ○ Any patient who utilizes intermittent catheterization can receive one sterile urological catheter and one packet of lubricant for each catheterization ○ Important Points: ▪ First, the prescription should reflect the actual number of times that the patient actually catheterizes him/herself per day; for example, if the patient self-catheterizes four times per day, the prescription should be for approximately 120 catheters per month – Although the LCD says that Medicare will cover up to 200 intermittent catheters per month, this is a maximum number and most patients self-catheterize less than 6 times per day – It would be inappropriate to order 200 catheters per month for every patient – The prescription must be individualized for each patient

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	▪ The second important point is that the provider should clearly document in the chart the number of times per day that the patient performs self-catheterization; just listing that value on the prescription or on a separate form provided by the supplier is not sufficient ▪ Refer to the *Joint DME MAC Letter – Intermittent Urinary Catheterization* ***Cervical Collar (Semi-Rigid, Soft and Rigid)*** • Revised coverage guidelines to indicate item is covered as a brace; refer to the *Medicare Benefit Policy Manual, Chapter 15, §130 Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes* ***Cochlear Implant (External Component of Device)*** • Removed language indicating item is considered a high end prosthetic device ***Cold Therapy*** • Added reference link to the *DME MAC LCD for Cold Therapy (L33735)* ***Colostomy Bag*** • Removed language indicating item is covered as prosthetic ***Commode, Bedside (Without Wheels Only)*** • Added reference link to the: o *NCD for Durable Medical Equipment Reference List (280.1)* o *DME MAC LCD for Commodes (L33736)* ***Commode Chair With Seat Lift Mechanism*** • Added language to indicate DME coverage criteria apply; refer to the *DME MAC LCD for Commodes (L33736)* ***Compression Garment/Bandages for Lymphedema*** • Replaced coverage guidelines with instruction to refer to the *Lymphedema Compression Treatment Items* section of the policy ***Continuous Glucose Monitoring (CGM) Device or System*** • Added language to indicate DME coverage criteria apply; refer to the Benefit Interpretation Policy titled *Diabetic Management, Services and Supplies* and the Medical Policy titled *Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes* ***Cough Assist Device/Mechanical In-Exsufflation Devices*** • Added reference link to the *DME MAC LCD for Mechanical In-exsufflation Devices (L33795)* ***Crib (Pediatric)*** • Added language to indicate DME coverage criteria apply; refer to the Medical Policy titled *Beds and Mattresses* ***Crutches*** • Replaced coverage guidelines with instruction to refer to the *Mobility Assistive Equipment* section of the policy ***Deep Brain Stimulation (DBS), Unilateral or Bilateral Thalamic Ventralis Intermedius Nucleus (VIM) DBS and Unilateral or Bilateral Subthalamic Nucleus (STN) or Globus Pallidus Interna (GPI) DBS*** • Added language to indicate DME coverage criteria apply; refer to the Medical Policy titled *Deep Brain and Cortical Stimulation* ***Dialysis Home Kit, Peritoneal*** • Added reference link to the Benefit Interpretation Policy titled *Dialysis Services* ***Diathermy Machines (Standard Pulses Wave Type, e.g., Diapulse)*** • Added language to indicate DME coverage criteria apply; refer to the Benefit Interpretation Policy titled *Rehabilitation Services (Physical, Occupational, and Speech Therapy)* and the Medical Policy titled *Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech)*

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	Disposable Items
	• Relocated and revised language to indicate:
	  ○ Items are not covered
	  ○ Examples include but are not limited to:
	  ▪ Diapers (refer to the *Diapers/Adult Incontinence Garments* section of the policy)
	  ▪ Disposable sheets and bags (refer to the *Disposable Sheets* section of the policy)
	  ▪ Elastic stockings
	  ▪ Incontinence pads (relocated
	  ▪ Irrigating kits
	  ▪ Support hose/fabric support (e.g., Ted Hose)
	  ▪ Surgical face mask
	  ▪ Surgical leggings
	  ▪ Surgical stockings
	  ▪ Syringes (ear bulb)
	  ▪ Wedge pillow
	  ○ Refer to the:
	  ▪ *DME MAC LCD for Urological Supplies (L33803)*
	  ▪ *LCA for Urological Supplies (A52521)*
	  ▪ *Medicare Benefit Policy Manual, Chapter 16, §80 Personal Comfort Items*
	  ▪ *NCD for Durable Medical Equipment Reference List (280.1)*
	  ▪ *Social Security Act Section 1861(n)*
	  ▪ *Social Security Act Section 1862(a)(6)*
	Diapers/Adult Incontinence Garments
	• Added language to indicate items are covered as medical supply
	• Removed language indicating items are covered as prosthetic
	Dressings/Bandages
	Non-Surgical Dressings/Bandages (e.g., Ace Bandages)
	• Added reference link to the *Medicare Benefit Policy Manual, Chapter 15, §60.1 Incident To Physician's Professional Services*
	Surgical Dressings
	• Revised coverage guidelines to indicate:
	  ○ Surgical dressings may be covered as:
	  ▪ Medical supply when provided the physician's office; refer to the *Medicare Benefit Policy Manual, Chapter 15, §60.1 Incident To Physician's Professional Services*
	  ▪ DME when ordered by the treating physician or other healthcare professional for the patient's home use in conjunction with a durable medical equipment (e.g., infusion pumps); refer to the *Medicare Benefit Policy Manual, Chapter 15, §110.3 Coverage of Supplies and Accessories*
	  ▪ Prosthetic when ordered by the treating physician or other healthcare professional for the patient's home use as dressing for surgical wound or for wound debridement or in conjunction with a prosthetic device (e.g., tracheostomy) refer to the *Medicare Benefit Policy Manual, Chapter 15, §§120(D) Supplies, Repairs, Adjustments, and Replacement*
	  ○ Surgical dressings are limited to primary dressings (therapeutic or protective coverings applied directly to a wound) or secondary dressings (dressings that serve a therapeutic or protective function and are needed to secure a primary dressing,

