BLUE CROSS OF NORTHEASTERN PA "BCNEPA" MEDICAL POLICY BULLETIN	**MANUAL:** MEDICAL POLICY
	REFERENCE NO.: MPO-490-0006
EFFECTIVE DATE October 1, 2014	**SUBJECT:** Durable Medical Equipment (DME)

Blue Cross of Northeastern Pennsylvania ("BCNEPA") Medical Policy

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical policy and claims payment policy are applied. Policies are provided for informational purposes only and are developed to assist in administering plan benefits and do not constitute medical advice. Treating providers are solely responsible for medical advice and treatment. Policies are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and information are constantly changing and BCNEPA may review and revise its medical policies periodically. Also, due to the rapid pace of changing technology and the advent of new medical procedures, BCNEPA may not have a policy to address every procedure. In those cases, BCNEPA may review other sources of information including, but not limited to, current medical literature and other medical resources, such as Technology Evaluation Center Assessments (TEC) published by the Blue Cross Blue Shield Association. BCNEPA may also consult with health care providers possessing particular expertise in the services at issue.

I. DESCRIPTION:

Durable Medical Equipment (DME) is equipment which can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home.

II. BENEFIT POLICY STATEMENT:

BCNEPA makes decisions on coverage based on Policy Bulletins, benefit plan documents, and the member's medical history and condition. Benefits may vary based on product line, group or contract, therefore, Member benefits must be verified. In the event of a conflict between the Member's benefit plan document and topics addressed in Medical Policy Bulletins (i.e., specific contract exclusions), the Member's benefit plan document always supersedes the information in the Medical Policy Bulletins. BCNEPA determines medical necessity only if the benefit exists and no contract exclusions are applicable.

Benefits are determined by the terms of the Member's specific benefit plan document [i.e., the Fully Insured policy, the Administrative Services Only (ASO) agreement applicable to the Self-Funded Plan Participant, or the Individual Policy] that is in effect at the time services are rendered.

III. MEDICAL POLICY STATEMENT:

Coverage is subject to the terms, conditions, and limitations of the member's contract.

Indications

A. BCNEPA will provide coverage for durable medical equipment (DME). DME is equipment that meets all of the following criteria:

1. It can withstand repeated use; and

2. It is primarily and customarily used to serve a medical purpose; and

3. It is generally not useful to a person in the absence of illness or injury; and

4. It is appropriate for use in the home.

B. BCNEPA will provide coverage for DME when the equipment is medically necessary.

1. DME may be considered medically necessary when the equipment provided meets all of the above criteria; and,

2. DME may be considered medically necessary when:

   a) it is reasonable for treatment of an illness or injury; or

   b) it will improve the functioning of a malformed body member; or

   c) it performs a therapeutic function.

3. Some DME items may be required to meet additional coverage criteria specific to that item in order to be considered medically necessary. Those items are addressed separately under "**Limitations**".

4. DME may be considered medically necessary when prescribed by a licensed health care professional; and,

5. DME may be considered medically necessary when the prescription and other available medical information establish the patient's need for the equipment (Medical information includes the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and/or test reports which must be available upon request).

C. BCNEPA will not provide coverage for a DME item which does not meet the above criteria as this is considered not medically necessary.

Limitations

D. BCNEPA will not provide coverage for DME under the following circumstances:

1. Deluxe or non-standard DME items (See Definitions).

2. Modification or customization of any DME item.

3. Repair of any DME item.

4. Replacement of a DME item (See Definitions).

5. Professional fees, delivery charges or other associated costs related to the provision of a DME item.

Canes or Crutches

E. BCNEPA will provide coverage for canes or crutches when medically necessary.

1. Canes or crutches may be considered medically necessary when all of the above DME criteria have been met, and

2. The patient's condition impairs ambulation.

3. Canes or crutches are considered not medically necessary when the above criteria have not been met.

Commodes

F. BCNEPA will provide coverage for commodes when medically necessary.

1. A commode may be considered medically necessary when all of the above DME criteria have been met, and

2. The patient is confined to bed or room (see Definitions), or

3. The patient has poor trunk control (e.g. associated with spinal cord injury or severe neuromuscular disease) and there is a safety concern with sitting unsupported and the need for a more physiologic elimination process.

