Neighborhood Health Plan OF RHODE ISLAND™

Clinical Medical Policy

Durable Medical Equipment # 018

Last reviewed: 08/19/26

Application

Application of this Medical Policy applies to:
Commercial (HBE), RIte Care (MED), Children with Special Needs (CSN), Substitute Care (SUB), Rhody Health Partners (RHP), Rhody Health Expansion (RHE), INTEGRITY for Duals (FIDE), Duals CONNECT (CO-DSNP)
Application Excluded for:
Extended Family Planning (EFP)

Medicare Distinction

For INTEGRITY for Duals (FIDE) and Duals CONNECT (CO-DSNP) members: Neighborhood Health Plan of Rhode Island (Neighborhood) uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations, including medical necessity. Coverage determinations are based on applicable payment policies, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and other available CMS published guidance.

In the absence of an applicable or incomplete NCD, LCD, or other Medicare guidelines, then Neighborhood will apply coverage guidance from other widely used treatment guidelines with peer-reviewed scientific evidence, such as InterQual® and/or internal Clinical Medical Policies.

Description:

Durable medical equipment is any equipment that meets ALL the following requirements:

1. Provides therapeutic benefits or enables the individual to perform certain tasks that they are unable to undertake otherwise due to certain medical conditions or illnesses.
2. Can withstand repeated use.
3. Is primarily and customarily used to serve a medical purpose.
4. Generally is not useful to a person in the absence of an illness or injury.
5. Is appropriate for use in the home but may be transported to other locations to allow the individual to complete instrumental activities of daily living (IADL), which are more complex tasks required for independent living.

Moreover, DME must meet the following definitions of "durable" AND "medical equipment":

1. Durable — An item is considered durable if it can withstand repeated use, i.e., the type of item that could normally be rented.
2. Medical Equipment — Medical equipment is equipment which is primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury.

Medical Supplies are covered only when they are incidental to a physician's professional services or authorized home health services and are furnished as an integral, although incidental, part of those services in the course of diagnosis or treatment of an injury or illness.

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Important Note: This policy does not include all the covered DME, Prosthetics, Orthotics and Medical Supplies.

Definitions:

Durable Medical Equipment, Orthotics, Prosthetics, and Supplies (DMEPOS)	Medically necessary equipment, devices, and supplies to treat a medical condition, improve function, or maintain health that fall under several benefit categories.
Durable Medical Equipment (DME)	Equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home. (e.g., wheelchairs, hospital beds, oxygen equipment)
Face-to-Face Requirement	A face-to-face encounter is mandatory in-person or telehealth visit between a member and a certifying physician or authorized non-physician practitioner (NPP). This encounter is required under Medicare and Medicaid regulations to establish the member's eligibility for certain services such as Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). • The encounter must take place within six (6) months prior to the order • The face-to-face encounter must be related to the primary reason the member requires the DMEPOS FIDE & CO-DSNP Members: For the most current Medicare face-to-face encounter requirement guidance and DMEPOS List, refer to CMS Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Order Requirements. Also refer to LCA for Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426). FIDE, Medicaid, & Commercial Members: For the most current EOHHS face-to-face encounter requirement guidance and DMEPOS List, refer to RI Medicaid Provider Reference Manual Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.
Frequently Serviced Items	Covered items that require frequent and substantial servicing in order to avoid risk to the patient's health. Examples of Frequently Serviced Items include: • Ventilators (excluding ventilators that are either continuous airway pressure devices or intermittent assist devices with continuous airway pressure devices) • Intermittent Positive Pressure Breathing (IPPB) machines • Oxygen systems, concentrators, compressors
Member's Home	For the purposes of rental and purchase of DME, the Member's Home may be his own dwelling, an apartment, a relative's home, a home for the aged, or

	some other type of institution. However, an institution may not be considered the Member's Home if it: • Meets at least the basic requirement in the definition of a hospital (i.e., it is primarily engaged in providing, by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons). • Meets at least the basic requirement in the definition of a skilled nursing facility (i.e., it is primarily engaged in providing skilled nursing care and related services to inpatients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons)
Orthotic	Devices that are designed to support a weakened body part. These appliances are manufactured or custom-fitted to an individual member.
Proof of Medical Necessity	All prescriptions for DMEPOS, regardless of the format used (e.g., Prescription pad, letter) must contain the following elements: • Member name and Date of Birth • ICD-10-CM code for which the DMEPOS is required • Description of the DMEPOS, to include the quantity, special options, add-ons, accessories, or other features • Length of need to include start and end date • Name, address, NPI of the prescribing provider • Prescribing provider signature and date of signature • Order is valid for 1 year of issuance (e.g., 12 months from the date of issue)
Prosthetic Device	Articles or equipment, other than dental, that replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ.
Reasonable Useful Lifetime (RUL)	RUL is the amount of time that is considered standard for the reasonable use of DME. The standard for DME is set at five (5) years. Computation of the useful lifetime is based on when the equipment is delivered to the member, not the age of the equipment.
Same or Similar	Identical equipment or items that serve a similar purpose or are worn on the same part of the body, even if they have different functions (e.g., different types of braces) within the Reasonable Useful Lifetime of the original item provided.
Supplies	Ancillary items related to DME prosthetics, or orthotics (e.g., catheters, wound care supplies)

Coverage Determination
Medically necessary services must be provided in the most cost-effective and appropriate setting and shall not be provided solely for the convenience of the member, caretaker, or service provider.

