NO. 91110

DURABLE MEDICAL EQUIPMENT

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Instructions for use: This document is for informational purposes only. Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion. Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

Policy scope: This policy defines coverage, medical necessity criteria, limitations, and exclusions for durable medical equipment (DME), including purchase, rental, repair, replacement, and associated supplies.

Related policies:

- Blood Pressure Monitors and Ambulatory Blood Pressure Monitoring No. 91503
- Enteral Nutritional Therapy No. 91278
- Enuresis Therapy No. 91418
- Hearing Augmentation No. 91544
- Home Prothrombin Time or INR Monitoring No. 91507
- Infusion Services and Equipment No. 91414
- Orthotics/Orthoses/Support Devices No. 91339
- Orthotics: Shoe Inserts, Orthopedic Shoes No. 91420
- Parenteral Nutritional Therapy No. 91517
- Peripheral Nerve Stimulation No. 91634
- Pulse Oximetry for Home Use No. 91452
- Skin Conditions No. 91456
- Sleep Apnea: Obstructive and Central No. 91333
- Stimulation Therapy and Devices No. 91468

I. MEDICAL NECESSITY CRITERIA

A. Inclusions:

Durable medical equipment (DME) is medically necessary when applicable **InterQual** criteria are met. Restrictions and limitations, some of which are described below, apply.

1. The decision to purchase or rent DME (and the supplies and accessories necessary for their functioning) will be at the discretion of the Health Management Department.

2. If quality and effectiveness are comparable, the least costly equipment will be covered.

3. The decision to repair or replace DME will be at the decision of the Health Management Department. A one-month rental period will be covered for a beneficiary-owned unit when the unit is sent in for repair / replacement estimate (except for Medicaid/Healthy Michigan Plan products). The following guidelines apply:
   - **a.** Repair of Customer-Owned Durable Medical Equipment (DME):
     - i. Repairs or maintenance as a result of normal use are a covered benefit.
     - ii. Repairs or maintenance as a result of misuse or abuse are not a covered benefit and are the responsibility of the member.
     - iii. For repairs greater than 60% of the cost of new, replacement will be at the discretion of Priority Health.
     - iv. Claims for repairs should include an itemized invoice.
   - **b.** Replacement of Durable Medical Equipment (DME)
     - i. Replacement of DME damaged by normal use or required due to body growth is a covered benefit.
     - ii. Replacement of DME is covered if equipment is past the useful lifetime period.
       - i. Useful lifetime is considered to be no less than 5 years beginning with the date of delivery. Obsolescence of electronic components (e.g., CPAP compliance monitoring) qualifies for DME replacement.
       - ii. Functioning DME that meets the clinical need is not eligible for replacement, regardless of the age of the equipment.

iii. Replacement will be at the discretion of Priority Health if cost of repairs is greater than 60% of the cost of new.
iv. Replacement of DME as a result of misuse or abuse is not a covered benefit and is the responsibility of the member.
v. Replacement of lost or stolen DME is not a covered benefit.

4. Supplies and accessories, including disposable supplies, necessary for the proper functioning or application of covered durable medical equipment (DME) are a covered benefit.

5. Loaner Equipment:
- **a.** Priority Health will pay for loaner equipment on member-owned equipment outside the capped rental period.
- **b.** Payment will not be made for the rental of equipment on supplier owned equipment (within the 10-month capped rental period).

6. Transfer of Capped Rental Equipment:
- **a.** In the event that the member changes carriers during a 10-month capped rental period a new rental period will not begin. Priority Health will allow coverage for capped rental equipment and will pay the number of months remaining on the capped rental amount up to 10 months on new members to the plans or on members who have lost a primary carrier, therefore making Priority Health their primary carrier.

7. Ownership of capped rental items shall be transferred to the beneficiary after the capped-rental period of 10 months has been completed.

8. In the event that the member requires an upgrade of equipment during the capped rental period (i.e.: CPAP to BIPAP), Priority Health will apply the amount already paid on the capped rental toward the balance of the upgraded item.

9. Pneumatic compression devices are considered medically necessary durable medical equipment (DME) as follows:
- **a.** Segmental or non-segmental pneumatic compression devices with non-calibrated or calibrated gradient pressure, in the home setting, are considered medically necessary when InterQual criteria are met.
- **b.** Segmental or non-segmental pneumatic compression devices with non-calibrated or calibrated gradient pressure, in the home setting, are not medically necessary for all other indications including but not limited to:

I. Active cellulitis
II. Ischemic vascular disease
III. Lymphedema only in the head, neck, trunk, chest, or abdomen
IV. Prevention of deep venous thrombosis in the home setting
V. Severe peripheral neuropathy

c. There is insufficient literature demonstrating the superiority of calibrated gradient pressure devices over non-calibrated pressure devices; therefore, the least costly equipment will be covered.

d. Requests for calibrated gradient pressure devices require documentation of failure with non-calibrated gradient pressure devices to improve treatment.

B. Limitations:

1. Coverage is limited to one (1) piece of same-use equipment (e.g., mobilization, suction), unless replacement is covered under the replacement guidelines in this policy.

2. Professional fees related to dispensing or customizing the item, educating or training the member are covered as part of the equipment cost. These services are the responsibility of the vendor or provider and are not reimbursable as a separate fee.

