Benefit Guideline: Durable Medical Equipment

Service: Durable Medical Equipment (DME)
Effective: 5/10/16
Review Date: 12/11/2020, 12/13/2021, 12/28/2022, 12/27/2023

Products: Medica DUAL Solution® (Minnesota Senior Health Options, or MSHO), Medica Choice Care℠ (Minnesota Senior Care Plus, or MSC+), Medica AccessAbility Solution® (Special Needs Basic Care, or SNBC), AccessAbility Solution Enhanced® (Integrated SNBC, or I-SNBC)

Definition of Service: Any equipment that supports members in need because of certain medical conditions and/or illnesses so they can maintain their highest level of functioning. DME consists of items which: are primarily and customarily used to serve a medical purpose; are not useful to a person in the absence of illness, disability, or injury; are ordered or prescribed by a physician, are reusable, can stand repeated use, and are appropriate for use in the home.

Covered: DME may be covered when all the following are met:

- The equipment provides a therapeutic benefit due to certain medical conditions and/or illness.
- Items necessary for life support and items necessary for the proper functioning of such
- The DME is prescribed by a licensed provider.
- The DME does not have significant non-medical use.

DME can be covered for the following:

- Replacement of a DME device due to normal wear and use, when a written physician's statement documents a change in member's medical condition warranting a different type of covered DME device or DME has exceeded normal lifetime limit.
- Rental of medically necessary equipment while a member's own equipment is being repaired. If the item is being rented, the provider should provide a replacement during the repair of a rental without additional cost.

Not Covered: The following categories of equipment and supplies are never covered by Minnesota Health Care Programs (MHCP):

1) Items of convenience
2) Items that are useful for individuals who don't have an illness or injury
3) Environmental or home modifications
4) Lack of scientific evidence
5) Not the standard of treatment for an illness or injury

Process:

- Care Coordinator (CC) assesses member and determines possible need for DME.
- Contact a contracted DME provider. It is the DME Provider responsibility to know who the primary payer is on items and determine if member meets criteria for coverage through that payer.
- If member has non-integrated Medicare with SNBC or MSC+ Medicare is the primary coverage and must be accessed first.
- Refer member to Primary Care Provider (PCP) for DME item order if needed. DME provider can also obtain order from PCP. PCP may consider other modalities to determine needs or refer to Physical Therapy (PT) for functional assessment. CC can also refer for PT assessment if recommended for specific DME item.
- If an item is covered, CC to document in member record and include it in member's plan of care.
- Referrals are not needed for most DME items. Providers need to submit claims using the correct Healthcare Common Procedure Coding system (HCPCS code). If the item is being covered by EW, the provider must use the HCPCS code with the U3 modifier. If it is an Elderly Waiver item and there is no assigned HCPCS code, then HCPCS T2029 can be used. **If** the cost of the item is over $30 and T2029 the CC will need to

complete a referral request form and submit it to their support specialist.

- Message was sent to providers November 2019 via *Connections:* https://partner.medica.com/-/media/documents/provider/connections/2019/nov2019conn.pdf?la=en&hash=4E99D4BDBC5BF1CF7D35628EC39010CD
- For any EW DME item, DME providers should work with the member's care coordinator. Care coordinators need to approve all expenses billed under the T2029 code and other U3-modified HCPCS code for any EW items. Code T2029 should only be used if there is not a valid HCPCS code for a specific item for a member on the elderly waiver (e.g., blender, non-slip socks). Any item that has a related valid HCPCS code must be billed using the HCPCS code along with modifier U3. Doing so will alert Medica that the item does not meet Medicare or Medicaid criteria but that the DME provider has received care coordinator approval for it (e.g., a shower chair or walker being provided under the EW budget).
- If a DME item is on the Medica prior authorization list (available on Medica.com), the DME provider needs to submit authorization request to Medica per the form instructions. The form is available on Medica.com.
- It is the expectation that the Care Coordinator will follow up with DME provider after referral is made to ensure member receives item, or as appropriate, provide direction to the member/family to contact the CC if it is not received within the timeline expected.

