

**Policy terminated because coverage is provided under  
NCHC Durable Medical Equipment and Supplies**

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## **1.0 Description of the Procedure, Product, or Service**

### **1.1 Definitions**

Durable medical equipment (DME) is standard equipment which normally is used in an institutional setting, 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. All requirements of this definition must be met before an item is considered to be durable medical equipment.

An orthotic device is an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of movable parts of the body.

A prosthesis is the replacement with an artificial substitute of an absent body part, such as an eye or a leg.

## **2.0 Eligible Recipients**

### **2.1 General Provisions**

To be eligible, NCHC recipients must be enrolled on the date of service.

## **3.0 When the Procedure, Product, or Service Is Covered**

### **3.1 General Criteria**

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

### **3.2 Specific Criteria**

- a. DME may be covered when it meets all the requirements as in **Subsection 1.1**.
- b. Coverage is based on the fact that it is reasonable and medically necessary for the treatment of a specific illness or injury.

- c. Orthotic devices, including custom molded foot orthotics, orthopedic corsets, trusses, fracture braces, and scoliosis braces, are covered when prescribed by a physician for a specific diagnosis and considered medically necessary. Coverage for therapeutic shoes is provided only when one or both of the shoes is/are an integral part of a leg brace; or for recipients with diabetes or other conditions at increased risk of amputation due to circulatory insufficiency and is limited to \$350.00 per pair of shoes. Orthotic devices and prosthetics may be covered when they meet the definitions in **Subsection 1.1**.
- d. Rental of DME may not exceed the purchase price.
- e. Duplicate purchases of DME, orthotic devices, and prostheses are subject to medical review for medical necessity.
- f. Repairs of DME, orthotic devices, and prostheses are covered.
- g. Replacement of DME, orthotic devices, and prostheses is covered with verification that the equipment is beyond repair.
- h. A lift is covered if transfer between bed and a chair, wheelchair, or commode requires the assistance of more than one person and, without the use of a lift, the recipient would be bed-confined.

E0621 (sling or seat, patient lift, canvas or nylon) is covered as an accessory when ordered as a replacement for the original equipment item. The usual payment rules for accessory items apply to this code.

An order for the patient lift which is signed and dated by the ordering physician must be kept on file by the supplier. Refer to **Subsection 5.2 a**.

- i. Mobility devices, positioning devices and adaptive equipment may be covered if medically necessary and coverage criteria and required documentation specific to the mobility and positioning equipment are met.
- j. Hospital beds may be:
  - 1. Totally manual and of fixed height, having manual (a cranking mechanism) head and leg elevation adjustments, but no height adjustment;
  - 2. Totally manual and with variable height, having additionally, manual height adjustment;
  - 3. Semi-electric, having electric head and leg adjustment, but still manual height adjustment;
  - 4. Total electric, having electric head and leg adjustment, plus electric height adjustment. Except for the total electric model (refer to below), hospital beds are covered using the following criteria.

- (a) For fixed height (one or more of the following):
  - (i.) A recipient requires positioning of the body in ways not feasible with an ordinary bed, for the alleviation of pain
  - (ii.) A recipient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges should first have been considered.
  - (iii.) A recipient who requires traction equipment which can only be attached to a hospital bed.
- (b) For variable height (in addition to one of the above)
  - (i.) The recipient requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.
- (c) For semi-electric:
  - (i.) In addition to the above indications, the recipient requires frequent immediate changes in body position.
- (d) For total electric:
  - (i.) Not covered by NCHC because it is considered deluxe and non-standard. If the indications for a semi-electric bed are met, then payment will be made by NCHC at the level of a semi-electric bed which is considered standard equipment.
- k. Wheelchairs are considered medically necessary and eligible for coverage under the following conditions:
  - 1. The wheelchair is required by the recipient for mobility in the performance of activities of daily living in the recipient's residence;  
**AND**
  - 2. For manually operated wheelchairs:
    - (a) The recipient has a disease process or injury that would contraindicate weight bearing or ambulation; or
    - (b) The recipient has a disease process or injury in which there is a decrease in neuromuscular function in the lower extremities (appropriate diagnoses include multiple sclerosis; paraplegia; cerebral palsy; cerebrovascular accident; severe congestive heart failure; fracture of the femur, hip, pelvis, and/or bilateral lower extremity); and the recipient's mobility limitation cannot be sufficiently resolved by use of an appropriately fitted cane or walker.  
**OR**