4. Commodes are considered not medically necessary when the above criteria have not been met.

Compression Burn Garments

G. BCNEPA will provide coverage for compression burn garments when medically necessary.

1. Compression burn garments may be considered medically necessary when used to reduce hypertrophic scarring and joint contractures following a burn injury.

2. Compression burn garments are considered not medically necessary when the above criteria have not been met.

Continuous Passive Motion (CPM) in the home setting

H. BCNEPA will provide coverage for the use of Continuous Passive Motion (CPM) in the home setting when medically necessary.

1. Use of continuous passive motion (CPM) in the home setting may be considered medically necessary as an adjunct to physical therapy in the following situations:

a) Under conditions of low postoperative mobility or inability to comply with rehabilitation exercises following a total knee arthroplasty (TKA) or TKA revision. This may include patients with complex regional pain syndrome (reflex sympathetic dystrophy), extensive arthrofibrosis or tendon fibrosis, or physical, mental, or behavioral inability to participate in active physical therapy.

(1) Following total knee arthroplasty (TKA), continuous passive motion (CPM) in the home setting will be allowable for up to 17 days after surgery while patients are immobile or unable to bear weight.

b) During the non-weight bearing rehabilitation period following intra-articular cartilage repair procedures of the knee (e.g., microfracture, osteochondral grafting, autologous chondrocyte implantation, treatment of osteochondritis dissecans, repair of tibial plateau fractures).

(1) Following intra-articular cartilage repair procedures of the knee, CPM in the home setting will be allowable for up to 6 weeks during non-weight bearing rehabilitation.

2. Continuous Passive Motion (CPM) in the home setting for longer periods of time or for all other applications is considered not medically necessary.

Continuous Positive Airway Pressure (CPAP) and Respiratory Assist Devices

I. BCNEPA will provide coverage for continuous positive airway pressure devices (CPAP) when medically necessary.

1. CPAP may be considered medically necessary when all of the above DME criteria have been met, and

2. In adult or pediatric patients with clinically significant obstructive sleep apnea.

a) Clinically Significant OSA – Adult Patients: defined as those patients who have:

- Apnea/hypopnea index (AHI) or respiratory disturbance index (RDI) greater than or equal to 15 events per hour, or

- AHI or RDI greater than or equal to 5 events and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

b) Clinically Significant OSA – Pediatric Patients: defined as those patients who have:

- AHI or RDI of at least 5 per hour, or

- AHI or RDI of at least 1.5 per hour in a patient with excessive daytime sleepiness, behavioral problems or hyperactivity.

3. Auto-adjusting CPAP may be considered medically necessary during a 2-week trial to initiate and titrate CPAP in adult patients with clinically significant OSA.

4. Bilevel positive airway pressure or auto-adjusting CPAP may be considered medically necessary in patients with clinically significant OSA AND who have failed a prior trial of CPAP or for whom BiPAP is found to be more effective in the sleep lab.

5. Requests for positive airway pressure devices not meeting criteria outlined above will be considered not medically necessary.

6. A nasal expiratory positive airway pressure (EPAP) device (e.g., PROVENT Sleep Apnea Therapy) is considered investigational.

7. Oral pressure therapy (OPT) devices (e.g., The Winx™System) are considered investigational.

J. BCNEPA will provide coverage for respiratory assist devices when medically necessary.

1. Respiratory assist devices may be considered medically necessary when all of the above DME criteria have been met, and

