

CHAPTER 18: DURABLE MEDICAL EQUIPMENT

REVISION HISTORY LOG				
Revised/Issued Date	Section	Section Title	Number of Page (s)	Reason for Revision
02/28/23		Table of Contents	8	Revisions to identify subheadings in Section 18.2.
02/28/23	18.2	Specific Coverage Criteria	94	Technical edits to the below subsections.

18.2.1 Respiratory Supplies and Equipment**18.2.1.1 Apnea Monitors**

Medical Criteria for Authorization of Payment for Apnea Monitor

Apnea of Prematurity

Apnea of Infancy

Following an Apparent Life-Threatening Event

Apnea Monitor Initial Authorization Period for Rentals

Apnea Monitor Extensions after Initial Three Months

Apnea Monitor Emergency Requests

18.2.1.2 Oxygen Concentrators

Reimbursement for Oxygen Concentrators

Portable Oxygen

18.2.1.3 High Frequency Chest Wall Oscillation Devices**18.2.1.4 Peak Flow Meters and Mucus Clearance (Flutter) Devices****18.2.1.5 Pulse Oximeter****18.2.1.6 Oxygen Probes****18.2.1.7 Ventilator Assist Devices**

Bi-Level Positive Airway Pressure

Continuous Positive Airway Pressure

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Criteria for Adults
Pediatric Criteria (Under Age 21)
Humidifiers

18.2.1.8 Nebulizers**18.2.1.9 Tracheostomy Care Supplies****18.2.1.10 Suction Pumps****18.2.2 Intraocular Lens (IOL)****18.2.3 Artificial Eyes****18.2.4 Artificial Larynxes****18.2.5 Augmentative and Alternative Communication Devices**

General Provisions
Assessment/Evaluation
Trial Use Periods
Repairs
Replacement or Modification

18.2.6 Bath and Toileting Aids

Elevated Toilet Seats
Bath or Shower Chairs
Safety Guardrails
Footrest for Use with Toilet
Commode Chairs
Commode Chairs with Detachable Arms
Urinals (Hospital Type) and Bed Pans

18.2.7 Environmental Modifications or Environmental Modification Repairs**18.2.8 Batteries****18.2.9 Blood Pressure Devices****18.2.10 Breast Milk and supplies**

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- 18.2.10.1 Donor Human Milk**
Reimbursement
- 18.2.10.2 Electric Breast Pump**
Equipment Criteria
Replacement Criteria
Electric Breast Pump Supplies
Human Milk Storage Bags
- 18.2.11 Enteral Nutrition**
Enteral Infusion Pump
Hyperalimentation Therapy Aid- Intradialytic Parental Nutrition Therapy
Enteral Formula Coverage for Beneficiaries with Inborn Errors of Metabolism
- 18.2.12 Total Parenteral Nutrition (TPN)**
- 18.2.13 Binders and Supports**
 - 18.2.13.1 Abdominal Binder and Hernia Supports**
Abdominal Binders
Hernia Supports
 - 18.2.13.2 Lumbar Orthosis and Truss Supports**
- 18.2.14 Support Garments**
 - 18.2.14.1 Support Hose
 - 18.2.14.2 Surgical Mastectomy Bras
- 18.2.15 Hearing Aids**
- 18.2.16 Cochlear Implant (EPSDT Only)**
Covered Expenses
Cochlear Implant Device Criteria
Non-Covered Expenses of Cochlear Device
Prior Authorization for Cochlear Device
- 18.2.17 Dialysis Equipment and Supplies**
- 18.2.18 Baclofen Therapy**

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Exclusive Criteria
Diagnoses Covered
Prior Authorization for IBT

18.2.19 Ambulatory Equipment**18.2.19.1 Canes and Crutches****18.2.19.2 Walkers and Walker Accessories**

Wheeled Walker
Heavy Duty Walker
Heavy Duty, Multiple Braking System, Variable Wheel Resistance Walker
Leg Extensions
Arm Rests
Non-Covered Walker Items
Enhancement Accessories
Walking Belts

18.2.19.3 Wheelchairs

Standard Wheelchairs
Standard Wheelchair Attachments
Wheelchairs, Motorized and/or Custom Motorized
Wheelchair Prior Authorization
Repairs and Modifications

18.2.19.4 Standing Frame

Specific Criteria
Exclusion Criteria
Documentation Requirements

18.2.19.5 Strollers of a Therapeutic Type**18.2.19.6 Special Needs Car Seat****18.2.20 Diabetic Supplies and Equipment**

Glucometer
Continuous Subcutaneous Insulin External Infusion Pumps
Continuous Glucose Monitoring Device (CGM)

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- 18.2.21 **Orthopedic, Prosthetics, Orthotics and Supplies**
- 18.2.21.1 **Orthotic Devices**
- 18.2.21.2 **Orthopedic Shoes and Corrections**
 - Diabetics
 - Shoe Lifts
 - Reimbursement
 - Shoes for Minor Orthopedic Problems
- 18.2.21.2 **Prosthetic Devices**
- 18.2.21.3 **Traction Equipment**
- 18.2.21.4 **Breast or Mammary Prostheses**
- 18.2.22 **Disposable Incontinence Products)**
 - Diapers
 - Pull-on Briefs
 - Documentation Requirements
 - Prior Authorization Requirements for Incontinence Supplies
 - Quantity Limitations
 - Dispensing
 - Catheters
- 18.2.23 **Hospital Beds, Lifts, and Trapeze Bar**
- 18.2.23.1 **Hospital Beds**
 - Hospital Beds, Fixed and Variable Height
 - Hospital Bed, Semi-Electric
 - Hospital Bed, Total Electric
 - Hospital Bed Mattresses
 - Egg-Crate Mattresses & Alternating Air Pressure Mattress/Pads
 - Sheepskins
 - Side Rails
 - Hospital Bed, Pediatric
 - Specific Criteria
 - Hospital Bed, Pediatric without Safety Enclosure
 - Hospital Bed, Pediatric with Safety Enclosure
 - Exclusion Criteria

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Documentation Requirements

18.2.23.2 **Patient Lifts**

Lift Slings

18.2.24 **Trapeze Bar**18.2.25 **Electrical Stimulators**18.2.25.1 **Osteogenic Bone Growth Stimulators**

Non-Spinal, Noninvasive Electrical

Spinal Noninvasive Electrical

18.2.25.2 **Vagus Nerve Stimulators**

Criteria for Beneficiary Selection

Exclusion Criteria

Place of Service Restriction

Prior Authorization

Billing for the Cost of the Vagus Nerve Stimulator

Subsequent Implants and Battery Replacement

18.2.26 **Intravenous (IV) Therapy and Administrative Supplies**18.2.26.1 **Syringes and Needles**18.2.27 **Wound Care Supplies**

Wound Care Reimbursement

Wound Care System

Surgical Dressings or Bandages

Burn Garments and Stockings