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	e.g., tape, roll gauze, transparent film) that are medically necessary for the treatment of a wound caused by, or treated by, a surgical procedure or wound debridement ○ Refer to the *Medicare Benefit Policy Manual, Chapter 15, §100 Surgical Dressings, Splints, Casts, and Other Devices Used for Reductions of Fractures and Dislocations*; for specific coverage guidelines for surgical dressings, refer to the *DME MAC LCD for Surgical Dressings (L33831)* Porcine Skin Surgical Dressings • Added language to indicate item is covered, if reasonable and necessary for the individual patient as an occlusive dressing for burns, donor sites of a homograft, and decubiti and other ulcers; refer to the *NCD for Porcine Skin and Gradient Pressure Dressings (270.5)* Gradient Pressure Dressings (e.g., Jobst Elasticized Heavy Duty Stockings) • Added language to indicate: ○ Item is covered when used to reduce hypertrophic scarring and joint contractures following burn injury; refer to the *NCD for Porcine Skin and Gradient Pressure Dressings (270.5)* ○ LCDs/ LCAs exist and compliance with these policies is required where applicable; refer to the *DME MAC LCD for Surgical Dressings (L33831)* ***Elbow Orthosis*** • Added language to indicate face-to-face requirement may apply • Added reference link to the *Medicare Benefit Policy Manual, Chapter 15, §130 Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes* ***Electrical Stimulation Devices*** Interferential Device • Added language to indicate item is not covered • Removed language indicating item is not medically necessary Transcutaneous Electrical Nerve Stimulator (TENS) Unit • Revised coverage guidelines to indicate DME coverage criteria apply; refer to the Medical Policy titled *Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation* ***Electronic Speech Aids*** • Added language to indicate [item is covered] for member post laryngectomy or permanently inoperative larynx condition; refer to the *NCD for Electronic Speech Aids (50.2)* ***Eye Prosthesis*** • Added instruction to refer to the *Artificial Eye* section of the policy ***External Breast Prostheses*** • Added instruction to refer to the *Breast Prosthesis* section of the policy ***Face Masks, Oxygen*** • Revised coverage guidelines to indicate: ○ Item is covered if oxygen is covered ○ Coverage criteria for oxygen apply ○ For coverage criteria, refer to the *NCD for Home Use of Oxygen (240.2)* ○ Also refer to the *DME MAC LCD for Oxygen and Oxygen Equipment (L33797)* ***Facial Prosthesis*** • Added reference link to the *DME MAC LCD for Facial Prostheses (L33738)*

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	Flutter Device/ Oscillatory Positive Expiratory Pressure Devices • Added language to indicate coverage criteria apply • Removed language indicating item is covered when medically necessary ***Foot Cradle*** • Removed language indicating item is covered as DME ***Formula (Enteral Feedings)*** • Removed language indicating coverage criteria apply • Removed reference link to the Medical Policy titled *Enteral Nutrition (Oral and Tube Feeding)* • Added instruction to refer to the *Nutritional Therapy* section of the policy ***Gait Trainers*** • Revised coverage guidelines to indicate DME coverage criteria apply; refer to the Medical Policy titled *Walkers* ***Hearing Aid*** • Added language to indicate DME coverage criteria apply ***Heat Lamp*** • Revised language to indicate item is covered if patient's condition is one for which the application of heat in the form of heat lamp is therapeutically effective; refer to the *NCD for Durable Medical Equipment Reference List (280.1)* ***Heating Pads, Steam Packs or Hot Packs*** • Added language to indicate: Electrical or Non-Electrical ○ Item is covered if member's medical condition is one for which the application of heat in the form of heat pad is therapeutically effective ○ Refer to the: ▪ *NCD for Durable Medical Equipment Reference List (280.1)* ▪ *DME MAC LCD for Heating Pads and Heat Lamps (L33784)* Infrared ○ Item is not primarily medical in nature ○ Refer to the: ▪ *NCD for Infrared Therapy Devices (270.6)* ▪ *DME MAC LCD for Infrared Heating Pad Systems (L33825)* ***Helmets (Cranial Orthosis)*** • Removed language indicating item is covered as corrective appliance/orthotic ***High Frequency Chest Wall Compression Devices (e.g., ThAIRapy® Vest System)*** • Added language to indicate DME coverage criteria apply ***Hospital Beds and Accessories*** • Revised coverage guidelines to indicate: ○ Face-to-face requirement may be applicable ○ DME coverage criteria apply; refer to the Medical Policy titled *Beds and Mattresses* ***Hot Packs*** • Added instruction to refer to the *Heating Pads* section of the policy ***Humidifiers***