2. For treatment of those patients with clinical disorder groups characterized as:

a) restrictive thoracic disorders (i.e., neuromuscular diseases or severe thoracic cage abnormalities),

b) severe chronic obstructive pulmonary disease (COPD),

c) central sleep apnea (CSA) or complex sleep apnea (Comp SA), or

d) hypoventilation syndrome,

3. Respiratory assist devices are considered not medically necessary when the above criteria have not been met.

Dynamic Splinting Devices

- **Dynamic Low-load Prolonged-duration Stretch (LLPS) Devices**

K. BCNEPA will provide coverage for dynamic low-load prolonged-duration stretch (LLPS) devices when medically necessary.

1. Dynamic low-load prolonged-duration stretch devices (LLPS) for the toe, knee, elbow, wrist or finger (including, but not limited to, Dynasplint Systems, LMB Pro-glide, EMPI Advance Ultraflex, and Advanced Biomedics) may be considered medically necessary for use on the toe, knee, elbow, wrist or finger in any of the following clinical settings:

a) As an addition to physical therapy in the subacute injury or post-operative period (≥ 3 weeks but ≤ 4 months after injury or operation) in patients with signs and symptoms of persistent joint stiffness or contracture:

- For an initial period of up to 4 months; and
- If the patient shows improvement after the initial period, thereafter for as long as improvement can continue to be demonstrated; OR

b) In the subacute injury or post-operative period (≥ 3 weeks but ≤ 4 months after injury or operation) in a patient whose limited range of motion poses a meaningful (as judged by the physician) functional limitation, AND who has not responded to other therapy (including physical therapy);

- For an initial period of up to 4 months; and
- If the patient shows improvement after the initial period, thereafter for as long as improvement can continue to be demonstrated; OR

c) In the acute post-operative period for patients who have undergone additional surgery to improve the range of motion of a previously affected joint:

- For an initial period of up to 4 months; and
- If the patient shows improvement after the initial period, thereafter for as long as improvement can continue to be demonstrated; OR

d) For patients unable to benefit from standard physical therapy modalities because of an inability to exercise:

- For an initial period of up to 4 months; and

- If the patient shows improvement after the initial period, thereafter for as long as improvement can continue to be

demonstrated.

2. If there is no significant improvement after four months of use, dynamic LLPS devices for the toe, knee, elbow, wrist or finger are considered not medically necessary under any circumstance, including but not limited to, use in patients unable to benefit from standard physical therapy modalities because of an inability to exercise.

3. Dynamic LLPS devices not meeting the above criteria are considered not medically necessary.

4. Dynamic LLPS devices which are specific to the ankle and shoulder are considered investigational for all indications including, but not limited, to the management of chronic joint stiffness due to trauma, fractures, burns, head and spinal cord injuries, rheumatoid arthritis, multiple sclerosis, muscular dystrophy or cerebral palsy or chronic or fixed contractures.

5. Dynamic splinting is considered investigational for the following indications because there is a lack of scientific evidence regarding its effectiveness for these indications:

   a) Carpal tunnel syndrome
   b) Cerebral palsy
   c) Foot drop associated with neuromuscular diseases
   d) Head and spinal cord injuries
   e) Injuries of the ankle, and shoulder
   f) Multiple sclerosis
   g) Muscular dystrophy
   h) Plantar fasciitis
   i) Rheumatoid arthritis
   j) Stroke
   k) Trismus

- **Bi-directional Static Progressive (SP) Stretch Devices**

5. Bi-directional static progressive (SP) stretch devices (e.g., Joint Active Systems Static Progressive Stretch) are considered investigational for all indications.

- **Patient-actuated Serial Stretch (PASS) Devices**

6. Patient-actuated serial stretch (PASS) devices (e.g., ERMI Knee, MPJ, or Elbow Extensionator®, ERMI Knee/Ankle or Shoulder Flexionator®) are considered investigational for all indications.

Gait Trainers

L. BCNEPA will provide coverage for gait trainers when medically necessary.

1. Gait trainers may be considered medically necessary when all of the above DME criteria have been met, and

2. The patient requires moderate to maximum support for walking, and

3. The patient is capable of walking with this device.

4. Gait trainers are considered not medically necessary when the above criteria have not been met.

Home Apnea Monitoring

M. BCNEPA will provide coverage for home cardiorespiratory monitoring (pneumogram) when medically necessary.

1. Home cardiorespiratory monitoring may be considered medically necessary in infants younger than 12 months of age in the following situations:

a) Those who have experienced an apparent life-threatening event; OR

b) Those with tracheostomies or anatomic abnormalities that make them vulnerable to airway compromise; OR

c) Those with neurologic or metabolic disorders affecting respiratory control, including central apnea and apnea of prematurity; OR

d) Those with chronic lung disease (i.e., bronchopulmonary dysplasia), particularly those requiring supplemental oxygen; continuous positive airway pressure; or mechanical ventilation.