C. Exclusions:

1. Not Medically Necessary:

a. Pneumatic Compression (PCD) Devices

i. **Non-pneumatic** Compression Devices

i. Non-pneumatic compression devices (e.g. Koya DaySpring) are not medically necessary due to insufficient evidence of effectiveness in improving long-term health outcomes.

ii. **Intermittent** Pneumatic Compression (IPC) Devices

i. Intermittent pneumatic compression devices are not medically necessary for **any** indication due to insufficient evidence of effectiveness in improving long-term health outcomes.

b. Continuous Passive Motion (CPM) Devices

i. Continuous passive motion devices are not considered medically necessary for **any** condition at any anatomic location (e.g., knee, shoulder, hip, ankle).

2. **Not a Covered Benefit:**

   a. Repair of Customer-Owned Durable Medical Equipment (DME):
      i. Repairs or maintenance as a result of misuse or abuse are not a covered benefit and are the responsibility of the member.
   b. Deluxe equipment
   c. Duplicate or back up equipment is not a covered benefit. Multiple devices (e.g., electric wheelchair for home and manual wheelchair for transportation, or wheelchair and buggy) are not a covered benefit.
   d. First aid or precautionary equipment such as standby portable oxygen units
   e. Maintenance and Service fee for capped-rental items
   f. Personal or household items are not a covered benefit, including but not limited to:
      i. Personal comfort or convenience items
      ii. Household fixtures or equipment, or home modifications (e.g., bath bars, ramps, air conditioners, pillows, elevators)
      iii. Furnishing such as lift chairs, whirlpools and safety beds
   g. Self-help and adaptive aids are not medically necessary, including training aids.
   h. Physical fitness equipment such as treadmills, stationary bikes
   i. Upgrade of equipment for outdoor use, or equipment needed for use outside of the home that is not needed for in-home use, are not covered.

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals.
For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare Coverage Database website for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

National Coverage Determinations (NCDs)
NCD - Pneumatic Compression Devices (280.6)

NCD - Speech Generating Devices (50.1) NCD - Home Use of Oxygen in Approved Clinical Trials (240.2.1) NCD - Seat Lift (280.4)	
Local Coverage Determinations (LCDs)	
CGS Administrators, LLC	LCD - Negative Pressure Wound Therapy Pumps (L33821) LCD - Speech Generating Devices (SGD) (L33739) LCD - Power Mobility Devices (L33789) LCD - Pressure Reducing Support Surfaces - Group 2 (L33642) LCD - Oxygen and Oxygen Equipment (L33797) LCD - Hospital Beds and Accessories (L33820) LCD - Commodes (L33736) LCD - Seat Lift Mechanisms (L33801) LCD - Patient Lifts (L33799) LCD - Walkers (L33791) LCD - Manual Wheelchair Bases (L33788) LCD - Power Mobility Devices (L33789) LCD - High Frequency Chest Wall Oscillation Devices (L33785) LCD - Tracheostomy Care Supplies (L33832)
First Coast Service Options, Inc.	None Identified
Wellpoint Federal (formerly National Government Services, Inc.)	None Identified
Noridian Healthcare Solutions	LCD - Negative Pressure Wound Therapy Pumps (L33821) LCD - Speech Generating Devices (SGD) (L33739)

	LCD - Power Mobility Devices (L33789) LCD - Pressure Reducing Support Surfaces - Group 2 (L33642) LCD - Oxygen and Oxygen Equipment (L33797) LCD - Hospital Beds And Accessories (L33820) LCD - Commodes (L33736) LCD - Seat Lift Mechanisms (L33801) LCD - Patient Lifts (L33799) LCD - Walkers (L33791) LCD - Manual Wheelchair Bases (L33788) LCD - Power Mobility Devices (L33789) LCD - High Frequency Chest Wall Oscillation Devices (L33785) LCD - Tracheostomy Care Supplies (L33832)
Novitas Solutions, Inc.	None Identified
Palmetto GBA	None Identified
WPS Insurance Corporation	None Identified

III. BACKGROUND

Durable Medical Equipment (DME) refers to medical equipment that can withstand repeated use, is primarily and customarily used for a medical purpose, is not generally useful without illness, injury, or disease, and is appropriate for use in the member's home. A member's home may be defined as the member's own dwelling, relative's home, apartment, home for the aged or other type of institution.

Common DME Categories:

Bilirubin Light
A bilirubin light, also known as phototherapy, is a medical device used to treat neonatal hyperbilirubinemia by reducing elevated bilirubin levels in newborns. The device emits specific wavelengths of light that alter unconjugated bilirubin in the skin into water-soluble forms that can be excreted without further metabolism. Bilirubin lights are

used when clinically indicated to prevent complications such as kernicterus and may be provided in hospital settings or, in selected cases, for home use under medical supervision.

Continuous Passive Motion (CPM) Devices
Continuous passive motion (CPM) devices are motorized systems designed to move a joint through a controlled range of motion without active patient participation. They have historically been used following knee surgeries, particularly total knee arthroplasty (TKA) and other intra-articular procedures, as well as shoulder surgeries such as rotator cuff repair and shoulder arthroplasty. However, contemporary evidence and professional society guidance do not support the routine use of CPM for postoperative rehabilitation.

For **knee rehabilitation**, the American Academy of Orthopaedic Surgeons (AAOS) recommends against the routine use of CPM following total knee arthroplasty, emphasizing early mobilization, structured physical therapy, and patient-directed exercises to restore function and range of motion instead (American Academy of Orthopaedic Surgeons [AAOS], 2015). Systematic reviews and meta-analyses have consistently shown that CPM does not result in clinically meaningful improvements in long-term pain, function, quality of life, or sustained range of motion compared with standard postoperative rehabilitation alone, despite occasional short-term gains in knee flexion (Harvey et al., 2014). In alignment with these findings, Choosing Wisely campaigns supported by orthopedic societies advise against routine CPM use after knee surgery due to lack of demonstrated benefit as well as added cost and treatment burden. Overall, the available literature indicates that CPM does not improve durable clinical outcomes following knee surgery when compared with conventional rehabilitation (AAOS, 2015; Harvey et al., 2014).