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	For Use With Respiratory Assist Devices
	• Added reference link to the *DME MAC LCD for Respiratory Assist Devices (L33800)*
	For use with Oxygen System
	• Replaced language indicating "item is covered if criteria for oxygen *are met*" with "coverage criteria for oxygen *apply*"
	• Added reference link to the:
	  ○ *NCD for Home Use of Oxygen (240.2)* for coverage criteria
	  ○ *DME MAC LCD for Oxygen and Oxygen Equipment (L33797)*
	Hydraulic Lifts
	• Removed language indicating item is covered as DME
	Immobilizer (Extremity)
	• Removed language indicating item is covered as corrective appliance/orthotic
	Incontinence Control Devices (Mechanical and Hydraulic)
	• Revised coverage guidelines to indicate prosthetic coverage criteria apply; refer to the *NCD for Incontinence Control Devices (230.10)*
	Infusion Pump
	• Removed language indicating item is covered as DME
	Inhalation Machine
	• Removed language indicating item is covered as DME
	Intermittent Positive Pressure Breathing (IPPB) Machines
	• Revised coverage guidelines to indicate item is covered if patient's ability to breathe is severely impaired (includes fluidic breathing assisters); refer to the *NCD for Durable Medical Equipment Reference List (280.1)*
	Iron Lungs
	• Added instruction to refer to the *Ventilators* section of the policy
	Jaw Motion Rehabilitation System (Passive Rehabilitation Therapy)
	• Added reference link to the Medical Policy titled *Treatment of Temporomandibular Joint Disorders*
	Knee Orthosis (e.g., Knee Immobilizer, Range of Motion Knee Orthosis, Rigid Ace Design Knee Orthosis, Anterior Cruciate Ligament/ACL Brace)
	• Added language to indicate face-to-face requirement may be applicable
	• Revised coverage guidelines to indicate corrective appliance/orthotic coverage criteria apply; refer to the *DME MAC LCD for Knee Orthoses (L33318)*
	Lamb's Wool Pads/Sheep Skins
	• Removed language indicating item is covered as DME
	Lifts
	Hydraulic (Hoyer) Lift/ Patient Lift
	• Added reference link to the:
	  ○ *NCD for Durable Medical Equipment Reference List (280.1)*
	  ○ *DME MAC LCD for Patient Lifts (L33799)*
	Motorized (Electric), Ceiling Modified
	• Added reference link to the:

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	○ *Medicare Benefit Policy Manual, Chapter 15, §110.2 Equipment Presumptively Non-Medical* ○ *Social Security Act §1861(n) and 1862(a)(6)* Seat Lift Mechanism • Added reference link to the *DME MAC LCD for Seat Lift Mechanisms (L33801)* For Wheelchairs/Scooters/POVs • Added reference link to the: ○ *Social Security Act §1861(n)* ○ *Social Security Act §1862(a)(6)* ○ *Medicare Benefit Policy Manual, Chapter 16, §80 Personal Comfort Items* ○ *Wheelchairs* section of the policy ***Light Therapy Box*** • Revised coverage guidelines to indicate: ○ Item is not primarily medical in nature; other devices and equipment used for environmental control or to enhance the environmental setting in which the member is placed are not considered covered DME ○ Refer to the *Medicare Benefit Policy Manual, Chapter 15, §110.1 Equipment Presumptively Non-Medical* ***Lumbar Orthosis (LO)/Lumbar-Sacral Orthosis (LSO)*** • Removed language indicating item is covered as corrective appliance/orthotic ***Lymphedema Pumps*** • Added instruction to refer to the *Pneumatic Compression Devices* section of the policy ***Mandibular Device (for Sleep Apnea)*** • Revised coverage guidelines to indicate DME coverage criteria apply; refer to the Medical Policy titled *Obstructive and Central Sleep Apnea Treatment* ***Mechanical In-Exsufflation Devices*** • Added instruction to refer to the *Cough Assist Devices* section of the policy ***Mobility Assistive Equipment (MAE)*** • Added language to indicate: Canes ○ DME coverage criteria apply ○ Refer to the ▪ *NCD for Mobility Assistive Equipment (MAE) (280.3)* ▪ *DME MAC LCD for Canes and Crutches (L33733)* ▪ *NCD for Durable Medical Equipment Reference List (280.1)* ○ White canes are not covered, not primarily medical in nature, and not considered mobility assistive equipment; refer to the *NCD for White Cane for Use by a Blind Person (280.2)* Crutches ○ DME coverage criteria apply; refer to the *NCD for Mobility Assistive Equipment (MAE) (280.3)* and *DME MAC LCD for Canes and Crutches (L33733)* ○ Crutch substitute (HCPCS code E0118) is not covered ▪ There is insufficient published clinical literature demonstrating safety and effectiveness in the Medicare population to establish the medical necessity for this device ▪ Refer to the *Noridian Article E0118 - Crutch Substitute*