3. For electrically operated wheelchairs:
  - (a) A manually operated wheelchair is determined to be inadequate to address the recipient's need for mobility in the their home;
  - (b) The recipient is capable of safely operating the controls of an electrically operated wheelchair,
  - (c) There has been an evaluation either in a specialized seating/mobility clinic or by a physician and therapist who are knowledgeable about prescribing mobility devices for long-term disability and are independent from the vendor supplying the equipment, **AND**
  - (d) The recipient has a condition in which
    - (i.) There is a disease process or injury where there is decreased neuromuscular function in all four extremities and support of the body's trunk is required; **OR**
    - (ii.) There is a disease process or injury that would contraindicate weight bearing or ambulation and the recipient is unable to propel a manual wheelchair because of a disease process/injury or disability.
1. Purchase of used wheelchairs and hospital beds will be approved by the NCHC program when the following conditions have been met:
  1. The dealer has determined that the used equipment will adequately meet the needs of the recipient, and has so informed the recipient.
  2. The dealer has reconditioned the equipment, which includes:
    - (a) New seat, new back upholstery (wheelchair), or new mattress (bed)
    - (b) Replacement of all wheel bearings
  3. The dealer has agreed to warrant the used equipment for not less than 90 days
  4. The reimbursement for used equipment will not exceed 75% of the allowance for similar new equipment
- m. Power Operated Vehicles (three or four-wheeled motor carts and scooters). Power operated vehicles may be covered on an individual consideration basis when all of the following criteria are met:
  1. It is clearly established that the vehicle serves a therapeutic purpose for the recipient;
  2. The recipient has a mobility limitation that significantly impairs his/her ability to participate in mobility-related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home;
  3. The recipient does not have sufficient upper extremity function to safely self-propel an optimally configured manual wheelchair;
  4. Without a wheelchair, the recipient would be confined to bed or a chair in the home;

5. The recipient has sufficient strength, postural stability, and other physical and mental capabilities needed to safely operate a power operated vehicle in the home (i.e. adequate range of motion, coordination, trunk control, appropriate judgment, cognitive skills, vision and perceptual abilities);
  6. The recipient has expressed a willingness to use a power operated vehicle;
  7. The recipient's home provides adequate access between rooms, maneuvering space, and surfaces for the safe operation of a power operated vehicle;
  8. There has been an evaluation either in a specialized seating/mobility clinic or by a physician and therapist who are knowledgeable about prescribing mobility devices for long-term disability and are independent from the vendor supplying the equipment; **AND**
  9. The mobility limitation/disability is expected to continue for six months or longer and the prescribed vehicle is anticipated to meet the recipient's mobility needs for a reasonable period of time.
- n. Glucometers are eligible for benefit coverage for diabetics receiving medication management and for gestational diabetics.
- o. External insulin pumps are eligible for benefit coverage for recipients with diabetes mellitus when medical necessity criteria under 1, or 2, or 3, or 4 below are met:
1. For insulin dependent diabetics, **ALL** of the following apply:
    - (a) The recipient is involved in a comprehensive diabetes care program;
    - (b) An endocrinologist or physician with similar skill and training in the management of external insulin pumps prescribes the pump or is involved in the care of the recipient (this may include initial consult visit and phone or written follow-up);
    - (c) The recipient has required and been compliant with a program of multiple daily injections of insulin (i.e. at least three injections per day and usually mixed long-acting/short-acting insulin), with frequent self-adjustments of insulin dose for at least the past six months (or for at least the past three months with documentation of extenuating circumstances);
    - (d) There is also documented recipient compliance with glucose self-testing an average of at least four times per day, diet, appointments and other treatment recommendations during that time; **AND**
    - (e) In spite of recipient compliance with the recommended treatment program, there is the recipient has one or more of the following problems:
      - (i.) Hgb A-1C greater than 7.0%;
      - (ii.) History of recurring ketoacidosis or recurring hypoglycemia (blood glucose less than 60 mg/dl);
      - (iii.) Wide fluctuations in blood glucose before mealtime;
      - (iv.) Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl; or

(v.) History of severe glyceemic excursions.