Similarly, for **shoulder rehabilitation**, contemporary evidence and professional society guidance do not support routine CPM use. The AAOS emphasizes structured postoperative rehabilitation consisting of therapist-directed passive motion followed by progressive active motion and strengthening, without recommending CPM as a standard modality (American Academy of Orthopaedic Surgeons [AAOS], 2025). Systematic reviews have demonstrated that while CPM may provide limited short-term improvements in passive range of motion, these effects are not sustained and do not result in meaningful long-term improvements in pain, function, strength, or overall range of motion compared with standard rehabilitation alone (Du Plessis et al., 2011). In addition, consensus recommendations from the American Society of Shoulder and Elbow Therapists (ASSET) prioritize phased, therapist-guided rehabilitation protocols and do not endorse routine CPM use after shoulder surgery (Kennedy et al., 2020).

Observational analyses of publicly available postoperative protocols further demonstrate that CPM use varies widely despite the lack of supporting evidence or guideline endorsement (Mehta et al., 2024). Overall, the available literature does not demonstrate a clear clinical benefit of routine shoulder CPM beyond conventional physical therapy,

and its use should be limited to exceptional, individualized circumstances rather than standard postoperative care.

Hospital Beds
Hospital beds are specialized medical equipment designed to support individuals with significant medical or functional limitations who require frequent or complex positioning adjustments. They allow for safe head, foot, and height elevation to facilitate medically necessary positioning, improve comfort, support respiratory and circulatory function, and reduce the risk of pressure injuries. Hospital beds may also accommodate accessories such as pressure-redistributing mattresses, side rails, or trapeze bars, enabling safer care delivery and assisting with transfers, mobility, and activities of daily living when standard beds are insufficient to meet the individual's medical needs.

Manual and Power Wheelchairs
Manual and power wheelchairs are mobility devices intended to address functional mobility limitations that interfere with activities of daily living and independent functioning, particularly within the home environment. They provide medically necessary seated mobility for individuals who are unable to ambulate safely or effectively due to neuromuscular, musculoskeletal, cardiopulmonary, or other disabling conditions. Manual wheelchairs are typically appropriate for individuals with sufficient upper-extremity strength or caregiver support, while power wheelchairs are used when an individual lacks the physical capacity to propel a manual device and requires powered mobility to perform essential daily activities safely and independently.

Mattresses and Support Surfaces
Pressure-reducing mattresses and support surfaces are medical devices used to prevent, treat, or manage pressure injuries in individuals at increased risk due to impaired mobility, reduced sensation, or prolonged periods of bed confinement. These products are designed to redistribute pressure, reduce shear and friction, and improve tissue perfusion, thereby supporting skin integrity and wound healing when standard mattresses are insufficient to meet the individual's medical needs.

Negative Pressure Wound Therapy (NPWT)
Negative pressure wound therapy (NPWT) is an advanced wound care modality that applies controlled sub-atmospheric pressure to the wound bed through a sealed dressing system. It is used to promote healing of acute and chronic wounds by removing excess exudate, reducing edema, improving local blood flow, and supporting granulation tissue formation. NPWT is typically considered when standard wound care measures have been insufficient, particularly for complex, non-healing, surgical, traumatic, or large wounds requiring enhanced healing support.

Percussion Vests
Percussion vests, also known as high-frequency chest wall oscillation (HFCWO) devices, are used to assist with airway clearance in individuals with conditions that

impair effective cough or mucus clearance. These devices deliver external chest wall compression and rapid oscillations to loosen bronchial secretions, promote mobilization of mucus, and facilitate expectoration. Percussion vests are commonly utilized in patients with chronic pulmonary disorders, such as cystic fibrosis or neuromuscular diseases when conventional airway clearance techniques are ineffective, not tolerated, or cannot be performed independently.

Pneumatic Compression Devices (PCDs)
PCDs provide intermittent external compression to support venous and lymphatic return and are commonly used after conservative therapy has been attempted. The International Society of Lymphology (ISL) 2023 Consensus recognizes intermittent pneumatic compression as an adjunctive option within comprehensive lymphedema management, typically alongside compression garments and CDT; and the International Lymphoedema Framework endorses stepwise, conservative-first management of lymphedema, with devices used when standard measures are insufficient (Executive Committee of the International Society of Lymphology [ISL], 2023).

Intermittent Pneumatic Compression for Arterial Insufficiency
The use of intermittent pneumatic compression for arterial insufficiency, peripheral artery disease (PAD), chronic limb-threatening ischemia (CLTI), or critical limb ischemia (CLI) differs substantially from its established role in lymphedema management. Although intermittent pneumatic compression has been proposed as a noninvasive method to augment arterial blood flow, improve wound healing, reduce ischemic pain, and decrease amputation risk in patients who are not candidates for revascularization, the available evidence remains limited and of low methodological quality. Most published studies consist of small observational studies, uncontrolled case series, retrospective analyses, or nonrandomized trials, with substantial heterogeneity in patient populations, device specifications, treatment protocols, and outcome measures (Moran et al., 2015; Abu Dabrh et al., 2015).