2. Home cardiorespiratory monitoring is considered not medically necessary in infants with any siblings with a history of sudden infant death syndrome (SIDS), but without at least one of the above indications cited.

3. Home cardiorespiratory monitoring in all other conditions, including but not limited to the diagnosis of obstructive sleep apnea, is considered investigational.

Home Phototherapy for Neonatal Jaundice

N. BCNEPA will provide coverage for home phototherapy when medically necessary.

1. Home phototherapy may be considered medically necessary in infants who meet all of the following:

a) Term infants, older than 48 hours, otherwise healthy;

b) Serum bilirubin concentration greater than 14mg/dl but less than 18mg/dl;

c) No elevation in direct-reacting bilirubin concentration; and

d) Diagnostic evaluation fails to reveal a primary cause for the hyperbilirubinemia (e.g., hemolytic anemia, primary hepatic disorder, etc.)

2. Home phototherapy is considered not medically necessary when the above criteria have not been met.

Hospital Beds

O. BCNEPA will provide coverage for hospital beds when medically necessary.

1. Hospital beds may be considered medically necessary when all of the above DME criteria have been met, and

a) The patient has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed (Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed), or

b) The patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or

c) The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been considered and ruled out, or

d) The patient requires traction equipment, which can only be attached to a hospital bed.

2. Hospital beds other than fixed height beds may be considered medically necessary when one of these appropriate criteria is met in addition to those above:

a) A variable height hospital bed is needed because the patient requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.

b) A semi-electric hospital bed is needed because the patient requires frequent changes in body position and/or has an immediate need for a change in body position.

c) A heavy duty extra wide hospital bed is needed because the patient's weight is more than 350 pounds, but does not exceed 600 pounds.

d) An extra heavy-duty hospital bed is needed because the patient's weight exceeds 600 pounds.

e) A powered air flotation bed is needed because the patient is in the third or fourth stage of decubitus ulceration; and the physician will be supervising the use of the bed during the course of treatment.

3. Hospital beds are considered not medically necessary when the above criteria have not been met.

Lymphedema Pumps

P. BCNEPA will provide coverage for pneumatic compression pumps for the treatment of lymphedema when medically necessary.

1. Single compartment or multi-chamber non-programmable lymphedema pumps applied to the limb may be considered medically necessary for the treatment of lymphedema that has failed to respond to conservative measures such as elevation of the limb and use of compression garments.

2. Single compartment or multi-chamber programmable lymphedema pumps applied to the limb are considered medically necessary for the treatment of lymphedema when:

a) The individual is otherwise eligible for non-programmable pumps; and

b) There is documentation that the individual has unique characteristics that prevent satisfactory pneumatic compression with single-compartment or multi-chamber non-programmable lymphedema pumps (e.g., significant scarring).

3. BCNEPA will not provide coverage for the following uses of single compartment or multichamber lymphedema pumps as they are considered investigational and, therefore, not covered because the safety and effectiveness of these services cannot be established by review of the available published peer-reviewed literature:

a) Single compartment or multichamber lymphedema pumps applied to the limb in all other situations not identified above as medically necessary.

b) Segmental pneumatic compression pumps and appliances for the treatment of lymphedema of the chest or trunk.

c) Pneumatic compression pumps when used for the treatment of arterial insufficiency.

d) Lymphedema pumps for the treatment of venous ulcers.

Mechanical Insufflation-Exsufflation as an Expiratory Muscle Aid

Q. BCNEPA will provide coverage for mechanical insufflation-exsufflation (MI-E) when medically necessary.

1. MI-E may be considered medically necessary in patients with the following conditions who have an impaired ability to cough, expectorate secretions and require ventilatory assistance:

a) Pulmonary disease,

b) Neuromuscular disease,

c) Spinal cord injury.

