

Medical Policy

Prior Authorization Criteria: Durable Medical Equipment (DME) (Commercial)



POLICY NUMBER	EFFECTIVE DATE	APPROVED BY
M20200046	01/15/2020	MPC (Medical Policy Committee)

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

Property of ConnectiCare, Inc. All rights reserved. The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP). All coding and web site links are accurate at time of publication.

Definitions:

Durable Medical Equipment (DME)	Defined as equipment that can stand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury; and, is appropriate for use in a patient's home.
Orthotic Devices	Orthotic devices are rigid and semi-rigid devices used for the purpose of supporting a weak or deformed body part or restricting or eliminating motion in a disease or injured body part.
Prosthetic Devices	Prosthetic devices are custom-made artificial limbs or other assistive devices for people who have lost limbs as a result of traumatic injuries, vascular disease, diabetes, cancer or congenital disorders.

Guidelines:

Services **90 days following** an acute hospital admission would be handled by CareCentrix

Services **greater than 90 days** following an acute hospital admission would be handled by ConnectiCare

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Related Guidelines:

[Insulin Delivery Devices and Continuous Glucose Monitoring Systems](#)
[Vacuum-Assisted Wound Closure](#)
[Obstructive Sleep Apnea Diagnosis and Treatment](#)

MCG Criteria: Effective 5/1/2019

Requests will be considered using Milliman Clinical Care Guidelines (MCGs). Guidelines are developed using publications that have been assessed in terms of quality, utility, and relevance. Preference is given to publications that:

1. Are designed with rigorous scientific methodology.
2. Are published in higher-quality journals (e.g., journals that are read and cited most often within their field).
3. Address an aspect of specific importance to the guideline in question (e.g., admission criteria, length of stay).
4. Represent an update or contain new data or information not reflected in the current guideline.

On an annual basis, each guideline undergoes external review by clinically active experts (e.g., board-certified specialist physicians without stated financial conflicts of interest) to confirm the clinical appropriateness, accuracy, validity, and applicability of each guideline.

[Click Here: ConnectiCare-MCG Clinical Criteria](#)

Related MCG guidelines (not a complete list):

A-0177 AC ACG Cochlear Implant
A-0241 AC ACG Electrical Nerve Stimulation, Transcutaneous (TENS)
A-0243 AC ACG Implanted Electrical Stimulator, Spinal Cord
A-0339 AC ACG Insulin Pump
A-0340 AC ACG Intermittent Pneumatic Compression with Extremity Pump
A-0342 AC ACG Foot Orthotics, Custom
A-0346 AC ACG Negative Pressure Wound Therapy (Vacuum-Assisted Wound Closure)
A-0352 AC ACG Scooters
A-0353 AC ACG Wheelchairs, Powered
A-0354 AC ACG Wheelchairs, Manual
A-0395 AC ACG Gastric Stimulation (Electrical)
A-0403 AC ACG Deep Brain Stimulation (DBS)
A-0407 AC ACG Cranial Orthotic Devices
A-0414 AC ACG Bone Growth Stimulators, Ultrasonic
A-0424 AC ACG Vagus Nerve Stimulation, Implantable
A-0487-AC ACG Lower Limb Prosthesis
A-0507 AC ACG Functional Electrical Stimulation
A-0516 AC ACG Augmentative Communication Devices, Electronic
A-0517 AC ACG Bed, Active (Dynamic)
A-0564 AC ACG Hearing Aids, Bone Anchored and Bone Conduction
A-0565 AC ACG Bone Growth Stimulators, Electrical and Electromagnetic
A-0566 AC ACG Cardioverter-Defibrillator, Wearable
A-0618 AC ACG Infusion Pump
A-0645 AC ACG Implanted Electrical Stimulator, Sacral Nerve
A-0700 AC ACG Cryounits and Cryotherapy Machines
A-0701-AC-ACG Myoelectric Prosthesis

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- A-0716 AC ACG Occipital Nerve Stimulation
- A-0878 AC ACG Hospital Bed (Semi-Electric or Total Electric)
- A-0879 AC ACG Knee Braces, Custom
- A-0880 AC ACG Lumbar, Lumbosacral, and Thoracolumbosacral Orthoses
- A-0889 AC ACG Static Joint Extension and Flexion Devices
- A-0882 AC ACG Dynamic Joint Extension and Flexion
- A-0893 AC ACG Home Ventilator (Invasive or Noninvasive Interface)
- A-0894 AC ACG Ankle-Foot and Knee-Ankle Foot Orthotics
- A-0896 AC ACG Altered Auditory Feedback Devices
- A-0974 AC ACG Phrenic Nerve Stimulation, Implantable

In the absence of Related Guidelines or MCG criteria, ConnectiCare, Inc. will use applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP).