In accordance with CMS and EOHHS regulations, approved DMEPOS is furnished exclusively for authorized members and must be used in the home/community setting rather than retained by a facility or used by non-members.

Please refer to Durable Medical Equipment (DME) Guide for Frequency, Quantity Limits, and Prior Authorization Requirements (DME FQLI Grid) for guidance on coverage, allowed quantity limits, and prior authorization requirements

- **NOTE: Requests for quantities exceeding the allowed amounts in this grid must include medical necessity documentation that clearly explains the clinical rational for the increased usage. See the Over-Quantity section of this policy.**

Prior Authorization (PA): When a prior authorization is required, the PA form must be signed and dated by the DME Supplier as to the accuracy of the service requested.

Included with the Prior Authorization Request form as applicable must be:

- Certificate of Medical Necessity signed by the prescribing physician. This proof of medical necessity is valid for 12 months from the date of issue.
- Face-to-Face Encounter details per CMS and EOHHS(see definition of Face-to-Face Encounter above).
- Medical Record documentation to include clear explanation of why the DME is required, clinical findings demonstrating the member's functional limitation or impairment, explanation of how the equipment will improve safety, mobility, ADLs, respiratory function, or other health outcomes. For example, history and progress notes, therapy evaluations, or specialist reports, documentation of conservative treatments previously attempted and member's response, relevant assessments (home safety evaluations).

Criteria

DME, Prosthetics, Orthotics, and Medical Supplies are medically necessary when the general and applicable equipment-specific criteria are met:

General Criteria:

DME, Prosthetics, Orthotics, and Medical Supplies are covered when **all** of the following are met:

1. The requested item(s) is necessary and reasonable for the treatment of an illness or injury or to improve the functioning of a physical deficit;**
2. Both of the following have been provided to the member and/or caregiver, as

applicable:

a. Education regarding use of the device, with demonstrated understanding;
b. A trial of the requested device, with demonstrated ability to use it safely and effectively.

3. All criteria specific to the actual item(s) are met.

- ****Important Information:**
  - Equipment is necessary when it can be expected to make a meaningful contribution to the treatment of the member's illness or injury or to the improvement of their malformed portion of the body.
  - Although the requested item(s) may serve a useful medical purpose, additional considerations should be made to whether the item is reasonable, such as, whether the expense of the item is disproportionate to the therapeutic benefits, whether it is substantially more costly than a medically appropriate and realistically feasible alternative plan of care, and/or whether the item will serve essentially the same purpose as equipment already available.
  - Additional "deluxe" features or items that are rented or purchased for aesthetic reasons or added convenience, do not meet the reasonableness test.
  - If a medically necessary, lesser cost item exists and will suit the member's medical needs, a higher cost item will be denied.

Breast Pumps and Supplies

A breast pump is a device used to extract milk from the breast of a lactating mother for infant feeding. Breast pumps may be manual, electric, or hospital-grade.

A. Breast Pump Rental

Electric Breast Pump are covered when any of the following apply:

- Baby in NICU with anticipated extended stay
- Failure to establish effective breastfeeding pair
- Difficult latch/suppressed latch
- Inadequate milk production
- Poor infant weight gain
- Jaundice
- Mastitis
- Engorgement
- Retracted nipple(s)
- Cracked nipple(s)

Hospital-Grade Breast Pumps are covered as rentals only and are covered when the following applies:

1. There is prolonged infant hospitalization after the mother is discharged, **and**
2. One or more of the following conditions that may adversely impact feeding directly from the breast exists:
   - Prematurity (including multiple gestation)
   - Anatomic & mechanical malformation (e.g cleft lip/palate)
   - Congenital malformation requiring surgery (e.g. respiratory, cardiac, gastrointestinal, or central nervous system)
   - Neurologic disorder
   - Genetic abnormality

B. Supplies

Neighborhood reimburses for covered breast pump supplies that are medically necessary during the rental of the breast pump.

Breast Pump Exclusions and Limitations:

1. Neighborhood does not cover:
   a. Baby weight scales
   b. Batteries, battery-powered adaptors, and battery packs
   c. Breast milk, ice-packs, labels, labeling lids, and other similar products
   d. Breast pump cleaning supplies including soap, sprays, wipes, steam cleaning bags and other similar products
   e. Creams, ointments, and other products that relieve breasts or nipples
   f. Electrical power adapters for travel
   g. Garments or other products that allow hands-free pump operation
   h. Nursing bras, bra pads, breast shells, nipple shields, and other similar products
   i. Travel bags, and other similar travel or carrying accessories.
2. Continued rental of a hospital-grade breast pump after the baby is discharged from the hospital is not covered.
3. Wearable, battery operated (electric) breast pumps are not covered.
4. See **the General Exclusions and Limitations** section of this policy.

Compression Garments

A compression garment (stocking/burn garment/gradient pressure aid garment/sleeve) is a custom made or custom fitted elastic support garment that is fabricated to apply varying pressure gradients to an area. They work by relieving stress on vein walls, restoring venous hemodynamics by aiding muscle pump function, decreasing vein reflux, increasing tissue pressures that lead to decreased edema, and stimulate circulation. Compression stockings/garments require fitting and measuring by a specially trained individual and require a physician order.

Advancements in technology allow many of the compression garments to be pre-made. Very few need to be custom made unless the degree of gradient pressure is one that cannot be provided in a pre-made garment. Please note pre-made stockings are not the same as over-the-counter stockings.