2. Other indications for use of MI-E are considered not medically necessary.

Nebulizers

R. BCNEPA will provide coverage for nebulizers when medically necessary.

1. Nebulizers may be considered medically necessary when all of the above DME criteria have been met, and

2. If a patient's ability to breathe is severely impaired, and

3. If it is required to administer FDA-approved inhalation solutions for the management of respiratory diseases.

4. Nebulizers are considered not medically necessary when the above criteria have not been met.

Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders

S. BCNEPA will provide coverage for high-frequency chest wall compression devices and intrapulmonary percussive ventilation devices when medically necessary.

1. High-frequency chest wall compression devices and intrapulmonary percussive ventilation devices may be considered medically necessary in patients with cystic fibrosis or chronic bronchiectasis when standard chest physiotherapy has failed OR standard chest physiotherapy is unavailable or not tolerated.

a) In considering the chest wall compression and IPV devices, the following guidelines should be followed:

(1) There should be demonstrated need for airway clearance; and

(2) Documented failure of standard treatments i.e. the patient has frequent severe exacerbations of respiratory distress involving inability to clear mucus despite standard treatment (chest physiotherapy and, if appropriate, use of the FLUTTER device); or

(3) Valid reasons why standard chest physiotherapy cannot be performed, such as inability of the caregiver to perform it.

2. Use of the flutter valve or acapella device may be considered medically necessary in patients with hypersecretory lung disease (i.e., produce excessive mucus) who have difficulty clearing secretions and recurrent disease exacerbations.

3. High frequency chest-wall compression devices and intrapulmonary percussive ventilation devices are considered not medically necessary as an alternative to chest physical therapy in patients with cystic fibrosis or chronic bronchiectasis in

any other clinical situations; there are no clinical data to show that these services provide any additional health benefit compared to conventional chest physical therapy in these situations other than those specified above.

4. Other applications of high frequency chest wall compression devices and intrapulmonary percussive ventilation devices, including, but not limited to, their use as an adjunct to chest physical therapy or their use in other lung diseases, such as Chronic Obstructive Pulmonary Disease (COPD), are considered investigational.

Limb Pneumatic Compression Devices for Venous Thromboembolism Prophylaxis

T. BCNEPA will provide coverage for the outpatient use of limb pneumatic compression devices for venous thromboembolism prophylaxis when medically necessary.

1. Limb pneumatic compression devices may be considered medically necessary after major orthopedic surgery in patients with a contraindication to pharmacological agents i.e., at high-risk for bleeding; or

2. After major non-orthopedic surgery or non-major orthopedic surgery in patients who are at moderate or high risk of venous thromboembolism with a contraindication to pharmacological agents i.e., at high-risk for bleeding.

Note:

"Major Orthopedic Surgery" includes total hip arthroplasty(THA), total knee arthroplasty(TKA), or hip fracture surgery(HFS).

The ACCP guidelines on prevention of VTE in orthopedic surgery patients list the following general risk factors for bleeding (3):

1. Previous major bleeding (and previous bleeding risk similar to current risk)

2. Severe renal failure

3. Concomitant antiplatelet agent

4. Surgical factors: history of or difficult-to-control surgical bleeding during the current operative procedure, extensive surgical dissection, and revision surgery.

The guidelines note, however, that "specific thresholds for using mechanical compression devices or no prophylaxis instead of anticoagulant thromboprophylaxis have not been established."

U. BCNEPA will not provide coverage for the outpatient use of limb pneumatic compression devices for venous thromboembolism prophylaxis for the following as these are considered investigational:

1. After major orthopedic surgery in patients without a contraindication to pharmacological prophylaxis.

2. After major non-orthopedic surgery or non-major orthopedic surgery in patients who are at moderate or high risk of venous thromboembolism without a contraindication to pharmacological prophylaxis and in patients who are at low-risk of venous thromboembolism.