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	Power Mobility Device (PMDs) [includes Power Wheelchairs and Power Operated Vehicle (also known as POVs or scooters)] ○ DME coverage criteria apply; refer to the *NCD for Mobility Assistive Equipment (MAE) (280.3)* and *DME MAC LCD for Power Mobility Devices (L33789)* ○ For guidelines for repairs, replacements, and maintenance, refer to the *Medicare Benefit Policy Manual, Chapter 15, §110.2 Repairs, Replacement and Maintenance and Delivery* ○ For guidelines for PMD options and accessories, refer to the *DME MAC LCD for Wheelchair Options/Accessories (L33792)* ○ For guidelines for PMD seating, refer to the *DME MAC LCD for Wheelchair Seating (L33312)* ○ For documentation and face-to-face requirements for PMDs, refer to the *LCD for Power Mobility Devices (L33789)* and *MLN Matters SE1112 Power Mobility Device Face-to-Face Examination Checklist* ○ Home Assessment ▪ Prior to or at the time of delivery of a POV or PWC, the supplier or practitioner must perform an on-site evaluation of the member's home to verify that the member can adequately maneuver the device that is provided considering physical layout, doorway width, doorway thresholds, and surfaces ▪ There must be a written report of this evaluation available on request; refer to the *DME MAC LCD for Power Mobility Devices (L33789)* ○ Battery replacement (purchased equipment) is covered only when the member owns or is purchasing (not renting) the electric wheelchair or POV; refer to the *Medicare Benefit Policy Manual, Chapter 15, §110.3 Coverage of Supplies and Accessories* and the *DME MAC LCD for Wheelchair Options/Accessories (L33792)* ○ The following are not covered: ▪ POVs for members who are capable of ambulation within the home but require a power vehicle for movement outside of the home; refer to the *DME MAC LCD for Power Mobility Devices (L33789)* ▪ POVs that are primarily used to allow the member to perform leisure or recreational activities; refer to the *DME MAC LCD for Power Mobility Devices (L33789)* ▪ Replacement of a wheelchair due to malicious damage, neglect, or abuse; refer to the *Medicare Benefit Policy Manual, Chapter 15, §110.2 Repairs, Replacement and Maintenance and Delivery* ○ Repairs on rented DME items (DME provider is responsible for such repairs); refer to the *Medicare Benefit Policy Manual, Chapter 15, §110.2 Repairs, Replacement and Maintenance and Delivery* Walkers • Revised coverage guidelines [relocated from the *Walkers (Standard)* section of the policy] to indicate: ○ DME coverage criteria apply; refer to the *NCD for Mobility Assistive Equipment (MAE) (280.3)* and the *DME MAC LCD for Walkers (L33791)* ○ The medical necessity for a walker with an enclosed frame (E0144) has not been established; therefore, if an enclosed frame walker is provided, it will be denied as not reasonable and necessary ▪ Refer to the *DME MAC LCD for Walkers (L33791)* Wheelchairs (Manual) • Revised coverage guidelines (relocated from the *Wheelchairs and Accessories* section of the policy) to indicate: ○ DME coverage criteria apply; refer to the *NCD for Mobility Assistive Equipment (MAE) (280.3)* and *DME MAC LCD for Manual Wheelchair Bases (L33788)* ○ For guidelines for wheelchair options and accessories, refer to *DME MAC LCD for Wheelchair Options/Accessories (L33792)* ○ For guidelines for wheelchair seating, refer to the *DME MAC LCD for Wheelchair Seating (L33312)* ○ For guidelines for repairs, replacements, and maintenance, refer to the *Medicare Benefit Policy Manual, Chapter 15, §110.2 Repairs, Replacement and Maintenance and Delivery*