Systematic reviews have reported potential improvements in limb perfusion, wound healing, ischemic pain, and limb salvage; however, conclusions are limited by the low quality of the available evidence. Moran et al. (2015) found that studies evaluating IPC for critical limb ischemia were generally small and subject to significant risk of bias. Similarly, Abu Dabrh et al. (2015) concluded that available evidence was insufficient to determine the effectiveness of IPC because reported benefits were derived largely from uncontrolled or nonrandomized studies. Subsequent reviews have continued to identify important limitations, including small sample sizes, inconsistent outcome reporting, and uncertainty regarding optimal treatment parameters.

Current professional society guidelines provide only limited support for IPC in carefully selected patients with CLTI who are not candidates for revascularization. The 2024 American College of Cardiology/American Heart Association (ACC/AHA) Guideline for the Management of Lower Extremity Peripheral Artery Disease states that arterial

intermittent pneumatic compression devices may be considered to augment wound healing or reduce ischemic rest pain in patients with CLTI for whom revascularization is not an option (Class 2b; Level of Evidence B-NR). Similarly, the 2019 Global Vascular Guidelines on the Management of Chronic Limb-Threatening Ischemia recommend consideration of IPC only in carefully selected patients when revascularization is not feasible and characterize the recommendation as weak. The limited strength of these recommendations reflects the absence of robust randomized evidence demonstrating consistent clinical benefit.

Despite reported physiologic improvements in blood flow and perfusion, the current body of evidence remains insufficient to establish that IPC provides durable and clinically meaningful improvements in health outcomes, including wound healing, amputation-free survival, limb salvage, functional status, or quality of life. Given the limited quantity and quality of evidence, uncertainty regarding patient selection and treatment protocols, and lack of high-quality randomized controlled trials demonstrating net health benefit, the effectiveness of IPC for arterial insufficiency, PAD, CLTI, or CLI has not been established. Therefore, use of intermittent pneumatic compression for these indications is considered investigational/unproven and not medically necessary.

Positive Airway Pressure (PAP) Devices (CPAP, APAP, BiPAP)
Positive airway pressure (PAP) devices are noninvasive respiratory therapies used primarily to treat obstructive sleep apnea and related sleep-disordered breathing conditions. These devices deliver pressurized air through a mask to maintain upper airway patency during sleep, preventing airway collapse and associated apneic (breathing cessation) or hypopneic (restricted airflow) events. Continuous positive airway pressure (CPAP) provides a fixed pressure, auto-titrating positive airway pressure (APAP) adjusts pressure based on detected airflow changes, and bilevel positive airway pressure (BiPAP) delivers different inspiratory and expiratory pressures to support ventilation in individuals who require additional respiratory assistance or cannot tolerate single-pressure therapy.

Power-Operated Vehicles (Scooters)
Power operated vehicles, commonly referred to as scooters, are mobility devices designed for individuals with limited ambulation who are unable to walk functional distances but retain the cognitive, postural, and physical ability to safely operate powered mobility. Scooters may assist in helping one maintain independence by enabling performance of essential activities of daily living, particularly within the home or community environment.

Pulse Oximeters
Pulse oximeters are noninvasive monitoring devices used to measure arterial oxygen saturation and pulse rate in individuals with selected respiratory, cardiac, or circulatory conditions. They support clinical assessment and ongoing monitoring by helping identify hypoxemia, guide supplemental oxygen use, and evaluate response to therapy in both

acute and chronic care settings. Pulse oximetry is commonly utilized when individuals are at risk for oxygen desaturation due to underlying disease, medical treatment, or functional limitations affecting respiratory status.

Speech-Generating Devices (SGDs)
Speech generating devices are a form of augmentative and alternative communication (AAC) used by individuals with severe expressive speech impairments who are unable to meet their functional communication needs through natural speech alone. These devices enable communication through electronically generated voice output using symbols, text, or other input methods. SGDs support effective communication for daily activities, social interaction, and medical decision-making in individuals with conditions such as neurological disorders, developmental disabilities, or acquired speech loss.

Vacuum Bell Therapy
Vacuum bell therapy (VBT) is a nonsurgical treatment for pectus excavatum that uses a small, pearshaped, manual pump to generate negative pressure over the anterior chest. This suction gradually elevates the sternum, facilitating progressive remodeling of the chest wall tissues. The level of negative pressure is adjusted according to patient tolerance. Treatment is typically applied for at least 30 minutes twice daily, although some protocols may require longer sessions reaching several hours per day. (Hayes Inc, 2026) There are currently no large-scale randomized controlled trials evaluating this therapy.

Ventilators
Ventilators are life-support medical devices used to provide mechanical assistance or full respiratory support for individuals who are unable to maintain adequate ventilation or oxygenation on their own. They deliver controlled airflow to the lungs through invasive or noninvasive interfaces to support breathing in conditions such as respiratory failure, neuromuscular disease, severe lung disease, or acute illness. Ventilators may be used in hospitals, long-term care, or home settings when continuous or intermittent ventilatory support is medically necessary to sustain life or prevent serious deterioration in respiratory function.

IV. GUIDELINES / POSITION STATEMENTS

Medical/Professional Society	Guideline
American Academy of Orthopaedic Surgeons (AAOS)	AAOS Rotator Cuff Injuries AAOS Surgical Management of Osteoarthritis of the Knee 2015-Surgical_Management_of_Osteoarthritis_of_the_Knee AAOS- Management of Rotator Cuff Injuries

American Society of Shoulder and Elbow Therapists (ASSET)	The American Society of Shoulder and Elbow Therapists' consensus statement on rehabilitation for anatomic total shoulder arthroplasty
American Academy of Family Physicians	Avoid routine use of continuous passive motion after knee arthroplasty
International Society of Lymphology (ISL)	The Diagnosis and Treatment of Peripheral Lymphedema: 2023 Consensus Document of The International Society of Lymphology

V. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

See U.S. Food & Drug Administration (FDA) Medical Device Databases for the most current information.