3. After all other surgeries.

V. BCNEPA will not provide coverage for outpatient use of limb pneumatic compression devices for venous thromboembolism prophylaxis for periods longer than 30 days post-surgery as this is considered not medically necessary.

Paraffin Bath Units

W. BCNEPA will provide coverage for paraffin bath units when medically necessary.

1. Paraffin bath units may be considered medically necessary when all of the above DME criteria have been met, and

2. The patient has undergone a successful trial period of paraffin therapy; and the patient's condition is expected to be relieved by long term use of the modality.

3. Paraffin bath units are considered not medically necessary when the above criteria have not been met.

Percussors

X. BCNEPA will provide coverage for a percussor when medically necessary.

1. Percussors may be considered medically necessary when all of the above DME criteria have been met, and

2. It is required for mobilizing respiratory tract secretions in patients with pulmonary conditions that limit the ability to expectorate secretions, and

3. When patient or operator of the percussor has received appropriate training by a physician or therapist, and no one competent to administer manual therapy is available.

4. Percussors are considered not medically necessary when the above criteria have not been met.

Phototherapy Light for the Treatment of Seasonal Affective Disorder (SAD)

Y. BCNEPA will provide coverage for a phototherapy light (e.g., high-intensity light unit, light box) when medically necessary.

1. A phototherapy light may be considered medically necessary when all of the above DME criteria have been met, and

2. It is required to treat seasonal affective disorder (SAD) when the member has been diagnosed with bipolar disorder or recurrent major depression with seasonal pattern.

3. BCNEPA will not provide coverage for the following uses of a phototherapy light as they are considered investigational and, therefore, not covered because the safety and effectiveness of these services cannot be established by review of the available published peer-reviewed literature:

1. Any indications not identified above as medically necessary;

b) The use of any other light delivery source (e.g., light visor) for the treatment of SAD;

c) Extraocular light therapy (application of phototherapy to areas of the body other than the retina) for the treatment of SAD.

Pressure Reducing Surfaces

Z. BCNEPA will provide coverage for a pressure reducing surface when medically necessary.

1. Pressure reducing surfaces may be considered medically necessary when all of the above DME criteria have been met, and

2. The patient has or is highly susceptible to decubitus ulcers; and the physician has specified that he will be supervising its use in connection with the course of treatment.

3. Pressure reducing surfaces are considered not medically necessary when the above criteria have not been met.

Protective Helmet

AA. BCNEPA will provide coverage for a protective helmet when medically necessary.

1. A protective helmet may be considered medically necessary for individuals with seizure or behavior disorders who are at risk for injury to the head and face.

2. A protective helmet is considered not medically necessary when the above criteria have not been met.

Pulse Oximetry Device

BB. BCNEPA will provide coverage for a pulse oximetry device for home use when medically necessary.

1. A pulse oximetry device for home use may be considered medically necessary when all of the above DME criteria have been met, and

2. One of the following indications is met:

   a) To determine appropriate home oxygen liter flow for ambulation, exercise, or sleep; or

   b) To monitor individuals on a ventilator at home; or

   c) When a change in the member's physical condition requires an adjustment in the liter flow of their home oxygen needs; or

   d) When weaning the member from home oxygen.

3. A pulse oximetry device is considered not medically necessary when used for indications other than those listed above including, but not limited to, asthma management or when used alone as a screening/testing technique for suspected obstructive sleep apnea (OSA).

Rollabout Chairs

CC. BCNEPA will provide coverage for rollabout chairs when medically necessary.

1. Rollabout chairs may be considered medically necessary when all of the above DME criteria have been met, and

2. The rollabout chair will be used in lieu of a wheelchair.

3. The rollabout chair has casters of at least 5” in diameter and specially designed to meet the needs of ill, injured, or otherwise impaired individuals.

4. Rollabout chairs are considered not medically necessary when the above criteria have not been met.

Standers

DD. BCNEPA will provide coverage for standers when medically necessary.