**OR**

2. For recipients with gestational diabetes or when pregnancy occurs or is anticipated within three months in a previously diagnosed diabetic, with documentation of either of the following:
  - (a) Erratic blood sugars in spite of recipient compliance and split dosing; and/or
  - (b) Other evidence that adequate control is not being achieved.

**OR**

3. For recipients with chronic renal failure and brittle diabetes, who are not receiving renal dialysis;

**OR**

4. For replacement of an insulin pump for a recipient who has been successfully using an insulin pump for treatment of their diabetes when the following criteria are met:
  - (a) Coverage for an external insulin pump was previously approved under the NCHC program or therapy with the insulin pump was initiated prior to enrollment in the NCHC program;
  - (b) The recipient has documented compliance with diabetic management, including frequency of glucose self-testing an average of at least four times per day and diet, during the previous month;
  - (c) There is documentation that the recipient's current pump is malfunctioning/non-functional, including documentation of the specific problem with the pump; **AND**
  - (d) There is documentation that the pump is out of warranty and that the problem with the pump cannot be repaired.

p. Implantable infusion pumps and portable infusion pumps are eligible for benefit coverage when used to deliver drugs having FDA approval for on-label uses.

q. Ultraviolet (UV) Light Box Therapy in the Home may be considered medically necessary and is eligible for coverage under NCHC when **ALL** of the following criteria are met:

1. Recipient has a diagnosis of extensive, severe and refractory psoriasis, atopic dermatitis, eczema, pruritus, or cutaneous T-cell lymphoma (CTCL)/mycosis fungoides. Severe and refractory involvement of the palms or soles with any of the listed conditions would be considered extensive;
2. Recipient requires UV light treatments at least three times per week;
3. Recipient has demonstrated some improvement with initial treatment in the provider's office. Refer to **Subsection 5.2 b**; **AND**
4. Recipient is capable of operating the light box and staying within prescribed periods of exposure.

- r. Certain DME may only be purchased and may not be rented.

## 4.0 When the Procedure, Product, or Service Is Not Covered

### 4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

### 4.2 Specific Criteria

- a. Although an item is classified as durable medical equipment, it may not be covered in every instance.
- b. No coverage is provided for DME that is placed in an institution which meets the basic definition of a hospital or skilled nursing facility.
- c. Coverage is limited to standard DME that will adequately meet the medical needs of the recipient. Add-ons, special features, and upgrades will be reviewed on an individual consideration basis for medical necessity.
  - 1. Add-ons, special features, and upgrades that are intended primarily for convenience of the recipient or caregiver are not covered.
  - 2. Add-ons, special features and upgrades beyond what is necessary to meet the recipient's legitimate medical needs are considered non-standard luxury, comfort, or convenience items and are not covered.
  - 3. Examples of non-covered non-standard DME add-ons, special features, and upgrades include electrical or mechanical features that enhance standard or basic equipment and serve a convenience function, decorative items, extra batteries, trays, backpacks, wheelchair racing equipment, and unique materials such as magnesium wheelchair wheels.
- d. Delivery and/or set up of durable medical equipment are considered an integral part of the rental or purchase allowance and are not covered when billed separately.
- e. Protective orthotic devices used during sports are not covered.
- f. Orthotic devices (such as the DOC Band) for treatment of positional plagiocephaly are considered to be not medically necessary as they are used for a cosmetic purpose.
- g. Benefits for a Sykes hernia control device are provided under the same considerations as a conventional truss.