VI. CODING

See also: Priority Health Billing Policies:

Durable Medical Equipment (DME) Capped Rental No. 110
Durable Medical Equipment (DME)/ Prosthetics and Orthotics Modifiers No. 060
Durable Medical Equipment (DME) Place of Service (POS) No. 050
Durable Medical Equipment (DME) Refill Requirements No. 087
Durable Medical Equipment (DME) Repair and Replacement No. 108
Miscellaneous Durable Medical Equipment No. 017
Compression Garments No. 067
High Frequency Chest Wall Oscillation Devices No. 171
Miscellaneous Durable Medical Equipment (DME) Supplies No. 106
Negative Pressure Wound Therapy Pumps No. 072
Ostomy Supply No. 019
Oxygen and Oxygen Supplies No. 082
Patient Lift No. 162
Positive Airway Pressure (PAP) Devices for Treatment of Obstructive Sleep Apnea No. 020
Pressure Reducing Support Surfaces No. 161
Urological Supplies No. 036
Tracheostomy Supplies No. 035
Transcranial Magnetic Stimulation (TMS) No. 127

See specific policies or reference documents for detailed coding information where indicated.

Capped Rental modifiers

- **KH** (DMEPOS item, initial claim, first month rental) is only to be used for the initial claim of the capped rental period
- **KI** (DMEPOS item, second- or third-month rental) is only to be used for the second and third months of the capped rental period
- **KJ** (DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months 4 to 15) is only to be used for the fourth through final month of the capped rental period

Rental modifier

- **RR** Rental (use the RR modifier when DME is to be rented)

Wheelchair modifiers

- **KX Modifier** – Modifier should be appended to indicate that policy criteria has been met for all wheelchair DME items (includes base, seating, power devices, and additional accessories). Claims reported without KX modifier will deny as non-payable per medical policy. (Commercial, Medicaid products)
- **KX, GA, GY, GZ Modifiers** – Per CMS local coverage determinations, one of these modifiers are required for claim processing all wheelchair DME items (includes base, power bases, seating, and additional accessories). Please review applicable LCD for additional guidelines. (Medicare)
- **RT, LT Modifiers** – Laterality modifiers should be utilized to identify the right or left side when a bilateral accessory is supplied. Missing modifiers will result in a claim denial

CPT/HCPCS Codes

Equipment and supplies requiring pre-authorizations

Enteral Feedings and Supplies

- See medical policy: *Enteral Nutritional Therapy No. 91278*

Shoe Inserts

- See medical policy: *Orthotics: Shoe Inserts, Orthopedic Shoes No. 91420*

Implanted and External Stimulator Devices

- See the following medical and/or billing policies:
    - *Medical policy-Peripheral Nerve Stimulation No. 91634*
    - *Medical policy- Stimulation Therapy and Devices No. 91468*
        - *For Transcranial Magnetic Stimulation (TMS) for depression-* Please see:
            - Priority Health's Provider Manual page on TMS
            - Billing policy: Transcranial Magnetic Stimulation (TMS) No. 127

Infusion/TPN Supplies and Services

- See medical policy: *Parenteral Nutritional Therapy No. 91517*
- All service lines for Home Infusion providers require prior authorization

Infusion Pumps, Implantable & External

- See medical policy: *Infusion Services and Equipment No. 91414*

Ventilators

E0465	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
E0466	Home ventilator, any type, used with noninvasive interface, (e.g., mask, chest shell)
E0467	Home ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions

Compression Appliances

- *Not separately payable when billed for use in conjunction with a procedure in office, OP facility or ambulatory surgical center.*

A4600	Sleeve for intermittent limb compression device, replacement only, each
A6548	Accessory to custom gradient compression garment, silicone band, any size
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code (Explanatory notes must accompany claim)
E0650	Pneumatic compressor, nonsegmental home model
E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure
E0655	Nonsegmental pneumatic appliance for use with pneumatic compressor, half arm
E0656	Segmental pneumatic appliance for use with pneumatic compressor, trunk
E0657	Segmental pneumatic appliance for use with pneumatic compressor, chest
E0658	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full arms and chest
E0659	Segmental pneumatic appliance for use with pneumatic compressor, integrated, head, neck and chest
E0660	Nonsegmental pneumatic appliance for use with pneumatic compressor, full leg

E0665	Nonsegmental pneumatic appliance for use with pneumatic compressor, full arm
E0666	Nonsegmental pneumatic appliance for use with pneumatic compressor, half leg
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg
E0670	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk
E0671	Segmental gradient pressure pneumatic appliance, full leg
E0672	Segmental gradient pressure pneumatic appliance, full arm
E0673	Segmental gradient pressure pneumatic appliance, half leg
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)
E0676	Intermittent limb compression device (includes all accessories), not otherwise specified (Explanatory notes must accompany claims billed with unlisted codes.)
E0677	Nonpneumatic sequential compression garment, trunk
E0678	Non-pneumatic sequential compression garment, full leg
E0679	Non-pneumatic sequential compression garment, half leg
E0680	Non-pneumatic compression controller with sequential calibrated gradient pressure
E0681	Non-pneumatic compression controller without calibrated gradient pressure
E0682	Non-pneumatic sequential compression garment, full arm
E0683	Non-pneumatic, non-sequential, peristaltic wave compression pump

Negative Pressure Wound Therapy (Wound Pump)