1. Standers may be considered medically necessary when all of the above DME criteria have been met, and

2. The patient is diagnosed with cerebral palsy, spasticity, multiple sclerosis, or parapareses.

3. Standers are considered not medically necessary when the above criteria have not been met.

Suction (Respiratory) Pump

EE. BCNEPA will provide coverage for a suction (respiratory) pump when medically necessary.

1. A suction (respiratory) pump may be considered medically necessary when all of the above DME criteria have been met, and

2. The patient has difficulty raising and clearing secretions secondary to:

   a) Cancer or surgery of the throat or mouth

   b) Dysfunction of the swallowing muscles

   c) Unconsciousness or obtunded state

   d) Tracheostomy

3. A suction (respiratory) pump is considered not medically necessary when the above criteria have not been met.

Thoracic-Lumbo-Sacral Orthosis with Pneumatics

FF. BCNEPA will not provide coverage for a thoracic-lumbo-sacral orthosis incorporating pneumatic inflation as this is considered investigational.

Traction Equipment

GG. BCNEPA will provide coverage for traction equipment when medically necessary.

1. Traction equipment may be considered medically necessary when all of the above DME criteria have been met, and

2. The patient has a musculoskeletal or neurologic impairment requiring traction which prevents ambulation during the period of use.

3. Traction equipment is considered not medically necessary when the above criteria have not been met.

4. Traction equipment, including but not limited to, the following: ambulatory devices, pneumatic devices, devices attached to a headboard or a free-standing frame is considered not medically necessary.

Trapeze Bars

HH. BCNEPA will provide coverage for trapeze bars when medically necessary.

1. Trapeze bars may be considered medically necessary when all of the above DME criteria have been met, and

2. The patient is bed confined and requires the trapeze to sit up because of a respiratory condition; or to change body position for other medical reasons; or to transfer in and out of bed.

3. Trapeze bars are considered not medically necessary when the above criteria have not been met.

Transtympanic Micropressure Applications

II. BCNEPA will not provide coverage for transtympanic micropressure applications as a treatment of Meniere's disease as these are considered investigational.

Tumor-Treating Fields Therapy for Glioblastoma

JJ. BCNEPA will not provide coverage for tumor treatment fields therapy (The NovoTTF-100A™ System) to treat glioblastoma as this is considered investigational.

a) The device must be approved by the Food and Drug Administration and safe for home use.

2. Ultraviolet light therapy in the home provided for other conditions or not meeting the above criteria is considered not medically necessary.

Walkers

KK. BCNEPA will provide coverage for walkers when medically necessary.

1. Walkers may be considered medically necessary when all of the above DME criteria have been met, and

2. The patient's condition impairs ambulation, and there is a potential for ambulation, and

3. There is a need for greater stability and security than provided by a cane or crutches.

4. Walkers are considered not medically necessary when the above criteria have not been met.

IV. DEFINITIONS:

Calendar Year: A one (1) year period which begins on January 1 and ends on December 31st.

Deluxe DME: an item that is non-standard or has special features; does not serve a therapeutic purpose or is not necessary in the effective treatment of the patient's condition; an upgrade for aesthetic purposes or the patient's convenience.

DME Replacement: the removal and substitution of a DME item or one of its components that is necessary for proper functioning and/or:

a) Was previously owned or purchased by or for the member and has been in use before the member enrolled in the present health plan; or

b) Was originally purchased by the current health plan for the member; or

c) Was requested and/or provided to the member due to malicious damage, neglect or abuse of the original; or

d) Was requested and/or provided to the member when the original was lost, stolen or broken; or

e) Was requested and/or provided to the member due to a change in his/her condition (eg, weight loss or gain); or

f) Was requested and/or provided to the member because the original has exceeded its reasonable useful lifetime; or

g) Is a duplicate of a same or similar device; or

h) Was requested and/or provided because the condition of the original requires repairs and the cost of such repairs would be greater than or equal to the cost of a new item.

Room Confined: the patient's condition is such that leaving the room is medically contraindicated; or if a patient's medical condition confines him or her to a floor of his or her home and there is not bathroom located on that floor.