- h. The following items are not considered to be orthotic devices and are not covered:
1. Arch supports
  2. Elastic stockings
  3. Garter belts
  4. Orthopedic shoes, except as stated in **Subsection 3.2.c.**
- i. In general, use of three or four-wheeled power operated vehicles are not appropriate for and are not covered for severe progressive demyelinating diseases such as severe multiple sclerosis or for progressive motor neuron disease such as amyotrophic lateral sclerosis. They are also not covered for the following:
1. For any condition requiring truncal support.
  2. For any condition requiring padding or additional support.
  3. When the recipient is disoriented or cannot be left unattended.
  4. When the recipient is unable to operate the controls.
  5. For use as a convenience item.
  6. When used only outside the home.
  7. When used primarily to allow the recipient to perform leisure or recreational activities.
  8. As a supplement to alternative mobilized system such as supplement to wheelchairs.
  9. For use as a “back-up item” in case of need.
  10. When purchased without a physician prescription.
  11. No accessory items are covered.
- j. Active and passive cooling devices in the outpatient setting are considered not medically necessary and are not eligible for coverage under the NCHC program. There is insufficient scientific evidence published in the peer reviewed medical literature based on results from well-designed, randomized, controlled clinical trials to determine that the use of these devices is associated with a benefit beyond convenience.
- k. A partial listing of non-covered equipment and supplies can be found in the NCHC Handbook available on-line at <http://www.dhhs.state.nc.us/DMA/CHIP/NCHChandbook.pdf>
1. No benefits are provided for back-up wheelchairs (e.g. a manual wheelchair as a back-up for an electric wheelchair) or for wheelchairs that will only be used outside of the home.
- m. The following codes are not-covered, as they are considered convenience items:
1. E0625 (Patient lift, kartop, bathroom or toilet)
  2. E0627, E0628 and E0629 (Seat lift mechanisms)

3. E0635 (Patient lift, electric with seat or sling) .When code E0635 is billed and if coverage criteria for patient lift are met, payment is based on the standard equipment, E0630 (Patient lift, hydraulic, with seat or sling.)
- n. The following codes are not-covered. They are considered to be deluxe items:
  1. E0636 (Multipositional patient support system, with integrated lift, patient accessible controls)
  2. E0637 (Combination sit to stand system, any size, with seat lift feature, with or without wheels)
  3. E0638 (Standing frame, any size, with or without wheels)
  4. E0639 (Patient lift, movable from room to room, includes all components/accessories)
  5. E0640 (Patient lift, fixed system, includes all components/ accessories)
  6. Refer to **Subsection 3.2.j.4** for Total electric hospital bed.
- o. Ultraviolet light box therapy in the home is not covered in any of the following situations:
  1. When it does not meet the criteria in **Subsection 3.2q**;
  2. When it is being prescribed solely for the recipient's convenience; **OR**
  3. When it is for cosmetic purposes including tanning or treatment of vitiligo.

## 5.0 Requirements for and Limitations on Coverage

### 5.1 Prior Approval

- a. Prior approval is required for DME as follows:
  1. All rental of DME with purchase price greater than \$1000;
  2. Purchase of DME in excess of \$1000;
  3. Expenses in excess of \$1000 for the repair of previously approved DME
- b. A letter of medical necessity signed and dated by the physician shall be submitted to DMA's vendor prior to the rendering of the service.
- c. Documentation must include:
  1. Recipient demographics (ID number, address)
  2. Recipient's diagnosis
  3. Type of equipment to be rented or purchased
  4. Recipient's prognosis
  5. Estimated duration of need for the equipment
  6. Recipient's or other family member's ability to operate equipment (if applicable)
  7. Reason equipment is being replaced or cannot be repaired

- d. In order to determine whether the equipment should be rented or purchased DMA's vendor requires the following documentation:
1. Estimated duration of need for the equipment
  2. Rental rates versus total purchase price
  3. Indication that the supplier will allow rental payments to be applied toward the purchase price.

## 5.2 Medical Records

- a. The medical records must contain information which supports the medical necessity of the item covered.
- b. Medical records must document the frequency of use for the UV light box in the provider's office for the previous two months.

## 6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

## 7.0 Additional Requirements

### 7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

## 8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."
October 31, 2011	Throughout	Policy Termination. Coverage for this policy is provided by NCHC policy 2011.09, Medical Equipment and Supplies.

## Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

### A. Claim Type

Professional (CMS-1500/837P transaction)

### B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

### C. Procedure Code(s)

HCPCS Codes							
B9000	B9002	B9004	B9006	E0100	E0105	E0116	E0135
E0140	E0141	E0143	E0147	E0148	E0149	E0153	E0154
E0155	E0156	E0157	E0158	E0159	E0163	E0165	E0168
E0175	E0181	E0182	E0184	E0185	E0186	E0187	E0188
E0190	E0193	E0196	E0197	E0198	E0199	E0202	E0221
E0235	E0250	E0255	E0260	E0265	E0266	E0270	E0277
E0294	E0295	E0296	E0297	E0303	E0304	E0316	E0480
E0600	E0630	E0691	E0692	E0693	E0705	E0720	E0730
E0747	E0748	E0776	E0779	E0781	E0784	E0791	E0855
E0870	E0910	E0911	E0912	E0940	E0951	E0952	E0955
E0956	E0957	E0958	E0959	E0960	E0961	E0966	E0967
E0971	E0973	E0974	E0978	E0981	E0982	E0990	E0992
E0995	E1002	E1028	E1029	E1030	E1031	E1037	E1038
E1039	E1060	E1070	E1084	E1086	E1090	E1092	E1093
E1110	E1130	E1140	E1150	E1160	E1161	E1190	E1195
E1220	E1226	E1230	E1231	E1232	E1233	E1234	E1235
E1236	E1237	E1238	E1240	E1260	E1280	E1285	E1290
E1295	E1630	E1801	E1805	E1806	E1810	E1811	E1816
E1818	E1825	E1840	E2100	E2201	E2202	E2203	E2204
E2205	E2206	E2207	E2208	E2209	E2210	E2211	E2212
E2213	E2214	E2215	E2216	E2217	E2218	E2219	E2220
E2221	E2222	E2224	E2225	E2226	E2291	E2292	E2293
E2294	E2310	E2311	E2321	E2322	E2323	E2324	E2325
E2326	E2327	E2328	E2329	E2330	E2340	E2341	E2342
E2343	E2360	E2361	E2362	E2363	E2364	E2365	E2366
E2367	E2368	E2369	E2370	E2371	E2372	E2373	E2374
E2375	E2376	E2377	E2381	E2382	E2383	E2384	E2385
E2386	E2387	E2388	E2389	E2390	E2391	E2392	E2394
E2395	E2396	E2601	E2602	E2603	E2604	E2605	E2606
E2607	E2608	E2611	E2612	E2613	E2614	E2615	E2616
E2620	E2621	K0001	K0002	K0003	K0004	K0005	K0006
K0007	K0009	K0010	K0011	K0012	K0014	K0015	K0017

K0018	K0019	K0020	K0037	K0038	K0039	K0040	K0041
<b>HCPCS Codes</b>							
K0042	K0043	K0044	K0045	K0046	K0047	K0050	K0051
K0052	K0053	K0056	K0065	K0069	K0070	K0071	K0072
K0073	K0077	K0098	K0105	K0108	K0195	K0455	K0733
K0813	K0814	K0815	K0816	K0820	K0821	K0822	K0823
K0824	K0825	K0826	K0827	K0828	K0829	K0830	K0831
K0835	K0836	K0837	K0838	K0839	K0840	K0841	K0842
K0843	K0848	K0849	K0850	K0851	K0852	K0853	K0854
K0855	K0856	K0857	K0858	K0859	K0860	K0861	K0862
K0863	K0864	K0868	K0869	K0870	K0871	K0877	K0878
K0879	K0880	K0884	K0885	K0886	K0890	L0700	L0710
L0810	L0820	L0830	L1005	L1200	L1300	L1310	L1500
L1520	L1690	L1700	L1710	L1844	L2036	L2128	L2525
L2627	L2628	L3901	L3207	L3230	L3250	L4210	L7500
L7510	S1015						

**D. Modifiers**

Providers are required to follow applicable modifier guidelines.

**E. Billing Units**

The appropriate procedure code(s) used determines the billing unit(s).

**F. Place of Service**

Home

**G. Co-payments**

Co-payment(s) may apply to covered prescription drugs and services.

**H. Reimbursement**

Providers must bill their usual and customary charges.