Compression stockings over-the-counter are a lower grade compression and may not be graduated. Prescription stockings are graduated (pressure decreases from ankle up) and are of specific grades of compression. Higher pressure stockings require a prescription and a trained fitter. These higher pressures range typically from 20-30 mmHg to 50+ mmHg.

Compression garments are covered when:

1. Documentation of a recent face to face evaluation by the prescribing provider which includes physical findings and recommendation for the use of requested garments, and
2. A qualified health professional has measured the patient for the requested garments, and
3. The compression garment is being used to treat one of the following:
    a. Primary and/or secondary edema or lymphedema, including post-mastectomy clinical and subclinical lymphedema syndrome and other lymphedema
    b. Open venous statis ulcers
    c. Prevention of initial or recurrent of venous stasis ulcers due to chronic venous insufficiency
    d. Hypertrophic scarring and joint contractures following burn injury or scarring from surgery
    e. Post amputation compression therapy (i.e. stump wraps, shrinkers, and shapers)
    f. Prevention of deep venous thrombosis during pre and postpartum periods
    g. Post thrombotic/phlebitic syndrome
    h. Thrombosis prevention during periods of immobilization
    i. Thrombophlebitis

Compression Garments Exclusions and Limitations:

1. Contraindications:
    a. Suspicion or diagnosis of arterial obstruction
    b. Severe peripheral arterial disease
    c. Septic phlebitis or other acute limb infections
    d. Unhealed irradiated soft tissues
    e. Peripheral edema secondary to severe Congestive Health Failure
    f. Suspicion of undiagnosed acute DVT
2. Not covered for:
    a. Exercise recovery
    b. Indications which can be treated with over-the-counter products
    c. Postural hypotension
3. See **the General Exclusions and Limitations** section of this policy.

Incontinence Supplies

Incontinence is the inability of the body to control urinary and bowel functions. Treatment of underlying factors can often improve incontinence. Absorbent products are diaper or brief-like garments and underpads (also known as chux) or liners used to contain incontinence. These products can provide an increased level of independence and ability to participate in self-care for individuals who:

- Elect not to pursue treatment
- Are waiting to receive treatment
- Are waiting for a treatment to take effect
- Are unable to be (fully) cured

Incontinence supplies are covered when **all** the following are met:

1. The member is three (3) years old and older.
2. Incontinence is due to a medical condition.
3. All other forms of treatment modalities have been exhausted.

Incontinence Supplies Exclusions and Limitations:

1. Non-covered for members under 3 years old, as incontinence is age-appropriate.
2. Adult, pediatric, and/or youth sized disposable incontinence products (T4521-T4535, T4543-T4544):
    a. Authorization is required when the requested quantities of any combination of brief, liners, and/or pull-ups is greater than the quantity limit in the DME FGLI grid (192 per month for Medicaid Members; 300 per month for FIDE members).
    b. The plans maximum monthly quantity limit is 300 per month for FIDE and Medicaid, inclusive of any medical necessary increase.
3. Disposable underpads - large and/or small (T4541-T4542):
    a. Authorization is required when the requested quantities of any combination of underpads is greater than 150 per month.
    b. The plans maximum monthly quantity limit is 150 per month, inclusive of any medical necessary increase.
4. See the **Over-Quantity Requests** section of this policy.
5. See **the General Exclusions and Limitations** section of this policy.

Labor Charges for DME Repairs

Neighborhood uses guidance from Noridian's Repair Labor Billing and Payment Policy for the allowable repair units of service for commonly repaired items billed under HCPCS code K0739 (Repair or Nonroutine Service for Durable Medical Equipment Other than Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes). Units of Service (1 UOS = 15 minutes) includes basic troubleshooting and problem diagnosis.

This applies to:

- Items not being rented.
- Items that are outside their warranty period.

Labor Charges for DME Repairs Exclusions and Limitations:

1. Neighborhood does not reimburse for:
    - Travel time
    - Equipment pick-up or delivery
    - Repairs for capped rental items during the rental period
    - Repairs to items under warranty.
2. See **the General Exclusions and Limitations** section of this policy.

Minor Environmental Modifications

Minor Environmental Modifications (Minor Assistive Devices) may include:

- Grab bars
- Versa frame (toilet safety frame)
- Hand held shower
- Diverter valve
- Raised toilet seats
- Other simple devices or appliances such as:
  - Eating Utensils
  - Transfer bath bench
  - Shower Chair
  - Personal care aides (i.e. reacher)
  - Standing Poles

Minor Environmental Modifications are covered when:

- The member's functional impairment is due to a medical condition; **and**
- The item will improve home accessibility adaptation, health, or safety.

Minor Environmental Modifications Exclusions and Limitations:

1. See **the General Exclusions and Limitations** section of this policy.

Oral Nutrition Supplements

An oral nutrition supplement is intended to meet unique nutrient needs for specific disease conditions. These are administered orally (by mouth), as a primary or supplementary source of nutrition.

- **NOTE:** Enteral nutrition administered by tube feeding (e.g., nasogastric, gastrostomy, or jejunostomy tube) is medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to InterQual®.