E2402	Negative pressure wound therapy electrical pump, stationary or portable
A6550	Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories
A7000	Canister, disposable, used with suction pump, each
A9272	Wound suction, disposable, includes dressing, all accessories and components, any type, each Not medically necessary

Speech Generating Device

E2500	Speech generating device, digitized speech, using prerecorded messages, less than or equal to eight minutes recording time
E2502	Speech generating device, digitized speech, using prerecorded messages, greater than eight minutes but less than or equal to 20 minutes recording time

E2504	Speech generating device, digitized speech, using prerecorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time
E2506	Speech generating device, digitized speech, using prerecorded messages, greater than 40 minutes recording time
E2508	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device
E2510	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access
E2511	Speech generating software program, for personal computer or personal digital assistant
E2512	Accessory for speech generating device, mounting system
E2513	Accessory for speech generating device, electromyographic sensor
E2599	Accessory for speech generating device, not otherwise classified

Power Vehicles

E1230	Power operated vehicle (3- or 4-wheel nonhighway), specify brand name and model number
K0800	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds
K0801	Power operated vehicle, group 1 heavy-duty, patient weight capacity 301 to 450 pounds
K0802	Power operated vehicle, group 1 very heavy-duty, patient weight capacity 451 to 600 pounds
K0806	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds
K0807	Power operated vehicle, group 2 heavy-duty, patient weight capacity 301 to 450 pounds
K0808	Power operated vehicle, group 2 very heavy-duty, patient weight capacity 451 to 600 pounds
K0812	Power operated vehicle, not otherwise classified (*Explanatory notes must accompany claims billed with unlisted codes.)*

Bilirubin Light

E0202	Phototherapy (bilirubin) light with photometer

<u>Capped Rental Durable Medical Equipment (DME)</u>

Mattresses, specialized sleep surfaces

E0193	Powered air flotation bed (low air loss therapy)
E0194	Air fluidized bed
E0371	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width
E0372	Powered air overlay for mattress, standard mattress length and width

E0373 Nonpowered advanced pressure reducing mattress

PAP Devices

- See medical policy*: Sleep Apnea: Obstructive and Central* *No. 91333*

Pulse Oximeter)

- See medical policy: *Pulse Oximetry for Home Use* *No. 91452*

E0445 Oximeter device for measuring blood oxygen levels noninvasively

- (*Not* Covered Medicare)

Hospital and Specialty Beds

E0250 Hospital bed, fixed height, with any type side rails, with mattress
E0251 Hospital bed, fixed height, with any type side rails, without mattress
E0255 Hospital bed, variable height, hi-lo, with any type side rails, with mattress
E0256 Hospital bed, variable height, hi-lo, with any type side rails, without mattress
E0260 Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress
E0261 Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress
E0265 Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress
E0266 Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress
E0270 Hospital bed, institutional type includes: oscillating, circulating and Stryker frame, with mattress
E0290 Hospital bed, fixed height, without side rails, with mattress
E0291 Hospital bed, fixed height, without side rails, without mattress
E0292 Hospital bed, variable height, hi-lo, without side rails, with mattress
E0293 Hospital bed, variable height, hi-lo, without side rails, without mattress
E0294 Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress
E0295 Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress
E0296 Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress
E0297 Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress
E0300 Pediatric crib, hospital grade, fully enclosed, with or without top enclosure
E0301 Hospital bed, heavy-duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress

E0302	Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress
E0303	Hospital bed, heavy-duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress
E0304	Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress
E0328	Hospital bed, pediatric, manual, 360-degree side enclosures, top of headboard, footboard and side rails up to 24 in above the spring, includes mattress
E0329	Hospital bed, pediatric, electric or semi-electric, 360-degree side enclosures, top of headboard, footboard and side rails up to 24 in above the spring, includes mattress

Commodes

E0170	Commode chair with integrated seat lift mechanism, electric, any type
E0171	Commode chair with integrated seat lift mechanism, nonelectric, any type

Seat Lift Mechanisms

E0172	Seat lift mechanism placed over or on top of toilet, any type (*Not Medically Necessary)*
E0627	Seat lift mechanism, electric, any type
E0629	Seat lift mechanism, non-electric, any type

Lifts

E0630	Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s), or pad(s)
E0635	Patient lift, electric, with seat or sling
E0636	Multi-positional patient support system, with integrated lift, patient accessible controls
E0637	Combination sit-to-stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels
E0638	Standing frame/table system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels
E0639	Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories
E0640	Patient lift, fixed system, includes all components/accessories
E0641	Standing frame/table system, multi-position (e.g., 3-way stander), any size including pediatric, with or without wheels
E0642	Standing frame/table system, mobile (dynamic stander), any size including pediatric

Multi-Positional Patient Transfer System

E1035	Multi-positional patient transfer system, with integrated seat, operated by care giver, patient weight capacity up to and including 300 lbs.
E1036	Multi-positional patient transfer system, extra-wide, with integrated seat, operated by caregiver, patient weight capacity greater than 300 lbs.