Date	Summary of Changes
	○ Mobile geriatric chairs may be covered when criteria are met; refer to the *NCD for Durable Medical Equipment Reference List (280.1)* and the *NCD for Mobility Assistive Equipment (MAE) (280.3)* ○ Payment is made for only one wheelchair at a time ▪ Backup chairs are denied as not reasonable and necessary ▪ One month's rental for a standard manual wheelchair is covered if a member-owned wheelchair is being repaired ▪ Refer to the *DME MAC LCD for Manual Wheelchair Bases (L33788)* ○ The following are not covered: ▪ Ramp for a wheelchair is not covered; not primarily medical in nature; refer to the *Medicare Benefit Policy Manual, Chapter 15, § 110.1 (B)(2) Equipment Presumptively Non-Medical* ▪ Wheelchair upgrades that are beneficial primarily in allowing the member to perform leisure or recreational activities; refer to the: – *Medicare Benefit Policy Manual, Chapter 16, §20 Services Not Reasonable and Necessary* and *§10 General Exclusions from Coverage* – *DME MAC LCD for Power Mobility Devices (L33789)* – *LCA for Power Mobility Devices - Policy Article (A52498)* ▪ Deluxe items or features; refer to the *Medicare Benefit Policy Manual, Chapter 16, §20 Services Not Reasonable and Necessary* and *§10 - General Exclusions from Coverage* ▪ Items purchased for comfort or added convenience for the member or the member's caretaker; refer to the *Medicare Benefit Policy Manual, Chapter 16, §20 Services Not Reasonable and Necessary* and *§10 General Exclusions from Coverage* ▪ Replacement of a wheelchair due to malicious damage, neglect, or abuse; refer to the *Medicare Benefit Policy Manual, Chapter 15, §110.2 Repairs, Replacement, and Maintenance and Delivery* ▪ Repairs on rented DME items (DME provider is responsible for such repairs); refer to the *Medicare Benefit Policy Manual, Chapter 15, §110.2 Repairs, Replacement, and Maintenance and Delivery* ***Myoelectric Arm Orthosis (i.e., MyoPro®)*** • Added language to indicate item is not covered; refer to the Medical Policy titled *Omnibus Codes* ***Negative Pressure Wound Therapy Pump*** • Removed language indicating item is covered as DME ***Nutritional Therapy, Enteral and Parenteral*** • Revised coverage criteria to indicate DME coverage criteria apply; refer to the Medical Policy titled *Enteral Nutrition (Oral and Tube Feeding)* ***Orthopedic Shoes*** • Removed language indicating item is covered as corrective appliance/orthotic ***Ostomy Supplies*** • Revised coverage guidelines to indicate: ○ Colostomy (and other ostomy) bags and necessary accouterments required for attachment are covered as prosthetic devices ○ This coverage also includes irrigation and flushing equipment and other items and supplies directly related to ostomy care, whether the attachment of a bag is required ○ Refer to the *Medicare Benefit Policy Manual, Chapter 15, §120 Prosthetic Devices* ○ For coverage guidelines, refer to the *DME MAC LCD for Ostomy Supplies (L33828)* ***Other Non-Covered Items***

Date	Summary of Changes

	• Relocated and revised language to indicate:
	  ○ Examples of items that are not primarily medical in nature, do not meet the definition of DME, and/or are personal comfort items include but are not limited to:
	  ▪ Air cleaner/purifier
	  ▪ Air conditioner
	  ▪ Back support (posture chair)
	  ▪ Bathtub lifts and seats
	  ▪ Bed baths (home type)
	  ▪ Bed boards
	  ▪ Bed lifter (bed elevator)
	  ▪ Bed specs
	  ▪ Bed wetting alarm
	  ▪ Braille teaching text
	  ▪ Breast pump (electric or manual)
	  ▪ Car seats
	  ▪ Carafes
	  ▪ Commode - chair foot rest
	  ▪ Commode - elevated seat (raised toilet seat)
	  ▪ Dehumidifier (room or central heating system type)
	  ▪ Electrostatic machines
	  ▪ Elevators
	  ▪ Emesis basin
	  ▪ Esophageal dilator
	  ▪ Exercise equipment (e.g., barbells, all types of tricycles)
	  ▪ Gait belt
	  ▪ Grab bars (for bath and toilet)
	  ▪ Heat and massage foam cushion pads
	  ▪ Heater (portable room heater)
	  ▪ Heating and cooling plants
	  ▪ Helmet (safety equipment)
	  ▪ Hypothermic blanket
	  ▪ Injectors (hypodermic jet pressure powered injectors
	  ▪ Jacuzzi
	  ▪ Leotard (pressure garment)
	  ▪ Massage devices
	  ▪ Parallel bars
	  ▪ Personal or comfort items
	  ▪ Pulse tachometer
	  ▪ Sauna baths
	  ▪ Stair lifts/stair elevator
	  ▪ Shower/bathtub seat
	  ▪ Speech teaching machines
	  ▪ Spirometer