Oral Nutrition Supplements are considered medically necessary when **all** the following criteria are met:

1. It is used as a therapeutic regimen to prevent serious disability or death in a person with a medically diagnosed condition that precludes the full use of regular food; **and**
2. The condition is chronic and is expected to last for an undetermined or prolonged period of time; **and**
3. A written plan of care has been developed for regular monitoring of signs and symptoms to detect improvement in the person's condition. Nutritional status should be monitored regularly; **and**
4. Adequate nutrition is not possible by dietary adjustment; **and**
5. The member presents with clinical signs and symptoms of impaired digestion mal-absorption, or nutritional risk, as indicated by the following anthropometric measures:

a. **Adults:**
    i. Involuntary or acute weight loss equal to or greater that 10% of usual body weight over a three-to-six-month period; **or**
    ii. A Body Mass Index (BMI) below 18.5.
b. **Neonates, Infants, and Children showing:**
    i. Very low birth weight (less than 1500 grams) even in the absence of gastrointestinal, pulmonary, or cardiac disorders.
    ii. Weight for height less than the tenth percentile, abnormal laboratory tests pertinent to the diagnosis, and risk factors for actual or potential malnutrition have been identified and documented.
    iii. **Children Under Six (6) Months Old:** Lack of weight gain or weight loss to a value less than two standard deviations below the age-appropriate mean in one month.
    iv. **Children 6-12 Months Old:** Lack of weight gain or weight loss to a value less than two standard deviations below the age-appropriate mean in two months.
    v. **Children Older than 12 Months:** No weight gain or abnormally slow weight gain for three months.

OR

6. The oral supplements are the member's primary source of nutrition due to factors that impair digestion or cause malabsorption, for surgical preparation, or post-operative care.

OR

7. The member has **one** of the following conditions:
    a. Inborn Errors of Metabolism such as phenylketonuria, maple syrup urine disease, homocystinuria, methylmalonic acidemia, propionic acidemia, isovaleric acidemia, and other disorders of leucine metabolism; glutaric aciduria type I and tyrosinemia types I and II; and urea cycle disorders.
    b. A malabsorption syndrome, sustained nutrient loss or increased metabolic need due to chronic disorder or acute condition (e.g. excessive burns, abscess, infection, anti-tumor therapy, Anorexia Nervosa, HIV/AIDS, short bowel syndrome, cystic fibrosis, renal dialysis, Crohn;s disease, etc.).
    c. Malnutrition or individual will become malnourished or have severe disorders such as physical disability, Intellectual Disability, or death if the nutritional therapy is not instituted.
    d. Severe food allergies, including eosinophilic esophagitis, other forms of eosinophilic gastrointestinal diseases, food protein–induced allergic proctocolitis, and food protein–induced enterocolitis syndrome, which, if left untreated, will cause life-threatening allergic reactions, malnourishment, or death.
    e. Pregnant and has extreme morning sickness, hyperemesis gravidarum, gestational diabetes or anatomic/neurologic impairment of the GI tract.
    f. Gastroesophageal reflux with failure to thrive (children only)

Oral Nutrition Supplement Exclusions and Limitations:

1. Commercial food thickeners
2. Electrolyte-containing fluids for oral intake used to replace fluids and electrolytes
3. Nutritional or cosmetic therapy using high doses or mega quantities of vitamins, minerals, or elements and other nutrition-based therapy (examples include supplements, electrolytes, and foods of any kind; these include but are not limited to high-protein foods, low-protein foods, and low-carbohydrate foods)
4. Formulas for the treatment of mild and moderate food allergies, food intolerance, or dental problems.
5. Oral nutrition supplements for the below is not covered:
    a. Lack of appetite or cognitive conditions (e.g., lack of appetite secondary to stimulant medications).
    b. Member is underweight but has ability to meet nutritional needs through the use of regular food consumption.
    c. Weight loss or dieting program
    d. Supplementation to a normal or regular diet in a person showing no clinical indicators of nutritional risk.
    e. Continued use once medical necessity is no longer met.
6. See **the General Exclusions and Limitations** section of this policy.

Orthotic and Prosthetic Devices

If no criteria is available in InterQual® for the requested item(s), then the following will be applied. The Orthotic/Prosthetic may be covered for members when the following criteria are met:

1. The member has a medical condition that results in the need for an orthotic/prosthetic to:
    a. artificially replace a missing portion of the body;
    b. prevent or correct physical deformity or malfunction; or
    c. to support a weak or deformed portion of the body.
2. When the device is prescribed by a licensed medical provider operating within their scope of practice, and who is knowledgeable in the use of prosthetics/orthotics, and who provides medical care to the member.

Orthotic and Prosthetic Devices Exclusions and Limitations:

1. This benefit is for external devices only and does not include any device that is fully implanted into the body.
2. Devices used as safety items or to help performance in exercise and sports-related activities are not covered.
3. See **the General Exclusions and Limitations** section of this policy.

Over-Quantity Requests

A provider may request DME and/or medical supplies that exceed the amount and frequency (quantity limits) covered by Neighborhood. Requests that exceed Neighborhood's quantity limits will require a Prior Authorization (PA).

Please refer to Neighborhood's Durable Medical Equipment (DME) Guide for Frequency, Quantity Limits, and Prior Authorization Requirements for guidance on coverage, allowed quantity limits, and prior authorization requirements.

- **Please note:**
  - All items that exceed the quantity limits require PA.
  - There are some items with a quantity limit that requires PA regardless of the quantity requested.
  - **Requests for quantities exceeding the allowed amounts in this grid must include medical necessity documentation that clearly explains the clinical rational for the increased usage.**

Requests for excess quantities will be reviewed on a case-by-case basis and may be covered if:

1. They are ordered by a doctor; **and**
2. Up-to-date detailed documentation is provided explaining the medical necessity for use of greater quantities than the amounts Neighborhood covers from the ordering practitioner.