Common Requested DME Items with product coverage and considerations:

	MSHO/SNBC Enhanced	SNBC/MSC+	Considerations
Eyeglass **add-ons** can be added to the covered frame/lenses, examples lens coating, special edge treatments, anti-reflective lens coating, etc. **Upgrades** require the member to pay for the glasses (frame/lenses) out of pocket example no-line bifocals. *Reach out to Eye Kraft for coverage of vision needs*	Not covered except for anti-glare lens coating eyewear safety upgrade limited to one anti-glare coating for one pair of eyeglasses every 24 months	SNBC and MSC+ Not covered	The **Add-on** cost is the responsibility of the provider and member agreement. **Upgrades** are the responsibility of the member. Recipients may be billed for non-covered **upgrades**. If a recipient chooses to purchase upgraded lenses that are not medically necessary (such as non-covered high-index or photo chromatic lenses, no-line bifocals) or a non-contract frame, the recipient is responsible for payment of the entire cost of the lenses or frame. The provider cannot bill the recipient for the difference between covered lenses and frame and the upgraded lenses and frame. MHCP will not pay for the dispensing fee, repairs or adjustments made to upgraded products or non-covered items. Tint or UV protection may be covered for medical need (doctor must put the diagnosis on the member's optical prescription); responsibility of provider. *Considerations: *Does the member have a medical or safety need for additions to their eyeglasses? Is it covered due to diagnosis?*
Eyeglasses (frame/lenses) every 24 months and must be Eye Kraft Optical Medica Selection	Covered	Covered (Medicare covers on qualifying event such as Cataract surgery)	Examples of exceptions to the policy may be lost, damaged or stolen glasses or a change in member's vision before 24 months. *Does member require a plan in place to prevent lost, damaged, or stolen glasses?*
Animatronic Pets	Not covered	Not covered	Considered alternative therapy and not covered under Elderly Waiver.

Diabetic Supplies including glucometer, alcohol wipes, and batteries; talking glucometers are covered.	Covered Medica Dual Solution/Accessibility Solution Enhanced covers some non-drug OTC products when they are written as prescriptions by your provider. Examples of non-drug OTC products include glucose test strips, insulin syringes, or lancets. (2024 List of Covered Drugs (Formulary) Link: Medica | Medica DUAL Solution	Covered	Covered by Pharmacy, DME (*SNBC or MSC+ with Medicare; mail order may work best) *Utilize the pharmacy whenever possible for diabetic supplies as it is much more cost effective* cost. Members with Medicare, diabetic testing supplies are covered under Part B. https://www.medica.com/providers/pharmacy *Not all members are candidates for insulin pumps* *Has the member had diabetic education? Do they need to see a dietician? Are they able to monitor their blood sugars independently?*
Hospital Bed Includes the mattress. Includes Bariatric, extra-duty, extra wide hospital beds. -no prior authorization needed -may renew after five years	Covered If criteria met	Covered If criteria met	Standard and/or adjustable hospital beds are covered when criteria are met; **adjustable. commercially marketed beds are not covered**. Medicare B covers hospital beds and air fluidized beds through DME. Enclosed beds for members with one-on-one caregiver supervision 24 hours per day are not covered. *Who is recommending the bed? Does the member need more assist to get in and out of bed, if so, would an assist rail be enough? Do they need to see a Physical therapist?*
Pressure Reducing Support Surfaces	Covered	Covered	Mattress is covered for a member owned hospital bed one allowed every three years; other mattresses that are covered with a medical need are: mattress for alternating pressure pad, water pressure mattress/pad, egg crate mattress, and gel flotation mattress/pad. Medicare B covers support surfaces with medical need. *If member has pressure sores, are they able to move independently? Have they been assessed by a dietician? Is there a support plan to prevent skin breakdown?*
Humidifiers used in conjunction with oxygen or C-PAP.	Covered	Covered	Room humidifiers are not covered to increase the moisture in a room except with waiver if medically necessary; Medicare B covers oxygen and needed supplies including humidifiers for oxygen.