Date	Summary of Changes
	▪ Standing tables ▪ Telephone alert system ▪ Telephone arms/cradle ▪ Toilet seat, elevated bidet ▪ Transfer bench (for tub or toilet) ▪ Treadmill exerciser ▪ Vehicle/trunk modification ▪ Vitrectomy face support (positioning pillow) ▪ Walk-in bathtub/showers ▪ Wedge pillow ▪ Whirlpool pump (portable) ▪ Wig/hairpiece ○ Refer to the: ▪ *Medicare Benefit Policy Manual, Chapter 15, §110.1 Definition of DME* ▪ *Medicare Benefit Policy Manual, Chapter 16, §80 Personal Comfort Items* ▪ *NCD for Durable Medical Equipment Reference List (280.1)* ***Oxygen and Oxygen Equipment*** • Revised coverage guidelines to indicate DME coverage criteria apply; refer to the *NCD for Home Use of Oxygen (240.2)* and the *DME MAC LCD for Oxygen and Oxygen Equipment (L33797)* ***Paraffin Bath Unit*** Portable • Added reference link to the *NCD for Durable Medical Equipment Reference List (280.1)* Standard • Revised coverage guidelines to indicate item is institutional equipment and not appropriate for home use; refer to the *NCD for Durable Medical Equipment Reference List (280.1)* ***Patient Lift*** • Added instruction to refer to the *Lifts* section of the policy ***Penile Prosthesis*** • Added language to indicate prosthetic coverage criteria apply; refer to the *NCD for Diagnosis and Treatment of Impotence (230.4)* ***Percussor (Non-Vest Type), Intrapulmonary Percussive Ventilator (IPV)*** • Replaced coverage guidelines with instruction to refer to the Medical Policy titled *Airway Clearance Devices* ***Pessary*** • Revised coverage guidelines to indicate item is covered when performed as part of the physician services; refer to the *Medicare Benefit Policy Manual, Chapter 15, §60.1 Services and Supplies Incident To Physician's Professional Services* ***Pneumatic Compression Devices*** • Revised coverage guidelines to indicate: For the Treatment of Lymphedema or Chronic venous Insufficiency With Venous Stasis Ulcer ○ DME coverage criteria apply; refer to the Medical Policy titled *Pneumatic Compression Devices* For the Prevention of Illnesses/Disease Including Deep Vein Thrombosis (DVT) ○ DME coverage criteria apply; refer to the Medical Policy titled *Pneumatic Compression Devices* For the Treatment of Peripheral Arterial Disease

Date	Summary of Changes
	○ Item is not covered; refer to the Medical Policy titled *Pneumatic Compression Devices* ***Pneumatic Splints*** • Removed language indicating item is covered as corrective appliance/orthotic ***Postural Drainage Boards*** • Added reference link to the *NCD for Durable Medical Equipment Reference List (280.1)* ***Power Mobility Devices*** • Added instruction to refer to the *Mobility Assistive Equipment* section of the policy ***Power Operated Vehicles (POV)/ Scooters*** • Removed language indicating item is covered as DME ***Power Traction Equipment/Devices (e.g., VAX-D®, DRX9000, SpineMED™, Spina System™, Lordex® Decompression Unit, DRS System™)*** • Removed language indicating item is not covered ***Protector, Heel or Elbow*** • Added language to item is considered a medical supply and not covered as DME; [item is] billed as part of an inpatient hospital or SNF care or as incident to a physician's service ***Pulse Oximeter*** • Revised coverage guidelines to indicate oximeters (HCPCS code E0445) and replacement probes (HCPCS code A4606) will be denied as non-covered because they are monitoring devices that provide information to physicians to assist in managing the member's treatment; refer to the *DME MAC LCD for Oxygen and Oxygen Equipment (L33797)* ***Pumps, Including Medications and Necessary Supplies*** Enteral • Replaced coverage guidelines with instruction to refer to the *Nutritional Therapy (Enteral)* section of the policy Infusion (e.g., HCPCS code E0784) • Revised coverage guidelines to indicate DME coverage criteria apply; refer to the Benefit Interpretation Policy titled *Diabetic Management, Services and Supplies* • Revised language pertaining to medical necessity clinical coverage criteria; removed reference to the InterQual® Medicare: Durable Medical Equipment, External Infusion Pumps Insulin, External *and* Implantable • Added language to indicate external continuous subcutaneous insulin infusion (CSII) pumps and related drugs and supplies are covered when coverage criteria are met Lymphedema • Added language to indicate DME coverage criteria apply; refer to the Medical Policy titled *Pneumatic Compression Device* Negative Pressure Wound • Added instruction to refer to the *Vacuum Assisted Closure Device* section of the policy For Erectile Dysfunction • Removed language indicating item is not covered ***Recliner (Chair)*** • Added reference link to the Benefit Interpretation Policy titled *Dialysis Services* • Removed reference link to the *Medicare Benefit Policy Manual, Chapter 11, §20.4 (A)(1) Equipment and Supplies*