If documentation justifying medical necessity of over-quantity is not present, the quantity limits in the DME FQLI grid will be enforced and the excess quantities will be denied as non-covered.

Over-Quantity Exclusions and Limitations:

1. See **the General Exclusions and Limitations** section of this policy.

Suction Pumps & Supplies – Respiratory & Gastric

Suction pumps are electrical aspirator devices designed for upper respiratory oral pharyngeal and tracheal suction or for gastric suction.

Respiratory Suction Pumps

A respiratory suction pump is a device designed to remove respiratory secretions that cannot be managed by the member due to compromised cough mechanism or tracheostomy. Respiratory Suction Pumps are considered medically necessary when the following criteria are met:

1. The member has difficulty raising and clearing secretions secondary to *any* of the following conditions:
   a. Cancer or surgery of the throat or mouth
   b. Dysfunction of the swallowing muscles
   c. Unconscious or obtunded state
   d. Tracheostomy

Tracheal suction catheters and sterile water/saline as supplies for suction pumps.

1. Closed system catheters when *all* of the following are met:
    a. The member has a tracheostomy; *and*
    b. The member requires the use of a medically necessary respiratory suction pump, as described above, for tracheostomy suctioning; *and*
    c. The member requires the use of a medically necessary ventilator.
2. Tracheal suction catheters other than closed system catheters when *all* of the following are met:
    a. The member has a tracheostomy; *and*
    b. The member requires the use of a medically necessary respiratory suction pump, as described above, for tracheostomy suctioning.
3. An oral interface used with a respiratory suction pump is considered not medically necessary because it is not used to remove secretions for the indications described above.
4. Sterile saline solution when used to clear a suction catheter after tracheostomy suctioning. It is not usually considered medically necessary for oropharyngeal suctioning.
5. The following supplies for use with a suction pump:
    a. Disposable or non-disposable canister used with suction pump;
    b. Oropharyngeal suction catheters;
    c. Tubing used with suction pump.

Gastric Pumps

A gastric suction pump is used to remove gastrointestinal fluids under continuous or intermittent suction via a tube for patients who are unable to empty gastric secretions through normal gastrointestinal functions.

Gastric Suction Pumps are considered medically necessary when the following criteria are met:

1. Member has a gastrointestinal tube in place; and
2. Documentation from treating clinician of an obstructive gastrointestinal diagnosis.

Suction Pumps & Supplies Exclusions and Limitations:

1. Supplies included in a tracheal care kit (e.g., basins, cups, gloves, solutions, etc.) whether in a kit or supplied separately are not considered medically necessary when the suction pump is used for oropharyngeal suctioning.
2. Sterile water/saline and tracheal suction catheters are covered only for members with a tracheostomy.
3. Gastric Suction Pump accessories and supplies are included in the rental fee.
4. See **the General Exclusions and Limitations** section of this policy.

Surgical Dressing and Wound Care Supplies

Surgical dressings and wound care supplies are covered for members who require home treatment of a specific medical condition, protection or support of a wound, surgical incision or diseased or injured body part.

Dressings are defined as:

- Primary dressings - Therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin.
- Secondary dressings - Materials that serve a therapeutic or protective function and that are needed to secure a primary dressing. Items such as adhesive tape, roll gauze, bandages, and disposable compression material are examples of secondary dressings.

Surgical dressings and wound care supplies are considered medically necessary when the following criteria are met:

1. Provider's orders are on file for all supplies and quantities requested that indicates the duration of therapy.
2. The treating provider's medical record, nursing home, or home care nursing records must specify:
    a. The type of wound; and
    b. Information regarding the location, number, and size of wounds being treated with a dressing; and
    c. Whether the dressing is being used as a primary or secondary dressing or for some noncovered use (e.g., wound cleansing); and
    d. Amount of drainage; and
    e. The type of dressing (e.g., hydrocolloid wound cover, hydrogel wound filler, etc.); and
    f. The number/amount to be used at one time; and
    g. The frequency of dressing change; and
    h. Any other relevant clinical information.
3. A new order is needed:
    a. If a new dressing is added, or
    b. If the quantity of an existing dressing to be used is increased; and/or
    c. Every 3 months for each dressing being used.
4. Wounds must be evaluated by the treating provider (or their designee) on at least a monthly basis, unless there is documentation in the medical record which justifies why an evaluation could not be done within this timeframe and what other monitoring methods were used to evaluate the member's need for ongoing use of dressings. The evaluation must include:
    a. The type of each wound (e.g., surgical wound, pressure ulcer, burn, etc.)
    b. Wound(s) location
    c. Wound size (length x width) and depth
    d. Amount of drainage, and
    e. Any other relevant wound status information.

Surgical Dressing and Wound Care Supplies Exclusions and Limitations:

1. Due to changes in wound status and dressing requirements throughout the healing process, dressing supplies will be authorized for no more than a 3-month period of time at a time. The quantity and type of dressings dispensed at any one time must take into account the current status of the wound(s), the likelihood of change, and the recent use of dressings.
2. Dressings used with feeding tubes, infusion pumps, and parenteral nutrition are included in payment for the kit. Neighborhood may pay for additional dressings if the dressings from kits are exhausted if documentation supports medical necessity of the number of units of dressings being dispensed beyond the quantity included in the kit.
3. See **the General Exclusions and Limitations** section of this policy.