Related Coverage Determinations (not a complete list):

- N2803v2 NCD Mobility Assistive Equipment (MAE) (280.3) Version 2
- N2806v1 NCD Pneumatic Compression Devices (280.6) Version 1
- N2807v1 NCD Hospital Beds (280.7) Version 1
- N402v2 NCD Home Blood Glucose Monitors (40.2) Version 2
- L33820 LCD Hospital Beds And Accessories (L33820) Revision 4
- L33642 LCD Pressure Reducing Support Surfaces-Group 2 (L33642) Revision 5
- L33822 LCD Glucose Monitors (L33822) Revision 6
- L33829 LCD Pneumatic Compression Devices (L33829) Revision 9
- L33312 LCD Wheelchair Seating (L33312) Revision 10
- L33686 LCD Ankle-Foot/Knee-Ankle_Foot Orthosis (L33686) Revision 6
- L33737 LCD Eye Prostheses (L33737) Revision 5
- L33738 LCD Facial Prostheses (L33738) Revision 4
- L33787 LCD Lower Limb Prostheses (L33787) Revision 6
- L33790 LCD Spinal Orthoses: TLSO and LSO (L33790) Revision 4
- L33317 LCD External Breast Prostheses (L33317) Revision 5
- L33641 LCD Orthopedic Footwear (L33641)

In the absence of Related Guidelines, MCG criteria, or CMS coverage statements (LCD's, NCD's or LMRP), the following guidelines will apply.

Description	Criteria	HCPCS
Spinal orthotics	Requests for spinal orthotics will be reviewed using relevant nationally recognized decision support tool criteria for similar codes	L0700, L0710, L1000, L1005
Halo procedure equipment	Halo placement is generally performed on an emergent or inpatient basis and will be reviewed at the appropriate level of care using nationally recognized decision support tools	L0810, L0820, L0830, L0859
Hip Orthotics	Medically necessary when ordered by an orthopedist for treatment of, or postoperatively for, total hip arthroplasty, slipped capital femoral epiphysis, Legg-Calvé-Perthes disease, and hip dysplasia for Charcot-Marie-Tooth disease.	L1640, L1680, L1685, L1690

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	Lateral replacements are considered medically necessary in pediatrics due to growth for diagnoses such as hip dysplasia with Charcot-Marie-Tooth disease	
Legg Perthes orthotics	Medically necessary when ordered by an orthopedist for use in the treatment for Legg-Calvé-Perthes disease in children.	L1700, L1710, L1720, L1730, L1755
Orthotics and Orthotic components	Requests for orthotic components listed will be reviewed using relevant nationally recognized decision support tool criteria for similar codes. Custom-fabricated: Documentation must clearly indicate what was modified, why, and why the modifications required an expert, such as an occupational therapist.	L0220, L1200, L1300, L2627, L2628, L3961, L3967, L3971, L3973, L3975, L3976, L3977, L3978
Shoulder, elbow, wrist, hand, finger orthotics	Medically necessary when ordered immediately post-operative for orthopedic surgeries such as rotator cuff repair, tendon repair, or ORIF. Replacement due to normal wear and tear is considered medically necessary when the item is a lateral purchase and the orthotic is still needed; Coverage is based on contract guidelines for replacement DME	L3900, L3901, L3904, L4000,
Prosthetics and Additions	Requests for prosthetics and additions listed will be reviewed using relevant nationally recognized decision support tool criteria for similar codes. Custom-fabricated: Documentation must clearly indicate what was modified, why, and why the modifications required an expert, such as an occupational therapist.	L6000, L6010, L6020, L6050, L6055, L6100, L6110, L6120, L6130, L6200, L6205, L6250, L6300, L6310, L6320, L6350, L6360, L6370, L6380, L6382, L6384, L6400, L6450, L6500, L6550, L6570, L6580, L6582, L6584, L6586, L6588, L6590, L6621, L6624, L6638, L6646, L6648, L6693, L6696, L6697, L6707, L6709, L6712, L6713, L6714, L6715, L6721, L6722, L6881, L6883, L6884, L6885, L6900, L6905, L6910, L6920, L6930, L6940, L6950, L6960, L6965, L6970, L7040, L7170, L7180, L7181, L7185, L7186, L7259, L7499, L8609, L8631, L8659

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Review history:

DATE	REVISION
03/04/2020	Removed MCG criteria A-0973 AC ACG Hypoglossal Nerve Stimulation, Implantable Added Obstructive Sleep Apnea Diagnosis and Treatment to Related Guidelines.
01/15/2020	New policy created to include: Related MCG criteria Added in the absence of MCG criteria, related NCD's and LCD's Added Guidelines Added Related Guidelines Added Definitions
05/01/2019	Adopted MCG Clinical Care Guidelines