Date	Summary of Changes

	Reflectance Colorimeters
	• Added instruction to refer to the *Blood Glucose Analyzer-Reflectance Colorimeter* section of the policy
	Respirators
	• Added instruction to refer to the *Ventilators* section of the policy
	Rib Belt
	• Revised coverage guidelines to indicate item is covered when medically necessary
	Safety Rollers
	• Removed language indicating item is covered as DME
	Scleral Shell
	• Added language to indicate:
	  ○ Scleral shell (or shield) is a catchall term for different types of hard scleral contact lenses
	  ○ Scleral shell may be covered as prosthetic when:
	  ▪ Used as an artificial eye when the eye has been rendered sightless and shrunken by inflammatory disease; or
	  ▪ Used in combination with artificial tears in the treatment of "dry eye" of diverse etiology
	  ○ Refer to the *NCD for Scleral Shell (80.5)*
	Scoliosis Orthosis
	• Replaced coverage guidelines with instruction to refer to the *Spinal Orthosis/Cervical-Thoracic-Lumbar Sacral Orthosis (CTLSO) and Thoracic-Lumbar-Sacral Orthosis (TLSO)* section of the policy
	Sitz Bath (Portable)
	• Added reference link to the *NCD for Durable Medical Equipment Reference List (280.1)*
	Sleep Apnea Device
	• Removed language indicating item is covered as DME
	Slings
	• Added reference link to the *Medicare Benefit Policy Manual, Chapter 15, §60.1 Incident To Physician's Professional Services*
	Speech Generating Device
	• Added language to indicate:
	  ○ Item is covered as DME and coverage criteria apply; refer to the NCD for Speech Generating Devices (50.1)
	  ○ LCDs/LCAs exist and compliance with these policies is required where applicable, refer to the *DME MAC LCD for Speech Generating Devices (SGD) (L33739)*
	Spinal Orthosis (Body Jacket)
	Cervical-Thoracic-Lumbar Sacral Orthosis (CTLSO), Lumbar-Sacral Orthosis (LSO), *and* Thoracic-Lumbar-Sacral Orthosis (TLSO)
	• Revised coverage guidelines to indicate corrective appliance/orthotic coverage criteria apply; refer to the *DME MAC LCD for Spinal Orthoses: TLSO and LSO (L33790)*
	• Added language to indicate face-to-face requirement may be applicable
	Lumbar Orthosis (LO)
	• Added language to indicate:
	  ○ Corrective appliance/orthotic coverage criteria apply; refer to the *DME MAC LCD for Spinal Orthoses: TLSO and LSO (L33790)*
	  ○ Face-to-face requirement may be applicable

Date	Summary of Changes

	Splints
	Bi-Directional Static Progressive Stretch Splinting, Dynamic (e.g., Dyna Splint), Low-Load Prolonged-Duration Stretch (LLPS) Devices such as the Dynasplint System, *and* Patient Actuated Serial Stretch (PASS) Devices
	• Updated instruction to refer to the Medical Policy titled *Mechanical Stretching Devices for coverage guidelines*
	Foot (e.g., Dennis-Browne)
	• Added reference link to the Benefit Interpretation Policy titled *Shoes and Foot Orthotics*
	Occlusal Splint (Custom Fabricated Bite Plate For TMJ)
	• Revised coverage guidelines to indicate item is not covered; refer to the Medical Policy titled *Treatment of Temporomandibular Joint Disorders* for coverage guidelines
	Static Progressive (SP) Stretch (Splinting) Devices [e.g., Joint Active Systems (JAS)] *and* Patient-Actuated Serial Stretch (PASS) (e.g., ERMI System)
	• Added instruction to refer to the Medical Policy titled *Mechanical Stretching Devices* for coverage guidelines
	Standing Frames/Mobile Stander
	• Replaced language indicating "items covered *if* medically necessary" with "items covered *when* medically necessary"
	• Revised language pertaining to medical necessity clinical coverage criteria; removed reference to the InterQual® CP: Durable Medical Equipment, Standing Frames
	• Removed reference link to the *CMS NCD for Mobility Assistive Equipment (MAE) (280.3)* and the *CMS NCD for Durable Medical Equipment Reference List (280.1)*
	Steam Packs
	• Added language to indicate item covered under the same conditions as heating pads; refer to the *Heating Pads* section of the policy
	Stockings, Gradient Compression Stockings, Below Knee
	• Revised coverage guidelines to indicate:
	  ○ Item is covered when used to secure a primary dressing over an open venous stasis ulcer that has been treated by a physician or other healthcare professional requiring medically necessary debridement or treatment of a wound caused by, or treated by, a surgical procedure
	  ○ Refer to the:
	  ▪ *DME MAC LCD for Surgical Dressings (L33831).*
	  ▪ *Medicare Benefit Policy Manual, Chapter 15, §100 Surgical Dressings, Splints, Casts, and Other Devices Used for Reductions of Fractures and Dislocations*
	Stump Socks
	• Removed language indicating item is covered as medical supplies
	Suction Pump or Machine
	• Added reference link to the:
	  ○ *DME MAC LCD for Suction Pumps (L33612)*
	  ○ *NCD for Durable Medical Equipment Reference List (280.1)*
	Sykes Hernia Control
	• Added language to indicate corrective appliance/orthotic coverage criteria apply; refer to the *NCD for Sykes Hernia Control (280.12)*
	Syringes, Hypodermic