Therapeutic Positioning Chairs - Activity Chairs and Car Seats

Therapeutic positioning chairs are designed to provide stability and support, maintain body alignment, decrease likelihood of postural deformities, and enhance upper body extremity function for an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) member with physical disabilities.

An **Activity Chair** is considered medically necessary when a member meets the following criteria:

1. Under 21 years old; **and**
2. Cannot safely sit in a regular chair, commercially available highchair, or other conventional seating option; **and**
3. Require specialized positioning to safely perform essential activities of daily living as applicable for age; **and**
4. There has been a specialized seating/mobility evaluation performed by a therapist or a professional that is independent from the vendor supplying the equipment; **and**
5. Exhibits ONE or more of the following:
    a. Has decreased head and/or trunk support and stability, requiring additional support for fine motor activities.
    b. Requires use of arms and/or external support to maintain balance, upright position, and good body alignment while sitting.
    c. Has no functional protective or righting reaction.
    d. Significant hypotonicity, hypertonicity, athetosis (writhing movements), ataxia (loss of muscle control/coordination), spasticity, or muscle spasming which results in uncontrollable movement and position change.
    e. Must be in an upright supported position for safe and effective feeding and without this chair would have to be held by the caregiver for feeding.

Seating and positioning components and accessories may be covered when the following criteria are met:

1. The components/accessories contribute to the therapeutic function of the chair and are not primarily for caregiver convenience; **and**
2. The criteria specific to the actual item are met (see item criteria below).
    a. Tilt/Recline features are considered medically necessary when the member:
        i. Has extensive weakness, contractures, or abnormal tone requiring full body support; **or**
        ii. Cannot maintain head control in the upright position even with head support cushions; **or**
        iii. Has a medical need that requires the tilted or reclined position when upright; **or**
        iv. Requires pressure relief at all times when sitting (such as for prevention or treatment of pressure sores).
    b. A mobile base is covered when it is medically necessary to move the member to different parts of the environment with the rest of the family for safety or for medically necessary activities.
    c. A Hi Lo Indoor Base is covered when:
        i. The member has a wheelchair seating system that can be transferred from a mobility base to an indoor base and is used as an activity/positioning chair; **and**
        ii. A variety of heights are needed for the member to perform medically necessary activities; **or**
        iii. At the low height, the member is able to get into and out of the chair independently.
    d. A Hi Lo Positioning Chair is considered medically necessary when the member meets any **one** of the following criteria:
        i. Has non-functional head or trunk control requiring customized postural support to maintain a sitting position.
        ii. Cannot sit unsupported due to poor static and dynamic sitting balance.
        iii. Requires maximum support for upright positioning.
        iv. Cannot interact with the environment without this level of support.
        v. Requires varying sitting heights to participate in medically necessary activities.

A **Car Seat** is considered medically necessary when a member meets the following criteria:

1. Under 21 years old; **and**
2. Are not able to fit safely into a conventional car seat; and
3. Are unable to be properly supported safely in a vehicle during normal transport; **and**
4. Exhibits one or more of the following medical conditions:
    a. Significant head and trunk instability and/or weakness.

b. Significant hypotonicity, hypertonicity, athetosis, spasticity, or muscle spasming which results in uncontrollable movement and position change.
c. Absence or latency or protective reactions.
d. Inability to maintain an unsupported seating position independently.
e. Severe seizure activity that results in uncontrollable movement and position change (such as tonic-clonic seizures).
f. Orthopedic disease process resulting in significant bony fragility (e.g., osteogenesis imperfecta) or significant contractures that would result in a child's instability to perform postural corrections (e.g., arthrogryposis) .
g. Behaviors from a documented condition that put the member or driver at risk of injury.
h. Children in spica casts.

Therapeutic Positioning Chairs Exclusions and Limitations:

1. If a member has a wheelchair that provides postural support and positioning components, they are not a candidate for an activity chair, this would be considered a duplicate DME item.
2. Conventional car and booster seats used to prevent injury to a child as required by law and community practice.
3. Feeding chairs or highchairs for children without positioning needs due to a medical condition.
4. Bean bag positioning seats, as they do not offer the support of similar available alternatives (e.g., P-Pod positioning seat).
5. Positioning equipment that is primarily for the purpose of the member to perform leisure, recreation, or sports activities.
6. Positioning seats for use in vehicles for children whose primary caregiver has a van equipped for wheelchair transportation is a duplication of service.
7. Vehicle modifications to accommodate positioning seats for use in a vehicle.
8. See **the General Exclusions and Limitations** section of this policy.

Therapy Related Equipment

Therapy Related Equipment will be covered for those members under the EPSDT Program who are enrolled in a Physical, Occupational or Speech Therapy Program. The equipment must be an integral and necessary part of the program. Equipment included in this therapy may include, but is not limited to: mats, grasshoppers, bolster chairs, therapy balls, etc.

Therapy Related Equipment is considered medically necessary when the following criteria is met:

1. Member is under 21 years old; **and**

2. There is documentation from the Physical, Speech or Occupational Therapist that the member is enrolled in a therapy program and the equipment is an integral and necessary part of the program.

Therapy Related Equipment Exclusions and Limitations:

1. Tricycles, bicycles, swings, or any other equipment that is not primarily medical in nature is not covered.
2. See **the General Exclusions and Limitations** section of this policy.

Transcutaneous Electrical Nerve Stimulator (TENS) Supplies

A transcutaneous electrical nerve stimulator (TENS) is a portable device that uses electrodes placed on the member's skin to generate electrical current to decrease perception of pain. Electrodes prevent the transmission of sensory pain nerve impulses to the brain and stimulate the release of endorphins.