			Can member put a pan of water on the stove to add some moisture, dry clothes on a rack versus the dryer?
Elevated or Raised Toilet seat. HCPC E0244	Covered	Covered	Used to facilitate independence in toileting; covered in Long Term Care per diem; allowed one per every three years; Purchase only, no rental. *Do they need strengthening exercises? Would therapy be appropriate? Do they need a fall prevention plan? Would non-skid strips on bathroom floor be beneficial?*
Toilet frame	Not covered	Not covered	***May be covered by the Elderly Waiver for medical need*** *Could member benefit from Physical Therapy? Should a home safety evaluation be ordered?*
Lift Chair	Lift mechanism may be covered if MA criteria Met	Lift Mechanism may be covered if MA criteria Met	Only lift mechanism is covered not the furniture piece with Medicaid or Medicare. Waiver or a BEI would be needed for recliner (furniture). Waiver can also cover entire chair if MA criteria is not met for lift mechanism. 1 per 5 years EW coverage is for the most cost-effective chair to meet assessed need and not items of convenience or comfort such as heat, massager, leather upholstery, etc. *Have all appropriate therapeutic modalities to enable the member to transfer to a standing position (ex: medications, physical therapy, other adaptive equipment) been tried? Is the member capable of transferring independently and requesting lift chair for convenience? Members need to be ambulatory. Purchase under EW needs to be the usual and customary cost for basic model to meet member assessed medical need.*
Walkers HCPC E0130-E0149 HCPC 0154-0159 *Reverse walkers do not have specific HCPCS code, use miscellaneous code E1399	Covered if meets criteria	Covered if meets criteria	Medicare Part B covers walkers if criteria met. Standard and seated walkers are covered if medical criteria are met. One per 5 years. *Consider therapy evaluation to determine appropriate walker and height to meet member needs. If walker or additions to walker are not covered by Medicare or Medical Assistance (MA) benefit, it could be obtained through the Elderly Waiver.*
Wheelchairs	Covered with Prior Auth approval from Utilization Management (UM)	Covered with Prior Auth approval from UM	Medicare Part B covers wheelchairs and power mobility devices. One per 5 years. Must meet coverage criteria. Standard Wheelchairs are part of the nursing home per diem. Please refer to ***Medica Utilization Management Policy: Wheelchairs, Scooters and Accessories*** effective 9/30/2020 Refer to SPP section: *Therapy evaluation to determine need and appropriate chair. Is member able to propel wheelchair independently or have a caregiver to aid? Does it enable member to*

			participate in mobility related activities and appropriate to the member's needs and abilities? Can the mobility limitation be resolved using an appropriately fitted cane or walker? Consider renting device if need is temporary.
Power Mobility: Scooters and Power Chairs	Covered with Prior Auth approval from UM	Covered with Prior Auth approval from UM	Medicare Part B covers power-operated vehicles. One per 5 years. Must meet criteria for mobility device. Please refer to ***Medica Utilization Management Policy: Wheelchairs, Scooters and Accessories*** effective 9/30/2020 Refer to SPP section: For members residing in a nursing home, a power wheelchair will be considered only if it allows the recipient to complete most activities of daily living independently. All other coverage criteria must be met. *It requires a therapy evaluation to determine need and appropriate device. Does member have the cognitive and physical ability to operate device safely? Where will device be used?*
Air Conditioners	Not Covered	Not Covered	May be covered under the Elderly Waiver if the primary care provider or appropriate specialists verifies that member has a medical condition including a respiratory or cardiovascular diagnosis which significantly impacts the member's health, and an air conditioner would directly improve member's health and functioning. The A/C unit should also fit within the waiver budget. Once medical necessity is determined, a contracted Durable Medical Equipment (DME) provider can be contacted for ordering and installation if needed. For members not receiving EW services or for EW member's that do not have sufficient funds in their budget, a Benefit Exception Inquiry (BEI) can be submitted for consideration. Same applies for SNBC members. *If member is in a customized living, can it be provided by Customized Living? What type of unit is the most appropriate for the member considering living situation? If in apartment setting, is it approved by the building management, and will the building maintenance install the unit? Can member rent Air conditioning unit from apartment management? For EW, there is a one-time purchase of an air conditioner if member meets criteria.*
Grab bars	Not Covered	Not Covered	May be covered by Waiver for medical need. *If living in an apartment has member checked with management to make sure grab bars could be installed? Who will pay install? If this is an assisted living site has member checked to make sure they aren't already available? Does member have a shower chair/bench? If not, could that help meet needs? Is member on a waiver and are the funds in budget to cover cost? Could member benefit from PT for strengthening?*