Date	Summary of Changes

	• Removed notation indicating if a member does not have pharmacy benefit, then all syringes/needles are covered under medical
	• Added instruction to refer to the *Diabetic Supplies* section of the policy
	TMJ Splint
	• Removed language indicating item is covered as corrective appliance/orthotic
	TENS Unit/Muscle Stimulator
	• Added instruction to refer to the *Electrical Stimulation Devices* section of the policy
	ThAIRapy® Vest System
	• Removed language indicating item is covered as corrective appliance/orthotic
	Thoracic Lumbar Sacral Orthoses (TLSO)
	• Removed language indicating item is covered as corrective appliance/orthotic
	Tracheostomy
	Care Kit (Initial and Replacements)
	• Replaced language indicating "a tracheostomy care kit is covered for a member following an open surgical tracheostomy *which has been open or is expected to remain open for at least 3 months*" with "a tracheostomy care *or cleaning started* kit is covered for a member following an open surgical tracheostomy *up to 2 weeks post-operatively*"
	• Added reference link to the *DME MAC LCD for Tracheostomy Care Supplies (L33832)*
	Speaking Valve and Tubes
	• Added reference link to the *NCD for Tracheostomy Speaking Valve (50.4)*
	Traction Equipment
	Cervical, Attached to Headboard, Cervical, Not Requiring Additional Stand or Frame (e.g., Orthotrac Pneumatic Vest or Pronex), *and* Freestanding Traction Stand
	• Added reference link to the DME MAC LCD for Cervical Traction Devices (L33823)
	General Coverage Guidelines
	• Added language to indicate:
	  ○ Item is covered if member has orthopedic impairment requiring traction equipment that prevents ambulation during the period of use [consider covering devices usable during ambulation (e.g., cervical traction collar, under the brace provision)]
	  ○ Refer to the *NCD for Durable Medical Equipment Reference List (280.1)*
	Transfer (Sliding) Board
	• Revised coverage guidelines to indicate item is covered as DME and covered when part of an authorized treatment plan necessary to treat an illness or injury
	Trapeze Bar
	• Removed language indicating a "free standing" trapeze equipment is covered if the member does not have a covered hospital bed but the member needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed
	• Added instruction to refer to the:
	  ○ *NCD for Durable Medical Equipment Reference List (280.1)*
	  ○ *Hospital Beds and Accessories* section of the policy
	Truss
	• Added reference link to the:

Date	Summary of Changes
	○ *Medicare Benefit Policy Manual, Chapter 15, §120 Prosthetic Devices and §130 Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes* ○ *NCD for Corset Used as Hernia Support (280.11)* ***Ultraviolet Cabinet*** • Replaced language indicating "item is covered for members with generalized intractable psoriasis" with "item is covered for *selected* members with generalized intractable psoriasis" • Added language to indicate using appropriate consultation, the contractor should determine whether medical and other factors justify treatment at home rather than at alternative sites (e.g., outpatient department of a hospital); refer to the *NCD for Durable Medical Equipment Reference List (280.1)* ***Unna Boot/Strapping*** • Added reference link to the *DME MAC LCD for Surgical Dressings (L33831)* ***Urinal (Autoclavable)*** • Added reference link to the *NCD for Durable Medical Equipment Reference List (280.1)* ***Urinary Drainage Bags*** • Added language to indicate: ○ Urinary collection and retention system that replace bladder function in the case of permanent urinary incontinence are covered as prosthetic devices ○ There is insufficient evidence to support the medical necessity of a single use system bag rather than the multi-use bag; therefore, a single use drainage system is subject to the same coverage parameters as the multi-use drainage bags ○ Refer to the *NCD for Urinary Drainage Bags (230.17)* ***Urological Supplies*** • Added instruction to refer to the *Catheters and Supplies* section of the policy ***Vacuum Assisted Closure Device (VAC) or Negative Pressure Wound Therapy Pump*** • Revised coverage guidelines to indicate DME coverage criteria apply ***Vaporizers*** • Revised coverage guidelines to indicate item is covered as DME and only for members with respiratory illness; refer to the *NCD for Durable Medical Equipment Reference List (280.1)* ***Ventilators (Including Supplies)*** • Replaced language indicating "*ventilators (respirators) are recommended* for the treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease; *this recommendation* includes both positive and negative pressure types" with "*[item is] covered* for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease; includes both positive and negative pressure types" ***Walkers*** • Replaced coverage guidelines with instruction to refer to the *Mobility Assistive Equipment* section of the policy ***Wheelchairs (Manual, Motorized, Power Operated, Scooters, POVs, Specially Sized)*** • Added language to indicate face-to-face requirement may be applicable General Coverage Guidelines *and* Ramp for Wheelchair • Added instruction to refer to the *Mobility Assistive Equipment* section of the policy Seat Elevator for PWC

Date	Summary of Changes
	• Added language to indicate DME coverage criteria apply for Group 2 power wheelchair with power options that can accommodate rehabilitative features (for example, tilt in space) or Group 3 power wheelchair; refer to the *NCD for Seat Elevation Equipment (Power Operated) on Power Wheelchairs (280.16)* ***Wearable Cardioverter Defibrillators, Replacement Battery for Automated External Defibrillator, Each*** • Added reference link to the Benefit Interpretation Policy titled *Cardiac Pacemakers and Defibrillators* ***Whirlpool Bath Equipment (Standard/Non-Portable)*** • Revised coverage guidelines to indicate: ○ Item is covered if member is homebound and has a (standard) condition for which the whirlpool bath can be expected to provide substantial therapeutic benefit justifying its cost ○ Where member is not homebound but has such a condition, payment is restricted to the cost of providing the services elsewhere (e.g., an outpatient department of a participating hospital, if that alternative is less costly) ○ In all cases, refer claim to medical staff for a determination ○ Refer to the *NCD for Durable Medical Equipment Reference List (280.1)* **Supporting Information** • Archived previous policy version BIP050.CC

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.