Transcutaneous Electrical Nerve Stimulator (TENS) replacement supplies may be covered if:

1. The TENS unit is still medically necessary; and
2. They are being used with a TENS unit that has been by Neighborhood; **and**
3. The requested supplies are proportional to the frequency of use of the TENS units.

A conductive garment for use with a TENS unit is rarely medically necessary, but may be covered if all of the following conditions are met:

- It has received permission or approval for marketing by the Food and Drug Administration; **and**
- It has been prescribed by a physician for use in delivering covered TENS treatment; **and**
- The physician ordering the TENS unit must be the attending physician or a consulting physician for the disease or condition resulting in the need for the TENS unit; **and**
- One of the medical indications outlined below is met:
    - The member cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires; **or**
    - The member cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires; **or**

- The member has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires; **or**
- The member requires electrical stimulation beneath a cast either to treat disuse atrophy where the nerve supply to the muscle is intact or to treat chronic intractable pain.

Transcutaneous Electrical Nerve Stimulator (TENS) Supplies Exclusions and Limitations:

1. During the rental of a TENS unit, supplies for the unit are included in the rental allowance; there is no additional allowance for electrodes, lead wires, batteries, etc.
2. If a TENS unit is purchased, the allowance includes lead wires and one month's supply of electrodes, conductive paste or gel (if needed), and batteries.
3. Other supplies, including but not limited to the following, will not be separately allowed: adapters (snap, banana, alligator, tab, button, clip), belt clips, adhesive remover, additional connecting cable for lead wires, carrying pouches, or cover.
4. See **the General Exclusions and Limitations** section of this policy.

General Exclusions and Limitations:

- Please refer to Durable Medical Equipment (DME) Guide for Frequency, Quantity Limits, and Prior Authorization Requirements for guidance on coverage, allowed quantity limits, and prior authorization requirements.
- Coverage of same or similar DME is not allowed if a member already possesses similar equipment unless the new item is for a different condition, or the original is lost, stolen, or damaged. Durable Medical Equipment Same or Similar chart resource: https://med.noridianmedicare.com/web/jddme/topics/same-or-similar
- Delivery, assembly, installation, and setting up of equipment is considered included in the rental or purchase fee and is not separately reimbursed.
- Repairs to and supplies for rental equipment used during the rental period are included in the rental allowance. The only exception is for CPAP/BiPAP supplies.
- Repair or replacement of DME covered by the manufacturer, under warranty, will be the responsibility of the manufacturer and coordinated by the DME provider.
- The following are not covered:
  - Purchase, repair, or replacement of materials, or equipment, when the result of misuse, neglect, abuse, or disposal.
  - Purchase, repair, or replacement of materials or equipment that has been stolen or destroyed except when the following documentation is provided:
    - Explanation of continuing medical necessity for the item.
    - Explanation of the item that was stolen or destroyed.
    - Copy of police, fire department, or insurance report if applicable.

- Coverage is allowed for the basic item needed to meet the functional need of the average person. Deluxe or enhanced items and/or accessories are not covered.
- DME items and medical supplies which function primarily for the convenience of the member and/or caregiver.
- DME (e.g., wheelchairs, hospital beds, walkers) and supplies other than personal needs (hearing aids, prosthetics/orthotics, braces, stockings, etc) for members in a Nursing Facility or Intermediate Care Facility (ICF).
- Duplicate DME items for use in multiple locations and/or rooms.
- Items or supplies used primarily to assist a caregiver.
- Items that are a product upgrade to a current piece of equipment that is either fully functional or replacement of a device when the item can be cost-effectively repaired.
- Items specifically designed for outdoor use (e.g., specially designed manual wheelchairs for beach access, specially designed power mobility devices for rough terrain, manual wheelchairs for sports, etc.).
- Labor, parts, repairs, replacements, modifications, or maintenance associated with a denied and/or noncovered item.
- Maintenance, defined as the routine periodic servicing (ie: testing, cleaning, regulating, and checking of the equipment).
- Items that are experimental and/or investigational, including but not limited to:
  - U.S. Food and Drug Administration (FDA) Category A or B devices or equipment.
  - Medical devices not approved by the FDA.
  - See Neighborhood Clinical Medical Policy #026 Experimental Investigational for additional information.

Reimbursement Requirements:

DME Rental or Purchase

DME may be rented or purchased and must meet all of the following criteria:

- The equipment meets the definition of DME (refer to the Definitions section)
- The equipment is necessary and reasonable for the treatment of the member's illness or injury or to improve the functioning of his/her malformed body member
- The equipment is used in the Member's Home (refer to the Definitions section)

Prosthetic and Orthotics

Prosthetic Devices and Orthotics must meet all of the following criteria:

- The item meets the definition of Prosthetic or Orthotics (refer to the Definitions)
- The item is furnished on a physician's order

Supplies for DME Items and Prosthetic Devices

Supplies for DME items and Prosthetic Devices (e.g., oxygen, batteries for an artificial larynx) are covered only when they are necessary for the effective use of the item/device.