Shower chair/bench HCPC E0240 *When the shower chair is highly specialized the DME provider will want to use the U3 modifier when billing to indicate the chair is above the fee schedule rate	Covered	Covered	Allowed 1 per 5 years. Included in LTC per diem. If lost, stolen, or broken before 5-year period, will need BEI. . *Does member know how to use chair/bench safely? If not, is further assistance required, such as PCA or HHA? Will the chair accommodate the size of the member? Will the chair safely fit in tub/shower?*
Reacher/grabbers	Not covered	Not covered	May be covered by Waiver for medical need. Although helpful, this is not a medical necessity.
Hearing Aids	Covered	Covered	Two kinds: Air Conduction Hearing Aids (ACHAs) and Bone Anchored Hearing Aides (BAHAs). BAHA and Cochlear Implants **are not** the same. Covered once every 5 years. An in-network ENT or Audiologist MUST perform the hearing exam. Over the Counter (OTC) hearing aids are not covered. Replacement: hearing aids can be replaced due to change in hearing, or hearing aid loss, theft, or irreparable damage two times in a five-year period (five-year period stars from original dispensed date). Refer provider to Provider Service Center for replacement process 1-800-458-5512. Repair: Medica will pay for repairs to the aid once the warranty has expired. Prior Authorization policy is followed if member/provider is requesting payment for a hearing aid that is not on the DHS Contracted Hearing Aid Model List found here (see Audiologists)
PERS (Personal Emergency Response System) May receive up to $3000 total of PERS equipment and services per waiver year.	Not Covered	Not Covered	Installation and service can be covered by Waiver budget when medically necessary. *MSHO members without EW please refer to REEMO Smartwatch (MSHO Supplemental Benefit) If living in 24 hour supervised setting, the facility will be responsible for a personal response system in the facility. *Has member enrolled in Lifeline? If so, it won't exclude member from receiving PERS. Are there other supports in place to prevent falls and increase safety? Has a home safety evaluation been completed? Is member cognitively capable of pressing button in emergency? Is there medical documentation to support the need?*
Therapeutic Shoes, Modifications, and Inserts HCPC for members with diabetics A5500-A5501 A5503-5507 A5510-A5513 K0903	Covered w/diabetes diagnosis.	Covered w/diabetes diagnosis.	Two pairs of therapeutic shoes, three pairs of inserts (A5512, A5513, K0903), and two pairs of inserts (A5510) are covered in a calendar year. They can be dispensed at the same time, or at different times. Custom-made or stock therapeutic shoes and modifications to therapeutic shoes are covered for member with diagnosed diabetes **and** one or more of the following conditions: Previous amputation of the other foot, or part of either foot, History of foot ulceration of

			either foot, History of pre-ulcerative calluses of either foot, Peripheral neuropathy of either foot, Foot deformity of either foot, Poor circulation of either foot. Prescription must come from a podiatrist or physician knowledgeable in the fitting of diabetic shoes and inserts. *Does member ambulate? If not, consider well-fitting pair of athletic or supportive shoes first.*
Orthopedic Shoes and Inserts HCPC for members with other qualifying diagnoses L3000-L3031 L3040-L3060 L3070-L3100 L3140-L3150 L3224-L3253 L3300-L3595 L3600-3640 L3649	Covered w/specific medical conditions.	Covered w/specific medical conditions	Two pairs of orthopedic shoes and two pairs of inserts are covered in a calendar year. Custom-made orthopedic shoes, modifications and inserts when the shoe is an integral part of a leg brace, or for recipients with one or more of the following medical conditions are covered: Foot deformity accompanied by pain, Plantar fasciitis, Calcaneal bursitis (acute or chronic), Calcaneal spur, Inflammatory conditions such as sub metatarsal bursitis, synovial cyst or plantar fascial fibromatosis, Medial osteoarthritis of the knee, Musculoskeletal/arthropathic deformities, Neurologically impaired feet, Vascular conditions The following products are covered: custom inserts, pre-molded, removable arch supports, non-removable arch supports, abduction and rotation bars, orthopedic footwear, additions and modifications to orthopedic shoes, transfer of orthotic. Prescription must come from a podiatrist or physician knowledgeable in the fitting of orthopedic shoes and inserts. *Does member ambulate? If not, consider well-fitting pair of athletic or supportive shoes first.*

Refer to DHS Medical Supply Coverage Guide for detailed information for MA Coverage Criteria:

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008993

Elderly Waiver Specialized Equipment and Supplies:

Definition: Devices, controls or medical appliances or supplies specified in the community support plan. Equipment or supplies that exceeds the limits set for state plan covered services.