TENS Units

- *See medical policy: Peripheral Nerve Stimulation No. 91634*

Manual and Power Wheelchairs

E0150	Combination wheeled walker with seat and transport chair, folding, adjustable or fixed height.
E1037	Transport chair, pediatric size
E1038	Transport chair, adult size, patient weight capacity up to and including 300 pounds
E1039	Transport chair, adult size, heavy duty, patient weight capacity greater than 300 pounds
E1050	Fully-reclining wheelchair, fixed full-length arms, swing-away detachable elevating leg rests
E1060	Fully-reclining wheelchair, detachable arms, desk or full-length, swing-away detachable elevating leg rests
E1070	Fully-reclining wheelchair, detachable arms (desk or full-length) swing-away detachable footrest
E1083	Hemi-wheelchair, fixed full-length arms, swing-away detachable elevating leg rest
E1084	Hemi-wheelchair, detachable arms desk or full-length arms, swing-away detachable elevating leg rests
E1085	Hemi-wheelchair, fixed full-length arms, swing-away detachable footrests
E1086	Hemi-wheelchair, detachable arms, desk or full-length, swing-away detachable footrests
E1087	High strength lightweight wheelchair, fixed full-length arms, swing-away detachable elevating leg rests
E1088	High strength lightweight wheelchair, detachable arms desk or full-length, swing-away detachable elevating leg rests
E1089	High-strength lightweight wheelchair, fixed-length arms, swing-away detachable footrest
E1090	High-strength lightweight wheelchair, detachable arms, desk or full-length, swing-away detachable footrests
E1092	Wide heavy-duty wheelchair, detachable arms (desk or full-length), swing-away detachable elevating leg rests
E1093	Wide heavy-duty wheelchair, detachable arms, desk or full-length arms, s swing-away detachable footrests
E1100	Semi-reclining wheelchair, fixed full-length arms, swing-away detachable elevating leg rests
E1110	Semi-reclining wheelchair, detachable arms (desk or full-length) elevating

	leg rest
E1130	Standard wheelchair, fixed full-length arms, fixed or swing-away detachable footrests
E1140	Wheelchair, detachable arms, desk or full-length, swing-away detachable footrests
E1150	Wheelchair, detachable arms, desk or full-length swing-away detachable elevating leg rests
E1160	Wheelchair, fixed full-length arms, swing-away detachable elevating leg rests
E1161	Manual adult size wheelchair, includes tilt in space
E1170	Amputee wheelchair, fixed full-length arms, swing-away detachable elevating leg rests
E1171	Amputee wheelchair, fixed full-length arms, without footrests or leg rest
E1172	Amputee wheelchair, detachable arms (desk or full-length) without footrests or leg rest
E1180	Amputee wheelchair, detachable arms (desk or full-length) swing-away detachable footrests
E1190	Amputee wheelchair, detachable arms (desk or full-length) swing-away detachable elevating leg rests
E1195	Heavy-duty wheelchair, fixed full-length arms, swing-away detachable elevating leg rests
E1200	Amputee wheelchair, fixed full-length arms, swing-away detachable footrest
E1220	Wheelchair; specially sized or constructed, (indicate brand name, model number, if any) and justification
E1221	Wheelchair with fixed arm, footrests
E1222	Wheelchair with fixed arm, elevating leg rests
E1223	Wheelchair with detachable arms, footrests
E1224	Wheelchair with detachable arms, elevating leg rests
E1231	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system
E1232	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system
E1233	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system
E1234	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system
E1235	Wheelchair, pediatric size, rigid, adjustable, with seating system
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system
E1237	Wheelchair, pediatric size, rigid, adjustable, without seating system
E1238	Wheelchair, pediatric size, folding, adjustable, without seating system
E1240	Lightweight wheelchair, detachable arms, (desk or full-length) swing-away detachable, elevating leg rest
E1250	Lightweight wheelchair, fixed full-length arms, swing-away detachable

	footrest
E1260	Lightweight wheelchair, detachable arms (desk or full-length) swing-away detachable footrest
E1270	Lightweight wheelchair, fixed full-length arms, swing-away detachable elevating leg rests
E1280	Heavy-duty wheelchair, detachable arms (desk or full-length) elevating leg rests
E1285	Heavy-duty wheelchair, fixed full-length arms, swing-away detachable footrest
E1290	Heavy-duty wheelchair, detachable arms (desk or full-length) swing-away detachable footrest
E1295	Heavy-duty wheelchair, fixed full-length arms, elevating leg rest
E2298	Complex rehabilitative power wheelchair accessory, power seat elevation system, any type
K0001	Standard wheelchair
K0002	Standard hemi (low seat) wheelchair
K0003	Lightweight wheelchair
K0004	High strength, lightweight wheelchair
K0005	Ultralightweight wheelchair
K0006	Heavy-duty wheelchair
K0007	Extra heavy-duty wheelchair
K0008	Custom manual wheelchair/base
K0009	Other manual wheelchair/base
K0010	Standard-weight frame motorized/power wheelchair
K0011	Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking
K0012	Lightweight portable motorized/power wheelchair
K0013	Custom motorized/power wheelchair base
K0014	Other motorized/power wheelchair base
K0813	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds
K0814	Power wheelchair, group 1 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds
K0815	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds
K0816	Power wheelchair, group 1 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0820	Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0821	Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds
K0822	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds

K0823	Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0824	Power wheelchair, group 2 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0825	Power wheelchair, group 2 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds
K0826	Power wheelchair, group 2 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0827	Power wheelchair, group 2 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds
K0828	Power wheelchair, group 2 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more
K0829	Power wheelchair, group 2 extra heavy-duty, captain's chair, patient weight 601 pounds or more
K0830	Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0831	Power wheelchair, group 2 standard, seat elevator, captain's chair, patient weight capacity up to and including 300 pounds
K0835	Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0836	Power wheelchair, group 2 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds
K0837	Power wheelchair, group 2 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0838	Power wheelchair, group 2 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds
K0839	Power wheelchair, group 2 very heavy-duty, single power option sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0840	Power wheelchair, group 2 extra heavy-duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more
K0841	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0842	Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds
K0843	Power wheelchair, group 2 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0848	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0849	Power wheelchair, group 3 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0850	Power wheelchair, group 3 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0851	Power wheelchair, group 3 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds

K0852	Power wheelchair, group 3 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0853	Power wheelchair, group 3 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds
K0854	Power wheelchair, group 3 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more
K0855	Power wheelchair, group 3 extra heavy-duty, captain's chair, patient weight capacity 601 pounds or more
K0856	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0857	Power wheelchair, group 3 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds
K0858	Power wheelchair, group 3 heavy-duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds
K0859	Power wheelchair, group 3 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds
K0860	Power wheelchair, group 3 very heavy-duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0861	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0862	Power wheelchair, group 3 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0863	Power wheelchair, group 3 very heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0864	Power wheelchair, group 3 extra heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more
K0868	Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0869	Power wheelchair, group 4 standard, captain's chair, patient weight capacity up to and including 300 pounds
K0870	Power wheelchair, group 4 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0871	Power wheelchair, group 4 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0877	Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
K0878	Power wheelchair, group 4 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds
K0879	Power wheelchair, group 4 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0880	Power wheelchair, group 4 very heavy-duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds
K0884	Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds

K0885	Power wheelchair, group 4 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds
K0886	Power wheelchair, group 4 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0890	Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds
K0891	Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds
K0898	Power wheelchair, not otherwise classified *(Explanatory notes must accompany claims billed with unlisted codes.)*

Percussion Vests

E0483	High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each

Enteral Pumps

- *See medical policy: Enteral Nutritional Therapy No. 91278*

Loaner Equipment

K0462	Temporary replacement for patient-owned equipment being repaired, any type

Not Medically Necessary:

K1036	Supplies and accessories (e.g., transducer) for low frequency ultrasonic diathermy treatment device, per month
K1037	Docking station for use with oral device/appliance used to reduce upper airway collapsibility
E0152	Walker, battery powered, wheeled, folding, adjustable or fixed height
E0190	Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories
E0201	Penile contracture device, manual, greater than 3 lbs traction force
E0469	Lung expansion airway clearance, continuous high frequency oscillation, and nebulization device
E0715	Intravaginal device intended to strengthen pelvic floor muscles during kegel exercises
E0935	Continuous passive motion exercise device for use on knee only
E0936	Continuous passive motion exercise device for use other than knee

E1022	Wheelchair transportation securement system, any type includes all components and accessories
E1023	Wheelchair transit securement system, includes all components and accessories
E1831	Static progressive stretch toe device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories
E1832	Static progressive stretch finger device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories
E2001	Suction pump, home model, portable or stationary, electric, any type, for use with external urine management system
A4318	Female external urinary collection cup, with or without ring attachment, per day
A4479	Electronic transanal irrigation system, includes electronic pump, water reservoir, tubing, and accessories, without catheter, any type
A7523	Tracheostomy shower protector, each

VII. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, services and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service or procedure is medically necessary. For more information, refer to the Priority Health Provider Manual.

To access InterQual guidelines: Log into Priority Health Prism → Authorizations → Authorization Criteria Lookup.

Individual case review may allow coverage for care or treatment that is investigational yet promising for the conditions described. Requests for individual consideration require prior plan approval. All determinations of coverage for experimental, investigational, or unproven treatment will be made by a Priority Health medical director or clinical pharmacist. The exclusion of coverage for experimental, investigational, or unproven treatment may be reviewed for exception if the condition is either a terminal illness, or a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration.

VIII. APPLICATION TO PRODUCTS

Coverage is subject to the member's specific benefits. Group-specific policy will supersede this policy when applicable.

- **HMO/EPO**: This policy applies to insured HMO/EPO plans.
- **POS**: This policy applies to insured POS plans.
- **PPO**: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.

- **ASO**: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
- **INDIVIDUAL**: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
- **MEDICARE**: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
- **MEDICAID/HEALTHY MICHIGAN PLAN**: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

SPECIAL NOTES

- **See Applicable InterQual Criteria**

IX. REFERENCES

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Vacuum Bell Therapy

1. Hayes, Inc. (2026). *Vacuum Bell Therapy for Treatment of Pectus Excavatum.* https://evidence.hayesinc.com/report/earb.pectus6294

SUMMARY OF CHANGES

Deletions:

- Removed the following language: “Preauthorization of DME >$1,000.00 is required (>$500.00 is required for Medicaid and Healthy Michigan Plan members)”
- Removed Section I.A.11 language requiring member compliance with use of equipment.

Additions:

- Added links for related medical policies
- Added Behavioral Health Mental Health and Billing Policy links for Transcranial Magnetic Stimulation (TMS) under the coding section, Implanted and External Stimulator Devices.
- Added an exclusion for Intermittent Pneumatic Compression (IPC) devices.
- Updated background section and references.

Clarifications:

- Updated policy language for clarity and consistency.

Past committee review dates: 01/1993, 10/1995, 06/1999, 12/2001, 10/2002, 06/2003, 09/2003, 09/2004, 09/2005, 08/2006, 07/2007, 06/2008, 06/2009, 06/2010, 06/2011, 06/2012, 06/2013, 08/2014, 08/2015, 08/2016, 08/2017, 08/2018, 08/2019, 08/2020, 08/2020, 08/2021, 02/2022, 02/2023, 08/2024, 11/2025, 05/2026, 08/2026

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The name "Priority Health" and the term "plan" mean Priority Health, Priority Health Managed Benefits, Inc., Priority Health Insurance Company and Priority Health Government Programs, Inc.