Rent-to-Purchase DME Items

Neighborhood follows CMS rent-to-purchase guidelines. Unless CMS specifically designates an item as a rental only, the following rules apply:

- Neighborhood's allowance for a rental DME item will never exceed the allowance for a DME purchase price item.
- Items classified by CMS with a payment category of Frequently Serviced Items are considered a continuous rental. DME items that are identified as continuous rentals will be priced at the rental allowance and will be excluded from the rent-to-purchase cap. Payment continues until medical necessity ends. No payment is made for the purchase of equipment, maintenance and servicing or for replacement of items in this category. Supplies and accessories are not allowed separately.
- If a device is proven ineffective prior to reaching the end of the rental period and the member qualifies for an upgraded device, the remaining balance of the original rental period for the ineffective device will be used.
- **FIDE & CO-DSNP:** DME rentals are for a period of thirteen (13) continuous months, after which time they are considered paid up to the purchase price. Charges for monthly rentals beyond thirteen consecutive months are non-billable.
    - DME rentals will be priced at one-thirteenth (1/13) of the purchase price per month.
- **Medicaid and Commercial:** DME rentals are for a period of ten (10) continuous months, after which time they are considered paid up to the purchase price. Charges for monthly rentals beyond ten consecutive months are non-billable.
    - DME rentals will be priced at one-tenth (1/10) of the purchase price per month.

Interruption of Rental Period

A period of continuous use allows for temporary interruptions in the use of equipment. Interruptions may last up to 60 days.

- If an interruption lasts less than 60 consecutive days, a new rental period will NOT begin.
- If an interruption is greater than 60 consecutive days, a new rental period can begin if the physician submits a new prescription, new medical necessity documentation and a statement detailing the reason for the interruption.
- When there is a break in home use for the equipment during the rental period, such as when the patient is in a hospital, skilled nursing facility (SNF), hospice, but medical need continues within the facility, if that interruption continues beyond the end of the current rental month in which home use ceases, no additional payment will be made until the use of the item resumes in the home. A new date of service will be established when use resumes. Unreimbursed months of interruption will not apply toward the rental month limit.

Change in Suppliers during Rental Period

- A change to another DME supplier during a rental period will not initiate a new rental period whether or not there is a lapse in service between suppliers.
    - For example: a Medicaid member changes supplier after the 8th rental month, the new supplier will be allowed rental payment for the 2 remaining rental months. The supplier that provides the item in the 10th month of the rental period is responsible for supplying the equipment and for maintenance and servicing after the 10-month period.

Repair of DME Items

- Repair to a DME item is covered when the:
    - original equipment was ordered by a physician; and the equipment continues to be medically necessary.
    - repair is medically necessary to make the equipment serviceable and the cost of repair is comparable to replacing.
- Rental of a DME item will be covered while a covered DME item is being repaired (unless defective item is still under manufacturer warranty).
- Repairs to DME that has already been replaced with same or similar item are not covered as this is a duplication of service.

Replacement of DME Items

Neighborhood follows CMS guidelines regarding the time frame for replacement DME. Per CMS, the reasonable useful lifetime (RUL) of DME, orthotics, and prosthetics is typically 5 years. Replacement is considered covered when ALL of the following criteria are met:

- The equipment is ordered by a physician; and
- When a new item is required due to a change in the member's medical condition; OR
- The equipment no longer meets the member's functional needs due to the member's physical changes, such as skeletal growth or significant weight changes; OR
- Cost to repair the DME is comparable to replacing it (if repair cost exceeds 60% of the cost of a replacement item, replacement may be required); OR
- When an upgrade is required and the manufacturer no longer provides needed support for the item.
- For capped rental items (e.g., wheelchairs) once the title transfers to the member (after the specified rental period), the supplier may be required to replace the equipment if accumulated repair cost exceeds threshold.

References:

- Centers for Medicare & Medicaid Services. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Baltimore, MD: CMS 2025. http://www.cms.gov/medicare/dmepos

- Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services.
- Medicare Claims Processing Manual. Chapter 20 – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).
- Code of Federal Regulations Title 42 Chapter IV Subchapter B Part 410 Subpart b section 410.38
- Code of Federal Regulations Title 42 Chapter IV Subchapter B Part 414 subpart D Section 414.202
- Special Payment Rules for Particular Items and Services. Sec. 1834. [42 U.S.C. 1395m]. https://www.ssa.gov/OP_Home/ssact/title18/1834.htm
- Centers for Medicare & Medicaid Services. (2024, January 1). Local coverage article: Billing and coding guidelines (A55426). https://www.cms.gov/medicare-coverage-database/
- Rhode Island Executive Office of Health & Human Services (EOHHS): Rhode Island Medicaid Coverage Guidelines, Medicaid Provider Manual: Durable Medical Equipment
- Form CMS-20081
- Contract between The State of Rhode Island EOHHS and Neighborhood Health Plan of Rhode Island for Medicaid Managed Care Services, July 1, 2025
- Contract- Agreement between the State of Rhode Island Executive Office of Health and Human Services and Neighborhood Health Plan of Rhode Island Medicaid Managed Care Fully Integrated Dual Special Needs Plan, Effective January 1, 2026.

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CMP Cross Reference:	
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Neighborhood reviews clinical medical policies on an annual basis.

Disclaimer:

Neighborhood has developed medical policies to assist us in administering health benefits. This medical policy is made available to you for informational purposes only and does not constitute medical advice. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Members should always consult their physician before making any decisions about medical care. Treating providers are solely responsible for medical advice and treatment of members. Benefits and eligibility are determined by the member's coverage plan; a member's coverage plan will supersede the provisions of this medical policy. For information on member-specific benefits, call member services. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to review and revise this policy for any reason and at any time, with or without notice.