Covered:

- DME item is a necessary adjunct to direct treatment of remediation of the member's condition and are essential to keep the recipient in the community and
- Items necessary for life support or equipment necessary for the proper functioning of such life support items and
- Member is eligible or open to EW with an assessed need and documented in the EW Service Plan and cost is within the EW Monthly Service limits and
- It is the usual and customary cost of the item.
- Item is not covered by any other source such as private insurance, long term care insurance, medical assistance, or public payers.

Per Diem Coverage

Skilled Nursing Facility
Nearly all durable medical equipment and supplies are covered in the per diem for long-term care, with the exclusion of customized wheelchairs for members who cannot use a standard wheelchair. Medica Utilization Management Policy: Wheelchairs, Scooters and Accessories would apply. Nursing Facilities must exhaust other options for meeting a member's need before requesting authorization for a wheelchair. See the Medical Supply coverage guide (PDF) for details on specific HCPCS codes (the "Included in LTC per diem?" column lists whether or not something is covered in a skilled nursing facility).

Intermediate Care Facilities for individuals with developmental disabilities (ICF/DD)
Includes most durable medical equipment and supplies within its per diem. Wheelchair rentals and purchases are not included in the per diem. Medica Utilization Management Policy: Wheelchairs, Scooters and Accessories would apply. See the Medical Supply coverage guide (PDF) for details on specific HCPCS codes (the "Included in LTC per diem?" column lists whether or not something is covered in an intermediate care facility).

Hospice
All durable medical equipment and supplies related to a hospice diagnosis are covered by the hospice benefit. Other coverage may apply if the member requires durable medical equipment and supplies for an unrelated diagnosis. See the Hospice Services section of the MHCP Provider Manual for more details.

Considerations:

- Is this service necessary for the health, welfare, and safety of the member?
- Does the service enable the member to function with greater independence?
- Is the service of direct and specific benefit to the member (sole utility of the member)?
- Is this the most cost-effective solution?
- What can the recipient still do for self?
- Are there other formal or informal services, which can meet the identified need?
- Elderly Waiver Special Equipment Additional Considerations: is the cost of the service considered reasonable and customary?
- Can the item be rented for a cost less than the purchase price of the equipment?
- Is the purchase price of the item less expensive than the rental fees for the expected duration of use or when rental equipment is unavailable?
- Can a repair of an existing DME be more cost effective than replacing it with a new item?
- Is the existing item covered under a warranty?
- If the member is on a waiver managed by the county and needs an item that is not covered by the Medicare or Medical Assistance benefit, can it be obtained through the waiver?
- Have all options been assessed and does this DME meet the individual desires, needs and preferences of the person?
- Does the member have a condition that requires supplies above the MA allowable? If so, proceed to BEI process and supply medical documentation.

Note: If member insists on having a service after the care coordinator has provided education on why the service is not appropriate or the member is not eligible, then a Denial/Termination/Reduction (DTR) request needs to be pursued immediately. Refer to Medica DTR instructions and DTR forms for more information.

References:

DHS MSHO/MSC+ Contract
DHS SNBC Contract
DHS Medical Supply Coverage Guide
DHS Community-Based Services Manual (CBSM)
Medica Denial Termination Reduction (DTR) Policy
Medica Coverage Policy DME
Medica Utilization Management Policy: Wheelchairs, Scooters and Accessories
Medicare.gov
Minnesota Health Care Programs (MHCP) Provider Manual
Medica Prior Authorization list

This Medica Benefit Guideline for Care Coordination Products is intended to guide service plan development. This reflects current interpretation of the product benefit set and/or parameters for obtaining services. Medica staff should be consulted for further guidance or to vary from these recommendations.