CODING:

- **The identification of a code in this section does not denote coverage or separate reimbursement.**
- Covered procedure codes are dependent upon meeting criteria of the policy and appropriate diagnosis code.
- The following list of codes may not be all-inclusive, and are subject to change at any time.
- Benefits are determined by the terms of the Member's specific benefit plan document [i.e., the Fully Insured policy, the Administrative Services Only (ASO) agreement applicable to the Self-Funded Plan Participant, or the Individual Policy] that is in effect at the time services are rendered.

PROCEDURE CODES

94660	A6503	A7027	E0111	E0148
94669	A6504	A7030	E0112	E0149
94774	A6505	A7034	E0113	E0153
94775	A6506	A7035	E0114	E0154
94776	A6507	A7036	E0116	E0155
94777	A6508	A7047	E0118	E0156
99002	A6509	A8000	E0130	E0157
A4220	A6510	A8001	E0135	E0158
A4222	A6511	A8002	E0140	E0163
A4280	A6512	A8003	E0141	E0165
A4570	A6513	E0100	E0143	E0168
A6501	A7025	E0105	E0144	E0181
A6502	A7026	E0110	E0147	E0186

E0187	E0441	E0668	E0956	E1093
E0193	E0442	E0669	E0957	E1130
E0196	E0443	E0670	E0960	E1140
E0197	E0444	E0671	E0961	E1150
E0198	E0470	E0672	E0966	E1161
E0199	E0471	E0673	E0967	E1229
E0202	E0480	E0675	E0968	E1231
E0203	E0481	E0676	E0969	E1232
E0235	E0482	E0720	E0970	E1233
E0241	E0483	E0730	E0971	E1234
E0242	E0484	E0744	E0973	E1235
E0243	E0487	E0766	E0974	E1236
E0244	E0500	E0776	E0978	E1237
E0246	E0550	E0779	E0980	E1238
E0250	E0560	E0780	E0988	E1239
E0251	E0561	E0781	E0990	E1240
E0255	E0562	E0782	E0992	E1250
E0256	E0570	E0783	E0994	E1260
E0260	E0575	E0784	E0995	E1270
E0261	E0580	E0785	E1002	E1280
E0271	E0585	E0786	E1003	E1285
E0277	E0600	E0791	E1004	E1290
E0280	E0601	E0830	E1005	E1295
E0290	E0617	E0840	E1006	E1352
E0291	E0618	E0849	E1007	E1354
E0292	E0619	E0850	E1008	E1356
E0293	E0637	E0855	E1009	E1357
E0294	E0638	E0856	E1010	E1358
E0295	E0641	E0860	E1031	E1399
E0301	E0642	E0910	E1050	E1405
E0302	E0650	E0911	E1060	E1406
E0303	E0651	E0912	E1070	E1800
E0304	E0652	E0935	E1083	E1801
E0328	E0655	E0936	E1084	E1802
E0329	E0656	E0942	E1085	E1805
E0424	E0657	E0944	E1086	E1806
E0425	E0660	E0945	E1087	E1810
E0430	E0665	E0947	E1088	E1811
E0435	E0666	E0948	E1089	E1812
E0440	E0667	E0955	E1092	E1815

E1816	E2323	E2364	E2615	K0001
E1818	E2324	E2365	E2616	K0002
E1825	E2325	E2366	E2620	K0003
E1830	E2326	E2367	E2621	K0004
E1831	E2327	E2371	E2622	K0005
E1840	E2328	E2372	E2623	K0006
E1841	E2329	E2373	E2624	K0007
E2120	E2330	E2377	E2625	K0015
E2201	E2331	E2601	E2626	K0017
E2202	E2340	E2602	E2627	K0018
E2203	E2341	E2603	E2628	K0020
E2204	E2342	E2604	E2629	K0105
E2300	E2343	E2605	E2630	K0195
E2301	E2351	E2606	E2631	K0733
E2310	E2358	E2607	E2632	L8499
E2311	E2359	E2608	E2633	S8185
E2312	E2360	E2611	E8000	S8460
E2313	E2361	E2612	E8001	
E2321	E2362	E2613	E8002	
E2322	E2363	E2614	J7300	